

**SB**

**74**

**(FILE 1)**

<TARGET><BILL>SB 74</BILL><SUBJECT>SB 74 (FILE  
1)</SUBJECT><COMM>HFIN29</COMM></TARGET>

(11)

Date Referred to Committee: March 14, 2016

FURTHER REFERRALS:

Date of Committee Action: 4-9-2016

The FINANCE Committee considered:

CSSB 74(FIN) am

**CS FOR SENATE BILL NO. 74(FIN) am**

"An Act relating to diagnosis, treatment, and prescription of drugs without a physical examination by a physician; relating to the delivery of services by a licensed professional counselor, marriage and family therapist, psychologist, psychological associate, and social worker by audio, video, or data communications; relating to the duties of the State Medical Board; relating to limitations of actions; establishing the Alaska Medical Assistance False Claim and Reporting Act; relating to medical assistance programs administered by the Department of Health and Social Services; relating to the controlled substance prescription database; relating to the duties of the Board of Pharmacy; relating to the duties of the Department of Commerce, Community, and Economic Development; relating to accounting for program receipts; relating to public record status of records related to the Alaska Medical Assistance False Claim and Reporting Act; establishing a telemedicine business registry; relating to competitive bidding for medical assistance products and services; relating to verification of eligibility for public assistance programs administered by the Department of Health and Social Services; relating to annual audits of state medical assistance providers; relating to reporting overpayments of medical assistance payments; establishing authority to assess civil penalties for violations of medical assistance program requirements; relating to seizure and forfeiture of property for medical assistance fraud; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to Alaska Pioneers' Homes and Alaska Veterans' Homes; relating to the duties of the Department of Administration; relating to the Alaska Mental Health Trust Authority; relating to feasibility studies for the provision of specified state services; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89, Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure; and providing for an effective date."

**SB 74 MEDICAID REFORM;TELEMEDICINE;DRUG DATABAS**

Recommends it be replaced with  HCS or  CS for CSSB 74 (FIN)  
 For Senate Bills with new title:  Technical Title  New Title: HCR \_\_\_\_\_  Same Title  New Title

- attach amendments
- add new referral to \_\_\_\_\_ Committee
- Letter of Intent \_\_\_\_\_ Committee

**NEW**

- List of Abbrev for Depts.:
- ADM
  - AJS
  - CED
  - COR
  - EED
  - DEC
  - DFG
  - GOV
  - DHS
  - LWF
  - LAW
  - LEG
  - MVA
  - DNR
  - DPS
  - REV
  - DOT
  - UA

NEW FISCAL NOTES				
*FN# is assigned by Chief Clerk's Office				
*FN#	List by Dept(s):	Fiscal	Indet.	Zero
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		
	DHS	X		

<del>PREVIOUS</del> FISCAL NOTES				
FN#	List by Dept(s):	Fiscal	Indet.	Zero
	DHS	X		
	CED	X		
	LAW	X		
	COR	X		
<hr/>				
PREVIOUS FISCAL NOTES				
29	ADM	X		

Signing with recommendations		Printed Last Name	DP	DNP	NR	AM
		Muñoz	X			X
		SADLER			X	
		Frost			X	
		Wilson				X
		Edgmon			X	
		Galtis			X	
Chair:		NEUMAN				X
Chair:		THOMPSON	X			

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-AKPH-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Alaska Pioneer Homes  
Allocation: Pioneer Homes  
OMB Component Number: 2671

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Fund Source (Operating Only)**

1004 Gen Fund	(1,066.7)		(1,066.7)	(1,066.7)	(1,066.7)	(1,066.7)	(1,066.7)
1007 I/A Rcpts	1,066.7		1,066.7	1,066.7	1,066.7	1,066.7	1,066.7
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

**Why this fiscal note differs from previous version:**

Bill section references are updated.
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Prepared By:	Vickie Wilson, Director	Phone:	(907)458-2228
Division:	Alaska Pioneer Homes	Date:	04/08/2016 01:20 PM
Approved By:	Sana Efird, Assistant Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

**Analysis**

Included within the House Bill 30, State Agency Performance Audits (Chapter 19 SLA 2013), was a recommendation that the Department of Health and Social Services, Division of Alaska Pioneer Homes require that applicants for the payment assistance program first apply for Medicaid. **Section 44** of Senate Bill 74 would adopt this recommendation into law. The Division of Alaska Pioneer Homes estimates that 24 Level-3 residents will be eligible for the Alaskans Living Independently Waiver.

Once eligible, the division can bill Medicaid for the services being provided to the residents. This change would reduce the general fund required for the 24 residents by (\$1,066.7). However, in order to collect the revenue from Medicaid the division would need an additional \$1,066.7 in inter-agency receipts, as this is how the division is allocated revenue authority for Medicaid receipts.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-BHA-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Behavioral Health  
Allocation: Behavioral Health Administration  
OMB Component Number: 2665

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services					(226.7)	(453.4)	(453.4)	(453.4)
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(226.7)</b>	<b>(453.4)</b>	<b>(453.4)</b>	<b>(453.4)</b>	<b>(453.4)</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts				(113.4)	(226.7)	(226.7)	(226.7)
1003 G/F Match				(113.3)	(226.7)	(226.7)	(226.7)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(226.7)</b>	<b>(453.4)</b>	<b>(453.4)</b>	<b>(453.4)</b>

**Positions**

Full-time				(2.0)	(4.0)	(4.0)	(4.0)
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

**Why this fiscal note differs from previous version:**

Bill references are updated.

Prepared By: Randall P. Burns, Director  
Division: Behavioral Health  
Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services  
Agency: Health and Social Services

Phone: (907)269-5948  
Date: 04/07/2016 04:21 PM  
Date: 04/08/16

**Analysis**

**Section 36** of SB74 adds a new section, AS 47.05.270, entitled "Medical assistance reform program." New subsection AS 47.05.270(b) instructs the Department of Health and Social Services (DHSS), in coordination with the Alaska Mental Health Trust Authority, to "manage a comprehensive and integrated behavioral health program," including a plan for providing a continuum of community-based services from a wide array of providers and disciplines that addresses housing, employment, and criminal justice, and reduces barriers that fragment services and reduce effectiveness and efficiency. It is expected that Alaskans served by the criminal justice system will benefit from the reformed system of behavioral health care, and savings will be realized in the Department of Corrections, Public Safety and the Court system as well as within the Office of Children's Services.

**Section 38** adds new subsections AS 47.07.036(d)(4) and (5) that authorize the Department to develop demonstration projects for innovative service delivery and payment models, and provide incentives for telehealth. New subsection AS 47.07.036(e) requires the Department to seek 1115 demonstration waivers from the Centers for Medicare and Medicaid Services (CMS), and subsection (f) requires that one of these 1115 waivers focus on behavioral health system improvements for Medicaid recipients. These system improvements must be consistent with the improvements expected under Section 36 of the bill (47.05.270(b)) that are intended to improve access to quality care while managing costs.

**OPERATING BUDGET SAVINGS:** In FY2019 and again in FY2020, the Division of Behavioral Health will reduce its personal services line by one Mental Health Clinician III (\$119.8) and one Health Program Manager II (\$106.9), for a total of four positions between SFY2019 and SFY2020.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-MAA-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Health Care Services  
Allocation: Medical Assistance Administration  
OMB Component Number: 242

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	582.1		582.1	582.1	218.4	218.4	218.4	
Travel	1.0							
Services	95.3		93.8	93.8	93.8	93.8	93.8	
Commodities	19.2		4.0	4.0	4.0	4.0	4.0	
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>697.6</b>	<b>0.0</b>	<b>679.9</b>	<b>679.9</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>

### Fund Source (Operating Only)

1002 Fed Rcpts	348.9		340.0	340.0	158.1	158.1	158.1
1003 G/F Match	57.7		48.9	48.9	158.1	158.1	158.1
1092 MHTAAR	291.0		291.0	291.0			
<b>Total</b>	<b>697.6</b>	<b>0.0</b>	<b>679.9</b>	<b>679.9</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>

### Positions

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary	4.0		4.0	4.0			

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

### Why this fiscal note differs from previous version:

Updated bill section references. Narrative updated to delete references to seizure and forfeiture of real or personal property under section 36 (sec.47.05.260).

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2520
Division:	Health Care Services	Date:	04/08/2016 11:00 AM
Approved By:	Sana Efird, Assistant Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

## Analysis

**Sections 16-20 and 33-36** establish a series of new provisions intended to strengthen fraud and abuse prevention and remediation, and include the addition of a new Alaska Medicaid False Claim and Reporting Act. These provisions would authorize the department to assess interest and penalties on overpayments and impose civil fines of medical assistance providers who have or are committing medical assistance fraud.

Promulgation of associated regulations will take approximately six months, with implementation effective January 1, 2017. There will be a significant increase in appeals from these new policies. The department anticipates that it will need one long term non-permanent Medical Assistance Administrator III (position details, bottom of p.3) to handle this additional workload. It also anticipates additional training and minimal travel costs will be needed to support and implement these new policies. The estimated training cost for tuition is \$1.5 while the estimated travel costs are \$1.0.

Due to the increase in appeals with the Office of Administrative Hearings for fraud and abuse handled under these sections, the reimbursable services agreement with that office is increased by \$75.0 per year to address their increased workload.

**Section 37** directs the department to implement the Primary Care Case Management system or managed care organization (MCO) contract authorized under AS 47.07.030(d). This system would require certain Medicaid recipients to obtain approval from a case manager or MCO before receiving certain services in order to increase the use of primary and preventive care, and decrease the use of specialty care and hospital services.

Additional staff will be required to develop this program, including establishing and overseeing the contract with the Administrative Services Organization, and data development and analysis. Two positions will be established for FY2017 - FY2019 to support this and all other health delivery and payment reform initiatives in this bill (Section 38, subsection (d)(3), Health Homes; Section 38, subsection (d)(5) telemedicine; Section 39 (47.07.038) hospital emergency use reduction).

**Section 38 (d)(3)** directs the department to implement the Health Homes option under section 1945 of the Social Security Act. Health Homes provide integrated and coordinated care for people with chronic health conditions. The department would need approximately two years for planning and development prior to implementation in order to determine eligibility criteria for recipients and for providers, design the new payment methodology and required reporting systems, develop and receive approval on the State Plan Amendment and associated regulations, and make required modifications to the Medicaid Management Information System.

The planning phase for this initiative would begin in FY2018, with implementation in FY2020. The positions established to develop the Primary Care Case Management system (Section 37 of this bill) will staff this initiative.

**Section 39 (47.07.038)** directs the department to establish, in collaboration with the Alaska State Hospital and Nursing Home Association, a hospital-based project designed to reduce the use of hospital emergency departments by Medicaid enrollees.

The department proposes the existing Health Information Exchange (HIE) be utilized as the foundational technology for electronic exchange of patient information among hospital emergency departments. This technology is already in place, but education and outreach to emergency department staff to help them learn how to use the HIE is required.

**Analysis Continued**

Program staff support would be required for negotiation and contracting with hospitals for the shared-savings payment reform associated with this initiative, and also for data systems and analysis. The positions established to develop the Primary Care Case Management system (Section 37 of this bill) will staff this initiative.

**Section 39 (47.07.039)** directs the department to contract with one or more third parties to implement one or more coordinated care demonstration projects for Medicaid recipients, with proposals requested on or before 12/31/2016. Demonstration projects must include three or more of the following: comprehensive primary-care-based management for medical and behavioral health service; care coordination including assignment of recipients to local primary care providers, where possible; health promotion; comprehensive transitional care and post-discharge follow-up care; referrals to community and social support services; sustainability and the ability to implement in other areas of the state; integration and coordination of benefits and services; and local accountability for health and resource allocation.

This demonstration project will be implemented in three regions of the state. Planning and development would begin in FY2017, with implementation starting in FY2019. An estimated 30,000 Medicaid recipients would be enrolled to receive services through this demonstration project. For purposes of estimation, the Department assumes the entities would be reimbursed on a fee-for-service basis plus shared-savings, with the entities receiving a portion of any savings accrued to the state Medicaid program, for the first two years.

Program staff support would be required for negotiation and contracting with the entities, and also for data systems and analysis. The positions established to develop the Primary Care Case Management system (Section 37 of this bill) will staff this initiative.

**STAFFING FOR THE ABOVE EFFORTS****Personal Services:**

One permanent full-time Medical Assistance Administrator IV for program development and management; Range 21, Anchorage; \$112.4 annually (**Mental Health Trust providing MHTAAR for the State's 50% portion**)

One permanent full-time Medical Assistance Administrator III for data systems and analysis; Range 20 Anchorage; \$106.0 annually (**Mental Health Trust providing MHTAAR for the State's 50% portion**)

**Services:** Office space, phones, reimbursable service agreements (RSAs) for position support costs: \$18.8 annually

**Commodities:** Office supplies: \$4.0 annually

**One-Time Commodities Cost:** Computer, software, and office equipment: \$15.2

One long term non-permanent Medical Assistance Administrator IV to assist Behavioral Health program development and modifications to meet Medicaid reform goals; Range 21, Anchorage; \$102.3 annually (**Mental Health Trust providing MHTAAR for the State's 50% portion**)

One long term non-permanent Medical Assistance Administrator III to handle and manage the increased workload from appeals to the new regulations and policies associated with Medicaid fraud and abuse and the new Alaska Medicaid

**Analysis Continued**

False Claim and Reporting Act, Range 20, Anchorage; \$96.9 annually (**Mental Health Trust providing MHTAAR for the State's 50% portion**)

One long term non-permanent Medical Assistance Administrator II to assist with the 1115 waiver, and Behavioral Health program development and modifications to meet Medicaid reform goals; Range 18, Anchorage; \$86.9 annually (**Mental Health Trust providing MHTAAR for the State's 50% portion**)

One long term non-permanent Medical Assistance Administrator I to assist the Quality Assurance and Analysis section to reduce the number of super utilizers of hospital emergency departments by Medicaid enrollees; Range 16, Anchorage; \$77.6 annually (**Mental Health Trust providing MHTAAR for the State's 50% portion**)

# Fiscal Note



State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-RR-4-7-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Health Care Services  
Allocation: Rate Review  
OMB Component Number: 2696

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services	500.0		200.0	200.0	200.0	200.0	200.0	200.0
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>500.0</b>	<b>0.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	250.0		100.0	100.0	100.0	100.0	100.0	100.0
1003 G/F Match	250.0		100.0	100.0	100.0	100.0	100.0	100.0
<b>Total</b>	<b>500.0</b>	<b>0.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>

**Positions**

Full-time								
Part-time								
Temporary								

<b>Change in Revenues</b>								
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

**Why this fiscal note differs from previous version:**

The analysis section is revised to reflect updated bill references and a minor change to section 39.
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Prepared By: <u>Margaret Brodie, Director</u>	Phone: <u>(907)334-2520</u>
Division: <u>Health Care Services</u>	Date: <u>04/07/2016 12:50 PM</u>
Approved By: <u>Sana Efrid, Asst. Commissioner, Finance and Management Services</u>	Date: <u>04/07/16</u>
Agency: <u>Health and Social Services</u>	

**Analysis**

**Section 36 (47.05.270(a)(8))** requires the Department to adopt regulations to design and implement a program for reforming the state medical assistance program under AS 47.07. The reform program must include redesigning the payment process by implementing fee agreements that include certain premium payments, penalties, bundled payments, and global payments. This work will specifically be accomplished through the demonstration projects required under Section 38 of the bill because the projects will focus on innovative payment models. Therefore, fiscal impact for this section is fully accounted for in the analysis of Section 38 of the bill (see below).

**Section 38 (47.07.036(e))** requires the Department to apply for a §1115 demonstration waiver to establish one or more demonstration projects focused on innovative payment models. The projects may include managed care organizations, community care organizations, patient-centered medical homes, or innovative payment models.

Redesigning payment processes and/or service delivery models would require changes in regulation, and possibly State Plan Amendments (in addition to the demonstration waiver). Changes in regulation would vary for each provider type and would require stakeholder input before implementation.

Demonstration projects that focus on innovative payment models, including a managed care system with care coordination and global payments, will involve complex data analysis and calculations that require actuarial expertise. Once an innovative payment model is established, administration of the system would still require actuarial expertise that is available by contract.

The initial and ongoing costs associated with hiring a contractor to perform this work are not fully known at this time. Based on consultation with other states and experts concerning the cost of actuarial services for Medicaid managed care systems, the Department estimates a one-time \$500.0 contract for a firm to analyze and implement one or more innovative payment models, and an annual \$100.0 contract for actuarial work and assistance with administration.

While the Department will contract for actuarial services and support, the Office of Rate Review will be responsible for the rate calculations and financial analysis. The Department anticipates that this work can be accomplished without adding any positions.

**Section 39 (47.07.039(c))** requires that for any contract with a managed care organization, primary care case manager, accountable care organization, prepaid ambulatory health plan, or provider-led entity to implement a demonstration project, the fee structure may include global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures. Since this pertains to implementing a demonstration project and concerns innovative payment models, the fiscal impact for this section is fully accounted for in the analysis of Section 38 of the bill (see above).

**Section 39 (47.07.039(e))** requires the Department to contract with a third-party actuary to review demonstration projects after two years of implementation and make recommendations for the implementation of a similar project on a statewide basis. Starting in 2018, on or before December 31 of each year, the actuary must submit a final report to the department regarding any demonstration project that has been in operation for at least two years. Since this will likely result in actuarial review of multiple projects or project components each year in the immediate future, this work would be incorporated in the actuary contract described in the analysis of Section 38 of the bill (see above). To account for this increased workload, the Department estimates that the annual contract for actuarial work and assistance with administration would be increased by an additional \$100.0.

# Fiscal Note



State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-FI-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Public Assistance  
Allocation: Fraud Investigation  
OMB Component Number: 237

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services	980.0							
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>980.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### Fund Source (Operating Only)

1002 Fed Rcpts	61.2							
1004 Gen Fund	918.8							
<b>Total</b>	<b>980.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### Positions

Full-time								
Part-time								
Temporary								

<b>Change in Revenues</b>								
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

### Why this fiscal note differs from previous version:

Updated bill section references. Implementation is now scheduled for FY2018. Costs have been adjusted to reflect the inclusion of a remote identity proofing requirement.

Prepared By: Sean O'Brien, Director  
Division: Public Assistance  
Approved By: Sana Efrid, Asst. Commissioner, Finance and Management Services  
Agency: Health and Social Services

Phone: (907)465-5847  
Date: 04/08/2016 05:55 PM  
Date: 04/08/16

**Analysis**

**Section 32** of the proposed legislation directs the department to establish an enhanced computerized income, asset, and identity verification system that uses remote identity proofing through multiple layers of authentication in order to deter fraud and eliminate duplication of public assistance benefits. The department is directed to procure the system through a competitive contract with a third party vendor. The annual savings to the state resulting from the system must exceed the cost of the system.

Assumptions:

The system will be web-enabled and interface electronically with the department's eligibility and enrollment system. Following a competitive process, the selected system will be implemented in FY2018, to allow the interface to begin after full implementation of the division's new eligibility and enrollment system, ARIES.

This is considered to be a two-year pilot period so that by January 1, 2020, the cost/benefit of the implementation of this system will be evaluated. If it's determined annual savings to the state resulting from the system isn't exceeding the cost of the system, it will be discontinued.

The contracted systems cost will be based on the number of inquiries (encounters) submitted to the system. The estimated cost per encounter is 60 cents. The anticipated savings for the cost avoidance will be used to offset the costs of the system.

The department received federal financial participation to fund the existing 12 interfaces (two state and ten federal) that provide an array of information to verify residency, citizenship, incarceration, felons, date of death, child support, intentional program violations in another state, identity and income. We anticipate very little federal financial participation for this new system because it duplicates many of these functions.

Under 42 Code of Federal Regulations (CFR), states do not have the authority to deny or terminate Medicaid eligibility because an individual fails to complete an identity proofing process. Federal SNAP regulations at 7 CFR 273.2 list very specific types of verification that can be mandated to verify identity. The regulations do not allow states to require identity proofing prior to determining eligibility.

Because both Medicaid and SNAP prohibit delaying benefits due to remote identity proofing, the department will check for potential identification issues once the client has passed the first phase of this new verification system and is determined eligible. Possible identification issues will then be followed up by a staff person from the Fraud unit.

In addition, the Division's current ARIES system will be modified to include identity authentication through its self-service portal that will interface with the applicant in the application process. Since both Medicaid and SNAP do not allow for any delay regarding identification, applicants can opt out.

The department will not require remote identity proofing for applications filed via a paper application. Remote identity authentication is a data security safeguard and, as such, will be used for online applications only.

One-Time cost:

ARIES related changes (interface design, security setup to allow single sign on, potential page display within ARIES, testing, and training for both applicants and staff): \$500.0

State implementation costs (process define, documentation updates, user acceptance testing, training, heightened support during implementation, potential IV&V support) \$450.0

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-SDSA-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABASE  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: Senior and Disabilities Services Administration  
OMB Component Number: 2663

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	390.9		611.9	611.9	318.3	318.3	318.3	
Travel	2.3		6.9	6.9	6.9	6.9	6.9	
Services	2,761.8		408.6	325.9	10.5	10.5	10.5	
Commodities	2.5		7.5	7.5	7.5	7.5	7.5	
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>3,157.5</b>	<b>0.0</b>	<b>1,034.9</b>	<b>952.2</b>	<b>343.2</b>	<b>343.2</b>	<b>343.2</b>	<b>343.2</b>

### Fund Source (Operating Only)

1002 Fed Rcpts	1,652.1		590.8	549.4	171.6	171.6	171.6
1003 G/F Match	71.1		297.3	256.0	171.6	171.6	171.6
1092 MHTAAR	1,434.3		146.8	146.8			
<b>Total</b>	<b>3,157.5</b>	<b>0.0</b>	<b>1,034.9</b>	<b>952.2</b>	<b>343.2</b>	<b>343.2</b>	<b>343.2</b>

### Positions

Full-time	1.0		3.0	3.0	3.0	3.0	3.0
Part-time							
Temporary	4.0		4.0	4.0			

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

### Why this fiscal note differs from previous version:

Bill section references are updated.

Prepared By: <u>Duane Mayes, Director</u>	Phone: <u>(907)269-2083</u>
Division: <u>Senior and Disabilities Services</u>	Date: <u>04/08/2016 01:00 PM</u>
Approved By: <u>Sana Efirid, Asst. Commissioner, Finance and Management Services</u>	Date: <u>04/08/16</u>
Agency: <u>Health and Social Services</u>	

**Analysis**

**SB74** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 36** charges the Department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 38(d) (1) and (2)** of the bill more specifically directs the State to apply to the Centers for Medicare and Medicaid Services (CMS) to develop two new Medicaid funding authorities, the 1915(i) and 1915(k) State Plan options. Under these new authorities the state will realize savings in the provision of home and community-based services (HCBS).

Services under these new funding authorities will reduce general fund expenditures by replacing 100% general fund services with 50% fed / 50% GF match (1915(i) option) or capturing a higher federal match rate (1915(k)).

In FY2018 and FY2019, the Department anticipates new costs associated with initial eligibility assessments of individuals previously served through the general fund grant programs or services. The estimated number of new assessments = 1,539. Cost per assessment = \$225.41 (not including travel). Assessments for 953 recipients transitioning from Community Developmental Disabilities Grant total \$214.8 in FY2018, at 50% fed / 50% GF match. Assessments for 586 recipients transitioning from Senior Community Based Grants and General Relief / Temporary Assistance total \$132.1 in FY2019, at 50% fed / 50% GF match. Total estimated cost (FY2018 and FY2019) to manage the 1,539 initial eligibility assessments = \$346.9.

In FY2017, FY2018 and FY2019 the Department anticipates additional expenditures related to the "Automated Services Plan" management information system. State staff, providers, and consumers will have access to the system and a public web resource center. The Department will plan and configure substantial, necessary software changes to this system for new assessments, additional programmatic elements, and interfaces with other department data management systems. Additional user accounts and licenses, and training and support for all users, will need to be developed and supported. The estimated costs for case management system development = \$ 550.0, eligible for enhanced federal funding at a 90 percent federal match, and spread in equal thirds over FY2017-FY2019.

Both the increased assessments at \$346.9, and case management system development at \$550.0, will be services line item expenditures. These costs will be realized in the development years, while the savings will continue and grow as overall expenditures grow.

The Division of Senior and Disabilities Services (SDS) will need to implement a new assessment tool for persons served by home and community based services through 1915(c), 1915(i) and 1915(k). This tool will provide a comprehensive clinical assessment of recipient needs by acuity, which will feed into the development of identified services within the recipient's Plan of Care. Of importance is that this new assessment tool will allow SDS to improve our efficiencies and reform our payment system. The \$2,575.0 one-time cost to implement this new assessment tool in FY2017 will cover software development, development of algorithms within the assessment tool, internal systems change, and training. **The Alaska Mental Health Trust is providing \$1,287.5 MHTAAR for the State's 50% portion.**

## Analysis Continued

To plan, develop, and manage the new program, beginning in FY2017 Senior and Disabilities Services will require three additional permanent full-time positions and, due to accelerated time frame for the roll-out of reform initiatives, four additional long-term non-permanent positions.

Full-time positions:

One staff full-time position beginning in August 2016 (FY2017) and two more staff beginning in FY2018. These will be Health Program Manager II positions, located in Anchorage, in the GG unit, each = \$106.1; Travel = \$2.3; Services = \$3.5; Commodities = \$2.5. FY2017 personal services costs are prorated to reflect the August 1, 2016 start date.

Non-permanent positions:

Four long-term non-perm positions are requested for FY2017 - FY2019 so that SDS is staffed to accomplish the work required to implement 1915(i) and (k) and amend 1915 (c) on a short timeline while maintaining its current workload. These will be Health Program Manager II positions, Range 19, located in Anchorage, in the GG unit, each = \$73.4., for a \$293.6 annual total. **The Alaska Mental Health Trust is providing \$146.8 MHTAAR for the State's 50% portion in FY2017 - FY2019.**

The additional HPM II position in the *Research and Analysis Unit* will be responsible for ensuring continued data integrity as changes to the new automated service plan are implemented for 1915(i) and (k), building management reports necessary for Division operations and federal and state reporting requirements, and building subject matter expertise in a variety of data systems.

The additional HPM II position in the *Provider Certification and Compliance Unit* will be responsible for certifying providers as qualified to provide services to vulnerable Alaskans, and monitoring each provider's compliance with current and upcoming Federal regulatory requirements.

The additional HPM II position in the *Quality Assurance Unit* will be responsible for the quality assurance work, including fraud investigations, related to the system-wide change required to implement new 1915 (c), (i) and (k) mandates for conflict free care coordination and settings compliance.

The additional HPM II position in the *Policy and Program Development Unit* will be responsible for regular communication with CMS on Alaska's Medicaid reform goals, maintaining the Division's desire for transparency through provider and recipient education, outreach, and the formal public comment process, and the research for and development of State Plan Amendments and related amendments to Alaska's four 1915 c waivers as home and community based services transition from general fund programs to Medicaid.

Regulation changes are required to implement the new options and would involve extensive public comment. The estimated effective date of this regulation change is July 2017.

# Fiscal Note



State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-GRTAL-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABASES  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: General Relief/Temporary Assisted Living  
OMB Component Number: 2875

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>

**Fund Source (Operating Only)**

1004 Gen Fund				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>

**Positions**

Full-time							
Part-time							
Temporary							

**Change in Revenues**

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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

**Why this fiscal note differs from previous version:**

Bill references are updated.

Prepared By:	Duane Mayes, Director	Phone:	(907)269-2083
Division:	Senior and Disabilities Services	Date:	04/08/2016 01:00 PM
Approved By:	Sana Efrid, Asst. Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

BILL NO. HCSCSSB074(FIN)

Analysis

In part, SB74 authorizes the DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 36** requires the department to "reduce the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community based waiver."

**Section 38(d) (1)** of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the Department the opportunity to shift eligible recipients from 100% general funded grant programs to the 50% federal/50% general fund funded 1915(i) Medicaid option.

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs. The Department assumes that all general relief recipients will be assessed for eligibility under the 1915(i) or behavioral health 1115 demonstration project. Of those assessed, the Department anticipates 349 being eligible for the 1915(i) option.

Current funding for GR program: \$7,323.9

Total number served: 545

Average cost per individual: \$13,438.35

Estimated eligible for 1915(i): 349

General fund services to be refinanced through the 1915(i) Medicaid option = \$ 4,689.9

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for temporary assisted living services to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-SCBG-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: Senior Community Based Grants  
OMB Component Number: 2787

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					(735.2)	(735.2)	(735.2)	(735.2)
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>

**Fund Source (Operating Only)**

1004 Gen Fund				(735.2)	(735.2)	(735.2)	(735.2)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

**Why this fiscal note differs from previous version:**

Bill section references are updated.
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Prepared By: Duane Mayes, Director	Phone: (907)269-2083
Division: Senior and Disabilities Services	Date: 04/08/2016 01:00 PM
Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services	Date: 04/08/16
Agency: Health and Social Services	

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

BILL NO. HCSCSSB074(FIN)

**Analysis**

In part, SB74 authorizes the DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 36** charges the Department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 38** directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the Department the opportunity to shift eligible recipients from 100% general funded grant programs to the 50% federal/50% general fund funded 1915(i) Medicaid option.

The Department will use this option to refinance the Senior Community Based Grant component's Adult Day and Senior In-Home Services for those who are receiving the service and are also Medicaid eligible.

Adult Day Grant: Total general fund expenditures = \$1,757.0, serving 423 recipients. Of those, the Division of Senior and Disabilities Services (SDS) anticipates serving 114 under the 1915(i) option with an average cost per individual of \$4,153.69. Estimated general fund Adult Day grant services to be refinanced with the 1915(i) Medicaid option = \$473.5.

Senior In-Home Grant: Total general fund expenditures = \$2,917.3, serving 1,371 individuals. Of those, SDS anticipates serving 123 under the 1915(i) option with an average cost per individual of \$2,127.84. Estimated general Senior In-Home grant services to be refinanced with the 1915(i) Medicaid option = \$261.7.

The combined estimated general fund to be refinanced through the use of the 1915(i) option = \$735.2.

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for senior community based services to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74

Fiscal Note Number: \_\_\_\_\_

( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-CDDG-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: Community Developmental Disabilities Grants  
OMB Component Number: 309

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits			(5,817.9)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>(5,817.9)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>

**Fund Source (Operating Only)**

1037 GF/MH			(5,817.9)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>(5,817.9)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>

**Positions**

Full-time								
Part-time								
Temporary								

<b>Change in Revenues</b>								
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/18

**Why this fiscal note differs from previous version:**

Bill section references are updated.

Prepared By:	Duane Mayes, Director	Phone:	(907)269-2083
Division:	Senior and Disabilities Services	Date:	04/08/2016 01:00 PM
Approved By:	Sana Efird, Asst. Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

**Analysis**

In part, SB74 authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 36** charges the department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 38(d) (1)** of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the Department the opportunity to shift eligible recipients from 100% general funded grant programs to the 50% federal/50% general fund funded 1915(i) Medicaid option.

Individuals receiving home and community-based services through the Community Developmental Disabilities Grant (CDDG) program must meet the definition of a person with a developmental disability presented in AS 47.80.900. The CDDG program provides home and community-based services to support individuals' desire to live as independently as they are able.

The Department will use the 1915(i) funding option to refinance services provided through the Community Developmental Disabilities Grant program. 969 individuals accessed CDDG services in FY2015 with an average cost per recipient of \$12,008.04 per individual per year, for a total budget of \$11,635.8 general funds. All recipients could be transitioned from the CDDG program to the 1915(i) Medicaid option.

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for community developmental disabilities services to be implemented by January 1, 2018. Savings have been prorated for FY2018.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74

Fiscal Note Number: \_\_\_\_\_

( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-CO-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Departmental Support Services  
Allocation: Commissioner's Office  
OMB Component Number: 317

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>493.7</b>	<b>0.0</b>	<b>493.0</b>	<b>493.0</b>	<b>493.0</b>	<b>493.0</b>	<b>493.0</b>
Personal Services	493.7		493.7	493.7	493.7	493.7	493.7
Travel	9.6		9.6	9.6	9.6	9.6	9.6
Services	572.6		37.6	37.6	37.6	37.6	37.6
Commodities	38.5		8.1	8.1	8.1	8.1	8.1
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>1,114.4</b>	<b>0.0</b>	<b>549.0</b>	<b>549.0</b>	<b>549.0</b>	<b>549.0</b>	<b>549.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	289.7		274.5	274.5	274.5	274.5	274.5
1003 G/F Match	289.7		274.5	274.5	274.5	274.5	274.5
1004 Gen Fund	535.0						
<b>Total</b>	<b>1,114.4</b>	<b>0.0</b>	<b>549.0</b>	<b>549.0</b>	<b>549.0</b>	<b>549.0</b>	<b>549.0</b>

**Positions**

Full-time	4.0		4.0	4.0	4.0	4.0	4.0
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?   no  
If yes, by what date are the regulations to be adopted, amended or repealed?           n/a

**Why this fiscal note differs from previous version:**

Updated bill section references and requirements of the feasibility studies.

Prepared By:	Melissa Ordner, Budget Manager	Phone:	(907)465-1629
Division:	Departmental Support Services	Date:	04/08/2016 01:40 PM
Approved By:	Sana Efirid, Asst. Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

## Analysis

**Section 48:** Included in this note is the creation of the Tribal Federal Liaison Section that will aggressively move forward on the new Centers for Medicare and Medicaid Services (CMS) policy to obtain maximum savings in as quick a timeline as possible. This section would have statewide multi-division and departmental responsibility for effectively implementing tasks to obtain maximum refinancing and savings associated with the CMS policy clarification on tribal claiming. It would include federal tribal liaison work with CMS, covering all aspects of the Alaska Medicaid program.

This section will be responsible for achieving the enhanced savings in tribal claiming shown in the Health Care Medicaid Services component. **These positions were contained in the House and Senate Finance subcommittee recommendations for the DHSS operating budget and are included the operating budget bill currently awaiting action by the Conference Committee.**

Enhanced federal funding for the Medicaid program is contingent upon development and implementation of referrals, care plans and claiming for services to Alaska Native and American Indians (AN/AI). This will require maintaining and amending the Medicaid State Plan in accordance with federal requirements and regulations. As such, this section will provide department-wide oversight and expert policy analysis to meet the new CMS policy requirements.

This new section will be made up of four new positions: One Division Operations Manager, two Medical Assistance Administrator IVs, and one Medical Assistance Administrator I. Costs are as follows.

Personal Services: One permanent full-time Division Operations Manager; Range 24, Juneau; \$ 152.5 annual cost

Two permanent full-time Medical Assistance Administrator IV; Range 21, Juneau; \$ 247.9 annual cost

One permanent full-time Medical Assistance Administrator I; Range 16, Juneau; \$ 92.9 annual cost

Travel: 9.6 annually (only the Manager and one Administrator IV will travel)

Services: Office space, phones, reimbursable service agreements (RSA) for position support costs: \$37.6 annually

Commodities: Office supplies: \$8.1 annually

One-Time Commodities Cost: Computer, software, and office equipment: \$30.4 (FY2017)

**Section 50** of this bill directs the Department to conduct a study analyzing the feasibility of privatizing services delivered at select facilities within the Division of Juvenile Justice (DJJ) and the pharmacy functions of the Alaska Pioneer Homes (AKPH). In addition, the Department is directed to, in conjunction with the Alaska Mental Health Trust Authority, conduct a study analyzing the feasibility of privatizing services delivered at the Alaska Psychiatric Institute. A summary of the findings is due to the legislature by the 10th day of the first regular session of the thirtieth legislature.

The Division of Alaska Pioneer Homes (AKPH) has a central office, a pharmacy, and six 24-hour facilities which provide assisted living care and memory care to residents. In total, the central office, pharmacy, and six facilities account for 600 permanent positions and 499 licensed assisted living home beds. The AKPH pharmacy is a long-term care pharmacy, has six permanent positions, and provides daily services to over 400 residents.

The Division of Juvenile Justice operates eight 24-hour Alaska youth facilities that account for 342 permanent positions and 258 beds.

The Alaska Psychiatric Institute is a 24-hour, 80 bed, nationally accredited inpatient psychiatric hospital employing about 250 permanent staff and organizationally housed within the Division of Behavioral Health (DBH).

**Analysis Continued**

The Department will contract out for these studies, which will assess the most common types of privatization and rank them by applicability for DHSS services.

The contractor, or contractors, will need to provide:

- (1) a final written feasibility analysis report
- (2) a comprehensive assessment of the ranked privatization options
- (3) an analysis of the impact to DHSS DJJ, AKPH, and API services and clientele thereof that privatization will cause
- (4) employer costs resulting from any labor relations and/or union contract stipulations regarding privatizing state employee duties
- (5) recommendations for cost saving measures that would help the Department if privatization is not feasible

The contractor, or contractors, must consider:

- the complex nature of the population served by each facility
- the variety of Alaskan communities
- stakeholders' needs

The complexity of the services provided by the AKPH pharmacy will likely require a specialized feasibility study.

The contractor, or contractors, must bring to bear considerable expertise in the services and systems, legal authorities, frameworks and funding mechanisms specific to the three Divisions. Additionally, the contractor, or contractors, must have knowledge of the process and outcomes of privatization of similar services in other states, and specific application to services provided in Alaska.

To arrive at the estimated contract cost of \$535.0, the Department assumed that the options outlined by the National League of Cities guidance regarding privatizing municipal services are followed (see <http://www.nlc.org/Documents/Find%20City%20Solutions/Research%20Innovation/Economic%20Development/privitizing-municipal-services-gid-10.pdf>) and contractors would charge similar rates to those previously paid by DHSS. In addition, a well-planned feasibility study would require on-site visits.

# Fiscal Note



State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-BHMS-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Medicaid Services  
Allocation: Behavioral Health Medicaid Services  
OMB Component Number: 2660

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services	850.0		3,825.0	5,300.0	5,500.0	5,800.0	5,800.0	5,800.0
Commodities								
Capital Outlay								
Grants & Benefits			1,100.0	4,600.0	8,700.0	13,200.0	13,200.0	13,200.0
Miscellaneous								
<b>Total Operating</b>	<b>850.0</b>	<b>0.0</b>	<b>4,925.0</b>	<b>9,900.0</b>	<b>14,200.0</b>	<b>19,000.0</b>	<b>19,000.0</b>	<b>19,000.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	425.0	2,750.0	6,224.5	10,132.0	13,804.0	17,794.0	17,794.0
1037 GF/MH		(2,750.0)	(3,212.0)	(2,882.0)	396.0	1,206.0	1,206.0
1092 MHTAAR	425.0		1,912.5	2,650.0			
<b>Total</b>	<b>850.0</b>	<b>0.0</b>	<b>4,925.0</b>	<b>9,900.0</b>	<b>14,200.0</b>	<b>19,000.0</b>	<b>19,000.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 2,348.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

**Why this fiscal note differs from previous version:**

Bill section references are updated.

Prepared By:	Randall P. Burns, Director	Phone:	(907)269-5948
Division:	Behavioral Health	Date:	04/07/2016 04:21 PM
Approved By:	Sana Efirid, Asst. Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

## Analysis

**Section 36** of SB74 adds a new section, AS 47.05.270, entitled "Medical assistance reform program." New subsection AS 47.05.270(b) instructs the Department of Health and Social Services (DHSS), in coordination with the Alaska Mental Health Trust Authority, to "manage a comprehensive and integrated behavioral health program," including a plan for providing a continuum of community-based services from a wide array of providers and disciplines that addresses housing, employment, and criminal justice, and reduces barriers that fragment services and reduce effectiveness and efficiency. It is expected that Alaskans served by the criminal justice system will benefit from the reformed system of behavioral health care, and savings will be realized in the Department of Corrections, Public Safety and the Court system as well as within the Office of Children's Services.

**Capital Budget:** \$1,348.0 (90% federal\10% MHTAAR)

One-time costs to connect behavioral health providers to the Alaska Statewide Health Information Exchange (HIE) to improve care coordination and management in the comprehensive and integrated behavioral health system; and to connect Alaska's Automated Information Management System (AKAIMS), the behavioral health electronic health record and data system, to the HIE to increase efficiency and streamline provider documentation requirements.

**Section 38** adds new subsections AS 47.07.036(d)(4) and (5) that authorize the Department to develop demonstration projects for innovative service delivery and payment models, and provide incentives for telehealth. New subsection AS 47.07.036(e) requires the Department to seek 1115 demonstration waivers from the Centers for Medicare and Medicaid Services (CMS), and subsection (f) requires that one of these 1115 waivers focus on behavioral health system improvements for Medicaid recipients. These system improvements must be consistent with the improvements expected under Section 36, p. 32 of the bill [47.05.270(b)] that are intended to improve access to quality care while managing costs.

Following CMS approval of the 1115 behavioral health Medicaid demonstration waiver, DHSS will apply to amend that waiver to expand access to substance use disorder services. The amendment will seek an Institution for Mental Diseases (IMD) exclusion for those services currently not reimbursed by Medicaid that are provided in an inpatient or residential substance use disorder setting having more than 16 beds. Starting in FY2018, the Division of Behavioral Health will contract with an Administrative Services Organization (ASO) to develop and manage a network of providers; establish utilization management; provide quality and outcomes reporting; provide fraud, waste, and abuse auditing; and demonstrate benchmarks on healthcare outcomes and quality. **The state match required for the ASO contract for FY2018 and FY2019 is being provided by the Alaska Mental Health Trust Authority.**

This fiscal note includes \$700.0 in FY2017 and \$250.0 in FY2018 for consulting contracts to assist the Department in the design and implementation of a managed behavioral health system of care and development of the 1115 demonstration waiver application, to provide the required actuarial analysis for the waiver application, and to support the required public review process. Also included is \$150.0 in FY2017 and \$75.0 in FY2018 for contractual services to adapt a new prospective payment model designed for Certified Community Behavioral Health Centers for pilot testing with substance abuse providers. **The state match required for all of these contracts is being provided by the Alaska Mental Health Trust Authority.**

The design and implementation of a managed system of behavioral health care will require necessary changes to the Medicaid Management Information System (MMIS).

**Capital Budget:** One-time MMIS system changes: \$1,000.0 (90% federal\10% GF match)

Analysis Continued

The table below summarizes the Behavioral Health Medicaid Services operating costs of this legislation. Costs are subject to a blended FMAP rate of between 50% and 100%, depending on the populations served.

Behavioral Health Medicaid Services Summary of Operating Expenditures						
	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Grants: Change in Medical Costs due to Medicaid Redesign Initiatives		\$ 1,100.0	\$ 4,600.0	\$ 8,700.0	\$ 13,200.0	\$ 13,200.0
Services: Administrative Service Organization Contract		\$ 3,500.0	\$ 5,300.0	\$ 5,500.0	\$ 5,800.0	\$ 5,800.0
Services: 1115 Consulting Contract	\$ 700.0	\$ 250.0				
Certified Community Behavioral Health Clinic Prospective Payment Pilot	\$ 150.0	\$ 75.0				
<b>Total Expenditures</b>	<b>\$ 850.0</b>	<b>\$ 4,925.0</b>	<b>\$ 9,900.0</b>	<b>\$ 14,200.0</b>	<b>\$ 19,000.0</b>	<b>\$ 19,000.0</b>

**Section 48** directs the Department to collaborate with Alaska tribal health organizations to implement federal policy on tribal Medicaid reimbursement. The Department, anticipating benefits from the recently published CMS national policy allowing states to broaden the range of services eligible for 100% Federal Medical Assistance, has projected impacts in the initial years of policy implementation. This fiscal note addresses a percentage of the total expenditures for Alaska Native/American Indian (AN/AI) recipients served at the largest in-state, *non-tribal* residential psychiatric treatment facilities, then working into the out-of-state medium and smaller sized facilities as the contracting process is refined and the policy fully understood.

Percentage of total payments to non-tribal Residential Psychiatric Treatment Centers (RPTCs) FY2015

Based on FY2015 data, which indicated that there were a total of 193 unduplicated AN/AI recipients receiving RPTC services at non-tribal sites, DHSS projected the maximum State benefit that could be realized from the new tribal policy between now and FY2021; that total is \$6,050.0 (estimated \$12,100.0 in expenditures by 2021, at the previous FMAP rate of 50%). Under the new policy, the chart below shows in-state provider savings beginning in FY2017 (\$2,750.0). From FY2018 forward, out-of-state providers are added for an additional savings of \$825.0 in each subsequent year.

RPTC svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 2,750.0	\$ 3,575.0	\$ 4,400.0	\$ 5,225.0	\$ 6,050.0	\$ 6,050.0
GF/MH	\$ (2,750.0)	\$ (3,575.0)	\$ (4,400.0)	\$ (5,225.0)	\$ (6,050.0)	\$ (6,050.0)

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-HCMS-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Medicaid Services  
Allocation: Health Care Medicaid Services  
OMB Component Number: 2077

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services	1,887.5		536.5	436.5	436.5	436.5	436.5	436.5
Commodities								
Capital Outlay								
Grants & Benefits	(1,267.8)		(4,022.2)	(16,513.2)	(22,204.6)	(28,361.6)	(32,265.9)	
Miscellaneous								
<b>Total Operating</b>	<b>619.7</b>	<b>0.0</b>	<b>(3,485.7)</b>	<b>(16,076.7)</b>	<b>(21,768.1)</b>	<b>(27,925.1)</b>	<b>(31,829.4)</b>	

### Fund Source (Operating Only)

1002 Fed Rcpts	20,548.4	6,700.0	31,568.4	28,851.7	29,606.0	30,127.5	28,175.4
1003 G/F Match	(20,071.1)	(6,700.0)	(35,234.0)	(45,150.7)	(51,593.9)	(58,272.4)	(60,224.6)
1092 MHTAAR	7.5		2.5	2.5			
1247 MedRecover	134.9		177.4	219.8	219.8	219.8	219.8
<b>Total</b>	<b>619.7</b>	<b>0.0</b>	<b>(3,485.7)</b>	<b>(16,076.7)</b>	<b>(21,768.1)</b>	<b>(27,925.1)</b>	<b>(31,829.4)</b>

### Positions

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 6,900.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

### Why this fiscal note differs from previous version:

Updated bill section references. Narrative updated to delete references to seizure and forfeiture of real or personal property under section 36 (sec.47.05.260).

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2520
Division:	Health Care Services	Date:	04/08/2016 02:00 PM
Approved By:	Sana Efird, Asst. Commissioner, Finance and Management Services	Date:	04/08/16
Agency:	Health and Social Services		

Analysis

**Section 18 (Chapter 58) (Sec. 09.58.010)** establishes the Alaska Medicaid False Claim and Reporting Act (AMFCA) and includes several subsections related to liability for certain acts and omissions, civil actions, rights of participants in such actions, awards allowed, actions that are not allowed, limits on state liability, and protections for whistleblowers. Based on the Department's experience with whistleblower recoveries during the past two years, the Department is poised to recover approximately \$500.0, in FY2015-FY2016. The new law is estimated to triple the recoveries to \$750.0 annually. Whistleblowers will receive approximately 25% of the ultimate recovery, leaving 75% for the State, or \$562.5. Compared to current annual recoveries, this represents an increase of \$312.5 annually. In addition, the civil penalty provisions contained in Section 17 provides for civil penalties plus three times the amount of actual damages sustained by the State. A conservative estimate of \$100.0 of recoverable overpayments subject to the treble damages provision equates to an additional \$300.0 in recoveries annually. **Combined with above equates to \$612.5 annually for FY2018-2019. The Private right of action for realtor or private citizens is repealed on 7-1-2019, reducing recoveries by an estimated \$100.0 per year for FY 2020 through FY 2022. FY2017 is a phase in year and recoveries are estimated at \$306.2, 50% of normal annual recoveries.** Recoveries will be categorized as *abatements of expenditures*.

AMFCA recoveries FY 2017	\$306.2
AMFCA annual recoveries FY 2018-FY2019	\$612.5
AMFCA annual recoveries FY 2020-FY2022	\$512.5

**Section 33 (a)** decreases the number of required of Medicaid providers, conducted by an independent contractor, from at least 75 annually to at least 50 annually. Audits are conducted on a representative sample of all Medicaid providers in order to identify both overpayments and violations of criminal statutes. The department is directed to attempt to minimize concurrent state or federal audits of specific providers. This section of the bill will have no fiscal impact on the department. Any change in the cost of audits is estimated to be offset by a change in recoveries.

**Section 34 (b)** allows the Department to assess interest on recoveries for audits performed under AS 47.05.200 as well as other audits and reviews conducted by the state and federal government. There is no additional cost to the department to implement interest penalties on identified overpayments, but recoveries will increase. The Department estimates it will take three years to reach the current volume of outstanding appeals subject to interest penalties. Interest penalty recoveries are calculated by taking the current amount of outstanding appeals and applying an estimated recovery percentage. The result is multiplied by the statutory rate for post-judgment interest of 3.75% and phased in over a period of three years, as shown below. Recoveries will be categorized as revenue receipts, recorded under new fund code #1247, Medicaid Monetary Recoveries.

Amount of Interest Penalty Recoveries FY2017	\$ 84.9
Amount of Interest Penalty Recoveries FY2018	\$127.4
Amount for FY2019-FY2022	\$169.8

**Section 35** requires enrolled Medicaid providers to conduct an audit every two years unless they are subject to an audit under AS 47.05.200 to identify overpayment and report findings to the department. The DHSS currently receives an average of approximately \$500.0 in self disclosures annually. Although it is currently required by federal law, the DHSS estimates an increase in self-reporting of approximately 100% would result by requiring biennial audits and increasing awareness of the requirement when it is codified in Alaska Law. Based on the Department's prior experience with self-disclosure recoveries, the State can expect to receive an estimated \$500.0 in additional recoveries for the first two years, and then gradually decrease to \$25.0 decrements for the remainder of the period.

Analysis Continued

Regulations are required to implement the provisions of the bill. Receipt of repayments will be categorized as abatements.

Amount of Self-Identified Recoveries FY2017	\$ 500.0
Amount of Self-Identified Recoveries FY2018	\$ 500.0
Amount of Self-Identified Recoveries FY2019	\$ 475.0
FY 2020	\$ 450.0
FY 2021	\$ 425.0
FY 2022	\$ 400.0

**Section 36** grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers. Fines are to be assessed within a range of from \$100 to \$25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section. Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. The estimated amount of the recoveries would be \$50.0 per year. These recoveries are categorized as revenue receipts, under new fund code #1247, Medicaid Monetary Recoveries. Regulations will be required to implement these provisions of the bill.

**Annual recoveries for FY2017-FY2022**                      **\$ 50.0**

**Section 36 47.05.270 Medical assistance reform program (a) (2)** of this bill requires the department to provide an electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program. It is the intent of the department to fully implement this section of the bill through the My Alaska Portal. It estimates that it will cost \$707.5 (90% federal/10% GF) to fully implement the electronic distribution of an explanation of medical assistance benefits in FY2017. After the initial set-up, estimated on-going costs are the concurrent user license, \$76.5, and the yearly maintenance fee, \$17.0, for a total of \$93.5 (50% federal/50% GF) annual costs.

**Section 36 47.05.270(a)(9)** directs the department to provide for stakeholder involvement in setting annual targets for quality and cost effectiveness. Existing department employees will staff this effort, and meetings of the workgroup will occur telephonically with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 annually for consultant contract (Mental Health Trust Funded from FY2017 through FY2019)**

**Section 37** directs the department to implement the Primary Care Case Management system authorized under AS 47.07.030(d). This is a foundational component to other initiatives and projected savings. This system would assign Medicaid enrollees to a case manager in order to increase use of primary and preventive care, and decrease the use of specialty care and hospital services. The department proposes expansion of an existing case management contract, at \$500.0 across FY2017-2018 (50% federal/50% GF match). The contractor will case manage at \$3.85 per member per month to approximately 30,000 recipients. This approach would reduce implementation timelines.

This initiative will require planning and development in FY2017 with implementation in the 2<sup>nd</sup> quarter FY2018 (on Oct 1, 2017). Activities will include determining regions/communities for which Primary Care Case Management is practicable and determining populations/beneficiary groups to include in Primary Care Case Management. It also includes drafting a state plan amendment (SPA), regulations, revising beneficiary and provider manuals, provider education, evaluation and reporting plan, comparison of before and after costs and patient outcomes, and Medicaid Management Information System (MMIS) changes to add per member per month payments.

Analysis Continued

Funding is also required to implement associated changes to MMIS, including one-time capital funds for systems changes, and additional contractual costs for on-going operations.

**Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)**

Once primary care case management is fully implemented, the department projects an increase in expenditures for physician services, but a decrease in outpatient, inpatient, and pharmacy services to produce a net savings of:

FY2017	(\$596.4)
FY2018	(\$1,787.3)
FY2019	(\$4,375.5)
FY2020	(\$6,963.7)
FY2021	(\$9,517.5)
FY2022	(\$9,517.5)

**Section 38 (d)(3)** directs the department to implement the Health Homes option under section 1945 of the Social Security Act. Health Homes provide integrated and coordinated care for people with chronic health conditions. The federal government would provide a 90% enhanced Federal Medical Assistance Percentage (FMAP) reimbursement for the new Health Home services for the first eight quarters following their approval of the state’s Medicaid State Plan Amendment.

The department would need approximately two years (FY2017-2018) for planning and development prior to implementation in FY2019, in order to determine eligibility criteria for recipients and providers, design the new payment methodology and required reporting systems, develop and receive approval on the State Plan Amendment and process associated regulations, and make required IT modifications to the Medicaid payment system.

Additional resources would also be required to support systems changes required in MMIS. A portion of these would be a one-time capital budget request, but the MMIS contract would also need to be increased on an on-going basis to support the new workload associated with payment reform.

**Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)**

The above planning and development work would move the department to an enhanced reimbursement/provider payment model and would follow 2 years after the Primary Care Improvement Initiative. This would lead to potentially paying enrolled Health Home providers per month for enrolled recipients (on top of regular fee-for-service reimbursement). Projected savings would be assumed through utilization reduction factors specific to Health Homes and based on the above with a reduction in 0.25% of inpatient costs at \$5,230.0 (based on the FY2016 budget line items) for the projected population of 10,000 recipients and offset by the projected 10,000 recipients X \$15.00 per member per month = \$150.0 X 12 months = \$1,800.0 for a **total projected future savings of \$3,430.0.**

**Section 38 (d)(5)** directs the department to provide incentives for telehealth, including increasing the capability for and reimbursement of telehealth for recipients. The department’s first step in implementing this new provision will be to convene a workgroup, including stakeholders from the health care community, for one year to identify legal, technical and financial barriers to increasing use of telehealth in Alaska.

Existing department employees will staff this effort, and meetings of the workgroup will occur telephonically with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup’s findings and recommendations. **Services: \$5.0 one-time cost in FY2017 for consultant contract (Mental Health Trust Funded).**

**Analysis Continued**

FY2017 will be used to implement the final recommendations of the workgroup. Once those recommendations are fully implemented, the department expects the following savings:

FY2018	(\$1,300.0)
FY2019	(\$2,600.0)
FY2020	(\$5,800.0)
FY2021	(\$9,400.0)
FY2022	(\$13,300.0)

**Section 39 (47.07.038)** authorizes the department to support private initiatives designed to reduce non-urgent use of hospital emergency departments by Medicaid enrollees. The department's supporting role would include data sharing, support for the Prescription Drug Monitoring Program database, support for electronic health record sharing between participating hospitals' emergency departments, and development of a shared savings payment model reflected below.

The planning phase for this initiative would begin during FY2017, and the required data, reporting and information system infrastructure would be built in FY2018. The department would implement the shared-savings payment model in FY2019.

Resources would also be required to support Health Information Exchange interface and other changes related to payment reform for MMIS. A portion of these would be a one-time capital budget request.

**Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)**

The Prescription Drug Monitoring Program (PDMP) is an integral part of this initiative, as it is required to help prevent the misuse and abuse of opioids prescribed or administered through emergency departments. Access to the PDMP database by physicians and pharmacists could be improved if the current stand-alone system was integrated into the Health Information Exchange (HIE). The following costs are one-time in addition to \$20.0 annual operating costs:

**FY2017 PDMP system and interface to the HIE is \$285.0 (90%federal/10%GF), and  
FY2017 costs to connect pharmacies is \$480.0 (90%federal/10% GF)**

The projected DHSS savings from this would be calculated from reduced utilization in 2% of hospital outpatient services. **Total savings are estimated at \$3,200.0, including \$960.0 of shared savings paid to providers, for a savings to the department of \$2,240.0, with an increase of 0.5% to the savings in each subsequent year.**

**Section 39 (47.07.039)(C)** authorizes the department to contract with one or more entities to demonstrate the use of local, provider-led coordinated care entities that agree to monitor care across multiple care settings and that will be accountable to the department for the overall cost and quality of care. This demonstration project will be implemented in three regions of the state. Planning and development would begin in FY2017, with implementation starting in FY2019. An estimated 30,000 Medicaid recipients would be enrolled to receive services through this demonstration project. For purposes of estimation, the Department assumes the entities would be reimbursed on a fee-for-service basis plus shared-savings, with the entities receiving a portion of any savings accrued to the state Medicaid program, for the first two years. The department's best estimate at this time is approximately \$1,500.0 in GF savings. The state's fiscal agent will require an additional 3 staff members for the additional work in provider enrollment, claims processing, and telephone inquiries as a result of the change - **increase contract by \$318.0 (50% federal/50% GF)**. These individuals will provide support across the primary care case management project, health homes, and the hospital emergency room project as well.

Analysis Continued

The estimated capital budget start up cost for FY2017 is **\$3,125.0** for technical development and consulting services, reimbursed at 90% federal, 10% GF. On-going annual maintenance costs is expected to be approximately \$318.0 to the fiscal agent for Medicaid reform activities. These costs are placed in the operating budget and are reimbursed at 50% federal, 50% GF.

Program staff support would be required for negotiation and contracting with such entities, and also for data systems and analysis. The positions established to develop Sec. 38 (d)(3) Health Homes; and Sec 37 Primary Care Case Management system will staff this initiative as well.

**Section 48** directs the Department to implement federal policy on tribal Medicaid reimbursement to collaborate with Alaska tribal health organizations. The Department will utilize the Centers for Medicare and Medicaid (CMS) recent proposed clarification of national policy to allow states to broaden the range of services eligible for 100% Federal Medical Assistance. However, the Department is cautious in projecting the impacts in the initial years of implementation.

Total Transportation to US TRAVEL for 2015 Payments

Total Monthly average reimbursement for AI/AN transportation claims = \$3,000.0

Monthly average X 12 months = \$3,000.0 x 12 = \$36,000.0 total costs. The refinancing from 50% federal/50% GF match to 100% federal results in **\$18,000.0 in GF match savings**, with a reciprocal increase to federal costs. This fund source change is to be equally spread at 20% per year for five years, or \$3,600.0 in annual, cumulatively building GF match savings across each subsequent year from FY2017-2021. The multi-year spread is because the cost shift to 100% federal is assumed to take several years. Full savings achieved in FY2021, year five of the effort.

Total Ground and Air Ambulance for 2015

Total quarterly average reimbursement for AI/AN claims = \$3,100.0

Total quarterly at \$3,100.0 X 4 quarters = \$12,400.0 total costs. Results in **\$6,200.0 GF match savings** and a reciprocal increase in federal costs. Assume a two-year spread to shift costs to 100% federal. \$3,100.0 in annual, cumulatively building GF match savings across the two-year span, FY2017-2018. Full savings achieved in FY2018, year two.

To aggressively pursue the new Centers for Medicare and Medicaid Services (CMS) policy and realize an additional \$20,000.0 in savings in FY2017, the Department is requesting a Tribal Federal Liaison section, staffed with 4 positions in the Commissioner's Office. This section will focus on achieving these additional savings as referrals and care plans are approved by CMS. **This additional \$20,000.0 in savings for FY2017 has also been proposed in the House and Senate Finance subcommittee recommendations for the DHSS operating budget.**

US Travel	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 3,600.0	\$ 7,200.0	\$ 10,800.0	\$ 14,400.0	\$ 18,000.0	\$ 18,000.0
GF match	\$ (3,600.0)	\$ (7,200.0)	\$ (10,800.0)	\$ (14,400.0)	\$ (18,000.0)	\$ (18,000.0)
ambulance	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 3,100.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0
GF match	\$ (3,100.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)
Addn'l Savings	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0
GF match	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)
Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 26,700.0	\$ 33,400.0	\$ 37,000.0	\$ 40,600.0	\$ 44,200.0	\$ 44,200.0
GF match	\$ (26,700.0)	\$ (33,400.0)	\$ (37,000.0)	\$ (40,600.0)	\$ (44,200.0)	\$ (44,200.0)

**Analysis Continued**

**Section 49** directs the department to develop a health information infrastructure plan to support transformation of the healthcare system in the state by providing data health care providers require for care coordination and quality improvement, and the information support required by the department and providers to enable development and implementation of other provisions of this act.

The department's existing Health Information Technology program will staff this effort, and meetings of the workgroup will occur telephonically at minimal cost with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 one-time cost in FY2017 for consultant contract (Mental Health Trust Funded).**

**Capital Costs:**

Health Information Infrastructure Plan development to improve health care outcomes through:

**OUTCOMES:**

- Outcome I - Provide Personal Health View
- Outcome II - Provide Population Data Analytical view
- Outcome III - Provide Health Care Provider View

**ASSUMPTIONS:**

Assumption I - The Plan will include the use of the existing Health Information Exchange (HIE)

Assumption II - The Plan will provide a communication infrastructure plan that will utilize new and existing systems that include Electronic Medical Record Systems, Electronic Health Record Systems, Personal Health Record Systems, Registries and Data interchange capabilities.

Assumption III - The plan will provide:

- "As-Is" view of the existing systems.
- Gap analysis of what is missing.
- "To-Be/Desired" view of the future state.
- Design roadmap with milestone investment targets to incrementally achieve "To-Be" state.
- Implementation plan to achieve To-Be state.

**PHASES:**

Phase I - Requirements Gathering/Define As-Is environment.

Phase II - Development To-Be/Desired state roadmap with Gap analysis of what is missing.

Phase III - Design/Engineering Implementation Plan with phases and achievement goals to implement the Health Information Infrastructure Plan.

The estimated capital budget cost to implement these changes is **\$775.0**, 90% federal, 10% GF.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DHSS-SDMS-4-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABASES  
Sponsor: KELLY  
Requester: House Finance

Department: Department of Health and Social Services  
Appropriation: Medicaid Services  
Allocation: Senior and Disabilities Medicaid Services  
OMB Component Number: 2662

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits			5,817.9	17,061.0	17,061.0	17,061.0	17,061.0	17,061.0
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>5,817.9</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts		2,900.0	10,616.1	34,237.7	43,737.7	48,687.7	53,637.7
1003 G/F Match		(2,900.0)	(4,798.2)	(17,176.7)	(26,676.7)	(31,626.7)	(36,576.7)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>5,817.9</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 1,200.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

**Why this fiscal note differs from previous version:**

Bill section references are updated.
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Prepared By: <u>Duane Mayes, Director</u>	Phone: (907)269-2083
Division: <u>Senior and Disabilities Services</u>	Date: 04/08/2016 01:00 PM
Approved By: <u>Sana Efird, Asst. Commissioner, Finance and Management Services</u>	Date: 04/08/16
Agency: <u>Health and Social Services</u>	

**Analysis**

In part, **SB74** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 36** charges the Department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 38 (d) (1)** directs the Department to apply for the **1915(i)** option under Medicaid. The 1915(i) option includes a federal match of 50%, reducing to 50% what is currently a 100% general fund contribution for certain services.

The Department will use this option to refinance portions of the following 100% GF-funded grant programs: General Relief/Temporary Assistance (GR), certain Senior Community Based Grant components (SCBG), and Community Developmental Disabilities Grant (CDDG).

**1915(i) Refinancing (\$8,533.3 estimated net general fund savings across Senior and Disabilities Services (SDS) grant programs and SD Medicaid):**

General Relief/Temporary Assistance Grants: Services for 349 of 545 current recipients at an average cost of \$13,438.35 = \$4,689.9, or \$2,345.0 in net GF savings.

Adult Day Grants: Services for 114 of 423 recipients at an average cost of \$4,153.69 = \$473.5, or \$236.8 in net GF savings.

Senior In-Home Grants: Services for 123 of 1,371 recipients at an average cost of \$2,127.84 = \$267.1, or \$133.6 in net GF savings.

Community Developmental Disabilities Grants: Services for all recipients, total grant budget of \$11,635.8, or \$5,817.9 in net GF savings.

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for CDDG recipients to be implemented effective 01/01/2018 (FY2018) and for General Relief/Temporary Assistance and Senior Community Based Grant recipients to be implemented effective 07/01/2018 (FY2019).

**Section 38 (d) (2)** of the bill directs the Department to apply for the **1915(k)** option under Medicaid. The "Community First Choice Option" (CFC), also known as 1915(k), will be used for people who meet an institutional level of care (LOC). The 1915(k) option authorities will replace all current 1915(c) waivers for all 1915(k) services, as all 1915(c) recipients do meet the level of care. The 1915(k) option offers a 56% federal match, an increase of 6%, thus lowering the general fund match to 44%.

The service of Personal Care Assistance (PCA), for persons on the 1915(c) waivers, would transition to the 1915(k) state plan option authority.

Number of recipients on the 1915(c) waiver also receiving PCA Services = 1,603

General fund Spend (current) at FMAP (50%) = \$20,893.4

General fund Spend for PCA under proposed 1915(k) option at FMAP (56%) = \$18,386.2

The program transition results in annual general fund savings of \$2,507.2

Implementation of the new funding option will require substantial changes to the current Home and Community Based Services (HCBS) operational infrastructure. The estimated effective date for this refinancing proposal from (c) to (k) is 7/1/2017 (FY2018).

Design and implementation of 1915(i) and 1915(k) options will require resources to support necessary changes to

Analysis Continued

Enterprise, or the Medicaid Management Information System (MMIS). **Capital Budget: One-time MMIS system changes: \$1,200.0**

Under **Section 48** of the bill, the Department of Health and Social Services shall collaborate with Alaska tribal health organizations and the United States Department of Health and Human Services to fully implement changes in federal policy that authorize 100 percent federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid.

Based on this information from Centers for Medicare and Medicaid Services (CMS), the Department has examined the number of Alaska Native/American Indian (AN/AI) Medicaid beneficiaries who received services in FY2015 at non-tribal facilities in order to estimate the additional federal Medicaid funds Alaska could claim under the new rule.

For the Division of Seniors and Disabilities Services (SDS), tribal members who receive services at nontribal nursing facilities are impacted by these changes. This fiscal note addresses a percentage (spanning across FY2017 to FY2022) of the total expenditures for AN/AI recipients, starting with larger communities and then phasing in the rest of the state. The SDS will implement these provisions for home and community and based services in FY2019 to accommodate the implementation of the CMS-mandated Conflict Case Management in FY2017 and FY2018.

Total Nursing Facility for 2015

Includes 139 unduplicated AI/AN recipients at 14 non-tribal sites in SFY2015 (excluding existing tribal facilities). 50 percent of the 12 month total of \$25,650.0 = **\$12,800.0 to be realized incrementally over the six year, FY2017 - FY2022 period.**

- In 2017, \$2,900.0
- In 2018, \$5,200.0
- In 2019, \$8,300.0
- In 2020, \$9,800.0
- In 2021, \$11,300.0
- In 2022, \$12,800.0

Total Home and Community Based (HCB) for 2015

Total of 1,486 unduplicated AI/AN recipients at non-tribal HCB agencies in SFY2015 (excluding existing tribal facilities). 50 percent of the 12 month total of \$59,600,000 = **\$29,800.0 to be realized incrementally over the four year, FY2019 - FY2022 period.**

- In 2019, \$14,900.0
- In 2020, \$22,900.0
- In 2021, \$26,350.0
- In 2022, \$29,800.0

nursing facilities	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 2,900.0	\$ 5,200.0	\$ 8,300.0	\$ 9,800.0	\$ 11,300.0	\$ 12,800.0
GF match	\$ (2,900.0)	\$ (5,200.0)	\$ (8,300.0)	\$ (9,800.0)	\$ (11,300.0)	\$ (12,800.0)
HCB svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed			\$ 14,900.0	\$ 22,900.0	\$ 26,350.0	\$ 29,800.0
GF match			\$ (14,900.0)	\$ (22,900.0)	\$ (26,350.0)	\$ (29,800.0)
SDMS Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 2,900.0	\$ 5,200.0	\$ 23,200.0	\$ 32,700.0	\$ 37,650.0	\$ 42,600.0
GF match	\$ (2,900.0)	\$ (5,200.0)	\$ (23,200.0)	\$ (32,700.0)	\$ (37,650.0)	\$ (42,600.0)

# Fiscal Note



State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	29
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DOA-COM-03-06-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABASES  
 Sponsor: KELLY  
 Requester: Senate Finance Committee

Department: Department of Administration  
 Appropriation: Centralized Administrative Services  
 Allocation: Office of the Commissioner  
 OMB Component Number: 45

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>					
Personal Services	134.6		33.6				
Travel							
Services	700.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>834.6</b>	<b>0.0</b>	<b>33.6</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### Fund Source (Operating Only)

1004 Gen Fund	834.6		33.6				
<b>Total</b>	<b>834.6</b>	<b>0.0</b>	<b>33.6</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### Positions

Full-time							
Part-time							
Temporary	1.0		1.0				

### Change in Revenues

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Estimated SUPPLEMENTAL (FY2016) cost: 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
 If yes, by what date are the regulations to be adopted, amended or repealed?

### Why this fiscal note differs from previous version:

Not applicable, Initial version

Prepared By: John Boucher, Deputy Commissioner  
 Division: Commissioner's Office  
 Approved By: Sheldon Fisher, Commissioner  
 Agency: Administration

Phone: (907)465-2200  
 Date: 03/06/2016 08:00 PM  
 Date: 03/06/2016

REPORTED OUT OF  
SFC 03/08/2016

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

Analysis

The Committee Substitute for SB 74 requires the Department of Administration, in collaboration with the Legislative Finance Committees, to procure a study to determine the feasibility of creating a health care authority that could coordinate health care plans and consolidate purchasing effectiveness for all state employees, retired state employees, retired teachers, medical assistance recipients, University of Alaska, state corporation, and school district employees.

The study is also required to:

1. Specifically identify cost savings strategies a health care authority could implement.
2. Assess use of community-related health insurance risk pools,
3. Assess the use of the private market place,
4. Identify options for organizational models of the a health care authority including but not limited to private for- profit, private non-profit, government, and state corporation, and
5. Include a public review and comment opportunity for employers, employees, recipients and providers.

The study must be completed on or before June 30,2017.

In determining the feasibility for the authority the study needs to understand the current suite of benefit sets, rules, cost sharing, and payment for all employees and individuals whose health care benefits are funded directly and indirectly by the state of Alaska.

This study will require evaluation of a number of health care benefit delivery programs funded directly and indirectly by the State of Alaska, as well as the framework under which each of these benefit structures are delivered and administered. The department is aware of comparable studies evaluating subsets of these populations that have cost \$350.0 to \$500.0 and estimates that a study of this scope and complexity may require as much as \$700.0 to complete.

Additionally the Department will require additional staff to manage the activities associated with this contract including tracking all work of the contractor, coordinating activity with various state stakeholders including the Department of Health and Social Services, Department of Corrections, and the Division of Retirement and Benefits among others. It is anticipated that the position would need to be retained for a three-month period after completion of the study to coordinate, review and report on the feedback from the proposed review and comment period as well as take a leading role in providing guidance for next steps.

Personnel costs

FY17 Full time non-permanent Health Project Coordinator Range 22C	\$134,582 (annual)
FY18 Full time non-permanent Health Project Coordinator Range 22C	\$33,645 (3 months)

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB74HCSCS(FIN)-DCCED-CBPL-04-08-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABASES  
Sponsor: KELLY  
Requester: (H) Finance

Department: Department of Commerce, Community and  
              Economic Development  
Appropriation: Corporations, Business and Professional  
                  Licensing  
Allocation: Corporations, Business and Professional  
              Licensing  
OMB Component Number: 2360

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	443.6		443.6	443.6	443.6	443.6	443.6	443.6
Travel	3.0		3.0	3.0	3.0	3.0	3.0	3.0
Services	89.2		160.8	160.8	160.8	160.8	160.8	160.8
Commodities	27.5							
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>563.3</b>	<b>0.0</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>

## Fund Source (Operating Only)

1156 Rcpt Svcs	563.3		607.4	607.4	607.4	607.4	607.4	607.4
<b>Total</b>	<b>563.3</b>	<b>0.0</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>

## Positions

Full-time	5.0		5.0	5.0	5.0	5.0	5.0
Part-time							
Temporary							

<b>Change in Revenues</b>	<b>563.3</b>		<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>	<b>607.4</b>
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

## ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/17

## Why this fiscal note differs from previous version:

SB74HCSCS(FIN) removes Veterinary Examiners and adds Audiologists and Speech-Language pathologists, and Physical and Occupational Therapists; updated services to include regulations projects for these programs and updated analysis.

Prepared By:	Janey Hovenden, Director	Phone:	(907)465-2536
Division:	Corporations, Business and Professional Licensing	Date:	04/08/2016 06:00 PM
Approved By:	Catherine Reardon, Director	Date:	04/08/16
Agency:	Division of Administrative Services, DCCED		

**Analysis**

SB74HCSCS(FIN) requires that the pharmacist or practitioner who dispenses Schedule II, III, or IV controlled substances under federal law, other than those administered to a patient at a health care facility, shall submit to the Board of Pharmacy for inclusion in the Controlled Substance Prescription Database on a weekly basis. The bill requires the pharmacist or practitioner who dispenses Schedule II, III, or IV controlled substances under federal law, if a prescription is dispensed to a person other than the patient, to collect to whom the prescription was written, and the name and date of birth of the person to whom the prescription was dispensed.

This legislation requires a pharmacist or practitioner who prescribes or dispenses Schedule II, III, or IV controlled substances under federal law to register with the database by a procedure and in a format established by the Board of Pharmacy. And requires the Board of Pharmacy to promptly notify the pertinent board when a practitioner registers with the database. It allows licensed practitioners and licensed pharmacists to delegate access to the database on their behalf to an agent or employee, licensed or registered by the Division of Corporations, Business and Professional Licensing, of the practitioner to whom the practitioner has given authorization.

This legislation allows access to the PDMP by: the licensed pharmacist of DHSS responsible for administering prescription drugs coverage; the license pharmacist, licensed practitioner, or authorized employee of DHSS responsible for the utilization review of prescription drugs for the medical assistance program; the Medical Examiner to the extent that the information relates specifically to investigating the cause and manner of a person's death; and authorized personnel of DHSS who may receive undisclosed information for the purpose of identifying and monitoring public health issues in the state. Further, it allows access to a practitioner employed by the United States Indian Health Service.

SB74HCSCS(FIN) allows for disciplinary action for failure to register by either the Board of Pharmacy or by another licensing board and removes the option to access or check the Database before dispensing, prescribing, or administering a medication. It allows for a procedure and time frame for registration with the database and requires that a practitioner access the database to check a patient's prescription records before dispensing, prescribing, or administering a schedule II or III controlled substance under federal law allowing for certain exception under emergent and situational circumstances.

This legislation requires the Board to update the database on a weekly basis and authorizes the Board to provide unsolicited notification to a pharmacist or practitioner if a patient has received one or more prescriptions for controlled substances in quantities or with a frequency inconsistent with generally recognized standards of safe practice.

This bill allows the DCCED to assist the Pharmacy Board and provide necessary staff and equipment to implement the PDMP, and to consult with the board in establishing and setting fees the same for all to register with the database. Expansion of the scope and functionality of the PDMP will require a Program Coordinator I, range 18, in Juneau to manage all aspects of the PDMP, including registration, reporting, collaboration and engagement with the state's opioid control program, grant writing and reporting, vendor solicitation, and other facets of the PDMP.

SB74HCSCS(FIN) expands the practice of telemedicine from prescribing, dispensing, or administering a prescription drug without conducting a physical examination (as authorized under HB 281 during the 2014 legislative session) to also include diagnosing and treating patients without conducting a physical examination, allowing these practices by a physician who is not located in the state of Alaska, changing the patient consent requirements, and allowing prescription of controlled substances under certain circumstances.

The significant expansion of the practice of telemedicine authorized under this bill will require substantial administrative and investigative resources to pursue complaints pertaining to a rapidly expanding body of licensees who are practicing "in Alaska" but operating from locations across the nation.

**Analysis Continued**

The division has seen a 400% increase in medical license applications since telemedicine was expanded through legislation effective November 2014. This bill will exponentially increase the number of applicants, the geographic reach of applicant licensure, and the volume of supporting documentation required to examine fitness to practice. It will also multiply the potential for pre-application investigations. These changes will result in more costly investigative and legal support to respond to complaints, to discipline licensees for violations occurring across the nation, and to comply with increased licensee appeals of board actions.

This legislation expands telehealth outside Alaska's borders in the practices of social workers, professional counselors, psychologists, psychological associates, marital and family therapists audiologists, speech-language pathologist, speech-language pathologist assistants, physical therapists, and occupational therapists. Because these professions do not have prescriptive authority, the investigative concerns are not as high. The licensing workload, however, is anticipated to increase dramatically.

This legislation allows the Department to adopt regulations establishing and maintaining a registry of businesses performing telemedicine services in the state.

This fiscal note provides for two Occupational Licensing Examiners, range 14, to examine license applications and issue licenses. In addition, this fiscal note includes two Investigator III's, range 18, to investigate violations and enforce Alaska laws on this new population of licensees. Investigative personnel would also be tasked to regulate a new type of violation, "practice location." The additional staff would be necessary to determine violations of specific geographic scope.

If the bill passes the following expenses will be incurred:

Personal Services: \$443.6 (one full time permanent Program Coordinator I, range 18, two full time permanent Occupational Licensing Examiners, range 14, two full time permanent Investigator III's, range 18)

Travel: \$3.0 (Program Coordinator to attend two board meetings and engage with committees and stakeholders in the state's opioid control program)

Services: \$27.5 (legal costs to amend regulations, printing, and postage in first year)

\$12.0 (printing and postage to notify prescribers who would be required to register)

\$2.2 (contract to expand PDMP database from monthly to weekly based on current vendor quote)

\$108.6 (legal cost of investigations and appeals beginning in year two)

\$50.0 (department-wide services support for five new positions)

Commodities: \$25.0 in first year (computer, office panels, office furniture and other one-time needs for five new positions)

The PDMP as it is currently operating is funded by a federal grant through a reimbursable service agreement (RSA) with the Department of Health and Social Services (DHSS). The department is seeking additional federal grant funding in collaboration with DHSS. In the absence of federal grant funds, the cost will be paid by fees charged registrants with the PDMP registrants.

Professional licensing programs within the Division of Corporations, Business and Professional Licensing are funded by Receipt Supported Services, fund source 1156 Rcpt Svcs (DGF). Licensing fees for each occupation are set per AS 08.01.065 so the total amount of revenue collected approximately equals the occupation's actual regulatory costs.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074CS(FIN)-LAW-CRIM-03-18-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABAS  
Sponsor: KELLY  
Requester: Senate Finance

Department: Department of Law  
Appropriation: Criminal Division  
Allocation: Criminal Appeals/Special Litigation  
OMB Component Number: 2203

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	316.6		316.6	316.6	316.6	316.6	316.6	316.6
Travel	1.5		1.5	1.5	1.5	1.5	1.5	1.5
Services	39.8		39.8	39.8	39.8	39.8	39.8	39.8
Commodities	6.1		6.1	6.1	6.1	6.1	6.1	6.1
Capital Outlay	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>365.0</b>	<b>0.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	273.7		273.7	273.7	273.7	273.7	273.7
1003 G/F Match	91.3						
1005 GF/Prgm			91.3	91.3	91.3	91.3	91.3
<b>Total</b>	<b>365.0</b>	<b>0.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>

**Positions**

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

<b>Change in Revenues</b>	250.0		500.0	500.0	500.0	500.0	500.0
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

This version contains a technical adjustment to the fund sources for the state's 25% match requirement as well as a reduction in the anticipated revenue to be collected in FY17. These changes represent differences from both the initial version and version two.

Prepared By:	Valerie Rose, Budget Analyst IV	Phone:	(907)465-3674
Division:	Administrative Services Division	Date:	03/18/2016 11:03 AM
Approved By:	Craig W. Richards, Attorney General	Date:	03/18/16
Agency:	Department of Law		

**Analysis**

In addition to other provisions amending AS 47.05, the committee substitute for SB 74 (STA) would add a provision to Title 9, code of civil procedure, to establish an "Alaska Medical Assistance False Claim and Reporting Act." Under AS 09.58.010, sec. 4 of the bill, a medical assistance provider or medical assistance recipient may not knowingly submit, authorize, or cause to be submitted, a false or fraudulent claim under the medical assistance program. A beneficiary of a false or fraudulent claim, whether intentional or inadvertent, would be required to disclose the false or fraudulent claim to the state not later than 60 days after discovering the false claim.

Under proposed AS 09.58.010, a medical assistance provider or recipient who engages in the prohibited acts would be liable to the state in a civil action for a penalty of not less than \$5,500 and not more than \$11,000, three times the amount of damages sustained by the state and costs and attorney fees. Damages could be reduced if the person liable furnishes the attorney general or the Department of Health and Social Services all information known to the person about the violation not later than 30 days after the information was obtained and the person cooperates with the attorney general, and no action is pending with respect to the violation.

Under proposed AS 09.58.015 and 09.58.020, an action for damages due to a false or fraudulent claim for medical assistance may be brought by the attorney general, or by a private plaintiff. If a private person files a complaint, the complaint is under seal for at least 60 days to allow the attorney general time to investigate the action and decide whether to recommend dismissal due to lack of substantial evidence that a violation occurred, intervene and pursue the case on behalf of the state, or allow the private person to proceed with the action on behalf of the state. The attorney general may request an extension of time to conduct the investigation.

If the attorney general elects not to proceed with the action, and does not move to dismiss it, the person who brought the action has the right to proceed and conduct the action. The attorney general may request to be served with all documents related to an action pursued by a private plaintiff. To protect pending state investigations, under proposed AS 9.58.030(d), the attorney general may request a court to stay discovery for not more than 90 days.

For an action brought by a private plaintiff, if the claim is successful, a private plaintiff would be entitled to a percentage of damages. If the attorney general pursues the action, damages to the private plaintiff would be at least 15 percent but not more than 25 percent of the proceeds. If the attorney general does not proceed with the action, the available damages amount shall be at least 25 percent but not more than 30 percent of the proceeds.

Certain actions would be barred: actions based on evidence known to the state, actions based on allegation or transactions subject to an action in which the state is a party, actions based on public disclosure, and actions against the state or current or former state employees. The bill would also establish as part of AS 47.05, a provision authorizing seizure and forfeiture of property of a medical assistance provider if the attorney general finds probable cause that the provider has or is committing medical assistance fraud; seizure is subject to court review.

Both the proposed Medical Assistance False Claim and Reporting Act and provision on seizure and forfeiture of real property require involvement of the Department of Law. The Department of Law would require attorneys, investigators, and support staff in order to review the complaints and make recommendations as to which action to take under the Medical Assistance False Claim and Reporting Act. The department anticipates that the work could be done by attorneys in the Medicaid Fraud Control Unit (MFCU) of the Office of Special Prosecutions and Appeals. The bill would allow for recovery of attorney fees incurred in prosecuting civil action for Medicaid fraud, but under federal law fifty percent of attorney fees recovered must be paid to the federal government to reimburse the federal government its proportionate share of funding the Medicaid program.

**Analysis Continued**

The State of Alaska recovered approximately \$1.9 million in civil settlements in 2012 through the MFCU in the form of global class action cases as a result of the State's membership in the National Association of Medicaid Fraud Units. A portion of recovered monies could be used to pay MFCU attorney fees. While conservative estimates may not provide for full funding of the MFCU through attorney fee recoveries, it is likely that a significant portion will be recovered to pay for the twenty-five percent of matching state funds that are required. This fact combined with a positive fiscal note from the Department of Health and Social Services regarding this legislation (for savings in the amount of \$800,000 for the first year and approximately \$900,000 each year thereafter), along with the deterrent effect of the proposed legislation should result in significant savings for the State of Alaska.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074HCSCS(FIN)-DOC-PHC-04-09-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
          DATABASES  
Sponsor: KELLY  
Requester: Senate Finance

Department: Department of Corrections  
Appropriation: Health and Rehabilitation Services  
Allocation: Physical Health Care  
OMB Component Number: 2952

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>					
Personal Services							
Travel							
Services		(6,000.0)					
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>(6,000.0)</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Fund Source (Operating Only)**

1004 Gen Fund		(6,000.0)					
<b>Total</b>	<b>0.0</b>	<b>(6,000.0)</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

**Change in Revenues**

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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?  
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

Prepared By:	April Wilkerson	Phone:	(907)465-3460
Division:	Administrative Services - Department of Corrections	Date:	04/09/2016 12:00 PM
Approved By:	Dean Williams, Commissioner	Date:	04/09/16
Agency:	Department of Corrections		

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

BILL NO. SB 74 \_\_\_\_\_

**Analysis**

This legislation will allow the Department of Corrections (DOC) to apply for medical assistance for prisoners that are hospitalized outside of a correctional facility for more than 24-hours. Since September 01, 2015 There have been 11 individuals who released from DOC custody prior to the application being filed or refused to cooperate with the application process resulting in DOC medical expenditures of approximately \$300.0 instead of the Medicaid Program. The decrement in the FY2017 budget of (\$6,000.0) did not account for individuals refusing or unavailable to file an application and passage of this legislation will ensure the full projected savings are realized.

**HOUSE CS FOR CS FOR SENATE BILL NO. 74(FIN)**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-NINTH LEGISLATURE - SECOND SESSION**

**BY THE HOUSE FINANCE COMMITTEE**

**Offered:**  
**Referred:**

**Sponsor(s): SENATORS KELLY, Giessel, Micciche, Bishop, MacKinnon, Hoffman, Costello, McGuire, Stedman, Stevens, Coghill, Egan, Meyer**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to diagnosis, treatment, and prescription of drugs without a physical**  
2 **examination by a physician; relating to the delivery of services by a licensed audiologist,**  
3 **speech-language pathologist, professional counselor, marriage and family therapist,**  
4 **psychologist, psychological associate, social worker, physical therapist, occupational**  
5 **therapist, and registered speech-language pathologist assistant by audio, video, or data**  
6 **communications; relating to the duties of the State Medical Board; relating to**  
7 **limitations of actions; establishing the Alaska Medical Assistance False Claim and**  
8 **Reporting Act; relating to medical assistance programs administered by the Department**  
9 **of Health and Social Services; relating to the controlled substance prescription**  
10 **database; relating to the duties of the Board of Pharmacy; relating to the duties of the**  
11 **Board of Dental Examiners; relating to the duties of the Board of Nursing; relating to**  
12 **the duties of the Board of Examiners in Optometry; relating to the duties of the**

1 Department of Commerce, Community, and Economic Development; relating to the  
 2 duties of the Department of Corrections; relating to accounting for program receipts;  
 3 relating to public record status of records related to the Alaska Medical Assistance False  
 4 Claim and Reporting Act; establishing a telemedicine business registry; relating to  
 5 verification of eligibility for public assistance programs administered by the Department  
 6 of Health and Social Services; relating to annual audits of state medical assistance  
 7 providers; relating to reporting overpayments of medical assistance payments;  
 8 establishing authority to assess civil penalties for violations of medical assistance  
 9 program requirements; relating to the duties of the Department of Health and Social  
 10 Services; establishing medical assistance demonstration projects; relating to Alaska  
 11 Pioneers' Homes and Alaska Veterans' Homes; relating to the duties of the Department  
 12 of Administration; relating to the Alaska Mental Health Trust Authority; relating to  
 13 feasibility studies for the provision of specified state services; relating to a report by the  
 14 Board of Pharmacy, Board of Examiners in Optometry, Board of Dental Examiners,  
 15 Board of Nursing, and State Medical Board; amending Rules 4, 5, 7, 12, 24, 26, 27, 41,  
 16 77, 79, and 82, Alaska Rules of Civil Procedure; and providing for an effective date."

17 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

18 \* **Section 1.** AS 08.11.080 is amended by adding new subsections to read:

19 (b) The department may not impose disciplinary sanctions on an audiologist  
 20 for the evaluation, diagnosis, or treatment of a person through audio, video, or data  
 21 communications when physically separated from the person if the audiologist

22 (1) or another licensed health care provider is available to provide  
 23 follow-up care;

24 (2) requests that the person consent to sending a copy of all records of  
 25 the encounter to a primary care provider if the audiologist is not the person's primary

1 care provider and, if the person consents, the audiologist sends the records to the  
2 person's primary care provider; and

3 (3) meets the requirements established by the department in regulation.

4 (c) The department shall adopt regulations restricting the evaluation,  
5 diagnosis, supervision, and treatment of a person as authorized under (b) of this  
6 section by establishing standards of care, including standards for training,  
7 confidentiality, supervision, practice, and related issues.

8 \* **Sec. 2.** AS 08.11.083 is amended by adding new subsections to read:

9 (b) The department may not impose disciplinary sanctions on a speech-  
10 language pathologist assistant for the evaluation, diagnosis, or treatment of a person  
11 through audio, video, or data communications when physically separated from the  
12 person if the speech-language pathologist assistant

13 (1) or another licensed health care provider is available to provide  
14 follow-up care;

15 (2) requests that the person consent to sending a copy of all records of  
16 the encounter to a primary care provider if the speech-language pathologist assistant is  
17 not the person's primary care provider and, if the person consents, the speech-language  
18 pathologist assistant sends the records to the person's primary care provider; and

19 (3) meets the requirements established by the board in regulation.

20 (c) The department shall adopt regulations restricting the evaluation,  
21 diagnosis, supervision, and treatment of a person as authorized under (b) of this  
22 section by establishing standards of care, including standards for training,  
23 confidentiality, supervision, practice, and related issues.

24 \* **Sec. 3.** AS 08.11.085 is amended by adding new subsections to read:

25 (b) The department may not impose disciplinary sanctions on a speech-  
26 language pathologist for the evaluation, diagnosis, or treatment of a person through  
27 audio, video, or data communications when physically separated from the person if the  
28 speech-language pathologist

29 (1) or another licensed health care provider is available to provide  
30 follow-up care;

31 (2) requests that the person consent to sending a copy of all records of

1 the encounter to a primary care provider if the speech-language pathologist is not the  
 2 person's primary care provider and, if the person consents, the speech-language  
 3 pathologist sends the records to the person's primary care provider; and

4 (3) meets the requirements established by the board in regulation.

5 (c) The department shall adopt regulations restricting the evaluation,  
 6 diagnosis, supervision, and treatment of a person as authorized under (b) of this  
 7 section by establishing standards of care, including standards for training,  
 8 confidentiality, supervision, practice, and related issues.

9 \* **Sec. 4.** AS 08.29.400 is amended by adding new subsections to read:

10 (b) The board may not impose disciplinary sanctions on a licensee for the  
 11 evaluation, diagnosis, or treatment of a person through audio, video, or data  
 12 communications when physically separated from the person if

13 (1) the licensee or another licensed health care provider is available to  
 14 provide follow-up care;

15 (2) the licensee requests that the person consent to sending a copy of  
 16 all records of the encounter to a primary care provider if the licensee is not the  
 17 person's primary care provider and, if the person consents, the licensee sends the  
 18 records to the person's primary care provider; and

19 (3) the licensee meets the requirements established by the board in  
 20 regulation.

21 (c) The board shall adopt regulations restricting the evaluation, diagnosis,  
 22 supervision, and treatment of a person as authorized under (b) of this section by  
 23 establishing standards of care, including standards for training, confidentiality,  
 24 supervision, practice, and related issues.

25 \* **Sec. 5.** AS 08.36.070(a) is amended to read:

26 (a) The board shall

27 (1) provide for the examination of applicants and the credentialing,  
 28 registration, and licensure of those applicants it finds qualified;

29 (2) maintain a registry of licensed dentists, licensed dental hygienists,  
 30 and registered dental assistants who are in good standing;

31 (3) affiliate with the American Association of Dental Boards and pay

1 annual dues to the association;

2 (4) hold hearings and order the disciplinary sanction of a person who  
3 violates this chapter, AS 08.32, or a regulation of the board;

4 (5) supply forms for applications, licenses, permits, certificates,  
5 registration documents, and other papers and records;

6 (6) enforce the provisions of this chapter and AS 08.32 and adopt or  
7 amend the regulations necessary to make the provisions of this chapter and AS 08.32  
8 effective;

9 (7) adopt regulations ensuring that renewal of a license, registration, or  
10 certificate under this chapter or a license, certificate, or endorsement under AS 08.32  
11 is contingent upon proof of continued professional competence;

12 (8) at least annually, cause to be published on the Internet and in a  
13 newspaper of general circulation in each major city in the state a summary of  
14 disciplinary actions the board has taken during the preceding calendar year;

15 (9) issue permits or certificates to licensed dentists, licensed dental  
16 hygienists, and dental assistants who meet standards determined by the board for  
17 specific procedures that require specific education and training;

18 **(10) require that a licensed dentist who has a federal Drug**  
19 **Enforcement Administration registration number register with the controlled**  
20 **substance prescription database under AS 17.30.200(o).**

21 \* Sec. 6. AS 08.63.210 is amended by adding new subsections to read:

22 (c) The board may not impose disciplinary sanctions on a licensee for the  
23 evaluation, diagnosis, supervision, or treatment of a person through audio, video, or  
24 data communications when physically separated from the person if

25 (1) the licensee or another licensed health care provider is available to  
26 provide follow-up care;

27 (2) the licensee requests that the person consent to sending a copy of  
28 all records of the encounter to a primary care provider if the licensee is not the  
29 person's primary care provider and, if the person consents, the licensee sends the  
30 records to the person's primary care provider; and

31 (3) the licensee meets the requirements established by the board in

1 regulation.

2 (d) The board shall adopt regulations restricting the evaluation, diagnosis,  
3 supervision, and treatment of a person as authorized under (c) of this section by  
4 establishing standards of care, including standards for training, confidentiality,  
5 supervision, practice, and related issues.

6 \* Sec. 7. AS 08.64.101 is amended to read:

7 **Sec. 08.64.101. Duties.** The board shall

8 (1) examine and issue licenses to applicants;

9 (2) develop written guidelines to ensure that licensing requirements are  
10 not unreasonably burdensome and the issuance of licenses is not unreasonably  
11 withheld or delayed;

12 (3) after a hearing, impose disciplinary sanctions on persons who  
13 violate this chapter or the regulations or orders of the board;

14 (4) adopt regulations ensuring that renewal of licenses is contingent on  
15 [UPON] proof of continued competency on the part of the licensee; and

16 (5) under regulations adopted by the board, contract with private  
17 professional organizations to establish an impaired medical professionals program to  
18 identify, confront, evaluate, and treat persons licensed under this chapter who abuse  
19 alcohol, other drugs, or other substances or are mentally ill or cognitively impaired;

20 (6) adopt regulations that establish guidelines for a physician who  
21 is rendering a diagnosis, providing treatment, or prescribing, dispensing, or  
22 administering a prescription drug to a person without conducting a physical  
23 examination under AS 08.64.364; the guidelines must include a nationally  
24 recognized model policy for standards of care of a patient who is at a different  
25 location than the physician;

26 (7) require that a licensee who has a federal Drug Enforcement  
27 Administration registration number register with the controlled substance  
28 prescription database under AS 17.30.200(o).

29 \* Sec. 8. AS 08.64.364(a) is amended to read:

30 (a) The board may not impose disciplinary sanctions on a physician for  
31 rendering a diagnosis, providing treatment, or prescribing, dispensing, or

1 administering a prescription drug that is not a controlled substance to a person  
2 without conducting a physical examination if

3 (1) [THE PRESCRIPTION DRUG IS

4 (A) NOT A CONTROLLED SUBSTANCE; OR

5 (B) A CONTROLLED SUBSTANCE AND IS PRESCRIBED,  
6 DISPENSED, OR ADMINISTERED BY A PHYSICIAN WHEN AN  
7 APPROPRIATE LICENSED HEALTH CARE PROVIDER IS PRESENT  
8 WITH THE PATIENT TO ASSIST THE PHYSICIAN WITH  
9 EXAMINATION, DIAGNOSIS, AND TREATMENT;

10 (2) THE PHYSICIAN IS LOCATED IN THIS STATE AND] the  
11 physician or another licensed health care provider or physician in the physician's  
12 group practice is available to provide follow-up care; and

13 (2) the physician requests that [(3)] the person consent  
14 [CONSENTS] to sending a copy of all records of the encounter to the person's primary  
15 care provider if the prescribing physician is not the person's primary care provider,  
16 and, if the patient consents, the physician sends the records to the person's primary  
17 care provider.

18 \* **Sec. 9.** AS 08.64.364 is amended by adding new subsections to read:

19 (c) The board may not impose disciplinary sanctions on a physician for  
20 prescribing, dispensing, or administering a prescription drug that is a controlled  
21 substance or botulinum toxin if the requirements under (a) of this section are met and  
22 the physician prescribes, dispenses, or administers the controlled substance or  
23 botulinum toxin when an appropriate licensed health care provider is present with the  
24 patient to assist the physician with examination, diagnosis, and treatment.

25 (d) Notwithstanding (a) and (c) of this section, a physician may not

26 (1) prescribe, dispense, or administer an abortion-inducing drug under  
27 (a) of this section unless the physician complies with AS 18.16.010; or

28 (2) prescribe, dispense, or administer a prescription drug in response to  
29 an Internet questionnaire or electronic mail message to a person with whom the  
30 physician does not have a prior physician-patient relationship.

31 \* **Sec. 10.** AS 08.68.100(a) is amended to read:

1 (a) The board shall

2 (1) adopt regulations necessary to implement this chapter, including  
3 regulations

4 (A) pertaining to practice as an advanced nurse practitioner and  
5 a certified registered nurse anesthetist;

6 (B) necessary to implement AS 08.68.331 - 08.68.336 relating  
7 to certified nurse aides in order to protect the health, safety, and welfare of  
8 clients served by nurse aides;

9 (C) pertaining to retired nurse status; and

10 (D) establishing criteria for approval of practical nurse  
11 education programs that are not accredited by a national nursing accrediting  
12 body;

13 (2) approve curricula and adopt standards for basic education programs  
14 that prepare persons for licensing under AS 08.68.190;

15 (3) provide for surveys of the basic nursing education programs in the  
16 state at the times it considers necessary;

17 (4) approve education programs that meet the requirements of this  
18 chapter and of the board, and deny, revoke, or suspend approval of education  
19 programs for failure to meet the requirements;

20 (5) examine, license, and renew the licenses of qualified applicants;

21 (6) prescribe requirements for competence before a former nurse may  
22 resume the practice of nursing under this chapter;

23 (7) define by regulation the qualifications and duties of the executive  
24 administrator and delegate authority to the executive administrator that is necessary to  
25 conduct board business;

26 (8) develop reasonable and uniform standards for nursing practice;

27 (9) publish advisory opinions regarding whether nursing practice  
28 procedures or policies comply with acceptable standards of nursing practice as defined  
29 under this chapter;

30 (10) require applicants under this chapter to submit fingerprints and the  
31 fees required by the Department of Public Safety under AS 12.62.160 for criminal

1 justice information and a national criminal history record check; the department shall  
 2 submit the fingerprints and fees to the Department of Public Safety for a report of  
 3 criminal justice information under AS 12.62 and a national criminal history record  
 4 check under AS 12.62.400;

5 (11) require that a licensed advanced nurse practitioner who has a  
 6 federal Drug Enforcement Administration registration number register with the  
 7 controlled substance prescription database under AS 17.30.200(o).

8 \* Sec. 11. AS 08.72.060(c) is amended to read:

9 (c) The board shall

10 (1) elect a chair and secretary from among its members;

11 (2) order a licensee to submit to a reasonable physical examination if  
 12 the licensee's physical capacity to practice safely is at issue;

13 (3) require that a licensee who has a federal Drug Enforcement  
 14 Administration registration number register with the controlled substance  
 15 prescription database under AS 17.30.200(o).

16 \* Sec. 12. AS 08.80.030(b) is amended to read:

17 (b) In order to fulfill its responsibilities, the board has the powers necessary  
 18 for implementation and enforcement of this chapter, including the power to

19 (1) elect a president and secretary from its membership and adopt rules  
 20 for the conduct of its business;

21 (2) license by examination or by license transfer the applicants who are  
 22 qualified to engage in the practice of pharmacy;

23 (3) assist the department in inspections and investigations for  
 24 violations of this chapter, or of any other state or federal statute relating to the practice  
 25 of pharmacy;

26 (4) adopt regulations to carry out the purposes of this chapter;

27 (5) establish and enforce compliance with professional standards and  
 28 rules of conduct for pharmacists engaged in the practice of pharmacy;

29 (6) determine standards for recognition and approval of degree  
 30 programs of schools and colleges of pharmacy whose graduates shall be eligible for  
 31 licensure in this state, including the specification and enforcement of requirements for

1 practical training, including internships;

2 (7) establish for pharmacists and pharmacies minimum specifications  
3 for the physical facilities, technical equipment, personnel, and procedures for the  
4 storage, compounding, and dispensing of drugs or related devices, and for the  
5 monitoring of drug therapy;

6 (8) enforce the provisions of this chapter relating to the conduct or  
7 competence of pharmacists practicing in the state, and the suspension, revocation, or  
8 restriction of licenses to engage in the practice of pharmacy;

9 (9) license and regulate the training, qualifications, and employment of  
10 pharmacy interns and pharmacy technicians;

11 (10) issue licenses to persons engaged in the manufacture and  
12 distribution of drugs and related devices;

13 (11) establish and maintain a controlled substance prescription  
14 database as provided in AS 17.30.200;

15 (12) establish standards for the independent administration by a  
16 pharmacist of vaccines and related emergency medications under AS 08.80.168,  
17 including the completion of an immunization training program approved by the board;

18 **(13) require that a licensed pharmacist who has a federal Drug**  
19 **Enforcement Administration registration number register with the controlled**  
20 **substance prescription database under AS 17.30.200(o).**

21 \* Sec. 13. AS 08.84.120 is amended by adding new subsections to read:

22 (c) The board may not impose disciplinary sanctions on a licensee for the  
23 evaluation, diagnosis, or treatment of a person through audio, video, or data  
24 communications when physically separated from the person if the licensee

25 (1) or another licensed health care provider is available to provide  
26 follow-up care;

27 (2) requests that the person consent to sending a copy of all records of  
28 the encounter to a primary care provider if the licensee is not the person's primary care  
29 provider and, if the person consents, the licensee sends the records to the person's  
30 primary care provider; and

31 (3) meets the requirements established by the board in regulation.

1 (d) The board shall adopt regulations restricting the evaluation, diagnosis,  
2 supervision, and treatment of a person as authorized under (c) of this section by  
3 establishing standards of care, including standards for training, confidentiality,  
4 supervision, practice, and related issues.

5 \* **Sec. 14.** AS 08.86.204 is amended by adding new subsections to read:

6 (c) The board may not impose disciplinary sanctions on a licensee for the  
7 evaluation, diagnosis, or treatment of a person through audio, video, or data  
8 communications when physically separated from the person if

9 (1) the licensee or another licensed health care provider is available to  
10 provide follow-up care;

11 (2) the licensee requests that the person consent to sending a copy of  
12 all records of the encounter to a primary care provider if the licensee is not the  
13 person's primary care provider and, if the person consents, the licensee sends the  
14 records to the person's primary care provider; and

15 (3) the licensee meets the requirements established by the board in  
16 regulation.

17 (d) The board shall adopt regulations restricting the evaluation, diagnosis,  
18 supervision, and treatment of a person as authorized under (c) of this section by  
19 establishing standards of care, including standards for training, confidentiality,  
20 supervision, practice, and related issues.

21 \* **Sec. 15.** AS 08.95.050 is amended by adding new subsections to read:

22 (b) The board may not impose disciplinary sanctions on a licensee for the  
23 evaluation, diagnosis, or treatment of a person through audio, video, or data  
24 communications when physically separated from the person if

25 (1) the licensee or another licensed health care provider is available to  
26 provide follow-up care;

27 (2) the licensee requests that the person consent to sending a copy of  
28 all records of the encounter to a primary care provider if the licensee is not the  
29 person's primary care provider and, if the person consents, the licensee sends the  
30 records to the person's primary care provider; and

31 (3) the licensee meets the requirements established by the board in

1 regulation.

2 (c) The board shall adopt regulations restricting the evaluation, diagnosis,  
3 supervision, and treatment of a person as authorized under (b) of this section by  
4 establishing standards of care, including standards for training, confidentiality,  
5 supervision, practice, and related issues.

6 \* **Sec. 16.** AS 09.10 is amended by adding a new section to read:

7 **Sec. 09.10.075. Actions related to claims based on medical assistance**  
8 **payment fraud.** Except as provided in AS 09.58.070, a person may not bring an  
9 action under AS 09.58.010 - 09.58.060, unless the action is commenced by (1) six  
10 years after the act or omission was committed, or (2) three years after the date when  
11 facts material to the action were known, or reasonably should have been known, by  
12 the attorney general or the Department of Health and Social Services, whichever is  
13 later, but in no event more than 10 years after the date the violation under  
14 AS 09.58.010 occurred.

15 \* **Sec. 17.** AS 09.10.120(a) is amended to read:

16 (a) Except as provided in AS 09.10.075, an [AN] action brought in the name  
17 of or for the benefit of the state, any political subdivision, or public corporation may  
18 be commenced only within six years after [OF] the date of accrual of the cause of  
19 action. However, if the action is for relief on the ground of fraud, the limitation  
20 commences from the time of discovery by the aggrieved party of the facts constituting  
21 the fraud.

22 \* **Sec. 18.** AS 09 is amended by adding a new chapter to read:

23 **Chapter 58. Alaska Medical Assistance False Claim and Reporting Act.**

24 **Sec. 09.58.010. False claims for medical assistance; civil penalty.** (a) A  
25 medical assistance provider or medical assistance recipient may not

26 (1) knowingly submit, authorize, or cause to be submitted to an officer  
27 or employee of the state a false or fraudulent claim for payment or approval under the  
28 medical assistance program;

29 (2) knowingly make, use, or cause to be made or used, directly or  
30 indirectly, a false record or statement to get a false or fraudulent claim for payment  
31 paid or approved by the state under the medical assistance program;

1 (3) conspire to defraud the state by getting a false or fraudulent claim  
2 paid or approved under the medical assistance program;

3 (4) knowingly make, use, or cause to be made or used, a false record or  
4 statement to conceal, avoid, increase, or decrease an obligation to pay or transmit  
5 money or property to the medical assistance program;

6 (5) knowingly enter into an agreement, contract, or understanding with  
7 an officer or employee of the state for approval or payment of a claim under the  
8 medical assistance program knowing that the information in the agreement, contract,  
9 or understanding is false or fraudulent.

10 (b) A beneficiary of an intentional or inadvertent submission of a false or  
11 fraudulent claim under the medical assistance program who later discovers the claim is  
12 false or fraudulent shall disclose the false or fraudulent claim to the state not later than  
13 60 days after discovering the false claim.

14 (c) In addition to any criminal penalties under AS 47.05, a medical assistance  
15 provider or medical assistance recipient who violates (a) or (b) of this section shall be  
16 liable to the state in a civil action for

17 (1) a civil penalty of not less than \$5,500 and not more than \$11,000;

18 (2) three times the amount of actual damages sustained by the state;

19 (3) full reasonable attorney fees and costs in a case involving a  
20 fraudulent claim, agreement, contract, or understanding; and

21 (4) reasonable attorney fees and costs calculated under applicable court  
22 rules in a case that does not involve a fraudulent claim, agreement, contract, or  
23 understanding.

24 (d) Liability for actual damages under (c) of this section may be reduced to not  
25 less than twice the amount of actual damages that the state sustains if the court finds  
26 that a person liable for an act under (a) or (b) of this section

27 (1) furnished the attorney general or the Department of Health and  
28 Social Services with all information known to the person about the violation not later  
29 than 30 days after the date the information was obtained;

30 (2) fully cooperated with the investigation of the violation under  
31 AS 09.58.020;

1 (3) at the time the person furnished the attorney general with the  
2 information about the violation, no criminal prosecution, civil action, investigation, or  
3 administrative action had been started in this state with respect to the violation, and the  
4 person did not have actual knowledge of the existence of an investigation of the  
5 violation.

6 (e) A corporation, partnership, or other individual is liable under this section  
7 for acts of its agents if the agent acted with apparent authority, regardless of whether  
8 the agent acted, in whole or in part, to benefit the principal and regardless of whether  
9 the principal adopted or ratified the agent's claims, representations, statement, or other  
10 action or conduct.

11 **Sec. 09.58.015. Attorney general investigation; civil action.** (a) The attorney  
12 general or the Department of Health and Social Services may investigate an alleged  
13 violation of AS 09.58.010. The attorney general may request assistance from the  
14 Department of Health and Social Services in an investigation under this section.

15 (b) The attorney general may bring a civil action in superior court under  
16 AS 09.58.010 - 09.58.060.

17 **Sec. 09.58.020. Private plaintiff; civil action.** (a) Notwithstanding  
18 AS 09.58.015, a person may bring an action under this section for a violation of  
19 AS 09.58.010 in the name of the person and the state.

20 (b) To bring an action under this section, a person shall file a complaint, in  
21 camera and under seal, and serve on the attorney general

22 (1) a copy of the complaint; and

23 (2) written disclosure of substantially all material evidence and  
24 information the person possesses that pertains to the claim.

25 (c) A complaint filed under this section must remain under seal for at least 60  
26 days and may not be served on the defendant until the court so orders. The attorney  
27 general may elect to intervene and proceed with the action within 60 days after the  
28 attorney general receives both the complaint and the material evidence and the  
29 information required under (b) of this section. The attorney general may, for good  
30 cause shown, move the court, under seal, for an extension of the time during which the  
31 complaint remains under seal under this subsection.

1 (d) Before the expiration of the 60-day period or an extension of time granted  
2 under (c) of this section, the attorney general shall conduct an investigation and make  
3 a written determination as to whether substantial evidence exists that a violation of  
4 AS 09.58.010 has occurred. After the investigation and determination are complete,  
5 the attorney general shall provide the person who brought the action and the  
6 Department of Health and Social Services with a copy of the determination unless the  
7 action has been referred to the division of the Department of Law that has  
8 responsibility for criminal cases.

9 (e) Before the expiration of the 60-day period or an extension obtained under  
10 (c) of this section, the attorney general shall

11 (1) intervene in the action and proceed with the action on behalf of the  
12 state;

13 (2) notify the court that the attorney general declines to take over the  
14 action, in which case the person bringing the action has the right to conduct the action;  
15 or

16 (3) if the attorney general determines that substantial evidence does not  
17 exist that a violation of AS 09.58.010 has occurred, or that the action is barred under  
18 AS 09.58.050, the attorney general shall move the court to dismiss the action.

19 (f) The named defendant in a complaint filed under this section is not required  
20 to respond to a complaint filed under this section until after the complaint is unsealed  
21 by the court and a copy of the summons and complaint are served on the defendant  
22 under the applicable Alaska Rules of Civil Procedure.

23 (g) When a person brings an action under this section, only the attorney  
24 general may intervene or bring a related action based on similar facts to the underlying  
25 action.

26 **Sec. 09.58.025. Subpoenas.** In conducting an investigation under  
27 AS 09.58.015 or 09.58.020, the attorney general may issue subpoenas to compel the  
28 production of books, papers, correspondence, memoranda, and other records in  
29 connection with an investigation under or the administration of AS 09.58.010 -  
30 09.58.060. If a medical assistance provider or a medical assistance recipient fails or  
31 refuses, without just cause, to obey a subpoena issued under this subsection, the

1 superior court may, upon application by the attorney general, issue an order requiring  
2 the medical assistance provider or medical assistance recipient to appear before the  
3 attorney general to produce evidence.

4 **Sec. 09.58.030. Rights in false or fraudulent claims actions.** (a) If the  
5 attorney general elects to intervene and proceed with an action under AS 09.58.020,  
6 the attorney general has exclusive authority for prosecuting the action and is not bound  
7 by an act of the person bringing the action. The person who brought the action has the  
8 right to continue as a nominal party to the action, but does not have the right to  
9 participate in the action except as a witness or as otherwise directed by the attorney  
10 general. If the attorney general elects to intervene under AS 09.58.020, the attorney  
11 general may file a new complaint or amend the complaint filed by the person who  
12 brought the action under AS 09.58.020(b).

13 (b) Notwithstanding the objections of the person who brought the action, the  
14 attorney general may

15 (1) move to dismiss the action at any time under this chapter if the  
16 attorney general has notified the person who brought the action of the intent to seek  
17 dismissal and the court has provided the person who brought the action with an  
18 opportunity to respond to the motion;

19 (2) settle the action with the defendant at any time, if the court  
20 determines, after a hearing, that the proposed settlement is fair, adequate, and  
21 reasonable under all the circumstances; upon a showing of good cause, the hearing  
22 described in this paragraph shall be held in camera.

23 (c) If the attorney general elects not to proceed under AS 09.58.020 with the  
24 action, the person who brought the action has the right to proceed and conduct the  
25 action. The attorney general may request at any time during the proceedings to be  
26 served with copies of all documents related to the action, including pleadings,  
27 motions, and discovery. The attorney general shall pay for the reasonable copying  
28 charges for documents provided under this subsection. If the person who brought the  
29 action proceeds with the action, the court, without limiting the status and rights of the  
30 person who brought the action, shall allow the attorney general to intervene at any  
31 time.

1 (d) Whether or not the attorney general proceeds with the action under this  
2 chapter, on a showing by the attorney general that certain actions of discovery by the  
3 person bringing the action would interfere with pending investigation or prosecution  
4 of a criminal or civil proceeding arising out of the same matter, the court may stay the  
5 discovery for not more than 90 days. The court may extend the 90-day period on a  
6 further showing, in camera, that the state has pursued the criminal or civil  
7 investigation or proceedings with reasonable diligence and that proposed discovery in  
8 the civil action under AS 09.58.010 - 09.58.060 may interfere with the ongoing  
9 criminal or civil investigation or proceedings.

10 **Sec. 09.58.040. Award to false or fraudulent claim plaintiff.** (a) If the  
11 attorney general proceeds with an action brought by a person for a violation of  
12 AS 09.58.010, the person who brought the action shall receive at least 15 percent but  
13 not more than 25 percent of the proceeds of the action or settlement of the claim,  
14 depending on the extent to which the person bringing the action contributed to the  
15 prosecution of the action. The court order or settlement agreement shall state the  
16 percentage and the amount to be received by the person who brought the action. A  
17 payment under this subsection to the person who brought the action may only be paid  
18 from proceeds received from a judgment or settlement under this section.

19 (b) If the attorney general does not proceed with an action brought under  
20 AS 09.58.020, the person bringing the action to judgment or settlement by court order  
21 shall receive an amount that the court decides is reasonable for collecting the civil  
22 penalty and damages based on the person's effort to prosecute the action successfully.  
23 The amount shall be at least 25 percent but not more than 30 percent of the proceeds  
24 of the action or settlement of the claim. A payment under this subsection to the person  
25 who brought the action may only be paid from proceeds received from a judgment or  
26 settlement received under this section. In addition, if the person bringing the action  
27 prevails, the person is entitled to

28 (1) full reasonable attorney fees and court costs in a case involving a  
29 fraudulent claim, agreement, contract, or understanding; or

30 (2) reasonable attorney fees and court costs calculated under applicable  
31 court rules in a case that does not involve a fraudulent claim, agreement, contract, or

1 understanding.

2 (c) Whether or not the attorney general participates in the action, if the court  
3 finds that the action was brought by a person who planned or initiated the violation  
4 alleged in the action brought under AS 09.58.020, the court may, to the extent the  
5 court considers appropriate, reduce the share of the proceeds of the action that the  
6 person would otherwise receive under (a) or (b) of this section, taking into account the  
7 role of that person in advancing the case to litigation and any relevant circumstances  
8 pertaining to the violation. If the person bringing the action is convicted of criminal  
9 conduct arising from the person's role in the violation of AS 09.58.010, the court shall  
10 dismiss the person from the civil action and the person may not receive any share of  
11 the proceeds of the action or settlement. A dismissal under this subsection does not  
12 prejudice the right of the attorney general to continue the action.

13 (d) In this section, "proceeds of the action or settlement"

14 (1) includes damages, civil penalties, payment for cost of compliance,  
15 and other economic benefits realized by the state as a result of a civil action brought  
16 under AS 09.58.010 - 09.58.060;

17 (2) does not include attorney fees and costs awarded to the state.

18 **Sec. 09.58.050. Certain actions barred.** A person may not bring an action  
19 under AS 09.58.020 if the action is

20 (1) based on evidence or information known to the state when the  
21 action was brought;

22 (2) based on allegations or transactions that are the subject of a civil or  
23 criminal action or an administrative proceeding in which the state is already a party;

24 (3) based on the public disclosure of allegations or actions in a  
25 criminal or civil action or an administrative hearing, or from the news media, unless  
26 the action is brought by the attorney general or the person bringing the action is an  
27 original source of the information that was publicly disclosed; in this paragraph, a  
28 person is an original source of the information that was publicly disclosed if the  
29 person has independent knowledge, including knowledge based on personal  
30 investigation of the defendant's conduct, of the information on which the allegations  
31 are based, and has voluntarily provided or verified the information on which the

1 allegations are based or voluntarily provided the information to the attorney general  
2 before filing an action under AS 09.58.020 that is based on the information; or

3 (4) against the state or current or former state employees.

4 **Sec. 09.58.060. State not liable for attorney fees, costs, and other expenses.**

5 The state, its agencies, current or former officers, and current or former employees, are  
6 not liable for attorney fees, costs, and other expenses that a person incurs in bringing  
7 an action under AS 09.58.020.

8 **Sec. 09.58.070. Employee protection for retaliation.** (a) An employee of a  
9 medical assistance provider who is discharged, demoted, suspended, threatened,  
10 harassed, or discriminated against in the terms and conditions of employment by the  
11 employee's employer because of lawful acts done by the employee on behalf of the  
12 employee or others in furtherance of an action under AS 09.58.010 - 09.58.100,  
13 including investigation for, initiation of, testimony for or assistance in an action filed  
14 or to be filed under AS 09.58.010 - 09.58.100, is entitled to the same relief authorized  
15 under AS 39.90.120.

16 (b) Notwithstanding (a) of this section, a state employee who is discharged,  
17 demoted, suspended, threatened, harassed, or discriminated against in the terms and  
18 conditions of employment because of lawful acts done by the employee on behalf of  
19 the employee or a person who brings an action under AS 09.58.020 or in furtherance  
20 of an action under AS 09.58.010 - 09.58.100, including investigation, initiation of,  
21 testimony for or assistance in an action filed or to be filed under AS 09.58.010 -  
22 09.58.100, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska Whistleblower  
23 Act).

24 (c) A person may not bring an action under this section unless the action is  
25 commenced not later than three years after the date the employee was subject to  
26 retaliation under (a) or (b) of this section.

27 **Sec. 09.58.080. Regulations.** The attorney general may adopt regulations  
28 under AS 44.62 as necessary to carry out the purposes of this chapter.

29 **Sec. 09.58.090. Special provisions.** (a) This chapter does not apply to any  
30 controversy involving damages to the state of less than \$5,500 in value.

31 (b) No punitive damages may be awarded in an action brought under

1 AS 09.58.010 - 09.58.060.

2 **Sec. 09.58.100. Definitions.** In this chapter,

3 (1) "attorney general" includes a designee of the attorney general;

4 (2) "claim" means a request for payment of health care services or  
5 equipment, whether made to a contractor, grantee, or other person, when the state  
6 provides, directly or indirectly, a portion of the money, property, or services requested  
7 or demanded, or when the state will, directly or indirectly, reimburse the contractor,  
8 grantee, or other recipient for a portion of the money, property, or services requested  
9 or demanded;

10 (3) "controversy" means the aggregate of one or more false claims  
11 submitted by the same medical assistance provider or medical assistance recipient  
12 under this chapter;

13 (4) "knowingly" means that a person, with or without specific intent to  
14 defraud,

15 (A) has actual knowledge of the information;

16 (B) acts in deliberate ignorance of the truth or falsity of the  
17 information; or

18 (C) acts in reckless disregard of the truth or falsity of the  
19 information;

20 (5) "medical assistance program" means the federal-state program  
21 administered by the Department of Health and Social Services under AS 47.05 and  
22 AS 47.07 and regulations adopted under AS 47.05 and AS 47.07;

23 (6) "medical assistance provider" has the meaning given under  
24 AS 47.05.290;

25 (7) "medical assistance recipient" has the meaning given under  
26 AS 47.05.290;

27 (8) "obligation" means an established duty, whether or not fixed,  
28 arising from

29 (A) an express or implied contractual grantor or grantee or  
30 licensor or licensee relationship;

31 (B) a fee-based or similar relationship;

1 (C) a statute or regulation; or

2 (D) the retention of any overpayment.

3 **Sec. 09.58.110. Short title.** This chapter may be cited as the Alaska Medical  
4 Assistance False Claim and Reporting Act.

5 \* **Sec. 19.** AS 09.58.025, added by sec. 18 of this Act, is amended to read:

6 **Sec. 09.58.025. Subpoenas.** In conducting an investigation under  
7 AS 09.58.015 [OR 09.58.020], the attorney general may issue subpoenas to compel  
8 the production of books, papers, correspondence, memoranda, and other records in  
9 connection with an investigation under or the administration of AS 09.58.010 -  
10 09.58.060. If a medical assistance provider or a medical assistance recipient fails or  
11 refuses, without just cause, to obey a subpoena issued under this subsection, the  
12 superior court may, upon application by the attorney general, issue an order requiring  
13 the medical assistance provider or medical assistance recipient to appear before the  
14 attorney general to produce evidence.

15 \* **Sec. 20.** AS 09.58.070(b), added by sec. 18 of this Act, is amended to read:

16 (b) Notwithstanding (a) of this section, a state employee who is discharged,  
17 demoted, suspended, threatened, harassed, or discriminated against in the terms and  
18 conditions of employment because of lawful acts done by the employee on behalf of  
19 the employee [OR A PERSON WHO BRINGS AN ACTION UNDER AS 09.58.020]  
20 or in furtherance of an action under AS 09.58.010 - 09.58.060, including investigation,  
21 initiation of, testimony for or assistance in an action filed or to be filed under  
22 AS 09.58.010 - 09.58.060, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska  
23 Whistleblower Act).

24 \* **Sec. 21.** AS 17.30.200(a) is amended to read:

25 (a) The controlled substance prescription database is established in the Board  
26 of Pharmacy. The purpose of the database is to contain data as described in this  
27 section regarding every prescription for a schedule [IA, IIA, IIIA, IVA, OR VA  
28 CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III,  
29 or IV [, OR V] controlled substance under federal law dispensed in the state to a  
30 person other than those administered to a patient at a health care facility. [THE  
31 DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC

1 DEVELOPMENT SHALL ASSIST THE BOARD AND PROVIDE NECESSARY  
2 STAFF AND EQUIPMENT TO IMPLEMENT THIS SECTION.]

3 \* Sec. 22. AS 17.30.200(a), as amended by sec. 21 of this Act, is amended to read:

4 (a) The controlled substance prescription database is established in the Board  
5 of Pharmacy. The purpose of the database is to contain data as described in this  
6 section regarding every prescription for a schedule II, III, or IV controlled substance  
7 under federal law dispensed in the state to a person other than those administered to a  
8 patient at a health care facility. The Department of Commerce, Community, and  
9 Economic Development shall assist the board and provide necessary staff and  
10 equipment to implement this section.

11 \* Sec. 23. AS 17.30.200(b) is amended to read:

12 (b) The pharmacist-in-charge of each licensed or registered pharmacy,  
13 regarding each schedule [IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE  
14 UNDER STATE LAW OR A SCHEDULE I,] II, III, or IV [, OR V] controlled  
15 substance under federal law dispensed by a pharmacist under the supervision of the  
16 pharmacist-in-charge, and each practitioner who directly dispenses a schedule [IA,  
17 IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE LAW OR A  
18 SCHEDULE I,] II, III, or IV [, OR V] controlled substance under federal law other  
19 than those administered to a patient at a health care facility, shall submit to the board,  
20 by a procedure and in a format established by the board, the following information for  
21 inclusion in the database on at least a weekly basis:

22 (1) the name of the prescribing practitioner and the practitioner's  
23 federal Drug Enforcement Administration registration number or other appropriate  
24 identifier;

25 (2) the date of the prescription;

26 (3) the date the prescription was filled and the method of payment; this  
27 paragraph does not authorize the board to include individual credit card or other  
28 account numbers in the database;

29 (4) the name, address, and date of birth of the person for whom the  
30 prescription was written;

31 (5) the name and national drug code of the controlled substance;

- 1 (6) the quantity and strength of the controlled substance dispensed;  
 2 (7) the name of the drug outlet dispensing the controlled substance;

3 [AND]

4 (8) the name of the pharmacist or practitioner dispensing the controlled  
 5 substance and other appropriate identifying information; **and**

6 **(9) if a prescription is dispensed to a person other than the patient**  
 7 **for whom the prescription was written, the name and date of birth of the person**  
 8 **to whom the prescription was dispensed.**

9 \* Sec. 24. AS 17.30.200(b), as amended by sec. 23 of this Act, is amended to read:

10 (b) The pharmacist-in-charge of each licensed or registered pharmacy,  
 11 regarding each schedule II, III, or IV controlled substance under federal law dispensed  
 12 by a pharmacist under the supervision of the pharmacist-in-charge, and each  
 13 practitioner who directly dispenses a schedule II, III, or IV controlled substance under  
 14 federal law other than those administered to a patient at a health care facility, shall  
 15 submit to the board, by a procedure and in a format established by the board, the  
 16 following information for inclusion in the database [ON AT LEAST A WEEKLY  
 17 BASIS]:

18 (1) the name of the prescribing practitioner and the practitioner's  
 19 federal Drug Enforcement Administration registration number or other appropriate  
 20 identifier;

21 (2) the date of the prescription;

22 (3) the date the prescription was filled and the method of payment; this  
 23 paragraph does not authorize the board to include individual credit card or other  
 24 account numbers in the database;

25 (4) the name, address, and date of birth of the person for whom the  
 26 prescription was written;

27 (5) the name and national drug code of the controlled substance;

28 (6) the quantity and strength of the controlled substance dispensed;

29 (7) the name of the drug outlet dispensing the controlled substance;

30 **and**

31 (8) the name of the pharmacist or practitioner dispensing the controlled

1 substance and other appropriate identifying information [; AND

2 (9) IF A PRESCRIPTION IS DISPENSED TO A PERSON OTHER  
3 THAN THE PATIENT FOR WHOM THE PRESCRIPTION WAS WRITTEN, THE  
4 NAME AND DATE OF BIRTH OF THE PERSON TO WHOM THE  
5 PRESCRIPTION WAS DISPENSED].

6 \* Sec. 25. AS 17.30.200(d) is amended to read:

7 (d) The database and the information contained within the database are  
8 confidential, are not public records, and are not subject to public disclosure. The board  
9 shall undertake to ensure the security and confidentiality of the database and the  
10 information contained within the database. The board may allow access to the  
11 database only to the following persons, and in accordance with the limitations  
12 provided and regulations of the board:

13 (1) personnel of the board regarding inquiries concerning licensees or  
14 registrants of the board or personnel of another board or agency concerning a  
15 practitioner under a search warrant, subpoena, or order issued by an administrative law  
16 judge or a court;

17 (2) authorized board personnel or contractors as required for  
18 operational and review purposes;

19 (3) a licensed practitioner having authority to prescribe controlled  
20 substances **or an agent or employee of the practitioner whom the practitioner has**  
21 **authorized to access the database on the practitioner's behalf**, to the extent the  
22 information relates specifically to a current patient of the practitioner to whom the  
23 practitioner is prescribing or considering prescribing a controlled substance; **the agent**  
24 **or employee must be licensed or registered under AS 08;**

25 (4) a licensed or registered pharmacist having authority to dispense  
26 controlled substances **or an agent or employee of the pharmacist whom the**  
27 **pharmacist has authorized to access the database on the pharmacist's behalf**, to  
28 the extent the information relates specifically to a current patient to whom the  
29 pharmacist is dispensing or considering dispensing a controlled substance; **the agent**  
30 **or employee must be licensed or registered under AS 08;**

31 (5) federal, state, and local law enforcement authorities may receive

1 printouts of information contained in the database under a search warrant [,  
2 SUBPOENA,] or order issued by a court establishing probable cause for the access  
3 and use of the information; [AND]

4 (6) an individual who is the recipient of a controlled substance  
5 prescription entered into the database may receive information contained in the  
6 database concerning the individual on providing evidence satisfactory to the board that  
7 the individual requesting the information is in fact the person about whom the data  
8 entry was made and on payment of a fee set by the board under AS 37.10.050 that  
9 does not exceed \$10;

10 (7) a licensed pharmacist employed by the Department of Health  
11 and Social Services who is responsible for administering prescription drug  
12 coverage for the medical assistance program under AS 47.07, to the extent that  
13 the information relates specifically to prescription drug coverage under the  
14 program;

15 (8) a licensed pharmacist, licensed practitioner, or authorized  
16 employee of the Department of Health and Social Services responsible for  
17 utilization review of prescription drugs for the medical assistance program under  
18 AS 47.07, to the extent that the information relates specifically to utilization  
19 review of prescription drugs provided to recipients of medical assistance;

20 (9) the state medical examiner, to the extent that the information  
21 relates specifically to investigating the cause and manner of a person's death;

22 (10) an authorized employee of the Department of Health and  
23 Social Services may receive information from the database that does not disclose  
24 the identity of a patient, prescriber, dispenser, or dispenser location, for the  
25 purpose of identifying and monitoring public health issues in the state; however,  
26 the information provided under this paragraph may include the region of the  
27 state in which a patient, prescriber, and dispenser are located and the specialty of  
28 the prescriber; and

29 (11) a practitioner, pharmacist, or clinical staff employed by an  
30 Alaska tribal health organization, including commissioned corps officers of the  
31 United States Public Health Service employed under a memorandum of

1 agreement; in this paragraph, "Alaska tribal health organization" has the  
2 meaning given to "tribal health program" in 25 U.S.C. 1603.

3 \* Sec. 26. AS 17.30.200(d), as amended by sec. 25 of this Act, is amended to read:

4 (d) The database and the information contained within the database are  
5 confidential, are not public records, and are not subject to public disclosure. The board  
6 shall undertake to ensure the security and confidentiality of the database and the  
7 information contained within the database. The board may allow access to the  
8 database only to the following persons, and in accordance with the limitations  
9 provided and regulations of the board:

10 (1) personnel of the board regarding inquiries concerning licensees or  
11 registrants of the board or personnel of another board or agency concerning a  
12 practitioner under a search warrant, subpoena, or order issued by an administrative law  
13 judge or a court;

14 (2) authorized board personnel or contractors as required for  
15 operational and review purposes;

16 (3) a licensed practitioner having authority to prescribe controlled  
17 substances [OR AN AGENT OR EMPLOYEE OF THE PRACTITIONER WHOM  
18 THE PRACTITIONER HAS AUTHORIZED TO ACCESS THE DATABASE ON  
19 THE PRACTITIONER'S BEHALF], to the extent the information relates specifically  
20 to a current patient of the practitioner to whom the practitioner is prescribing or  
21 considering prescribing a controlled substance; [THE AGENT OR EMPLOYEE  
22 MUST BE LICENSED OR REGISTERED UNDER AS 08;]

23 (4) a licensed or registered pharmacist having authority to dispense  
24 controlled substances [OR AN AGENT OR EMPLOYEE OF THE PHARMACIST  
25 WHOM THE PHARMACIST HAS AUTHORIZED TO ACCESS THE DATABASE  
26 ON THE PHARMACIST'S BEHALF], to the extent the information relates  
27 specifically to a current patient to whom the pharmacist is dispensing or considering  
28 dispensing a controlled substance; [THE AGENT OR EMPLOYEE MUST BE  
29 LICENSED OR REGISTERED UNDER AS 08;]

30 (5) federal, state, and local law enforcement authorities may receive  
31 printouts of information contained in the database under a search warrant, subpoena,

1 or order issued by a court establishing probable cause for the access and use of the  
2 information; and

3 (6) an individual who is the recipient of a controlled substance  
4 prescription entered into the database may receive information contained in the  
5 database concerning the individual on providing evidence satisfactory to the board that  
6 the individual requesting the information is in fact the person about whom the data  
7 entry was made and on payment of a fee set by the board under AS 37.10.050 that  
8 does not exceed \$10 [;

9 (7) A LICENSED PHARMACIST EMPLOYED BY THE  
10 DEPARTMENT OF HEALTH AND SOCIAL SERVICES WHO IS RESPONSIBLE  
11 FOR ADMINISTERING PRESCRIPTION DRUG COVERAGE FOR THE  
12 MEDICAL ASSISTANCE PROGRAM UNDER AS 47.07, TO THE EXTENT  
13 THAT THE INFORMATION RELATES SPECIFICALLY TO PRESCRIPTION  
14 DRUG COVERAGE UNDER THE PROGRAM;

15 (8) A LICENSED PHARMACIST, LICENSED PRACTITIONER,  
16 OR AUTHORIZED EMPLOYEE OF THE DEPARTMENT OF HEALTH AND  
17 SOCIAL SERVICES RESPONSIBLE FOR UTILIZATION REVIEW OF  
18 PRESCRIPTION DRUGS FOR THE MEDICAL ASSISTANCE PROGRAM  
19 UNDER AS 47.07, TO THE EXTENT THAT THE INFORMATION RELATES  
20 SPECIFICALLY TO UTILIZATION REVIEW OF PRESCRIPTION DRUGS  
21 PROVIDED TO RECIPIENTS OF MEDICAL ASSISTANCE;

22 (9) THE STATE MEDICAL EXAMINER, TO THE EXTENT THAT  
23 THE INFORMATION RELATES SPECIFICALLY TO INVESTIGATING THE  
24 CAUSE AND MANNER OF A PERSON'S DEATH;

25 (10) AN AUTHORIZED EMPLOYEE OF THE DEPARTMENT OF  
26 HEALTH AND SOCIAL SERVICES MAY RECEIVE INFORMATION FROM  
27 THE DATABASE THAT DOES NOT DISCLOSE THE IDENTITY OF A  
28 PATIENT, PRESCRIBER, DISPENSER, OR DISPENSER LOCATION, FOR THE  
29 PURPOSE OF IDENTIFYING AND MONITORING PUBLIC HEALTH ISSUES IN  
30 THE STATE; HOWEVER, THE INFORMATION PROVIDED UNDER THIS  
31 PARAGRAPH MAY INCLUDE THE REGION OF THE STATE IN WHICH A

1 PATIENT, PRESCRIBER, AND DISPENSER ARE LOCATED AND THE  
2 SPECIALTY OF THE PRESCRIBER; AND

3 (11) A PRACTITIONER, PHARMACIST, OR CLINICAL STAFF  
4 EMPLOYED BY AN ALASKA TRIBAL HEALTH ORGANIZATION,  
5 INCLUDING COMMISSIONED CORPS OFFICERS OF THE UNITED STATES  
6 PUBLIC HEALTH SERVICE EMPLOYED UNDER A MEMORANDUM OF  
7 AGREEMENT; IN THIS PARAGRAPH, "ALASKA TRIBAL HEALTH  
8 ORGANIZATION" HAS THE MEANING GIVEN TO "TRIBAL HEALTH  
9 PROGRAM" IN 25 U.S.C. 1603].

10 \* **Sec. 27.** AS 17.30.200(e) is amended to read:

11 (e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to  
12 register or submit information to the database as required under this section is  
13 grounds for the board to take disciplinary action against the license or registration of  
14 the pharmacy or pharmacist or for another licensing board to take disciplinary action  
15 against a practitioner.

16 \* **Sec. 28.** AS 17.30.200(e), as amended by sec. 27 of this Act, is amended to read:

17 (e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to  
18 [REGISTER OR] submit information to the database as required under this section is  
19 grounds for the board to take disciplinary action against the license or registration of  
20 the pharmacy or pharmacist or for another licensing board to take disciplinary action  
21 against a practitioner.

22 \* **Sec. 29.** AS 17.30.200(h) is amended to read:

23 (h) An individual who has submitted information to the database in  
24 accordance with this section may not be held civilly liable for having submitted the  
25 information. [NOTHING IN THIS SECTION REQUIRES OR OBLIGATES A  
26 DISPENSER OR PRACTITIONER TO ACCESS OR CHECK THE DATABASE  
27 BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING A  
28 MEDICATION, OR PROVIDING MEDICAL CARE TO A PERSON.] Dispensers or  
29 practitioners may not be held civilly liable for damages for accessing or failing to  
30 access the information in the database.

31 \* **Sec. 30.** AS 17.30.200(h), as amended by sec. 29 of this Act, is amended to read:

1 (h) An individual who has submitted information to the database in  
 2 accordance with this section may not be held civilly liable for having submitted the  
 3 information. Nothing in this section requires or obligates a dispenser or  
 4 practitioner to access or check the database before dispensing, prescribing, or  
 5 administering a medication, or providing medical care to a person. Dispensers or  
 6 practitioners may not be held civilly liable for damages for accessing or failing to  
 7 access the information in the database.

8 \* **Sec. 31.** AS 17.30.200(k) is amended to read:

9 (k) In the regulations adopted under this section, the board shall provide

10 (1) that prescription information in the database [SHALL] be purged  
 11 from the database after two years have elapsed from the date the prescription was  
 12 dispensed;

13 (2) a method for an individual to challenge information in the database  
 14 about the individual that the person believes is incorrect or was incorrectly entered by  
 15 a dispenser;

16 (3) a procedure and time frame for registration with the database;

17 (4) that a practitioner review the information in the database to  
 18 check a patient's prescription records before dispensing, prescribing, or  
 19 administering a schedule II or III controlled substance under federal law to the  
 20 patient; the regulations must provide that a practitioner is not required to review  
 21 the information in the database before dispensing, prescribing, or administering

22 (A) a controlled substance to a person who is receiving  
 23 treatment

24 (i) in an inpatient setting;

25 (ii) at the scene of an emergency or in an ambulance;  
 26 in this sub-subparagraph, "ambulance" has the meaning given in  
 27 AS 18.08.200;

28 (iii) in an emergency room;

29 (iv) immediately before, during, or within the first  
 30 48 hours after surgery or a medical procedure;

31 (v) in a hospice or nursing home that has an in-

1 house pharmacy; or

2 (B) a nonrefillable prescription of a controlled substance in  
 3 a quantity intended to last for not more than three days.

4 \* Sec. 32. AS 17.30.200(k), as amended by sec. 31 of this Act, is amended to read:

5 (k) In the regulations adopted under this section, the board shall provide

6 (1) that prescription information in the database be purged from the  
 7 database after two years have elapsed from the date the prescription was dispensed;

8 (2) a method for an individual to challenge information in the database  
 9 about the individual that the person believes is incorrect or was incorrectly entered by  
 10 a dispenser [;

11 (3) A PROCEDURE AND TIME FRAME FOR REGISTRATION  
 12 WITH THE DATABASE;

13 (4) THAT A PRACTITIONER REVIEW THE INFORMATION IN  
 14 THE DATABASE TO CHECK A PATIENT'S PRESCRIPTION RECORDS  
 15 BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING A SCHEDULE II  
 16 OR III CONTROLLED SUBSTANCE UNDER FEDERAL LAW TO THE  
 17 PATIENT; THE REGULATIONS MUST PROVIDE THAT A PRACTITIONER IS  
 18 NOT REQUIRED TO REVIEW THE INFORMATION IN THE DATABASE  
 19 BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING

20 (A) A CONTROLLED SUBSTANCE TO A PERSON WHO  
 21 IS RECEIVING TREATMENT

22 (i) IN AN INPATIENT SETTING;

23 (ii) AT THE SCENE OF AN EMERGENCY OR IN  
 24 AN AMBULANCE; IN THIS SUB-SUBPARAGRAPH,  
 25 "AMBULANCE" HAS THE MEANING GIVEN IN AS 18.08.200;

26 (iii) IN AN EMERGENCY ROOM;

27 (iv) IMMEDIATELY BEFORE, DURING, OR  
 28 WITHIN THE FIRST 48 HOURS AFTER SURGERY OR A  
 29 MEDICAL PROCEDURE;

30 (v) IN A HOSPICE OR NURSING HOME THAT  
 31 HAS AN IN-HOUSE PHARMACY; OR

1 (B) A NONREFILLABLE PRESCRIPTION OF A  
 2 CONTROLLED SUBSTANCE IN A QUANTITY INTENDED TO LAST  
 3 FOR NOT MORE THAN THREE DAYS].

4 \* Sec. 33. AS 17.30.200(m) is amended to read:

5 (m) To assist in fulfilling the program responsibilities, performance measures  
 6 shall be reported to the legislature annually. Performance measures

7 (1) may include outcomes detailed in the federal prescription drug  
 8 monitoring program grant regarding efforts to

9 (A) [(1)] reduce the rate of inappropriate use of prescription  
 10 drugs by reporting education efforts conducted by the Board of Pharmacy;

11 (B) [(2)] reduce the quantity of pharmaceutical controlled  
 12 substances obtained by individuals attempting to engage in fraud and deceit;

13 (C) [(3)] increase coordination among prescription drug  
 14 monitoring program partners;

15 (D) [AND (4)] involve stakeholders in the planning process;

16 (2) shall include information related to the

17 (A) security of the database; and

18 (B) reductions, if any, in the inappropriate use or  
 19 prescription of controlled substances resulting from the use of the  
 20 database.

21 \* Sec. 34. AS 17.30.200 is amended by adding new subsections to read:

22 (o) A pharmacist who dispenses or a practitioner who prescribes, administers,  
 23 or directly dispenses a schedule II, III, or IV controlled substance under federal law  
 24 shall register with the database by a procedure and in a format established by the  
 25 board.

26 (p) The board shall promptly notify the State Medical Board, the Board of  
 27 Nursing, the Board of Dental Examiners, and the Board of Examiners in Optometry  
 28 when a practitioner registers with the database under (o) of this section.

29 (q) The board is authorized to provide unsolicited notification to a pharmacist  
 30 or practitioner if a patient has received one or more prescriptions for controlled  
 31 substances in quantities or with a frequency inconsistent with generally recognized

1 standards of safe practice.

2 (r) The board shall update the database on at least a weekly basis with the  
3 information submitted to the board under (b) of this section.

4 (s) The Department of Commerce, Community, and Economic Development  
5 shall

6 (1) assist the board and provide necessary staff and equipment to  
7 implement this section; and

8 (2) establish fees for registration with the database by a pharmacist or  
9 practitioner required to register under (o) of this section so that the total amount of  
10 fees collected by the department equals the total operational costs of the database  
11 minus all federal funds acquired for the operational costs of the database; in setting the  
12 fee levels, the department shall

13 (A) set the fees for registration with the database so that the  
14 fees are the same for all practitioners and pharmacists required to register; and

15 (B) consult with the board to establish the fees under this  
16 subsection.

17 \* **Sec. 35.** AS 33.30.028 is amended by adding new subsections to read:

18 (c) The commissioner shall apply for medical assistance under AS 47.07 and  
19 for general relief assistance under AS 47.25.120 - 47.25.300 on behalf of a prisoner  
20 incarcerated in a correctional facility to establish medical assistance coverage or  
21 general relief assistance for the prisoner during a period of hospitalization outside of  
22 the correctional facility.

23 (d) The commissioner may obtain information necessary to determine whether  
24 a prisoner incarcerated in a correctional facility is eligible for medical assistance under  
25 AS 47.07 or public assistance under AS 47.25. Information obtained under this  
26 subsection may only be used for the purpose of applying for medical assistance or  
27 public assistance under (c) of this section and may not be disclosed for any other  
28 purpose without the permission of the prisoner. An employee of the commissioner  
29 who discloses a prisoner's social security number in an application for medical  
30 assistance or public assistance under this section is considered to be acting in the  
31 performance of the employee's duties or responsibilities under AS 45.48.400(b).

1 \* **Sec. 36.** AS 37.05.146(c) is amended by adding a new paragraph to read:

2 (88) monetary recoveries under AS 09.58 (Alaska Medical Assistance  
3 False Claim and Reporting Act).

4 \* **Sec. 37.** AS 40.25.120(a) is amended by adding a new paragraph to read:

5 (15) records relating to proceedings under AS 09.58 (Alaska Medical  
6 Assistance False Claim and Reporting Act).

7 \* **Sec. 38.** AS 44.33 is amended by adding a new section to read:

8 **Article 5A. Telemedicine Business Registry.**

9 **Sec. 44.33.381. Telemedicine business registry.** (a) The department shall  
10 adopt regulations for establishing and maintaining a registry of businesses performing  
11 telemedicine services in the state.

12 (b) The department shall maintain the registry of businesses performing  
13 telemedicine services in the state. The registry must include the name, address, and  
14 contact information of businesses performing telemedicine services in the state.

15 (c) In this section,

16 (1) "department" means the Department of Commerce, Community,  
17 and Economic Development;

18 (2) "telemedicine services" means the delivery of health care services  
19 using the transfer of medical data through audio, visual, or data communications that  
20 are performed over two or more locations by a provider who is physically separated  
21 from the recipient of the health care services.

22 \* **Sec. 39.** AS 47.05 is amended by adding a new section to article 1 to read:

23 **Sec. 47.05.105. Enhanced computerized eligibility verification system.** (a)  
24 The department shall establish an enhanced computerized income, asset, and identity  
25 eligibility verification system for the purposes of verifying eligibility, eliminating  
26 duplication of public assistance payments, and deterring waste and fraud in public  
27 assistance programs administered by the department under AS 47.05.010. Nothing in  
28 this section prohibits the department from verifying eligibility for public assistance  
29 through additional procedures or authorizes the department or a third-party vendor to  
30 use data to verify eligibility for a federal program if the use of that data is prohibited  
31 by federal law.

1 (b) The department shall enter into a competitively bid contract with a third-  
2 party vendor for the purpose of developing a system under this section to prevent  
3 fraud, misrepresentation, and inadequate documentation when determining an  
4 applicant's eligibility for public assistance before the payment of benefits and for  
5 periodically verifying eligibility between eligibility redeterminations and during  
6 eligibility redeterminations and reviews under AS 47.05.110 - 47.05.120. The  
7 department may also contract with a third-party vendor to provide information to  
8 facilitate reviews of recipient eligibility and income verification.

9 (c) The annual savings to the state resulting from the use of the system under  
10 this section must exceed the cost of implementing the system. A contract under this  
11 section must require the third-party vendor to report annual savings to the state  
12 realized from implementing the system. Payment to the third-party vendor may be  
13 based on a fee for each applicant and may include incentives for achieving a rate of  
14 success established by the department for identifying duplication, waste, and fraud in  
15 public assistance programs.

16 (d) To avoid a conflict of interest, the department may not award a contract to  
17 provide services for the enrollment of public assistance providers or applicants under  
18 this title to a vendor that is awarded a contract under this section.

19 \* **Sec. 40.** AS 47.05.200(a) is amended to read:

20 (a) The department shall annually contract for independent audits of a  
21 statewide sample of all medical assistance providers in order to identify overpayments  
22 and violations of criminal statutes. The audits conducted under this section may not be  
23 conducted by the department or employees of the department. The number of audits  
24 under this section may not be less than 50 each year [, AS A TOTAL FOR THE  
25 MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL  
26 BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE  
27 PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE  
28 DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS  
29 SECTION MAY NOT BE LESS THAN 75]. The audits under this section must  
30 include both on-site audits and desk audits and must be of a variety of provider types.  
31 The department may not award a contract under this subsection to an organization that

1 does not retain persons with a significant level of expertise and recent professional  
 2 practice in the general areas of standard accounting principles and financial auditing  
 3 and in the specific areas of medical records review, investigative research, and Alaska  
 4 health care criminal law. The contractor, in consultation with the commissioner, shall  
 5 select the providers to be audited and decide the ratio of desk audits and on-site audits  
 6 to the total number selected. **In identifying providers who are subject to an audit**  
 7 **under this chapter, the department shall attempt to minimize concurrent state or**  
 8 **federal audits.**

9 \* Sec. 41. AS 47.05.200(b) is amended to read:

10 (b) Within 90 days after receiving each audit report from an audit conducted  
 11 under this section, the department shall begin administrative procedures to recoup  
 12 overpayments identified in the audits and shall allocate the reasonable and necessary  
 13 financial and human resources to ensure prompt recovery of overpayments unless the  
 14 attorney general has advised the commissioner in writing that a criminal investigation  
 15 of an audited provider has been or is about to be undertaken, in which case, the  
 16 commissioner shall hold the administrative procedure in abeyance until a final  
 17 charging decision by the attorney general has been made. The commissioner shall  
 18 provide copies of all audit reports to the attorney general so that the reports can be  
 19 screened for the purpose of bringing criminal charges. **The department may assess**  
 20 **interest and penalties on any identified overpayment. Interest under this**  
 21 **subsection shall be calculated using the statutory rates for postjudgment interest**  
 22 **accruing from the date of the issuance of the final agency decision to recoup**  
 23 **overpayments identified in the audit. In this subsection, the date of issuance of**  
 24 **the final agency decision is the later of the date of**

25 **(1) the department's written notification of the decision and the**  
 26 **provider's appeal rights; or**

27 **(2) if timely appealed by the provider, a final agency decision**  
 28 **under AS 44.64.060.**

29 \* Sec. 42. AS 47.05 is amended by adding a new section to read:

30 **Sec. 47.05.235. Duty to identify and repay self-identified overpayments. (a)**

31 Unless a provider is being audited under AS 47.05.200(a), an enrolled medical

1 assistance provider shall conduct a biennial review or audit of a statistically valid  
2 sample of claims submitted to the department for reimbursement. If overpayments are  
3 identified, the medical assistance provider shall report the overpayment to the  
4 department not later than 10 business days after identification of the overpayment. The  
5 report must also identify how the medical assistance provider intends to repay the  
6 department. After the department receives the report, the medical assistance provider  
7 and the department shall enter into an agreement establishing a schedule for  
8 repayment of the identified overpayment. The agreement may authorize repayment in  
9 a lump sum, a payment plan, or by offsetting future billings as approved by the  
10 department.

11 (b) The department may not assess interest or penalties on an overpayment  
12 identified and repaid by a medical assistance provider under this section.

13 \* **Sec. 43.** AS 47.05 is amended by adding new sections to read:

14 **Sec. 47.05.250. Civil penalties.** (a) The department may assess a civil penalty  
15 against a provider who violates this chapter, AS 47.07, or regulations adopted under  
16 this chapter or AS 47.07.

17 (b) The department shall adopt regulations establishing a range of civil  
18 penalties that the department may assess against a provider under this section. In  
19 establishing the range of civil penalties, the department shall take into account  
20 appropriate factors, including the seriousness of the violation, the service provided by  
21 the provider, and the severity of the penalty. The regulations may not provide for a  
22 civil penalty of less than \$100 or more than \$25,000 for each violation.

23 (c) The provisions of this section are in addition to any other remedies  
24 available under this chapter, AS 47.07, or regulations adopted under this chapter or  
25 AS 47.07.

26 (d) A provider against whom a civil penalty of less than \$2,500 is assessed  
27 may appeal the decision assessing the penalty to the commissioner or the  
28 commissioner's designee. The commissioner shall, by regulation, establish time limits  
29 and procedures for an appeal under this subsection. The decision of the commissioner  
30 or the commissioner's designee may be appealed to the office of administrative  
31 hearings established under AS 44.64.

1 (e) A provider against whom a civil penalty of \$2,500 or more is assessed may  
 2 appeal the decision assessing the penalty to the office of administrative hearings  
 3 established under AS 44.64.

4 **Sec. 47.05.270. Medical assistance reform program.** (a) The department  
 5 shall adopt regulations to design and implement a program for reforming the state  
 6 medical assistance program under AS 47.07. The reform program must include

7 (1) referrals to community and social support services, including career  
 8 and education training services available through the Department of Labor and  
 9 Workforce Development under AS 23.15, the University of Alaska, or other sources;

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

12 (3) expanding the use of telehealth for primary care, behavioral health,  
 13 and urgent care;

14 (4) enhancing fraud prevention, detection, and enforcement;

15 (5) reducing the cost of behavioral health, senior, and disabilities  
 16 services provided to recipients of medical assistance under the state's home and  
 17 community-based services waiver under AS 47.07.045;

18 (6) pharmacy initiatives;

19 (7) enhanced care management;

20 (8) redesigning the payment process by implementing fee agreements  
 21 that include one or more of the following:

22 (A) premium payments for centers of excellence;

23 (B) penalties for hospital-acquired infections, readmissions,  
 24 and outcome failures;

25 (C) bundled payments for specific episodes of care; or

26 (D) global payments for contracted payers, primary care  
 27 managers, and case managers for a recipient or for care related to a specific  
 28 diagnosis;

29 (9) stakeholder involvement in setting annual targets for quality and  
 30 cost-effectiveness;

31 (10) to the extent consistent with federal law, reducing travel costs by

1 requiring a recipient to obtain medical services in the recipient's home community, to  
2 the extent appropriate services are available in the recipient's home community;

3 (11) guidelines for health care providers to develop health care  
4 delivery models supported by evidence-based practices that encourage wellness and  
5 disease prevention.

6 (b) The department shall, in coordination with the Alaska Mental Health Trust  
7 Authority, efficiently manage a comprehensive and integrated behavioral health  
8 program that uses evidence-based, data-driven practices to achieve positive outcomes  
9 for people with mental health or substance abuse disorders and children with severe  
10 emotional disturbances. The goal of the program is to assist recipients of services  
11 under the program to recover by achieving the highest level of autonomy with the least  
12 dependence on state-funded services possible for each person. The program must  
13 include

14 (1) a plan for providing a continuum of community-based services to  
15 address housing, employment, criminal justice, and other relevant issues;

16 (2) services from a wide array of providers and disciplines, including  
17 licensed or certified mental health and primary care professionals; and

18 (3) efforts to reduce operational barriers that fragment services,  
19 minimize administrative burdens, and reduce the effectiveness and efficiency of the  
20 program.

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

28 (d) On or before November 15 of each year, the department shall prepare a  
29 report and submit the report to the senate secretary and the chief clerk of the house of  
30 representatives and notify the legislature that the report is available. The report must  
31 include

- 1 (1) realized cost savings related to reform efforts under this section;
- 2 (2) realized cost savings related to medical assistance reform efforts
- 3 undertaken by the department other than the reform efforts described in this Act;
- 4 (3) a statement of whether the department has met annual targets for
- 5 quality and cost-effectiveness;
- 6 (4) recommendations for legislative or budgetary changes related to
- 7 medical assistance reforms during the next fiscal year;
- 8 (5) changes in federal laws that the department expects will result in a
- 9 cost or savings to the state of more than \$1,000,000;
- 10 (6) a description of any medical assistance grants, options, or waivers
- 11 the department applied for in the previous fiscal year;
- 12 (7) the results of demonstration projects the department has
- 13 implemented;
- 14 (8) legal and technological barriers to the expanded use of telehealth,
- 15 improvements in the use of telehealth in the state, and recommendations for changes
- 16 or investments that would allow cost-effective expansion of telehealth;
- 17 (9) the percentage decrease in costs of travel for medical assistance
- 18 recipients compared to the previous fiscal year;
- 19 (10) the percentage decrease in the number of medical assistance
- 20 recipients identified as frequent users of emergency departments compared to the
- 21 previous fiscal year;
- 22 (11) the percentage increase or decrease in the number of hospital
- 23 readmissions within 30 days after a hospital stay for medical assistance recipients
- 24 compared to the previous fiscal year;
- 25 (12) the percentage increase or decrease in state general fund spending
- 26 for the average medical assistance recipient compared to the previous fiscal year;
- 27 (13) the percentage increase or decrease in uncompensated care costs
- 28 incurred by medical assistance providers compared to the percentage change in private
- 29 health insurance premiums for individual and small group health insurance;
- 30 (14) the cost, in state and federal funds, for providing optional services
- 31 under AS 47.07.030(b);

1 (15) the amount of state funds saved as a result of implementing  
 2 changes in federal policy authorizing 100 percent federal funding for services  
 3 provided to American Indian and Alaska Native individuals eligible for Medicaid, and  
 4 the estimated savings in state funds that could have been achieved if the department  
 5 had fully implemented the changes in policy.

6 (e) In this section, "telehealth" means the practice of health care delivery,  
 7 evaluation, diagnosis, consultation, or treatment, using the transfer of health care data  
 8 through audio, visual, or data communications, performed over two or more locations  
 9 between providers who are physically separated from the recipient or from each other  
 10 or between a provider and a recipient who are physically separated from each other.

11 \* Sec. 44. AS 47.07.030(d) is amended to read:

12 (d) The department **shall** [MAY] establish as optional services a primary care  
 13 case management system or a managed care organization contract in which certain  
 14 eligible individuals are required to enroll and seek approval from a case manager or  
 15 the managed care organization before receiving certain services. **The purpose of a**  
 16 **primary care case management system or managed care organization contract is**  
 17 **to increase the use of appropriate primary and preventive care by medical**  
 18 **assistance recipients, while decreasing the unnecessary use of specialty care and**  
 19 **hospital emergency department services.** The department shall

20 (1) establish enrollment criteria and determine eligibility for services  
 21 consistent with federal and state law; **the department shall require recipients with**  
 22 **multiple hospitalizations to enroll in a primary care case management system or**  
 23 **with a managed care organization under this subsection, except that the**  
 24 **department may exempt recipients with chronic, acute, or terminal medical**  
 25 **conditions from the requirement under this paragraph;**

26 (2) **define the coordinated care services and provider types eligible**  
 27 **to participate as primary care providers;**

28 (3) **create a performance and quality reporting system; and**

29 (4) **integrate the coordinated care demonstration projects**  
 30 **described under AS 47.07.039 and the demonstration projects described under**  
 31 **AS 47.07.036(e) with the primary care case management system or managed care**

**organization contract established under this subsection.**

\* **Sec. 45.** AS 47.07.036 is amended by adding new subsections to read:

(d) Notwithstanding (a) - (c) of this section, the department may

(1) apply for a section 1915(i) option under 42 U.S.C. 1396n to improve services and care through home and community-based services to obtain, at a minimum, a 50 percent federal match;

(2) apply for a section 1915(k) option under 42 U.S.C. 1396n to provide home and community-based services and support to increase the federal match for these programs from 50 percent to 56 percent;

(3) apply for a section 1945 option under 42 U.S.C. 1396w-4 to provide coordinated care through health homes for individuals with chronic conditions and to increase the federal match for the services to 90 percent for the first eight quarters the required state plan amendment is in effect;

(4) evaluate and seek permission from the United States Department of Health and Human Services Centers for Medicare and Medicaid Services to participate in various demonstration projects, including payment reform, care management programs, workforce development and innovation, and innovative services delivery models; and

(5) provide incentives for telehealth, including increasing the capability for and reimbursement of telehealth for recipients.

(e) Notwithstanding (a) - (c) of this section, and in addition to the projects and services described under (d) and (f) of this section, the department shall apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on innovative payment models for one or more groups of medical assistance recipients in one or more specific geographic areas. The demonstration project or projects may include

(1) managed care organizations as described under 42 U.S.C. 1396u-2;

(2) community care organizations;

(3) patient-centered medical homes as described under 42 U.S.C. 256a-

1; or

(4) other innovative payment models that ensure access to health care

1 without reducing the quality of care.

2 (f) Notwithstanding (a) - (c) of this section, and in addition to the projects and  
 3 services described under (d) and (e) of this section, the department shall apply for a  
 4 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration  
 5 projects focused on improving the state's behavioral health system for medical  
 6 assistance recipients. The department shall engage stakeholders and the community in  
 7 the development of a project or projects under this subsection. The demonstration  
 8 project or projects must

9 (1) be consistent with the comprehensive and integrated behavioral  
 10 health program described under AS 47.05.270(b); and

11 (2) include continuing cooperation with the grant-funded community  
 12 mental health clinics and drug and alcohol treatment centers that have historically  
 13 provided care to recipients of behavioral health services.

14 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

15 \* **Sec. 46.** AS 47.07 is amended by adding new sections to read:

16 **Sec. 47.07.038. Collaborative, hospital-based project to reduce use of**  
 17 **emergency department services.** (a) On or before December 1, 2016, the department  
 18 shall collaborate with a statewide professional hospital association to establish a  
 19 hospital-based project to reduce the use of emergency department services by medical  
 20 assistance recipients. The statewide professional hospital association shall operate the  
 21 project. Subject to (b) of this section, the project may include shared savings for  
 22 participating hospitals. The project must include

23 (1) an interdisciplinary process for defining, identifying, and  
 24 minimizing the number of frequent users of emergency department services;

25 (2) to the extent consistent with federal law, a system for real-time  
 26 electronic exchange of patient information, including recent emergency department  
 27 visits, hospital care plans for frequent users of emergency departments, and data from  
 28 the controlled substance prescription database;

29 (3) a procedure for educating patients about the use of emergency  
 30 departments and appropriate alternative services and facilities for nonurgent care;

31 (4) a process for assisting users of emergency departments in making

1 appointments with primary care or behavioral health providers within 96 hours after  
2 an emergency department visit;

3 (5) a collaborative process between the department and the statewide  
4 professional hospital association to establish uniform statewide guidelines for  
5 prescribing narcotics in an emergency department; and

6 (6) designation of health care personnel to review successes and  
7 challenges regarding appropriate emergency department use.

8 (b) After January 1, 2022, the department may not compensate hospital  
9 emergency departments, through shared savings, for a reduction in hospital fees  
10 resulting from the project.

11 (c) The department shall adopt regulations necessary to implement this  
12 section, request technical assistance from the United States Department of Health and  
13 Human Services, and apply to the United States Department of Health and Human  
14 Services for waivers or amendments to the state plan as necessary to implement the  
15 projects under this section.

16 **Sec. 47.07.039. Coordinated care demonstration projects.** (a) The  
17 department shall contract with one or more third parties to implement one or more  
18 coordinated care demonstration projects for recipients of medical assistance identified  
19 by the department. The purpose of a demonstration project under this section is to  
20 assess the efficacy of a proposed health care delivery model with respect to cost for,  
21 access to, and quality of care for medical assistance recipients. The department may  
22 contract for separate demonstration projects to coordinate care for different groups of  
23 medical assistance recipients to achieve more effective care for recipients at greater  
24 cost savings for the medical assistance program. The department shall request  
25 proposals for at least one project under this section on or before December 31, 2016,  
26 and may annually request proposals for additional projects under this section  
27 thereafter. The department may use an innovative procurement process as described  
28 under AS 36.30.308 to award a contract for a project under this section. A proposal for  
29 a demonstration project under this section must be submitted to the committee  
30 established under (b) of this section and must include three or more of the following  
31 elements:

1 (1) comprehensive primary-care-based management for medical  
2 assistance services, including behavioral health services and coordination of long-term  
3 services and support;

4 (2) care coordination, including the assignment of a primary care  
5 provider located in the local geographic area of the recipient, to the extent practical;

6 (3) health promotion;

7 (4) comprehensive transitional care and follow-up care after inpatient  
8 treatment;

9 (5) referral to community and social support services, including career  
10 and education training services available through the Department of Labor and  
11 Workforce Development under AS 23.15, the University of Alaska, or other sources;

12 (6) sustainability and the ability to achieve similar results in other  
13 regions of the state;

14 (7) integration and coordination of benefits, services, and utilization  
15 management;

16 (8) local accountability for health and resource allocation;

17 (9) an innovative payment process, including bundled payments or  
18 global payments.

19 (b) A project review committee is established in the department for the  
20 purpose of reviewing proposals for demonstration projects under this section. The  
21 project review committee consists of

22 (1) the commissioner of the department, or the commissioner's  
23 designee;

24 (2) the commissioner of administration, or the commissioner's  
25 designee;

26 (3) the chief executive officer of the Alaska Mental Health Trust  
27 Authority, or the chief executive officer's designee, who shall serve as chair of the  
28 committee;

29 (4) two representatives of stakeholder groups, appointed by the  
30 governor for staggered three-year terms, as follows:

31 (A) one representative of a stakeholder group who has direct

1 experience with health plan management and cost control for the medical  
2 assistance population;

3 (B) one representative of a stakeholder group who has direct  
4 experience with health plan management and cost control for a nongovernment  
5 employer of 500 or more employees in the state;

6 (5) a nonvoting member who is a member of the senate, appointed by  
7 the president of the senate; and

8 (6) a nonvoting member who is a member of the house of  
9 representatives, appointed by the speaker of the house of representatives.

10 (c) The department may contract with a managed care organization, primary  
11 care case manager, accountable care organization, prepaid ambulatory health plan, or  
12 provider-led entity to implement a demonstration project under this section. The fee  
13 structure for a contract under this subsection may include global payments, bundled  
14 payments, capitated payments, shared savings and risk, or other payment structures.  
15 The department shall work with the division of insurance, Department of Commerce,  
16 Community, and Economic Development, to streamline the application process for a  
17 company to obtain a certificate of authority required under AS 21.09.010 as necessary  
18 to participate in a demonstration project under this section.

19 (d) A proposal for a demonstration project under this section must include, in  
20 addition to the elements required under (a) of this section, information demonstrating  
21 how the project will implement additional cost-saving measures including innovations  
22 to reduce the cost of care for medical assistance recipients through the expanded use  
23 of telehealth for primary care, urgent care, and behavioral health services. The  
24 department shall identify legal or cost barriers preventing the expanded use of  
25 telehealth and shall recommend remedies for identified barriers.

26 (e) The department shall contract with a third-party actuary to review  
27 demonstration projects established under this section. The actuary shall review each  
28 demonstration project after two years of implementation and make recommendations  
29 for the implementation of a similar project on a statewide basis. The actuary shall  
30 evaluate each project based on cost savings for the medical assistance program, health  
31 outcomes for participants in the project, and the ability to achieve similar results on a

1 statewide basis. On or before December 31 of each year starting in 2018, the actuary  
 2 shall submit a final report to the department regarding any demonstration project that  
 3 has been in operation for at least two years.

4 (f) The department shall prepare a plan regarding regional or statewide  
 5 implementation of a coordinated care project based on the results of the demonstration  
 6 projects under this section. On or before November 15, 2019, the department shall  
 7 submit the plan to the senate secretary and the chief clerk of the house of  
 8 representatives and notify the legislature that the plan is available. On or before  
 9 November 15 of each year thereafter, the department shall submit a report regarding  
 10 any changes or recommendations regarding the plan developed under this subsection  
 11 to the senate secretary and the chief clerk of the house of representatives and notify the  
 12 legislature that the report is available.

13 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

14 \* **Sec. 47.** AS 47.07 is amended by adding a new section to read:

15 **Sec. 47.07.076. Reports to legislature.** (a) The department and the attorney  
 16 general shall annually prepare a report relating to the medical assistance program  
 17 under AS 47.07. The report must include the following information:

18 (1) the amount and source of funds used to prevent or prosecute fraud,  
 19 abuse, payment errors, and errors in eligibility determinations for the previous fiscal  
 20 year;

21 (2) actions taken to address fraud, abuse, payment errors, and errors in  
 22 eligibility determinations during the previous fiscal year;

23 (3) specific examples of fraud or abuse that were prevented or  
 24 prosecuted;

25 (4) identification of vulnerabilities in the medical assistance program,  
 26 including any vulnerabilities identified by independent auditors with whom the  
 27 department contracts under AS 47.05.200;

28 (5) initiatives the department has taken to prevent fraud or abuse;

29 (6) recommendations to increase effectiveness in preventing and  
 30 prosecuting fraud and abuse;

31 (7) the return to the state for every dollar expended by the department

1 and the attorney general to prevent and prosecute fraud and abuse;

2 (8) the most recent payment error rate measurement report for the  
3 medical assistance program, including fee for service programs and pilot or  
4 demonstration projects; the report must also explain the reasons for the payment errors  
5 and the total amount of state and federal funds paid in error during the reporting period  
6 and not recovered by the department at the time of the report;

7 (9) results from the Medicaid Eligibility Quality Control program.

8 (b) On or before November 15 of each year, the department shall submit the  
9 report required under (a) of this section to the senate secretary and the chief clerk of  
10 the house of representatives and notify the legislature that the report is available.

11 (c) On or before December 15 and June 15 of each year, the department shall  
12 prepare a semi-annual report and submit the report to the senate secretary and the chief  
13 clerk of the house of representatives and notify the legislature that the report is  
14 available. The report must include

15 (1) updates and status reports on the Medicaid Management  
16 Information System, including progress toward federal certification of the system,  
17 current measurements of the accuracy of the system, timeliness of payment of claims,  
18 and any backlog of claims; and

19 (2) information on the status of an administrative or legal proceeding  
20 relating to resolution of claims against the system contractor and related financial  
21 effects on the state.

22 \* **Sec. 48.** AS 47.07.900(4) is amended to read:

23 (4) "clinic services" means services provided by state-approved  
24 outpatient community mental health clinics [THAT RECEIVE GRANTS UNDER  
25 AS 47.30.520 - 47.30.620], state-operated community mental health clinics, outpatient  
26 surgical care centers, and physician clinics;

27 \* **Sec. 49.** AS 47.07.900(17) is amended to read:

28 (17) "rehabilitative services" means services for substance abusers and  
29 emotionally disturbed or chronically mentally ill adults provided by

30 (A) a drug or alcohol treatment center [THAT IS FUNDED  
31 WITH A GRANT UNDER AS 47.30.475]; or

1 (B) an outpatient community mental health clinic [THAT HAS  
2 A CONTRACT TO PROVIDE COMMUNITY MENTAL HEALTH  
3 SERVICES UNDER AS 47.30.520 - 47.30.620];

4 \* **Sec. 50.** AS 47.55.020(e) is amended to read:

5 (e) As a condition for receipt of payment assistance under (d) of this section,  
6 the department, under regulations adopted by the department, **shall** [MAY] require a  
7 person to

8 (1) apply for other state or federally sponsored programs that may  
9 reduce the amount of the payment assistance; **and**

10 (2) **submit to the department a copy of the person's application for**  
11 **medical assistance coverage under AS 47.07 and the decision letter the person**  
12 **receives regarding the application.**

13 \* **Sec. 51.** AS 09.58.020, 09.58.030, 09.58.040, 09.58.050, and 09.58.060 are repealed  
14 July 1, 2019.

15 \* **Sec. 52.** AS 08.36.070(a)(10); AS 08.64.101(7); AS 08.68.100(a)(11);  
16 AS 08.72.060(c)(3); AS 08.80.030(b)(13); AS 17.30.200(o), 17.30.200(p), 17.30.200(q),  
17 17.30.200(r), and 17.30.200(s) are repealed July 1, 2021.

18 \* **Sec. 53.** AS 47.07.076(c) is repealed.

19 \* **Sec. 54.** The uncodified law of the State of Alaska is amended by adding a new section to  
20 read:

21 **INDIRECT COURT RULE AMENDMENTS.** (a) AS 09.58.010, added by sec. 18 of  
22 this Act, has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, by  
23 providing that the state is entitled to full reasonable attorney fees and costs if the state prevails  
24 in a civil action under AS 09.58.010 - 09.58.060 that involves fraud, or reasonable attorney  
25 fees and costs if the state prevails in a civil action under AS 09.58.010 - 09.58.060 that does  
26 not involve fraud.

27 (b) AS 09.58.020, added by sec. 18 of this Act, and repealed by sec. 51 of this Act,  
28 has the effect of amending the following court rules in the manner specified from the effective  
29 date of sec. 18 of this Act until July 1, 2019:

30 (1) Rules 4, 5, 7, and 12, Alaska Rules of Civil Procedure, by requiring that a  
31 complaint under AS 09.58 be filed in camera and under seal and may not be served on the

1 defendant until unsealed and that a copy of the complaint be served on the attorney general;

2 (2) Rules 41 and 77, Alaska Rules of Civil Procedure, by authorizing the  
3 attorney general to move for dismissal of a complaint filed by another person under  
4 AS 09.58.020, added by sec. 18 of this Act and repealed by sec. 51 of this Act, and requiring  
5 court approval for dismissal of the action.

6 (c) AS 09.58.025, added by sec. 18 of this Act, and amended by sec. 19 of this Act,  
7 has the effect of amending Rule 27, Alaska Rules of Civil Procedure, by authorizing the  
8 attorney general to issue subpoenas as part of an investigation

9 (1) under AS 09.58.015, added by sec. 18 of this Act, from the effective date  
10 of sec. 18 of this Act; and

11 (2) under AS 09.58.020, added by sec. 18 of this Act, from the effective date  
12 of sec. 18 of this Act until July 1, 2019.

13 (d) AS 09.58.030, added by sec. 18 of this Act, and repealed by sec. 51 of this Act,  
14 has the effect of amending the following court rules in the manner specified from the effective  
15 date of sec. 18 of this Act until July 1, 2019:

16 (1) Rule 24, Alaska Rules of Civil Procedure, by authorizing the attorney  
17 general to intervene in a civil action filed by another person under AS 09.58.020 added by  
18 sec. 18 of this Act, and repealed by sec. 51 of this Act, and limiting the participation of a party  
19 to the litigation;

20 (2) Rules 26 and 27, Alaska Rules of Civil Procedure, by authorizing the  
21 attorney general to request that the court issue a stay of discovery for a 90-day period, or  
22 longer upon a showing by the attorney general.

23 (e) AS 09.58.040, added by sec. 18 of this Act, and repealed by sec. 51 of this Act,  
24 has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, from the  
25 effective date of sec. 18 of this Act until July 1, 2019, by giving a person who brings an action  
26 under AS 09.58.020, added by sec. 18 of this Act, and repealed by sec. 51 of this Act, the  
27 right to reasonable attorney fees and costs in an action prosecuted by the attorney general, and  
28 to full reasonable attorney fees and costs if the person prevails in an action not prosecuted by  
29 the attorney general that involves fraud, or reasonable attorney fees and costs in a case that  
30 does not involve fraud.

31 \* **Sec. 55.** The uncodified law of the State of Alaska is amended by adding a new section to

1 read:

2 IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT.

3 (a) The Department of Health and Social Services shall collaborate with Alaska tribal health  
4 organizations and the United States Department of Health and Human Services to fully  
5 implement changes in federal policy that authorize 100 percent federal funding for services  
6 provided to American Indian and Alaska Native individuals eligible for Medicaid.

7 (b) Within 30 days after the date the Centers for Medicare and Medicaid Services  
8 issues a final policy regarding the circumstances in which 100 percent federal funding is  
9 available for medical assistance services received through the United States Indian Health  
10 Service or tribal health facilities, the Department of Health and Social Services shall notify  
11 and submit a report to the co-chairs of the house and senate finance committees of the Alaska  
12 State Legislature that includes an estimate of the savings to the state resulting from the final  
13 policy. Within six months after the date the Centers for Medicare and Medicaid Services  
14 issues the final policy, the Department of Health and Social Services shall fully implement the  
15 policy in the state.

16 (c) In this section, "Alaska tribal health organization" means an organization  
17 recognized by the United States Indian Health Service to provide health-related services.

18 \* **Sec. 56.** The uncodified law of the State of Alaska is amended by adding a new section to  
19 read:

20 HEALTH INFORMATION INFRASTRUCTURE PLAN. (a) The Department of  
21 Health and Social Services shall develop a health information infrastructure plan to strengthen  
22 the health information infrastructure, including health data analytics capability. The purpose  
23 of the health information infrastructure plan is to transform the health care system in the state  
24 by providing

25 (1) data required by health care providers for care coordination and quality  
26 improvement; and

27 (2) the information support required by the Department of Health and Social  
28 Services and health care providers to enable development and implementation of the other  
29 provisions of this Act.

30 (b) To the greatest extent practicable, the health information infrastructure plan will  
31 leverage existing resources, including the health information exchange, and will identify

1 opportunities for integrating and streamlining health data systems administered by the state.

2 \* **Sec. 57.** The uncodified law of the State of Alaska is amended by adding a new section to  
3 read:

4 FEASIBILITY STUDIES FOR THE PROVISION OF SPECIFIED STATE  
5 SERVICES. (a) The Department of Health and Social Services, in conjunction with the  
6 Alaska Mental Health Trust Authority, shall procure a study analyzing the feasibility of  
7 privatizing services delivered at the Alaska Psychiatric Institute. The Department of Health  
8 and Social Services and the Alaska Mental Health Trust Authority shall deliver a joint report  
9 summarizing the conclusions of the Department of Health and Social Services and the Alaska  
10 Mental Health Trust Authority to the senate secretary and the chief clerk of the house of  
11 representatives and notify the legislature that the report is available within 10 days after the  
12 convening of the First Regular Session of the Thirtieth Alaska State Legislature.

13 (b) The Department of Administration shall, in collaboration with the house and  
14 senate finance committees, procure a study to be completed on or before June 30, 2017, to  
15 determine the feasibility of creating a health care authority to coordinate health care plans and  
16 consolidate purchasing effectiveness for all state employees, retired state employees, retired  
17 teachers, medical assistance recipients, University of Alaska employees, employees of state  
18 corporations, and school district employees and to develop appropriate benefit sets, rules,  
19 cost-sharing, and payment structures for all employees and individuals whose health care  
20 benefits are funded directly or indirectly by the state, with the goal of achieving the greatest  
21 possible savings to the state through a coordinated approach administered by a single entity.  
22 In developing the study, the Department of Administration shall seek input from the  
23 Department of Health and Social Services, administrators familiar with managing government  
24 employee health plans, and human resource professionals familiar with self-insured health  
25 care plans. The study must

- 26 (1) identify cost-saving strategies that a health care authority could implement;  
27 (2) analyze local government participation in the authority;  
28 (3) analyze a phased approach to adding groups to the health care plans  
29 coordinated by the health care authority;  
30 (4) consider previous studies procured by the Department of Administration  
31 and the legislature;

1 (5) assess the use of community-related health insurance risk pools and the use  
2 of the private marketplace;

3 (6) identify organizational models for a health care authority, including private  
4 for-profit, private nonprofit, government, and state corporations; and

5 (7) include a public review and comment opportunity for employers,  
6 employees, medical assistance recipients, retirees, and health care providers.

7 (c) The Department of Health and Social Services shall procure a study analyzing the  
8 feasibility of privatizing select facilities of the division of juvenile justice and privatizing  
9 pharmacy services delivered at Alaska Pioneers' Homes. The Department of Health and  
10 Social Services shall deliver a report summarizing the conclusions of the Department of  
11 Health and Social Services to the senate secretary and the chief clerk of the house of  
12 representatives and notify the legislature that the report is available within 10 days after the  
13 convening of the First Regular Session of the Thirtieth Alaska State Legislature.

14 (d) In this section, "school district" has the meaning given in AS 14.30.350.

15 \* **Sec. 58.** The uncodified law of the State of Alaska is amended by adding a new section to  
16 read:

17 REPORT TO LEGISLATURE. (a) The Board of Pharmacy, Board of Examiners in  
18 Optometry, Board of Dental Examiners, Board of Nursing, and State Medical Board shall  
19 jointly prepare a report that describes recommended guidelines for the prescription of  
20 schedule II controlled substances listed under federal law. The guidelines must be drafted  
21 with the goal of reducing the over-prescription of pain killers and highly addictive schedule II  
22 controlled substances. The report must include

23 (1) the following recommended guidelines for each schedule II controlled  
24 substance listed under federal law:

25 (A) quantity and strength of each dosage;

26 (B) number of doses for each day;

27 (C) number of days the drug may be prescribed; and

28 (2) other recommendations related to reducing the over-prescription of  
29 schedule II controlled substances.

30 (b) On or before January 1, 2017, the Board of Pharmacy, Board of Examiners in  
31 Optometry, Board of Dental Examiners, Board of Nursing, and State Medical Board shall

1 jointly deliver the report required under (a) of this section to the senate secretary and the chief  
2 clerk of the house of representatives and notify the legislature that the report is available.

3 \* **Sec. 59.** The uncodified law of the State of Alaska is amended by adding a new section to  
4 read:

5 MEDICAID STATE PLAN; WAIVERS; INSTRUCTIONS; NOTICE TO REVISOR  
6 OF STATUTES. The Department of Health and Social Services shall amend and submit for  
7 federal approval a state plan for medical assistance coverage consistent with this Act. The  
8 Department of Health and Social Services shall apply to the United States Department of  
9 Health and Human Services for any waivers necessary to implement this Act. The  
10 commissioner of health and social services shall certify to the revisor of statutes if the  
11 provisions of AS 47.05.270(a)(5), (8), and (10), added by sec. 43 of this Act, and the  
12 provisions of AS 47.07.038, added by sec. 46 of this Act, are approved by the United States  
13 Department of Health and Human Services.

14 \* **Sec. 60.** The uncodified law of the State of Alaska is amended by adding a new section to  
15 read:

16 TRANSITION: REGULATIONS. (a) The Department of Health and Social Services  
17 may adopt regulations necessary to implement the changes made by this Act. The regulations  
18 take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date  
19 of the relevant provision of this Act implemented by the regulation.

20 (b) The Department of Commerce, Community, and Economic Development and a  
21 board that regulates an occupation that includes a practitioner who is required to register with  
22 the controlled substances database under AS 17.30.200 shall adopt regulations to implement  
23 the changes made by AS 08.36.070(a), as amended by sec. 5 of this Act, AS 08.64.101(7),  
24 added by sec. 7 of this Act, AS 08.68.100(a), as amended by sec. 10 of this Act,  
25 AS 08.72.060(c), as amended by sec. 11 of this Act, AS 08.80.030(b), as amended by sec. 12  
26 of this Act, AS 17.30.200(a), as amended by sec. 21 of this Act, AS 17.30.200(b), as amended  
27 by sec. 23 of this Act, AS 17.30.200(d), as amended by sec. 25 of this Act, AS 17.30.200(e),  
28 as amended by sec. 27 of this Act, AS 17.30.200(h), as amended by sec. 29 of this Act,  
29 AS 17.30.200(k), as amended by sec. 31 of this Act, AS 17.30.200(m), as amended by sec. 33  
30 of this Act, and AS 17.30.200(o) - (s), enacted by sec. 34 of this Act. The regulations take  
31 effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the

1 relevant provisions of secs. 5, 7, 10, 11, 12, 21, 23, 25, 27, 29, 31, 33, or 34 of this Act. In this  
2 subsection,

3 (1) "board" has the meaning given in AS 08.01.110;

4 (2) "occupation" has the meaning given in AS 08.01.110;

5 (3) "practitioner" has the meaning given in AS 11.71.900.

6 \* **Sec. 61.** The uncodified law of the State of Alaska is amended by adding a new section to  
7 read:

8 **CONDITIONAL EFFECT.** (a) AS 47.05.270(a)(5), enacted by sec. 43 of this Act,  
9 takes effect only if the commissioner of health and social services certifies to the revisor of  
10 statutes under sec. 59 of this Act, on or before October 1, 2017, that all of the provisions  
11 added by AS 47.05.270(a)(5) have been approved by the United States Department of Health  
12 and Human Services.

13 (b) AS 47.05.270(a)(8), enacted by sec. 43 of this Act, takes effect only if the  
14 commissioner of health and social services certifies to the revisor of statutes under sec. 59 of  
15 this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.270(a)(8)  
16 have been approved by the United States Department of Health and Human Services.

17 (c) AS 47.05.270(a)(10), enacted by sec. 43 of this Act, takes effect only if the  
18 commissioner of health and social services certifies to the revisor of statutes under sec. 59 of  
19 this Act, on or before October 1, 2017, that all of the provisions added by  
20 AS 47.05.270(a)(10) have been approved by the United States Department of Health and  
21 Human Services.

22 (d) AS 47.07.038, enacted by sec. 46 of this Act, takes effect only if the commissioner  
23 of health and social services certifies to the revisor of statutes under sec. 59 of this Act, on or  
24 before October 1, 2017, that all of the provisions added by AS 47.07.038 have been approved  
25 by the United States Department of Health and Human Services.

26 (e) AS 09.58.020, added by sec. 18 of this Act, AS 09.58.025, added by sec. 18 of this  
27 Act, AS 09.58.030, added by sec. 18 of this Act, and AS 09.58.040, added by sec. 18 of this  
28 Act, the amendment to AS 09.58.025 by sec. 19 of this Act, and the repeals of AS 09.58.020,  
29 09.58.030, and 09.58.040, by sec. 51 of this Act, take effect only if sec. 54 of this Act receives  
30 the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the  
31 State of Alaska.

1 (f) Section 53 of this Act takes effect only if the commissioner of health and social  
2 services certifies to the revisor of statutes that the Medicaid Management Information System  
3 has been certified by the United States Department of Health and Human Services.

4 \* **Sec. 62.** If AS 47.05.270(a)(5), enacted by sec. 43 of this Act, takes effect, it takes effect  
5 on the day after the date the commissioner of health and social services makes a certification  
6 to the revisor of statutes under secs. 59 and 61(a) of this Act.

7 \* **Sec. 63.** If AS 47.05.270(a)(8), enacted by sec. 43 of this Act, takes effect, it takes effect  
8 on the day after the date the commissioner of health and social services makes a certification  
9 to the revisor of statutes under secs. 59 and 61(b) of this Act.

10 \* **Sec. 64.** If AS 47.05.270(a)(10), enacted by sec. 43 of this Act, takes effect, it takes effect  
11 on the day after the date the commissioner of health and social services makes a certification  
12 to the revisor of statutes under secs. 59 and 61(c) of this Act.

13 \* **Sec. 65.** If AS 47.07.038, enacted by sec. 46 of this Act, takes effect, it takes effect on the  
14 day after the date the commissioner of health and social services makes a certification to the  
15 revisor of statutes under secs. 59 and 61(d) of this Act.

16 \* **Sec. 66.** If sec. 53 of this Act takes effect, it takes effect on the day after the date the  
17 commissioner of health and social services makes a certification to the revisor of statutes  
18 under sec. 61(f) of this Act.

19 \* **Sec. 67.** Sections 57 and 59 - 61 of this Act take effect immediately under  
20 AS 01.10.070(c).

21 \* **Sec. 68.** AS 47.07.076(c), enacted by sec. 47 of this Act, takes effect July 1, 2016.

22 \* **Sec. 69.** AS 17.30.200(s), enacted by sec. 34 of this Act, takes effect September 1, 2016.

23 \* **Sec. 70.** Sections 5, 10 - 12, 21, 23, 25, 27, 29, 31, and 33 of this Act, AS 08.64.101(7),  
24 enacted by sec. 7 of this Act, and AS 17.30.200(o) - (r), enacted by sec. 34 of this Act, take  
25 effect July 17, 2017.

26 \* **Sec. 71.** Sections 19 and 20 of this Act take effect July 1, 2019.

27 \* **Sec. 72.** Sections 22, 24, 26, 28, 30, and 32 of this Act take effect January 1, 2021.

Y | N  
9 | 2

Passed

29-LS0692\T.1  
Glover  
4/7/16

AMENDMENT

1 as Amended

OFFERED IN THE HOUSE

BY REPRESENTATIVE NEUMAN

TO: HCS CSSB 74(FIN), Draft Version "T"

1 Page 22, following line 4:

2 Insert a new bill section to read:

3 **\*\* Sec. 22.** AS 17.30.200(a), as amended by sec. 21 of this Act, is amended to read:

4 (a) The controlled substance prescription database is established in the Board  
5 of Pharmacy. The purpose of the database is to contain data as described in this  
6 section regarding every prescription for a schedule IA, IIA, IIIA, IVA, or VA  
7 controlled substance under state law or a schedule I, II, III, [OR] IV, or V  
8 controlled substance under federal law dispensed in the state to a person other than  
9 those administered to a patient at a health care facility. The Department of  
10 Commerce, Community, and Economic Development shall assist the board and  
11 provide necessary staff and equipment to implement this section."

12

13 Renumber the following bill sections accordingly.

14

15 Page 23, following line 2:

16 Insert a new bill section to read:

17 **\*\* Sec. 24.** AS 17.30.200(b), as amended by sec. 23 of this Act, is amended to read:

18 (b) The pharmacist-in-charge of each licensed or registered pharmacy,  
19 regarding each schedule IA, IIA, IIIA, IVA, or VA controlled substance under  
20 state law or a schedule I, II, III, [OR] IV, or V controlled substance under federal  
21 law dispensed by a pharmacist under the supervision of the pharmacist-in-charge, and  
22 each practitioner who directly dispenses a schedule IA, IIA, IIIA, IVA, or VA  
23 controlled substance under state law or a schedule I, II, III, [OR] IV, or V

1 controlled substance under federal law other than those administered to a patient at a  
 2 health care facility, shall submit to the board, by a procedure and in a format  
 3 established by the board, the following information for inclusion in the database [ON  
 4 AT LEAST A WEEKLY BASIS]:

5 (1) the name of the prescribing practitioner and the practitioner's  
 6 federal Drug Enforcement Administration registration number or other appropriate  
 7 identifier;

8 (2) the date of the prescription;

9 (3) the date the prescription was filled and the method of payment; this  
 10 paragraph does not authorize the board to include individual credit card or other  
 11 account numbers in the database;

12 (4) the name, address, and date of birth of the person for whom the  
 13 prescription was written;

14 (5) the name and national drug code of the controlled substance;

15 (6) the quantity and strength of the controlled substance dispensed;

16 (7) the name of the drug outlet dispensing the controlled substance;

17 **and**

18 (8) the name of the pharmacist or practitioner dispensing the controlled  
 19 substance and other appropriate identifying information [; AND

20 (9) IF A PRESCRIPTION IS DISPENSED TO A PERSON OTHER  
 21 THAN THE PATIENT FOR WHOM THE PRESCRIPTION WAS WRITTEN, THE  
 22 NAME AND DATE OF BIRTH OF THE PERSON TO WHOM THE  
 23 PRESCRIPTION WAS DISPENSED]."

24  
 25 Renumber the following bill sections accordingly.

26  
 27 Page 24, following line 27:

28 Insert a new bill section to read:

29 **"\* Sec. 26.** AS 17.30.200(d), as amended by sec. 25 of this Act, is amended to read:

30 (d) The database and the information contained within the database are  
 31 confidential, are not public records, and are not subject to public disclosure. The board

1 shall undertake to ensure the security and confidentiality of the database and the  
2 information contained within the database. The board may allow access to the  
3 database only to the following persons, and in accordance with the limitations  
4 provided and regulations of the board:

5 (1) personnel of the board regarding inquiries concerning licensees or  
6 registrants of the board or personnel of another board or agency concerning a  
7 practitioner under a search warrant, subpoena, or order issued by an administrative law  
8 judge or a court;

9 (2) authorized board personnel or contractors as required for  
10 operational and review purposes;

11 (3) a licensed practitioner having authority to prescribe controlled  
12 substances [OR AN AGENT OR EMPLOYEE OF THE PRACTITIONER WHOM  
13 THE PRACTITIONER HAS AUTHORIZED TO ACCESS THE DATABASE ON  
14 THE PRACTITIONER'S BEHALF], to the extent the information relates specifically  
15 to a current patient of the practitioner to whom the practitioner is prescribing or  
16 considering prescribing a controlled substance; [THE AGENT OR EMPLOYEE  
17 MUST BE LICENSED OR REGISTERED UNDER AS 08;]

18 (4) a licensed or registered pharmacist having authority to dispense  
19 controlled substances [OR AN AGENT OR EMPLOYEE OF THE PHARMACIST  
20 WHOM THE PHARMACIST HAS AUTHORIZED TO ACCESS THE DATABASE  
21 ON THE PHARMACIST'S BEHALF], to the extent the information relates  
22 specifically to a current patient to whom the pharmacist is dispensing or considering  
23 dispensing a controlled substance; [THE AGENT OR EMPLOYEE MUST BE  
24 LICENSED OR REGISTERED UNDER AS 08;]

25 (5) federal, state, and local law enforcement authorities may receive  
26 printouts of information contained in the database under a search warrant, subpoena,  
27 or order issued by a court establishing probable cause for the access and use of the  
28 information; and

29 (6) an individual who is the recipient of a controlled substance  
30 prescription entered into the database may receive information contained in the  
31 database concerning the individual on providing evidence satisfactory to the board that

1 the individual requesting the information is in fact the person about whom the data  
2 entry was made and on payment of a fee set by the board under AS 37.10.050 that  
3 does not exceed \$10 [;

4 (7) A LICENSED PHARMACIST EMPLOYED BY THE  
5 DEPARTMENT OF HEALTH AND SOCIAL SERVICES WHO IS RESPONSIBLE  
6 FOR ADMINISTERING PRESCRIPTION DRUG COVERAGE FOR THE  
7 MEDICAL ASSISTANCE PROGRAM UNDER AS 47.07, TO THE EXTENT  
8 THAT THE INFORMATION RELATES SPECIFICALLY TO PRESCRIPTION  
9 DRUG COVERAGE UNDER THE PROGRAM;

10 (8) A LICENSED PHARMACIST, LICENSED PRACTITIONER,  
11 OR AUTHORIZED EMPLOYEE OF THE DEPARTMENT OF HEALTH AND  
12 SOCIAL SERVICES RESPONSIBLE FOR UTILIZATION REVIEW OF  
13 PRESCRIPTION DRUGS FOR THE MEDICAL ASSISTANCE PROGRAM  
14 UNDER AS 47.07, TO THE EXTENT THAT THE INFORMATION RELATES  
15 SPECIFICALLY TO UTILIZATION REVIEW OF PRESCRIPTION DRUGS  
16 PROVIDED TO RECIPIENTS OF MEDICAL ASSISTANCE;

17 (9) THE STATE MEDICAL EXAMINER, TO THE EXTENT THAT  
18 THE INFORMATION RELATES SPECIFICALLY TO INVESTIGATING THE  
19 CAUSE AND MANNER OF A PERSON'S DEATH;

20 (10) AN AUTHORIZED EMPLOYEE OF THE DEPARTMENT OF  
21 HEALTH AND SOCIAL SERVICES MAY RECEIVE INFORMATION FROM  
22 THE DATABASE THAT DOES NOT DISCLOSE THE IDENTITY OF A  
23 PATIENT, PRESCRIBER, DISPENSER, OR DISPENSER LOCATION, FOR THE  
24 PURPOSE OF IDENTIFYING AND MONITORING PUBLIC HEALTH ISSUES IN  
25 THE STATE; HOWEVER, THE INFORMATION PROVIDED UNDER THIS  
26 PARAGRAPH MAY INCLUDE THE REGION OF THE STATE IN WHICH A  
27 PATIENT, PRESCRIBER, AND DISPENSER ARE LOCATED AND THE  
28 SPECIALTY OF THE PRESCRIBER; AND

29 (11) A PRACTITIONER EMPLOYED BY THE UNITED STATES  
30 INDIAN HEALTH SERVICE]."  
31

1 Renumber the following bill sections accordingly.

2

3 Page 25, following line 2:

4 Insert a new bill section to read:

5 **"\* Sec. 28.** AS 17.30.200(e), as amended by sec. 27 of this Act, is amended to read:

6 (e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to  
7 [REGISTER OR] submit information to the database as required under this section is  
8 grounds for the board to take disciplinary action against the license or registration of  
9 the pharmacy or pharmacist or for another licensing board to take disciplinary action  
10 against a practitioner.

11

12 Renumber the following bill sections accordingly.

13

14 Page 25, following line 11:

15 Insert a new bill section to read:

16 **"\* Sec. 30.** AS 17.30.200(h), as amended by sec. 29 of this Act, is amended to read:

17 (h) An individual who has submitted information to the database in  
18 accordance with this section may not be held civilly liable for having submitted the  
19 information. **Nothing in this section requires or obligates a dispenser or**  
20 **practitioner to access or check the database before dispensing, prescribing, or**  
21 **administering a medication, or providing medical care to a person.** Dispensers or  
22 practitioners may not be held civilly liable for damages for accessing or failing to  
23 access the information in the database."

24

25 Renumber the following bill sections accordingly.

26

27 Page 26, following line 7:

28 Insert a new bill section to read:

29 **"\* Sec. 32.** AS 17.30.200(k), as amended by sec. 31 of this Act, is amended to read:

30 (k) In the regulations adopted under this section, the board shall provide

31

(1) that prescription information in the database be purged from the

1 database after two years have elapsed from the date the prescription was dispensed;

2 (2) a method for an individual to challenge information in the database  
3 about the individual that the person believes is incorrect or was incorrectly entered by  
4 a dispenser [;

5 (3) A PROCEDURE AND TIME FRAME FOR REGISTRATION  
6 WITH THE DATABASE;

7 (4) THAT A PRACTITIONER REVIEW THE INFORMATION IN  
8 THE DATABASE TO CHECK A PATIENT'S PRESCRIPTION RECORDS  
9 BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING A SCHEDULE II  
10 OR III CONTROLLED SUBSTANCE UNDER FEDERAL LAW TO THE  
11 PATIENT; THE REGULATIONS MUST PROVIDE THAT A PRACTITIONER IS  
12 NOT REQUIRED TO REVIEW THE INFORMATION IN THE DATABASE  
13 BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING

14 (A) A CONTROLLED SUBSTANCE TO A PERSON WHO  
15 IS RECEIVING TREATMENT

16 (i) IN AN INPATIENT SETTING;

17 (ii) AT THE SCENE OF AN EMERGENCY OR IN  
18 AN AMBULANCE; IN THIS SUB-SUBPARAGRAPH,  
19 "AMBULANCE" HAS THE MEANING GIVEN IN AS 18.08.200;

20 (iii) IN AN EMERGENCY ROOM;

21 (iv) IMMEDIATELY BEFORE, DURING, OR  
22 WITHIN THE FIRST 48 HOURS AFTER SURGERY OR A  
23 MEDICAL PROCEDURE;

24 (v) IN A HOSPICE OR NURSING HOME THAT  
25 HAS AN IN-HOUSE PHARMACY; OR

26 (B) A NONREFILLABLE PRESCRIPTION OF A  
27 CONTROLLED SUBSTANCE IN A QUANTITY INTENDED TO LAST  
28 FOR NOT MORE THAN THREE DAYS]."

29  
30 Renumber the following bill sections accordingly.

31

1 Page 43, following line 10:

2 Insert a new bill section to read:

3 **\*\* Sec. 52.** AS 08.36.070(a)(10); AS 08.64.101(7); AS 08.68.100(a)(11);  
4 AS 08.72.060(c)(3); AS 08.80.030(b)(13); AS 17.30.200(o), 17.30.200(p), 17.30.200(q),  
5 17.30.200(r), and 17.30.200(s) are repealed January 1, 2020."  
6

7 Renumber the following bill sections accordingly.  
8

9 Page 43, line 20:

10 Delete "sec. 45"

11 Insert "sec. 51"

12

13 Page 43, line 28:

14 Delete "sec. 45"

15 Insert "sec. 51"

16

17 Page 44, line 6:

18 Delete "sec. 45"

19 Insert "sec. 51"

20

21 Page 44, line 11:

22 Delete "sec. 45"

23 Insert "sec. 51"

24

25 Page 44, line 16:

26 Delete "sec. 45"

27 Insert "sec. 51"

28

29 Page 44, line 19:

30 Delete "sec. 45"

31 Insert "sec. 51"

- 1
- 2 Page 47, line 28:
  - 3 Delete "sec. 36"
  - 4 Insert "sec. 42"
  - 5
- 6 Page 47, line 29:
  - 7 Delete "sec. 39"
  - 8 Insert "sec. 45"
  - 9
- 10 Page 48, line 13:
  - 11 Delete "sec. 22"
  - 12 Insert "sec. 23"
  - 13 Delete "sec. 23"
  - 14 Insert "sec. 25"
  - 15
- 16 Page 48, line 14:
  - 17 Delete "sec. 24"
  - 18 Insert "sec. 27"
  - 19 Delete "sec. 25"
  - 20 Insert "sec. 29"
  - 21
- 22 Page 48, line 15:
  - 23 Delete "sec. 25"
  - 24 Insert "sec. 31"
  - 25
- 26 Page 48, line 16:
  - 27 Delete "sec. 27"
  - 28 Insert "sec. 33"
  - 29
- 30 Page 48, lines 17 - 18:
  - 31 Delete "or 21 - 27"

1           Insert "21, 23, 25, 27, 29, 31, or 33"

2

3   Page 48, line 24:

4           Delete "sec. 36"

5           Insert "sec. 42"

6

7   Page 48, line 26:

8.          Delete "sec. 52"

9           Insert "sec. 59"

10

11   Page 48, line 29:

12          Delete "sec. 36"

13          Insert "sec. 42"

14

15   Page 48, line 30:

16          Delete "sec. 52"

17          Insert "sec. 59"

18

19   Page 49, line 2:

20          Delete "sec. 36"

21          Insert "sec. 42"

22

23   Page 49, line 3:

24          Delete "sec. 52"

25          Insert "sec. 59"

26

27   Page 49, line 7:

28          Delete "sec. 39"

29          Insert "sec. 45"

30

31   Page 49, line 8:

- 1 Delete "sec. 52"
- 2 Insert "sec. 59"
- 3
- 4 Page 49, line 14:
  - 5 Delete "sec. 45"
  - 6 Insert "sec. 51"
  - 7 Delete "sec. 47"
  - 8 Insert "sec. 54"
  - 9
- 10 Page 49, line 17:
  - 11 Delete "Section 46"
  - 12 Insert "Section 53"
  - 13
- 14 Page 49, line 20:
  - 15 Delete "sec. 36"
  - 16 Insert "sec. 42"
  - 17
- 18 Page 49, line 22:
  - 19 Delete "secs. 52 and 54(a)"
  - 20 Insert "secs. 59 and 61(a)"
  - 21
- 22 Page 49, line 23:
  - 23 Delete "sec. 36"
  - 24 Insert "sec. 42"
  - 25
- 26 Page 49, line 25:
  - 27 Delete "secs. 52 and 54(b)"
  - 28 Insert "secs. 59 and 61(b)"
  - 29
- 30 Page 49, line 26:
  - 31 Delete "sec. 36"

- 1           Insert "sec. 42"
- 2
- 3   Page 49, line 28:
- 4           Delete "secs. 52 and 54(c)"
- 5           Insert "secs. 59 and 61(c)"
- 6
- 7   Page 49, line 29:
- 8           Delete "sec. 36"
- 9           Insert "sec. 45"
- 10
- 11   Page 49, line 31:
- 12           Delete "secs. 52 and 54(d)"
- 13           Insert "secs. 59 and 61(d)"
- 14
- 15   Page 50, line 1:
- 16           Delete "sec. 46"
- 17           Insert "sec. 53"
- 18
- 19   Page 50, line 3:
- 20           Delete "sec. 54(f)"
- 21           Insert "sec. 61(f)"
- 22
- 23   Page 50, line 4:
- 24           Delete "Sections 50, 52, 53, and 54"
- 25           Insert "Sections 57 and 59 - 61"
- 26
- 27   Page 50, line 6:
- 28           Delete "and 21 - 26"
- 29           Insert "21, 23, 25, 27, 29, and 31"
- 30
- 31   Page 50, line 7:

1 Delete "sec. 27"

2 Insert "sec. 33"

3

4 Page 50, line 8:

5 Delete "sec. 40"

6 Insert "sec. 46"

7

8 Page 50, line 9:

9 Delete "sec. 27"

10 Insert "sec. 33"

11

12 Page 50, following line 10:

13 Insert a new bill section to read:

14 **\*\* Sec. 72.** Sections 22, 24, 26, 28, 30, and 32 of this Act take effect January 1, 2020."

NOTE: CONCEPTUAL amend 1 TO RENEWED WITHDRAWN

**2016 HOUSE FINANCE COMMITTEE VOTE SHEET**

Passed  
No OBJECTION

DATE: 4.9.2016

Amendment: Conceptual amend #2 TO Amend #1

MEMBER

Favor

Oppose

REP. WILSON		
REP. EDGMON		
REP. GARA		
REP. GATTIS		
REP. GUTTENBERG		
REP. KAWASAKI		
REP. MUNOZ		
REP. PRUITT		
REP. SADDLER		
REP. NEUMAN		
REP. THOMPSON		

YEA

NAY

PG 7, LN 5  
PG 17, LN 14

change JAN 1 2020 TO JULY 1 2021  
change JAN 1 2020 TO JULY 1 2021

# 2016 HOUSE FINANCE COMMITTEE VOTE SHEET

Y/N  
9/2

DATE: 4.9.2016  
 amended  
 Amendment: # 1

MEMBER

Favor

Oppose

REP. EDGMON	X	
REP. GARA		X
REP. GATTIS	X	
REP. GUTTENBERG		X
REP. KAWASAKI	X	
REP. MUNOZ	X	
REP. PRUITT	X	
REP. SADDLER	X	
REP. WILSON	X	
REP. NEUMAN	X	
REP. THOMPSON	X	

YEA 9 NAY 2

Passed  
No OBJECTIONS

29-LS0692\T.13  
Glover  
4/8/16

AMENDMENT 2

OFFERED IN THE HOUSE

BY REPRESENTATIVE EDGMON

TO: HCS CSSB 74(FIN), Draft Version "T"

1 Page 24, lines 26 - 27:

2 Delete all material and insert:

3 "(11) a practitioner, pharmacist, or clinical staff employed by an  
4 Alaska tribal health organization, including commissioned corps officers of the  
5 United States Public Health Service employed under a memorandum of  
6 agreement; in this paragraph, "Alaska tribal health organization" has the  
7 meaning given to "tribal health program" in 25 U.S.C. 1603."

Y/N  
8/2

PASSED

29-LS0692\T.16

Glover

4/9/16

MUNOZ' ABSENT  
AMENDMENT 3

OFFERED IN THE HOUSE

BY REPRESENTATIVE

Gattis  
Thompson

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 2, lines 4 - 5:
- 2 Delete "relating to competitive bidding for medical assistance products and
- 3 services;"
- 4
- 5 Page 28, lines 6 - 11:
- 6 Delete all material.
- 7
- 8 Renumber the following bill sections accordingly.
- 9
- 10 Page 43, line 20:
- 11 Delete "sec. 45"
- 12 Insert "sec. 44"
- 13
- 14 Page 43, line 28:
- 15 Delete "sec. 45"
- 16 Insert "sec. 44"
- 17
- 18 Page 44, line 6:
- 19 Delete "sec. 45"
- 20 Insert "sec. 44"
- 21
- 22 Page 44, line 11:
- 23 Delete "sec. 45"

- 1           Insert "sec. 44"
- 2
- 3   Page 44, line 16:
- 4           Delete "sec. 45"
- 5           Insert "sec. 44"
- 6
- 7   Page 44, line 19:
- 8           Delete "sec. 45"
- 9           Insert "sec. 44"
- 10
- 11   Page 47, line 28:
- 12           Delete "sec. 36"
- 13           Insert "sec. 35"
- 14
- 15   Page 47, line 29:
- 16           Delete "sec. 39"
- 17           Insert "sec. 38"
- 18
- 19   Page 48, line 15:
- 20           Delete "sec. 25"
- 21           Insert "sec. 26"
- 22
- 23   Page 48, line 24:
- 24           Delete "sec. 36"
- 25           Insert "sec. 35"
- 26
- 27   Page 48, line 26:
- 28           Delete "sec. 52"
- 29           Insert "sec. 51"
- 30
- 31   Page 48, line 29:

- 1 Delete "sec. 36"
- 2 Insert "sec. 35"
- 3
- 4 Page 48, line 30:
- 5 Delete "sec. 52"
- 6 Insert "sec. 51"
- 7
- 8 Page 49, line 2:
- 9 Delete "sec. 36"
- 10 Insert "sec. 35"
- 11
- 12 Page 49, line 3:
- 13 Delete "sec. 52"
- 14 Insert "sec. 51"
- 15
- 16 Page 49, line 7:
- 17 Delete "sec. 39"
- 18 Insert "sec. 38"
- 19
- 20 Page 49, line 8:
- 21 Delete "sec. 52"
- 22 Insert "sec. 51"
- 23
- 24 Page 49, line 14:
- 25 Delete "sec. 45"
- 26 Insert "sec. 44"
- 27 Delete "sec. 47"
- 28 Insert "sec. 46"
- 29
- 30 Page 49, line 17:
- 31 Delete "Section 46"

- 1           Insert "Section 45"
- 2
- 3   Page 49, line 20:
- 4           Delete "sec. 36"
- 5           Insert "sec. 35"
- 6
- 7   Page 49, line 22:
- 8           Delete "secs. 52 and 54(a)"
- 9           Insert "secs. 51 and 53(a)"
- 10
- 11   Page 49, line 23:
- 12           Delete "sec. 36"
- 13           Insert "sec. 35"
- 14
- 15   Page 49, line 25:
- 16           Delete "secs. 52 and 54(b)"
- 17           Insert "secs. 51 and 53(b)"
- 18
- 19   Page 49, line 26:
- 20           Delete "sec. 36"
- 21           Insert "sec. 35"
- 22
- 23   Page 49, line 28:
- 24           Delete "secs. 52 and 54(c)"
- 25           Insert "secs. 51 and 53(c)"
- 26
- 27   Page 49, line 29:
- 28           Delete "sec. 36"
- 29           Insert "sec. 38"
- 30
- 31   Page 49, line 31:

1 Delete "secs. 52 and 54(d)"

2 Insert "secs. 51 and 53(d)"

3

4 Page 50, line 1:

5 Delete "sec. 46"

6 Insert "sec. 45"

7

8 Page 50, line 3:

9 Delete "sec. 54(f)"

10 Insert "sec. 53(f)"

11

12 Page 50, line 4:

13 Delete "Sections 50, 52, 53, and 54"

14 Insert "Sections 49 and 51 - 53"

15

16 Page 50, line 8:

17 Delete "sec. 40"

18 Insert "sec. 39"

# 2016 HOUSE FINANCE COMMITTEE VOTE SHEET

Y | N  
8 | 2      Passed

DATE: 4.9.16

Amendment: #3

MEMBER

Favor

Oppose

REP. GARA		X
REP. GATTIS	X	
REP. GUTTENBERG	X	
REP. KAWASAKI		X
REP. MUNOZ		
REP. PRUITT	X	
REP. SADDLER	X	
REP. WILSON	X	
REP. EDGMON	X	
REP. THOMPSON	X	
REP. NEUMAN	X	

YEA 8      NAY 2

\*MUNOZ ABSENT FROM VOTE

Passed  
NO OBJECTIONS

29-LS0692\T.15  
Glover  
4/9/16

AMENDMENT 4

OFFERED IN THE HOUSE

BY REPRESENTATIVE Gara

TO: HCS CSSB 74(FIN), Draft Version "T"

1 Page 37, line 12:

2 Delete the first occurrence of "The"

3 Insert "Subject to (b) of this section, the"

4

5 Page 37, following line 29:

6 Insert a new subsection to read:

7 "(b) After January 1, 2022, the department may not compensate hospital  
8 emergency departments, through shared savings, for a reduction in hospital fees  
9 resulting from the project."

10

11 Reletter the following subsection accordingly.

WITHDRAWN

AMENDMENT 5

OFFERED IN THE HOUSE

BY REPRESENTATIVE GUTTENBERG

TO: CSSB 74(FIN) am

1 Page <sup>7</sup>4, line <sup>2</sup>13:

2 Delete "controlled substance"

3 Insert "schedule II controlled substance under federal law"

4  
5 Page <sup>7</sup>5, lines <sup>21-22</sup>1-2:

6 Delete "controlled substance"

7 Insert "schedule II controlled substance under federal law"

8  
9 Page <sup>7</sup>7, line <sup>23</sup>8:

10 Delete "controlled substance"

11 Insert "schedule II controlled substance under federal law"

12  
13 Page <sup>43</sup>35, following line <sup>8</sup>23:

14 Insert a new bill section to read:

15 "\*\* Sec. 36. AS 08.64.364(b) is repealed."

16

17 Renumber the following bill sections accordingly. *Legal will need to correct bill sections referenced*

18  
19 Page <sup>43</sup>35, line <sup>15</sup>29:

20 Delete "sec. 36"

21 Insert "sec. 37"

22  
23 Page <sup>43</sup>36, line <sup>28</sup>5:

- 1 Delete "sec. 36"
- 2 Insert "sec. 37"
- 3
- 4 Page <sup>44</sup>~~36~~, line <sup>6</sup>~~14~~:
- 5 Delete "sec. 36"
- 6 Insert "sec. 37"
- 7
- 8 Page <sup>44</sup>~~36~~, line <sup>11</sup>~~19~~:
- 9 Delete "sec. 36"
- 10 Insert "sec. 37"
- 11
- 12 Page <sup>44</sup>~~36~~, line <sup>16</sup>~~24~~:
- 13 Delete "sec. 36"
- 14 Insert "sec. 37"
- 15
- 16 Page <sup>44</sup>~~36~~, line <sup>19</sup>~~27~~:
- 17 Delete "sec. 36"
- 18 Insert "sec. 37"
- 19
- 20 Page <sup>48</sup>~~40~~, line <sup>26</sup>~~11~~:
- 21 Delete "sec. 41"
- 22 Insert "sec. 42"
- 23
- 24 Page <sup>48</sup>~~40~~, line <sup>30</sup>~~15~~:
- 25 Delete "sec. 41"
- 26 Insert "sec. 42"
- 27
- 28 Page <sup>49</sup>~~40~~, line <sup>3</sup>~~19~~:
- 29 Delete "sec. 41"
- 30 Insert "sec. 42"
- 31

- 1 Page ~~40~~<sup>49</sup>, line ~~24~~<sup>8</sup>:
- 2 Delete "sec. 41"
- 3 Insert "sec. 42"
- 4
- 5 Page ~~40~~<sup>49</sup>, line ~~29~~<sup>14</sup>:
- 6 Delete "sec. 36"
- 7 Insert "sec. 37"
- 8
- 9 Page ~~40~~<sup>49</sup>, line ~~30~~<sup>14</sup>:
- 10 Delete "sec. 37"
- 11 Insert "sec. 38"
- 12
- 13 Page ~~41~~<sup>49</sup>, line ~~3~~<sup>22</sup>:
- 14 Delete "secs. 41 and 43(a)"
- 15 Insert "secs. 42 and 44(a)"
- 16
- 17 Page ~~41~~<sup>49</sup>, line ~~6~~<sup>25</sup>:
- 18 Delete "secs. 41 and 43(b)"
- 19 Insert "secs. 42 and 44(b)"
- 20
- 21 Page ~~41~~<sup>49</sup>, line ~~9~~<sup>28</sup>:
- 22 Delete "secs. 41 and 43(c)"
- 23 Insert "secs. 42 and 44(c)"
- 24
- 25 Page ~~41~~<sup>49</sup>, line ~~12~~<sup>31</sup>:
- 26 Delete "secs. 41 and 43(d)"
- 27 Insert "secs. 42 and 44(d)"
- 28
- 29 Page ~~41~~<sup>50</sup>, line ~~13~~<sup>4</sup>:
- 30 Delete "Sections 40, 41, 42(a), and 43"
- 31 Insert "Sections 41, 42, 43(a), and 44"

1

50 §

2

Page ~~41~~, line ~~16~~:

3

Delete "sec. 42(b)"

4

Insert "sec. 43(b)"

Passed  
NO OBJECTIONS  
AMENDMENT 6

29-LS0692\T.8  
Glover  
4/8/16

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 12, lines 10 - 11:
- 2 Delete "the earlier of"
- 3
- 4 Page 12, line 13, following "Services,":
- 5 Insert "whichever is later,"

Passed  
NO OBJECTIONS

29-LS0692\T.17  
Bruce/Glover  
4/9/16

AMENDMENT 7

OFFERED IN THE HOUSE

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 28, lines 15 - 16:
- 2 Delete "that uses remote identity proofing through multiple layers of authentication"

Passed  
NO OBJECTIONS

29-LS0692\T.5  
Glover  
4/8/16

AMENDMENT 8

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 37, line 2:
- 2 Delete "support for and"

Passed  
NO OBJECTIONS

29-LS0692\T.4  
Glover  
4/7/16

AMENDMENT 9

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 46, following line 30:  
2 Insert a new subsection to read:  
3 "(c) The Department of Health and Social Services shall procure a study analyzing the  
4 feasibility of privatizing select facilities of the division of juvenile justice and privatizing  
5 pharmacy services delivered at Alaska Pioneers' Homes. The Department of Health and  
6 Social Services shall deliver a report summarizing the conclusions of the Department of  
7 Health and Social Services to the senate secretary and the chief clerk of the house of  
8 representatives and notify the legislature that the report is available within 10 days after the  
9 convening of the First Regular Session of the Thirtieth Alaska State Legislature."  
10  
11 Reletter the following subsection accordingly.

GATTIS  
SADDLER  
NEWMAN



ADDED NAMES TO  
AMENDMENT SPONSOR

PASSED  
NO OBJECTIONS

29-LS0692\T.6  
Glover  
4/8/16

AMENDMENT

10

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 50, line 7:
- 2 Delete "January 1"
- 3 Insert "July 17"

Y | N  
7 | 4

PASSED

29-LS0692\T.9  
Mischel  
4/8/16

AMENDMENT 11

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 14, lines 11 - 12:
- 2 Delete "unless the evidence shows that the agent or apparent agent acted with intent to
- 3 deceive the principal"

# 2016 HOUSE FINANCE COMMITTEE VOTE SHEET

Y | N  
7 | 4

Passed

DATE: 4.9.2016

Amendment: # 11

MEMBER

Favor

Oppose

REP. GATTIS		X
REP. GUTTENBERG	X	
REP. KAWASAKI	X	
REP. MUNOZ	X	
REP. PRUITT		X
REP. SADDLER	X	
REP. WILSON		X
REP. EDGMON	X	
REP. GARA		X
REP. NEUMAN	X	
REP. THOMPSON	X	

YEA 7 NAY 4

PASSED  
NO OBJECTIONS

29-LS0692\T.12  
Glover  
4/8/16

AMENDMENT 12

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

1 Page 27, following line 18:

2 Insert a new bill section to read:

3 **\*\* Sec. 29.** AS 37.05.146(c) is amended by adding a new paragraph to read:

4 (88) monetary recoveries under AS 09.58 (Alaska Medical Assistance  
5 False Claim and Reporting Act)."

6

7 Renumber the following bill sections accordingly.

8

9 Page 43, line 20:

10 Delete "sec. 45"

11 Insert "sec. 46"

12

13 Page 43, line 28:

14 Delete "sec. 45"

15 Insert "sec. 46"

16

17 Page 44, line 6:

18 Delete "sec. 45"

19 Insert "sec. 46"

20

21 Page 44, line 11:

22 Delete "sec. 45"

23 Insert "sec. 46"

- 1
- 2 Page 44, line 16:
  - 3 Delete "sec. 45"
  - 4 Insert "sec. 46"
  - 5
- 6 Page 44, line 19:
  - 7 Delete "sec. 45"
  - 8 Insert "sec. 46"
  - 9
- 10 Page 47, line 28:
  - 11 Delete "sec. 36"
  - 12 Insert "sec. 37"
  - 13
- 14 Page 47, line 29:
  - 15 Delete "sec. 39"
  - 16 Insert "sec. 40"
  - 17
- 18 Page 48, line 24:
  - 19 Delete "sec. 36"
  - 20 Insert "sec. 37"
  - 21
- 22 Page 48, line 26:
  - 23 Delete "sec. 52"
  - 24 Insert "sec. 53"
  - 25
- 26 Page 48, line 29:
  - 27 Delete "sec. 36"
  - 28 Insert "sec. 37"
  - 29
- 30 Page 48, line 30:
  - 31 Delete "sec. 52"

1           Insert "sec. 53"

2

3   Page 49, line 2:

4           Delete "sec. 36"

5           Insert "sec. 37"

6

7   Page 49, line 3:

8           Delete "sec. 52"

9           Insert "sec. 53"

10

11   Page 49, line 7:

12           Delete "sec. 39"

13           Insert "sec. 40"

14

15   Page 49, line 8:

16           Delete "sec. 52"

17           Insert "sec. 53"

18

19   Page 49, line 14:

20           Delete "sec. 45"

21           Insert "sec. 46"

22           Delete "sec. 47"

23           Insert "sec. 48"

24

25   Page 49, line 17:

26           Delete "Section 46"

27           Insert "Section 47"

28

29   Page 49, line 20:

30           Delete "sec. 36"

31           Insert "sec. 37"

1

2 Page 49, line 22:

3 Delete "secs. 52 and 54(a)"

4 Insert "secs. 53 and 55(a)"

5

6 Page 49, line 23:

7 Delete "sec. 36"

8 Insert "sec. 37"

9

10 Page 49, line 25:

11 Delete "secs. 52 and 54(b)"

12 Insert "secs. 53 and 55(b)"

13

14 Page 49, line 26:

15 Delete "sec. 36"

16 Insert "sec. 37"

17

18 Page 49, line 28:

19 Delete "secs. 52 and 54(c)"

20 Insert "secs. 53 and 55(c)"

21

22 Page 49, line 29:

23 Delete "sec. 36"

24 Insert "sec. 37"

25

26 Page 49, line 31:

27 Delete "secs. 52 and 54(d)"

28 Insert "secs. 53 and 55(d)"

29

30 Page 50, line 1:

31 Delete "sec. 46"

1           Insert "sec. 47"

2

3   Page 50, line 3:

4           Delete "sec. 54(f)"

5           Insert "sec. 55(f)"

6

7   Page 50, line 4:

8           Delete "Sections 50, 52, 53, and 54"

9           Insert "Sections 51 and 53 - 55"

10

11   Page 50, line 8:

12           Delete "sec. 40"

13           Insert "sec. 41"

Passed  
NO OBJECTIONS  
AMENDMENT 113

29-LS0692\T.11  
Mischel/Glover  
4/8/16

OFFERED IN THE HOUSE

BY REPRESENTATIVE THOMPSON

TO: HCS CSSB 74(FIN), Draft Version "T"

- 1 Page 42, lines 23 - 30:
- 2 Delete all material.
- 3
- 4 Renumber the following bill section accordingly.
- 5
- 6 Page 43, line 20:
- 7 Delete "sec. 45"
- 8 Insert "sec. 44"
- 9
- 10 Page 43, line 28:
- 11 Delete "sec. 45"
- 12 Insert "sec. 44"
- 13
- 14 Page 44, line 6:
- 15 Delete "sec. 45"
- 16 Insert "sec. 44"
- 17
- 18 Page 44, line 11:
- 19 Delete "sec. 45"
- 20 Insert "sec. 44"
- 21
- 22 Page 44, line 16:
- 23 Delete "sec. 45"

1           Insert "sec. 44"  
2  
3   Page 44, line 19:  
4           Delete "sec. 45"  
5           Insert "sec. 44"  
6  
7   Page 48, line 26:  
8           Delete "sec. 52"  
9           Insert "sec. 51"  
10  
11   Page 48, line 30:  
12           Delete "sec. 52"  
13           Insert "sec. 51"  
14  
15   Page 49, line 3:  
16           Delete "sec. 52"  
17           Insert "sec. 51"  
18  
19   Page 49, line 8:  
20           Delete "sec. 52"  
21           Insert "sec. 51"  
22  
23   Page 49, line 14:  
24           Delete "sec. 45"  
25           Insert "sec. 44"  
26           Delete "sec. 47"  
27           Insert "sec. 46"  
28  
29   Page 49, line 17:  
30           Delete "Section 46"  
31           Insert "Section 45"

- 1
- 2 Page 49, line 22:
  - 3 Delete "secs. 52 and 54(a)"
  - 4 Insert "secs. 51 and 53(a)"
  - 5
- 6 Page 49, line 25:
  - 7 Delete "secs. 52 and 54(b)"
  - 8 Insert "secs. 51 and 53(b)"
  - 9
- 10 Page 49, line 28:
  - 11 Delete "secs. 52 and 54(c)"
  - 12 Insert "secs. 51 and 53(c)"
  - 13
- 14 Page 49, line 31:
  - 15 Delete "secs. 52 and 54(d)"
  - 16 Insert "secs. 51 and 53(d)"
  - 17
- 18 Page 50, line 1:
  - 19 Delete "sec. 46"
  - 20 Insert "sec. 45"
  - 21
- 22 Page 50, line 3:
  - 23 Delete "sec. 54(f)"
  - 24 Insert "sec. 53(f)"
  - 25
- 26 Page 50, line 4:
  - 27 Delete "Sections 50, 52, 53, and 54"
  - 28 Insert "Sections 49 and 51 - 53"

NO OBJECTIONS

Offer Conceptual amendment 1.A BY REP NEUMAN

Remove (State) Schedule IA, IIA, IIIA, IVA,  
and VA along with Federal schedule I and V  
from sections 22 and 24 of Amendment 1.

This would address the concern expressed

by members while discussing Amendment 1

ADOPTED -  
NO OBJECTIONS

29-LS0692\T.2  
Glover  
4/6/16

AMENDMENT

15

OFFERED IN THE HOUSE

BY REPRESENTATIVE NEUMAN <sup>SADLER</sup>

TO: HCS CSSB 74(FIN), Draft Version "T"

1 Page 26, following line 7:

2 Insert a new bill section to read:

3 **"\* Sec. 27.** AS 17.30.200(m) is amended to read:

4 (m) To assist in fulfilling the program responsibilities, performance measures  
5 shall be reported to the legislature annually. Performance measures

6 (1) may include outcomes detailed in the federal prescription drug  
7 monitoring program grant regarding efforts to

8 (A) [(1)] reduce the rate of inappropriate use of prescription  
9 drugs by reporting education efforts conducted by the Board of Pharmacy;

10 (B) [(2)] reduce the quantity of pharmaceutical controlled  
11 substances obtained by individuals attempting to engage in fraud and deceit;

12 (C) [(3)] increase coordination among prescription drug  
13 monitoring program partners;

14 (D) [AND (4)] involve stakeholders in the planning process;

15 (2) shall include information related to the

16 (A) security of the database; and

17 (B) reductions, if any, in the inappropriate use or  
18 prescription of controlled substances resulting from the use of the  
19 database."

20

21 Renumber the following bill sections accordingly.

22

23 Page 43, line 20:

1 Delete "sec. 45"

2 Insert "sec. 46"

3

4 Page 43, line 28:

5 Delete "sec. 45"

6 Insert "sec. 46"

7

8 Page 44, line 6:

9 Delete "sec. 45"

10 Insert "sec. 46"

11

12 Page 44, line 11:

13 Delete "sec. 45"

14 Insert "sec. 46"

15

16 Page 44, line 16:

17 Delete "sec. 45"

18 Insert "sec. 46"

19

20 Page 44, line 19:

21 Delete "sec. 45"

22 Insert "sec. 46"

23

24 Page 47, line 28:

25 Delete "sec. 36"

26 Insert "sec. 37"

27

28 Page 47, line 29:

29 Delete "sec. 39"

30 Insert "sec. 40"

31

1 Page 48, line 15:

2 Delete "sec. 25"

3 Insert "sec. 26"

4

5 Page 48, following "Act,":

6 Insert "AS 17.30.200(m), as amended by sec. 27 of this Act,"

7

8 Page 48, line 16:

9 Delete "sec. 27"

10 Insert "sec. 28"

11

12 Page 48, lines 17 - 18:

13 Delete "sec. 21 - 27"

14 Insert "sec. 21 - 28"

15

16 Page 48, line 24:

17 Delete "sec. 36"

18 Insert "sec. 37"

19

20 Page 48, line 26:

21 Delete "sec. 52"

22 Insert "sec. 53"

23

24 Page 48, line 29:

25 Delete "sec. 36"

26 Insert "sec. 37"

27

28 Page 48, line 30:

29 Delete "sec. 52"

30 Insert "sec. 53"

31

1 Page 49, line 2:

2 Delete "sec. 36"

3 Insert "sec. 37"

4

5 Page 49, line 3:

6 Delete "sec. 52"

7 Insert "sec. 53"

8

9 Page 49, line 7:

10 Delete "sec. 39"

11 Insert "sec. 40"

12

13 Page 49, line 8:

14 Delete "sec. 52"

15 Insert "sec. 53"

16

17 Page 49, line 14:

18 Delete "sec. 45"

19 Insert "sec. 46"

20 Delete "sec. 47"

21 Insert "sec. 48"

22

23 Page 49, line 17:

24 Delete "Section 46"

25 Insert "Section 47"

26

27 Page 49, line 20:

28 Delete "sec. 36"

29 Insert "sec. 37"

30

31 Page 49, line 22:

1 Delete "secs. 52 and 54(a)"

2 Insert "secs. 53 and 55(a)"

3

4 Page 49, line 23:

5 Delete "sec. 36"

6 Insert "sec. 37"

7

8 Page 49, line 25:

9 Delete "secs. 52 and 54(b)"

10 Insert "secs. 53 and 55(b)"

11

12 Page 49, line 26:

13 Delete "sec. 36"

14 Insert "sec. 37"

15

16 Page 49, line 28:

17 Delete "secs. 52 and 54(c)"

18 Insert "secs. 53 and 55(c)"

19

20 Page 49, line 29:

21 Delete "sec. 36"

22 Insert "sec. 40"

23

24 Page 49, line 31:

25 Delete "secs. 52 and 54(d)"

26 Insert "secs. 53 and 55(d)"

27

28 Page 50, line 1:

29 Delete "sec. 46"

30 Insert "sec. 47"

31

1 Page 50, line 3:

2 Delete "sec. 54(f)"

3 Insert "sec. 55(f)"

4

5 Page 50, line 4:

6 Delete "Sections 50, 52, 53, and 54"

7 Insert "Sections 51 and 53 - 55"

8

9 Page 50, line 6:

10 Delete "21 - 26"

11 Insert "21 - 27"

12

13 Page 50, line 7:

14 Delete "sec. 27"

15 Insert "sec. 28"

16

17 Page 50, line 8:

18 Delete "sec. 40"

19 Insert "sec. 41"

20

21 Page 50, line 9:

22 Delete "sec. 27"

23 Insert "sec. 28"

## Helen Phillips

---

**From:** Newman, Anthony (HSS) <anthony.newman@alaska.gov>  
**Sent:** Wednesday, March 30, 2016 6:50 PM  
**To:** Helen Phillips  
**Subject:** FW: Responses to questions from 3/24 House Finance hearing on SB 74  
**Attachments:** Alaska Medicaid Computed Tomography Reimbursement Rates.pdf

---

**From:** Newman, Anthony (HSS)  
**Sent:** Wednesday, March 30, 2016 6:48 PM  
**To:** Pierson, Jane (LAA); Shaddock, Heather R (LAA)  
**Cc:** Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Forrest, Karen L (HSS); Brodie, Margaret C (HSS); Dunkin, Susan M (HSS); Martin, Monique R (HSS); Erickson, Deborah L (HSS); Peterson, Darwin R (GOV); Wilcox, Lacy J (GOV); McClanahan, Natasha S (GOV)  
**Subject:** Responses to questions from 3/24 House Finance hearing on SB 74

Jane and Heather:

Here are responses to questions asked in the Thursday, March 24<sup>th</sup> House Finance hearing on SB 74 for which the Department offered to provide further details. Please distribute to committee members.

1. ***Rep. Saddler requested background on the legality of requiring Medicaid recipients to participate in care management programs, and limiting participation in Medicaid if someone refuses.***

Please see the following regulations. They outline, from both the state and federal perspective, how the Department can enroll Medicaid recipients in care management programs, enforce restrictions, and provide fair hearing rights for individuals who disagree with these decisions. Recipients in the care management program can still receive all medically necessary Medicaid covered services, as long as they comply with the rules of the care management program. If they do not they are liable for the cost of services provided outside the program.

[7 AAC 105.600 Restriction of recipient's choice of providers](#)

[42 CFR 431.54 Exceptions to certain state plan requirements](#)

2. ***Rep. Munoz requested the Medicaid reimbursement for a computed tomography (CT) scan.***

Please see the attached table of CT scan rates. Note that payment rates vary depending on whether the service is offered in a physician's office or hospital and depending on the type of scan performed.

3. ***Rep. Saddler requested summaries of the Department's care management programs, and Rep. Wilson requested enrollment figures for these programs, including the number of individuals who declined participation.***

The Department is operating three care management programs at this time:

- A. The Lock-In Care Management Program has been in place since the early 1990s to combat harmful and costly inappropriate use of Medicaid-covered services. The Lock-In Program

limits a recipient to a primary care provider and a single pharmacy to reduce misuse of Alaska Medicaid services, encourage continuity of care, and promote communication between the recipient's primary care provider and pharmacy. Providers eligible to serve as primary care providers under this program and they include Physicians, Advanced Nurse Practitioners, and Physician Assistants. Recipients who could benefit from the program are most often identified by the Department or its fiscal agent, Xerox State Healthcare, but are also referred to the program by medical providers or other concerned individuals. A utilization review of the most recent 12 months of medical and pharmacy records is then conducted to determine if the individual meets criteria for this program. If placement is determined appropriate, the recipient is sent a notice explaining the reason for, and the date of placement into the program. The notice includes reports detailing the area(s) the patient has overused medical services. Care Management Program participation generally lasts for twelve months, during which time the recipient is limited to services rendered by the primary care provider and a single pharmacy. With the exception of emergency services, a recipient may seek treatment from other providers only after receiving an advance written referral from the primary care provider. This program saves approximately \$1.9 million a year. To date the Lock-In Program has enrolled 162 individuals. Thirty-nine individuals have requested fair hearings to contest their enrollment in the program.

- B. The MedExpert Care Management Program is a voluntary pilot project for individuals who have been identified to have three or more hospital visits in a 12-month period. The program began in December 2014. Through a contract with the Department, MedExpert assigns Medicaid recipients to case management and care coordination to build trust, increase understanding of their medical conditions, and ultimately improve the quality of their lives and help them make healthier lifestyle decisions. Case work is primarily conducted by telephone. This program began in 2013. To date 5,269 Alaskans have been enrolled and 523 have declined participation in the program. The Department estimates that this program has saved about \$6 million in state general funding through avoidance of health care costs for these individuals.
  
- C. The Qualis Care Management Program is also a voluntary pilot project is similar to the MedExpert Care Management Program except that care coordination services are primarily provided by an in-person case manager. This approach is more in line with managed care as it has traditionally been understood. To date this program has 19 participants; 39 individuals have declined participation. Furthermore, Qualis offers information about conditions that people have whether they participate or not, so if individuals decline they are provided information that includes recommendations on how to manage their conditions. This project began in November 2015 so we do not yet have data on the savings generated by this program.

Tony

**Tony Newman** | Legislative Liaison

Office of the Commissioner | Alaska Department of Health and Social Services

350 Main Street, Room 404 | Juneau AK 99811

(desk) [907.465.1611](tel:907.465.1611) | (cell) [907.321.3989](tel:907.321.3989)

[anthony.newman@alaska.gov](mailto:anthony.newman@alaska.gov)

Alaska Medicaid Computed Tomography Reimbursement Rates

Provided by the Alaska Department of Health and Social Services, March 26, 2016

Procedure Code	Procedure Code Description	Physician Imaging	Hospital Imaging
70450	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL	\$251.01	\$618.76
70460	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST MATERIAL(S)	\$329.47	\$982.50
70470	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL, FOLLOWED	\$335.17	\$1,323.21
70480	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE,	\$419.10	\$658.77
70481	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE,	\$483.54	\$727.41
70482	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE,	\$534.18	\$486.00
70486	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL	\$346.41	\$593.31
70490	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL	\$340.63	\$593.67
70491	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST MATERIAL(S)	\$407.64	\$763.69
70496	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEAD, WITH CONTRAST MATERIAL(S), INCLU	\$746.83	\$929.43
70498	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, NECK, WITH CONTRAST MATERIAL(S), INCLU	\$771.23	\$846.21
71250	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL	\$318.24	\$666.81
71260	COMPUTED TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)	\$397.27	\$742.24
71270	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONT	\$479.42	\$601.00
71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST	\$611.19	\$855.81
72125	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL	\$325.91	\$679.90
72128	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL	\$318.33	\$800.94

Procedure Code	Procedure Code Description	Physician Imaging	Hospital Imaging
72131	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL	\$317.37	\$680.14
72192	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL	\$267.93	\$629.91
72193	COMPUTED TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)	\$411.99	\$792.34
72194	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONT	\$460.52	\$681.43
73200	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL	\$316.05	\$643.68
73700	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL	\$317.01	\$637.39
74150	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL	\$274.77	\$840.04
74160	COMPUTED TOMOGRAPHY, ABDOMEN; WITH CONTRAST MATERIAL(S)	\$420.82	\$914.00
74170	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CON	\$483.45	\$749.38
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST	\$752.92	\$966.74
74175	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN, WITH CONTRAST MATERIAL(S), IN	\$613.97	\$1,236.29
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL	\$358.59	\$1,043.45
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL	\$525.21	\$1,243.55
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ON	\$612.75	\$1,569.98
75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GR	\$696.17	\$560.82
75635	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMINAL AORTA AND BILATERAL ILIOFEMO	\$684.56	\$1,241.95

## Helen Phillips

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**From:** Newman, Anthony (HSS) <anthony.newman@alaska.gov>  
**Sent:** Saturday, April 02, 2016 3:14 PM  
**To:** Helen Phillips; Jane Pierson; Heather Shadduck  
**Cc:** Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Brodie, Margaret C (HSS); Martin, Monique R (HSS); Erickson, Deborah L (HSS); Forrest, Karen L (HSS); Withington, Roger P (HSS); Woods, Sarah B (HSS)  
**Subject:** responses to 3/30 H Fin hearings on SB 74

Heather, Jane, and Helen: In the Wednesday (3/30/16) House Finance Committee hearing on Senate Bill 74 we recorded the following questions for the Department of Health and Social Services, and we provide the following responses.

**1. What telemedicine services can and can't be reimbursed by the Department Medicaid? (Rep. Neuman)**

Alaska regulations [7 AAC 110.620 – 7 AAC 110.639](#) describe the scope and limitations of Medicaid services that can be provided through telemedicine. The services specifically excluded from telemedicine are listed in [7 AAC 110.635](#) and are:

- Home and community based waiver services
- Pharmacy services
- Durable medical equipment services
- Transportation services
- Accommodation services
- End stage renal disease services
- Direct entry midwife services
- Private duty nursing services
- Personal care assistant services
- Visual care, dispensing, or optician services

**2. How much does Medicaid spend on prescription narcotics? How much does Medicaid spend on all prescription drugs?**

Alaska Medicaid reimbursed pharmacies for prescriptions during the month of December 2015 and the most recent month, February 2016, as shown below. Two months are provided for comparison purposes.

	Dec 2015	Feb 2016
Number of Narcotic Analgesic Paid Claims	6,465	7,070
Number of All Paid Prescription Drug Claims	82,158	87,483
Reimbursement for Narcotic Analgesic Claims	\$288,728.36	\$300,761.28
Reimbursement for All Paid Prescription Drug Claims	\$7,766,496.30	\$8,377,789.04

*prepared 03/30/2016 - eynarus*

**Tony Newman | Legislative Liaison**

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## Helen Phillips

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**From:** Newman, Anthony (HSS) <anthony.newman@alaska.gov>  
**Sent:** Sunday, April 03, 2016 10:05 PM  
**To:** Heather Shadduck; Jane Pierson; Helen Phillips  
**Cc:** Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Forrest, Karen L (HSS); Brodie, Margaret C (HSS); Butler, Jay C (HSS); Erickson, Deborah L (HSS); Martin, Monique R (HSS); Burns, Randall P (HSS)  
**Subject:** FW: Responses to 3/29/16 question on SB 74 in House Finance  
**Attachments:** JPH Contracting Out Discussion 1988.docx; 1988 Senior Voices AKPH Privatization.pdf

Heather, Jane, and Helen: Here are the responses to questions #5 and #9 from the list in my previous email (below). My thanks to Deb Erickson for her assistance in pulling this information together. Tony

**5. Please provide additional information on how the 1115 Waiver would work for the behavioral health system reform? (Rep. Neuman)**

Section 1115 of the Social Security Act gives the U.S. Department of Health & Human Services Secretary the authority to approve State demonstration projects to test the use of innovative service delivery models in Medicaid. The purpose of the 1115 waiver is to provide States with flexibility and relief from federal Medicaid rules in order to improve care, increase efficiency, and reduce costs. Examples of federal requirements that can be waived through the 1115 process include freedom of provider choice, statewide-ness, and comparability of benefits.

One purpose for which States have used 1115 waivers is to utilize managed care for high-need populations, such as those with behavioral health needs. Another example is to obtain a waiver of the Institutes for Mental Disease (IMD) exclusion rule. The IMD exclusion prohibits the use of federal Medicaid funds for care provided to adults 21 to 64 years old in mental health or substance abuse residential treatment facilities with more than 16 beds.

Section 30 of SB 74 requires the department to apply for an 1115 waiver for a demonstration project focused on improving Alaska's behavioral health system. The department's approach to the demonstration project will be to contract with an Administrative Services Organization (ASO) to manage utilization; provide quality and outcomes reporting; and audit for fraud, waste, and abuse. Once the waiver is approved and the ASO contract is implemented, the department would apply for an amendment to add a waiver of the IMD exclusion rule. This approach was recommended by the Medicaid Redesign technical assistance consultants, Agnew::Beck and Health Management Associates, and the Mental Health Trust Authorities' consultants, the Curie Group. It also aligns with LB&A's consultant, the Menges Group, recommendation to contract for ASO services to provide utilization management.

The department's 1115 demonstration project will include:

- A plan for providing a continuum of community-based services to address housing, employment, criminal justice, and other relevant issues;
- Services from a wide array of providers and disciplines, including licensed or certified mental health and primary care professionals; and,
- Strategies to
  - Reduce operational barriers that fragment services,

- Minimize administrative burdens for providers, and
- Increase the effectiveness and efficiency of the program.

The department will hire consultants to help develop the 1115 waiver application. The federal application process for 1115 waivers is very involved and there are numerous requirements the department will have to meet in order to be successful. Examples of criteria on which the application will be evaluated include whether the waiver will:

- Strengthen coverage for low-income individuals;
- Increase access to, stabilize, and strengthen providers and provider networks;
- Increase efficiency and quality of care through initiatives to transform service delivery networks; and,
- Be budget neutral for the federal budget.

Demonstration projects implemented through an 1115 waiver are approved for five years, with an opportunity to request three-year extensions, in order to provide sufficient time to test innovative practice models.

**9. Could you clarify the projected annual costs and savings, and identify where there is overlap between the Senate and House versions of FY 17 Budget? (Unknown member)**

There is only one area of overlap between the fiscal notes, the House and Senate versions of the FY 17 budget, and the Governor’s FY 17 Budget Request, and that is for costs and savings associated with implementing the federal Tribal FMAP policy.

- The increased funding both the House and Senate have approved to increase staff capacity to implement the policy is included in the fiscal note for component #317 (though at a slightly different amount).
- The GF cuts that both the Governor’s Budget and the House and Senate made to the Medicaid budget attributed to implementation of this policy are included in the Fiscal Notes.
  - The portion of the savings attributed to the Governor’s Budget reduction is reflected in the 2<sup>nd</sup> column of the fiscal notes (“Included in Governor’s FY 17 Request”), and
  - The portion of savings attributed to the House and Senate cuts are in the 1<sup>st</sup> column of the fiscal notes (“FY 17 Appropriation Requested”)

The comparison is reflected in the table below. Note that the cuts made by both the Governor and the House/Senate total the amount of cuts reflected in the Fiscal Notes.

	Fiscal Note Component #	House & Senate FY 17 Budgets (GF)	Gov’s FY 17 Budget (GF)	FY 17 Fiscal Note Request (GF)
<b>COSTS:</b> Staff Capacity to implement the Policy	317	275.9	0	289.7
<b>SAVINGS:</b> Health Care Services Medicaid Claims	2077	<20,000.0>	<6,700.0>	<26,700.0>
<b>SAVINGS:</b> Behavioral Health Services Medicaid Claims	2660	0	<2,750.0>	<2,750.0>
<b>SAVINGS:</b> Senior & Disability Services Medicaid Claims	2662	0	<2,900.0>	<2,900.0>

<b>TOTAL SAVINGS</b> (w/o costs added)	<20,000.0>	<12,350.0>	<b>&lt;32,350.0&gt;</b>
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**From:** Newman, Anthony (HSS)  
**Sent:** Thursday, March 31, 2016 6:17 PM  
**To:** Shadduck, Heather R (LAA); Pierson, Jane (LAA); Phillips, Helen (LAA)  
**Cc:** Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Forrest, Karen L (HSS); Brodie, Margaret C (HSS); Butler, Jay C (HSS); Erickson, Deborah L (HSS); Martin, Monique R (HSS)  
**Subject:** Responses to 3/29/16 question on SB 74 in House Finance

Heather, Jane, and Helen: Please find the below responses to questions asked of the Department of Health and Social Services during the Tuesday 3/29/16 hearing on SB 74 in House Finance. We intend to follow up with answers to those questions below marked as "In Progress." Please distribute these responses to committee members.

**Menges Group Presentation**

**1. How would the "shared savings" provisions in the bill work? (Rep. Neuman)**

There are two provisions in SB 74, both in Section 31, that reference "shared savings":

- Page 30, beginning on line 19, adds AS 47.07.038 to require the department to collaborate with hospitals to reduce usage of emergency department services by Medicaid recipients. This provision allows (but doesn't require) the department to include shared savings for participating hospitals.
- Page 31, beginning on line 16, adds AS 47.07.039 to require the department to implement a Coordinated Care Demonstration project. Subsection (c) (page 33, beginning on line 1) provides a series of options for the payment model the department may use for this demonstration project, including global payment, bundled payment, capitated payment, shared savings and risk, or other payment structures.

"Shared savings" is a payment model designed to incentivize providers to reduce health care costs for a defined patient population by offering the providers a percentage of net savings realized as a result of their efforts. It recognizes the cost to the provider organization for developing and implementing new approaches to reduce costs, and also compensates them for a share of lost revenue they might incur in a fee-for-service system from more efficient utilization. There is no one methodology for a shared savings payment model — health care payer organizations that have implemented this model elsewhere have used a variety of approaches.

To implement the shared savings payment model option, the department would negotiate the methodology for determining shared savings with the hospitals and document that methodology in shared savings contracts. The methodology would include a process for setting a baseline projected spending level from which to determine the level of future savings, as well as the services and population to be included in the calculations. Implementation of the methodology may require the services of a health care actuary.

**2. Will any provisions of the bill cause a delay or prevent Medicaid recipients from being able to get the prescription drugs their provider wants them to have, whether generic or brand-name?**

No, there are no provisions in SB 74 that specifically limit access to prescribed drugs. The Menges Group recommends the legislature allow the department to more quickly adjust the Preferred Drug List (by moving it outside the regulatory process), and also recommends the department investigate lowering dispensing fees paid to

chain drug stores, but these are very recent recommendations transmitted in the Menges Group report just released on March 24, and are not included in SB 74.

**Fiscal Notes Presentation**

**3. How long do parents of OCS-involved youth have to wait to receive treatment? (Rep. Wilson)**

Data on access to behavioral health services specific to parents of OCS-involved youth is not available; however, data from the Division of Behavioral Health’s (DBH) information system shows that the average wait time from date of screening to initial treatment for all DBH-supported clients in FY 15 was:

- 13 days for behavioral health services
- 45 days for substance use treatment

One goal of the behavioral health system reform provisions in SB 74 is to improve access to services. Wait times will continue to be monitored as an indicator of access to care under the reform initiative.

**4. Please provide a summary comparing the consultants’ recommendations for care coordination/care management models with the related provisions of the bill. (Rep. Neuman)**

Care Coordination/Care Management Models	SB 74	Agnew::Beck	Menges Group
<b>Managed Care Organizations (MCO)</b> are organizations that manage cost, utilization, and quality of health care services through contracted arrangements with a payer, such as Medicaid, and accept a set per member per month (capitated) payment for their services. MCOs bear full financial risk for incurring costs that exceed their contracted payment amount.	Allows the department to contract with a MCO as one option for primary care case management (Section 29, pages 28-29); and as one option for the Coordinated Care Demonstration Project (Section 31, pages 31-34).	Recommends DHSS NOT contract with a MCO due to lack of experience with full-risk managed care in Alaska’s private sector health care industry.	Recommends DHSS NOT contract with a MCO due to Alaska’s relatively small and dispersed patient population.
<b>Accountable Care Organizations (ACO)</b> are local or regionally-based and provider-led groups of doctors, hospitals and other health care providers who organize voluntarily to assume some level of financial risk along with responsibility for patient outcomes, and collaborate to provide coordinated care for a defined patient population.	Doesn’t specifically address ACOs, but the Coordinated Care Demonstration Project required under Section 31 provides the flexibility to adopt an ACO model.	Recommends DHSS pilot test the ACO model to engage communities and local providers to form collaborative care arrangements and begin accepting some financial risk.	Recommends DHSS NOT use the ACO model due to lack of experience among Alaska providers in playing the role of medical cost reduction facilitator.
<b>Health Homes</b> are a particular service type authorized under Section 1945 of the Social Security Act to serve patients with complex needs such as multiple chronic conditions or behavioral health conditions	Authorizes DHSS to apply to provide the Section 1945 Health Home service (Section 30, page 29, line 17).	Recommends DHSS implement the Health Homes service.	References the benefit of linking enrollees to health homes, but does not specifically recommend DHSS implement the

through team-based integrated care models.			Health Home service.
<b>Primary Care Case Management (PCCM)</b> is model of care where the enrollee is required to choose, or has assigned, a primary care provider who is responsible for coordinating the enrollee's care, typically for an additional fee.	Requires DHSS to implement a PCCM system (Section 29, pages 28-29). DHSS is authorized to contract with an MCO as one option for implementing this system.	Recommends DHSS implement a PCCM program utilizing the services of an ASO (see below).	Recommends DHSS implement a program similar to PCCM by contracting with an MCO (see above) to provide only ASO services (see below).
<b>Administrative Services Organizations (ASO)</b> provide management and administrative services for a fixed fee and do not incur any financial risk for the cost of delivering care. Examples of services provided by ASOs in support of Medicaid programs include care coordination, utilization management, disease management, data reporting, and provider network development.	Does not directly refer to ASOs, but does not preclude their use in implementing care coordination provisions of the bill.	Recommends DHSS contract with ASOs to develop and run the primary care case management system, and the managed behavioral health system of care.	Recommends DHSS contract with an MCO to provide ASO services only, specifically to provide care coordination for high-need/cost beneficiaries, and to manage utilization through a prior authorization system for high-cost services.

**5. Please provide additional information on how the 1115 Waiver would work for the behavioral health system reform? (Rep. Neuman)**

IN PROGRESS

**6. Can't the existing data system provide the eligibility verification service (Section 24 of SB 74)? Why do we need a new data system? (Rep. Wilson)**

The department's new public assistance eligibility information system (ARIES) includes a module that provides for eligibility verification, but the Senate Finance Committee identified an opportunity for additional state savings through contracting with a separate, independent organization with expertise in matching eligibility data with data from other systems to identify and provide additional information needed for making eligibility determination decisions.

**7. Please provide a table showing all the MMIS systems changes required by the bill and how they "dovetail" with one another. (Rep. Gattis)**

Below is a table of the MMIS system changes that would be required to implement all provisions of the bill. The year the system change design process would begin is included in the table below. The changes would be staged so they do not conflict and to allow time for testing, so for example the Emergency Department change may begin in the 2nd quarter of FY 17 and the Coordinated Care project change may begin in the 4th quarter of FY 17. Note that all MMIS design and implementation changes are reimbursed by the federal government at 90%.

Section of SB 74	Program	Implementation Year	1-time MMIS Capital Costs (90% Fed/10% GF)
Sec. 31	Emergency Department Reduction Project	FY 2017	\$1,000.0
Sec. 31	Coordinated Care Demonstration Project	FY 2017	\$3,125.0
Sec. 29	Primary Care Case Management System	FY 2018	\$1,000.0
Sec. 30	Managed System of Behavioral Health Care	FY 2018	\$1,000.0
Sec. 30	Health Home Option	FY 2019	\$1,000.0
		<b>TOTAL</b>	<b>\$7,125.0</b>
		<b>Fed Total</b>	<b>\$6,412.5</b>
		<b>GF Match</b>	<b>\$ 712.5</b>

**8. Please provide a list of previous privatization studies of DHSS facilities. (Rep. Gara)**

There has been discussion regarding potential privatization of the Alaska Psychiatric Institute and the Pioneers' Homes, but to our knowledge an actual feasibility study has never been conducted. There was an attempt to privatize the newly constructed Juneau Pioneers' Home (JPH) when it was set to first open in 1988, but the solicitation process was not successful. A copy of an article describing that plan and the minutes from the LB&A meeting at which legislators subsequently voted to allow the administration to run JPH as a state-operated facility (following the failed solicitation attempt) are attached.

**Public Testimony**

**9. Could you clarify the projected annual costs and savings, and identify where there is overlap between the Senate and House versions of FY 17 Budget? (Unknown member)**

IN PROGRESS

Thank you.

Tony

**Tony Newman** | Legislative Liaison  
Office of the Commissioner | Alaska Department of Health and Social Services

350 Main Street, Room 404 | Juneau AK 99811  
(desk) [907.465.1611](tel:907.465.1611) | (cell) [907.321.3989](tel:907.321.3989)  
[anthony.newman@alaska.gov](mailto:anthony.newman@alaska.gov)

## Helen Phillips

---

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**Sent:** Thursday, March 31, 2016 6:17 PM  
**To:** Heather Shadduck; Jane Pierson; Helen Phillips  
**Cc:** Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Forrest, Karen L (HSS); Brodie, Margaret C (HSS); Butler, Jay C (HSS); Erickson, Deborah L (HSS); Martin, Monique R (HSS)  
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Section of SB 74	Program	Implementation Year	1-time MMIS Capital Costs
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(90% Fed/10% GF)			
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<b>Sec. 30</b>	Managed System of Behavioral Health Care	FY 2018	\$1,000.0
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<b>TOTAL</b>			<b>\$7,125.0</b>
<b>Fed Total</b>			<b>\$6,412.5</b>
<b>GF Match</b>			<b>\$ 712.5</b>

**8. Please provide a list of previous privatization studies of DHSS facilities. (Rep. Gara)**

There has been discussion regarding potential privatization of the Alaska Psychiatric Institute and the Pioneers' Homes, but to our knowledge an actual feasibility study has never been conducted. There was an attempt to privatize the newly constructed Juneau Pioneers' Home (JPH) when it was set to first open in 1988, but the solicitation process was not successful. A copy of an article describing that plan and the minutes from the LB&A meeting at which legislators subsequently voted to allow the administration to run JPH as a state-operated facility (following the failed solicitation attempt) are attached.

**Public Testimony**

**9. Could you clarify the projected annual costs and savings, and identify where there is overlap between the Senate and House versions of FY 17 Budget? (Unknown member)**

IN PROGRESS

Thank you.

Tony

**Tony Newman** | Legislative Liaison

Office of the Commissioner | Alaska Department of Health and Social Services

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88/02/25

0805

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
February 25, 1988  
8:05 a.m.

(Tape LBA 88-3, Side 1, #100-#792)

#### CALL TO ORDER

Chairman Larson called the meeting of the Budget and Audit Committee to order at 8:05 a.m. in the Senate Finance Committee Room, State Capitol Building, Juneau, Alaska.

#### PRESENT

The following members of the Committee were present:

Representative Adams  
Representative Hoffman  
Representative Larson  
Representative Pourchot  
Representative Zawacki  
Representative Davis (alternate)  
Senator Binkley  
Senator Duncan  
Senator Fischer  
Senator Halford  
Senator Jones

ALSO PRESENT: Jay Hogan, Associate Director, Budget Review, Office of Management and Budget; Mike Greany, Director, Legislative Finance Division; Jim Slocum, Karen Rehfeld, Cameron Kashani, Fiscal Analysts, Legislative Finance Division; Randy Welker, Legislative Auditor; Merle Jensen, Legislative Audit; Alison Elgee, Director, Administrative Services, Department of Revenue; Amy Kyle, Deputy

Commissioner, Department of Environmental Conservation; Steve Hole, Deputy Commissioner, Department of Education; Tom Ryan, Department of Education; Jan Mills, Division of Governmental Coordination, Office of the Governor; and Bob Grogan, Director, Division of Governmental Coordination, Office of the Governor.

#### APPROVAL OF MINUTES

Representative Zawacki MOVED that the minutes of the meeting held January 11, 1988, be approved. There being NO OBJECTION, it was so ordered.

#### REVISED PROGRAM REQUESTS

RPL 01-8-0213, Governor, Division of Governmental Coordination, request to receive and expend \$647,542 in federal funds for the Alaska Coastal Management Program.

Representative Adams acknowledged that only \$406,000 of the \$647,542 would go to grantees. He asked why more would not go directly to grantees rather than state agencies. JAN MILLS, COASTAL PROGRAM COORDINATOR, DIVISION OF GOVERNMENTAL COORDINATION, explained that approximately \$250,000 of the \$647,542 would be pass through funding to grantees to fund projects to resolve coastal resource conflicts in their areas.

Additionally each of the 32 coastal communities and regions which are funded would receive an additional 15% above their current funding level. Ms. Mills said they had reviewed the pass through funds to the grantees and funds going to the resource agencies. She said all parties concur with the proposed funding plan. Additionally, Ms. Mills noted that they had worked with the Office of Ocean and Coastal Management, the federal granting agency, which have concurred that these tasks would be eligible to receive funding.

Senator Duncan MOVED to approve RPL 01-8-0213, Governor, Division of Governmental Coordination, request to receive and expend \$647,542 in federal funds for the Alaska Coastal Management Program. There being NO OBJECTION, it was so ordered.

RPL 05-8-0406, Education, Finance and Support Services, request to receive and expend \$475,000 in federal funds for asbestos removal.

Senator Fischer asked how financial need is to be determined.

TOM RYAN, FACILITIES COORDINATOR, DEPARTMENT OF EDUCATION, explained that the financial need criteria was a requirement of the federal grant. He said originally only \$5 million was appropriated by the federal government for the AHERA program for the whole country. Mr. Ryan said that Alaskan income per capita and the assessed valuation per pupil have an adverse effect when Alaska is being compared to Lower 48 states.

Therefore, the department chose to use the impact of recent funding cutbacks upon school districts as a measure of financial need in its application for AHERA funds. Since the application was approved, this criteria is binding to acceptance of the grant.

Senator Fischer referenced the criteria listed in the request for proposal which states, "First consideration will be given to the LEAs with the largest decrease in state support over the last two fiscal years." He expressed concern that those districts which might not have received a substantial reduction in state aide, instead might have had a substantial local reduction, would not be considered. Additionally, districts with a number of sites would not benefit from the program as compared to the single site districts with fewer costs. He discussed two schools in his district which were recently constructed but unable to open due to lack of funds.

Mr. Ryan advised members that an additional \$15 million has been appropriated by Congress for the program and the department is currently applying for \$500,000.

Representative Pourchot asked if any of the past inspections which have been performed would qualify. Mr. Ryan said no.

He advised members that the new regulations are requiring an accountability for non-friable as well as friable material.

He said past inspections only included friable material therefore certified inspectors would not sign off on the inspections because the liability is too great.

Representative Zawacki asked if the department had determined where the funds would be allocated. Mr. Ryan said no. He informed members that the determination would be based on

applications from districts. The applications will not be received until the Committee accepts the funds so the department can issue the request for proposals. He said it would be approximately 60-90 days before the department would know who might be eligible to receive the funds.

Representative Zawacki desired to see where the funds would be allocated prior to approval of the request.

Senator Fischer noted that 10% of the funds would go to private schools. He asked how need is to be determined. Mr. Ryan said need would be based on their financial statements which would be a part of their application. Senator Fischer asked why that could not be done with all schools. MR. STEVE HOLE, DEPUTY COMMISSIONER, DEPARTMENT OF EDUCATION, said it would be inconsistent with the application submitted by the department to the federal government and upon which the grant award is based.

Senator Binkley asked if the decrease in state support would be as a result of the new foundation funding law, reduced debt service, reduced local effort, or reduced PL 874 funding. Mr. Ryan said it was intended to address foundation support changes as a result of the new law. Senator Binkley asked if the department could provide the Committee with a potential list of recipients. Mr. Hole said they would provide a list of the proposed distribution before it is made. He encouraged members to review the RFP to examine the specific criteria upon which applications will be received.

Senator Duncan acknowledged an attachment to the RPL request which listed the "gain and loss" per ADM per school district.

He asked if these districts applied, based on the criteria included in the RFP, would they qualify. Mr. Ryan said that the decrease in state aide would be one of the criteria used in assessing applications.

Senator Fischer reiterated his concern with the percentage loss in relationship to the size of a district.

Senator Duncan MOVED to approve RPL 05-8-0406, Education, Finance and Support Services, request to receive and expend \$475,000 in federal funds for asbestos removal. Senator Fischer OBJECTED.

A roll call vote was taken on the motion.

IN FAVOR: Adams, Hoffman, Larson, Pourchot, Binkley, Duncan, Halford, Jones

OPPOSED: Zawacki, Fischer

The MOTION PASSED (8-2).

Senator Fischer requested that the department provide the Committee with a copy of the applications and list of recommended recipients.

RPL 05-8-0466, Education, Alaska State Council on the Arts, request to receive and expend \$5,000 in program receipts from Eskimo doll sales.

Representative Adams asked if the Committee had authority to appropriate general fund program receipts. He believed the Committee did not and that the funds should be included in the budget. JAY HOGAN, ASSOCIATE DIRECTOR, BUDGET REVIEW, OFFICE OF MANAGEMENT AND BUDGET, said there currently is legislation pending which would define general fund program receipts. The legislation would clearly define the funds as general fund program receipts and there would be no revised program requests being brought before the Committee. Mr. Hogan said current language provides that federal, other program receipts, and program receipts undefined are to be brought before the Committee for approval. In response to a question from Representative Adams, Mr. Hogan advised members that the legislation had a technically unusual referral to House Resources. He said they hope the matter will be resolved in conference or possibly by returning the measure to the Senate for action. Representative Adams noted that the funds could go into the FY 89 budget. He requested that the request be held. RPL 05-8-0466 was HELD in Committee.

RPL 05-8-6011, Education, Alaska Commission on Postsecondary Education, request to receive and expend \$50,000 in corporation receipts.

Senator Duncan MOVED to approve RPL 05-8-6011. There being NO OBJECTION, it was so ordered.

RPL 06-8-0178, Health and Social Services, Division of Public Health, request to receive and expend \$103,000 in

federal funds for marine safety.

Representative Adams MOVED to approve RPL 06-8-0178. There being NO OBJECTION, it was so ordered.

RPL 08-8-0291, Commerce and Economic Development, Alaska Seafood Marketing Institute, request to receive and expend \$700,000 in federal funds.

Mr. Hogan advised members that this is the second revised program request to come before the Committee. He said there has been an increased share under the new federal International Fisheries Marketing program which has been earmarked for ASMI. Mr. Hogan said they will be presenting ASMI budget changes through a budget amendment early next month. Senator Halford asked Mr. Hogan to provide the Committee with information on the amount of funds matched by the industry. Mr. Hogan advised members that the budget amendment would include such information.

Representative Zawacki MOVED to approve RPL 08-8-0291. There being NO OBJECTION, it was so ordered.

RPL 11-8-0178, Fish and Game, Division of Subsistence, request to receive and expend \$3,000 in program receipts from the Northwest Arctic Borough.

Senator Duncan MOVED to approve RPL 11-8-0178. There being NO OBJECTION, it was so ordered.

RPL 11-8-0180, Fish and Game, Division of Subsistence, request to receive and expend \$44,723 in program receipts from the North Slope Borough.

Senator Duncan MOVED to approve RPL 11-8-0180. There being NO OBJECTION, it was so ordered.

RPL 18-8-3140, Environmental Conservation, Environmental Quality, request to receive and expend \$610,000 in federal funds.

Mr. Hogan advised members that they wished to WITHDRAW the revised program request, make a technical correction, and return the request to the Committee at its next regular meeting. RPL 18-8-3140 was WITHDRAWN.

RPL 18-8-3141, Environmental Conservation, Environmental Quality, request to receive and expend \$63,000 in federal grant funds for air special projects.

Representative Zawacki MOVED to approve RPL 18-8-3141. There being NO OBJECTION, it was so ordered.

RPL 20-8-0076, Corrections, request to receive and expend \$8,000 in federal funds.

Senator Fischer asked if the department would have made the request through the normal budget process. Mr. Hogan did not know.

Senator Duncan MOVED to approve RPL 20-8-0076. There being NO OBJECTION, it was so ordered.

RPL 21-8-0204, Community and Regional Affairs, Housing Assistance Division, request to receive and expend \$7,780 in federal funds for child care assistance.

Representative Pourchot MOVED to approve RPL 21-8-0204. There being NO OBJECTION, it was so ordered.

RPL 04-8-0028, Revenue, Child Support Enforcement Division, request to receive and expend \$80,000 in program receipts and \$170,000 in federal funds.

Representative Adams asked if the Committee did not approve the request, would the \$80,000 in program receipts go into the general fund. ALISON ELGEE, DIRECTOR, ADMINISTRATIVE SERVICES, DEPARTMENT OF REVENUE, said that was correct. She explained that the program receipts are federal incentive funds which are received on the basis of the collection ratio of AFDC to non-AFDC collections in a continued improvement of cost effectiveness ratio. According to Ms. Elgee, the program receipts are in part budgeted by the program. Where they exceed the estimate of the program they are deposited into the general fund. The federal funds are a match provided to the program at a 68/32 federal to state ratio. The incentive funds are available to use as match to the federal funds provided through that program.

Ms. Elgee explained that the Child Support Enforcement program has been found in non-compliance with a federal audit. The request is an attempt to satisfy the problems identified in

the federal audit prior to next year's audit review by the federal government. Senator Fischer asked if the FY 89 budget included funding for the program. Ms. Elgee said there is a \$200.0 increase in the FY 89 budget in program receipts offsetting general fund based on the collection experience of the program and receipt of the incentive funds.

Representative Pourchot MOVED to approve RPL 04-8-0028. There being NO OBJECTION, it was so ordered.

#### EXECUTIVE SESSION

Senator Duncan MOVED that the Committee meet in EXECUTIVE SESSION for the purpose of consideration of final and preliminary audits. There being NO OBJECTION, it was so ordered and the Committee met in EXECUTIVE SESSION from 8:45 a.m. to 8:55 a.m.

#### REGULAR SESSION

The Committee reconvened in REGULAR SESSION at 8:55 a.m.

#### FINAL AUDITS

Senator Fischer MOVED that the following FINAL AUDITS be approved and released to the public:

Department of Military and Veterans Affairs  
Department of Natural Resources

There being NO OBJECTION, it was so ordered.

#### PRELIMINARY AUDITS

Senator Fischer MOVED that the PRELIMINARY AUDIT for the Department of Fish and Game, Musk Ox Program, be released to the appropriate agency for response. There being NO OBJECTION, it was so ordered.

#### ADJOURNMENT

The meeting adjourned at 8:57 a.m.

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Representative Ron Larson, Chair  
Budget and Audit Committee

Joint  
88  
JLBA

88/03/08

0740

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
March 8, 1988  
7:40 a.m.

(Tape LBA 88-3, Side 2, #000-end)  
(Tape LBA 88-4, Side 1, #000-end)  
(Tape LBA 88-4, Side 2, #000-#016)

CALL TO ORDER

Chairman Larson called the meeting of the Budget and Audit Committee to order at 7:40 a.m.

PRESENT

The following members of the Committee were present:

Representative Hoffman  
Representative Larson  
Representative Pourchot  
Representative Zawacki  
Representative Davis (Alternate)  
Senator Binkley  
Senator Duncan  
Senator Fischer  
Senator Halford  
Senator Jones

ALSO PRESENT: Representative Herrmann; Representative Goll;

Representative Wallis; Steve Hole, Deputy Commissioner, Department of Education; Harry Purdy, Superintendent, Galena City School District; John Novak, Superintendent, Unalaska City School District; Bill Millhorn, Superintendent, Craig

School District; Mike Greany, Director, Legislative Finance;  
and Randy Welker, Legislative Auditor.

#### APPROVAL OF MINUTES

Representative Pourchot MOVED AND ASKED UNANIMOUS CONSENT that the minutes of the meeting held February 25, 1988, be approved. There being NO OBJECTION, it was so ordered.

#### SPECIAL AUDIT REQUEST

Senator Duncan MOVED to approve a special audit request by Representative Larson for a performance audit of the Department of Environmental Conservation's Wasilla office.

There being NO OBJECTION, it was so ordered.

#### CONTACT WITH MCDOWELL GROUP-AREA COST DIFFERENTIAL

Members were provided a copy of the work plan summary and proposed contract with the McDowell Group for preparation of an information base for school foundation funding issues (copy on file). Chairman Larson advised members that they were being asked to approve a sole source contract with the McDowell group which would include three primary tasks: (1) to prepare comprehensive school district profiles; (2) collect and analyze data necessary for computing district operations cost differentials; and (3) collect and analyze data necessary for computing district personnel cost differentials.

Senator Fischer asked what type of documentation would be provided by the contractor with regard to expenditures. For example, would there be certified payrolls, travel expense documentation and other types of receipts. Senator Fischer felt the project to be important but also felt public accountability important since the contract would not be going out to bid.

Representative Pourchot asked what was meant by the statement included in the work plan summary which read, "The final operations market basket list will be developed through mutual agreement of the contractor and representatives(s) of the committee."

Chairman Larson advised members that he would HOLD the

contract for consideration during the committee's next meeting, to be held March 15, so that a representative of the McDowell Group could attend and address member's questions.

#### DEPARTMENT OF EDUCATION-SECTION 154, CHAPTER 3, FSSLA 1987

Chairman Larson advised members that Section 154, Chapter 3, FSSLA 1987, appropriated the sum of \$2,000,000 from the general fund to the Department of Education for the purpose of mitigating adverse consequences to small single site schools and REAAs which could arise from the implementation of the new school foundation formula. In accordance with the Alaska Administrative Procedures Act, the Department of Education drafted regulations to implement chapter 3.

MR. STEVE HOLE, DEPUTY COMMISSIONER, DEPARTMENT OF EDUCATION, advised members of his letter to the Committee dated February 22, 1988, which responded to the Committee's concerns as expressed during the January 28 meeting (copy on file).

Senator Fischer reiterated his concern with regard to those communities determined to be eligible as small single site schools. He advised members that in the Kenai Peninsula Borough there are several small single site schools which were not determined to be eligible for funding by the Department of Education. These include Tyonek, English Bay, Port Graham, and Seldovia. Senator Fischer believed them to be eligible and felt they should have been granted an opportunity to apply for funding. Chairman Larson referenced a memorandum dated February 23, 1988, from Tamara Cook, Director, Division of Legal Services (copy on file). He said Ms. Cook indicated that the language in the reappropriation bill was vague and that the burden was placed on the Department of Education to define the language. There was discussion concerning the administrative procedures used by the Department of Education to adopt regulations to implement Ch. 3. It was noted that no written comments were submitted to the Department of Education under the notice requirement.

Senator Binkley indicated his concern with a lack of information on cash flow balances for those districts applying for funding. He indicated that the day to day cash position of a district could be substantially different than a district's end of year projection.

Representative Davis asked the department's recommendation

with regard to alternatives for those districts which are facing financial difficulties beyond the level of funding which would be available under Ch. 3. Mr. Hole understood that two schools would be in significant financial difficulty without legislative relief. The department identified Galena's need in excess of the appropriation to be \$350.0 and Kake's need to be \$127.8. Additionally, the department deemed the amounts necessary to fully fund pupil transportation for FY 88 to be \$2,613.2 and \$9,281.1 for debt retirement reimbursement for FY 88.

Representative Herrmann asked Mr. Hole if the department has examined the problems with small single site schools. She informed members that she had been advised by a representative of the Office of Management and Budget that there has historically been a problem with small single site schools in relationship to the foundation formula. Mr. Hole admitted there might be problems with the foundation program, however, could not with any degree of confidence specify what aspects of the formula may or may not be flawed. He discussed some of the changes and effects of the PL 874 problems. Mr. Hole noted that one of the primary purposes of the foundation formula was to equalize, and absent more money, equalization would mean some districts receive more money and some less money. Mr. Hole believed the proposed contract would provide better information, however, he believed the formula to be a step in the right direction.

Chairman Larson asked if there were any individuals wishing to testify.

MR. HARRY PURDY, SUPERINTENDENT, GALENA CITY SCHOOL DISTRICT, said Galena had a balanced budget until May 27 when they received a memorandum from the Department of Education indicating they were to defer their PL 874 funding. He said PL 874 funding for Galena represents \$701,221. Additionally, all the contracts with teachers were signed on May 27. These contracts represent approximately \$1.395 million.

Consequently, the deferment put their budget out of balance.

Mr. Purdy said the federal government would forward 75% of the current year's appropriation. He said that would represent \$525,000 which has been in the bank drawing interest. He said the district has \$80,000 in state foundation funding due. He said if they took the \$525,000 and put it in a CD where it

should be, then they would be operating at a deficit of about \$214,000.

Chairman Larson advised members that eight (8) of the ten (10) districts being recommended for funding are effected by the deferment of PL 874 funding.

There was discussion concerning Galena's existing cash flow, local tax effort, and pupil to teacher ratio. It was determined that operation of Galena's schools could continue to be maintained were there assurance that reimbursement would be forthcoming prior to the end of the fiscal year.

MR. JOHN NOVAK, SUPERINTENDENT, UNALASKA CITY SCHOOL DISTRICT, advised members that they had applied for funding under Section 154. He said many schools spend down to zero and do not carry a reserve forward each year. He said there is also unrealized reimbursements from the Department of Education in the areas of grants and transportation. Mr. Novak said some districts do not receive their PL 874 funds in advance so have no reserves. He urged the Committee to approve their request for funding as soon as possible.

Senator Binkley asked the account balances for the Unalaska City School District. Mr. Novak said they have \$11,000 in a cigarette tax fund and are overdrawn \$17,000 on their checking account. He said they anticipate receiving a check from the Department of Education under the foundation program in the amount of \$90,000 and \$16,000 from the City of Unalaska. Mr. Novak said their monthly expenses total approximately \$86,000.

(Tape change, LBA 88-4, Side 1)

Mr. Novak advised members that they expect \$140,000 in PL 874 funding, however, do not account for it until they actually receive it. He informed members of his intent to inquire as to the status of the anticipated date for receipt of these funds.

BILL MILLHORN, SUPERINTENDENT, CRAIG SCHOOL DISTRICT, felt they had complied with the intent of the statute and regulations. He said they need assistance to alleviate the problems their district is facing. He encouraged the immediate release of the funding by the Committee.

Senator Binkley asked how many students had left the district.

Mr. Millhorn said they had 231 last year and 207 this year.

Senator Binkley asked how the district reduced costs to adjust to the loss in students. Mr. Millhorn advised members that the count was taken October 1 with the budget prepared in April. He said they had reduced their hot lunch program, secretarial service, and custodial service. Mr. Millhorn discussed the increments to their budget which had been included in April based on an anticipated increase in students. He said the foundation change represented a loss to the district of \$1,000 per student.

Mr. Millhorn said they were not negatively impacted by PL 874.

The district has applied for \$24,000 in PL 874 funding and just recently received \$6,000 of their FY 82 allotment. In response to a question from Senator Binkley concerning the district's account balances, Mr. Millhorn responded that their balance is \$218,000 with \$96,000 forthcoming from the state.

He said their monthly expenses total \$126,000. Senator Binkley acknowledged that the district did not have a cash flow problem instead there would be an end of the year budget deficit without receipt of additional funds.

Senator Binkley provided members with a proposal of options with regard to the funding provided in Chapter 3 (Attachments 1, 2, 3). He suggested that because of legal and regulatory problems, the mitigation account would become a part of [HB 444](#) (supplemental bill) and would be used to offset the costs of funding the Department of Education recommendations, the PL 874 Impact Aid payment, and the 10% PL 874/interim area differential equalization (column 3, Attachment 2). Senator Binkley said having a deficit at the end of the fiscal year, rather than having a cash flow problem, appears to be the problem of most of the district. He proposed that the issue be examined in its totality rather than allowing \$2 million to be allocated to districts at this time. The Department would be allowed to maintain some part of the \$2 million, approximately \$500.0 or less, to cover actual cash shortages between now and the point at which the supplemental is passed.

Senator Binkley believed there to be a significant difference of opinion regarding the disbursement of the mitigation monies. He did not agree with the department's analysis and

recommendations. Senator Binkley said the language was drafted as a compromise in passing the foundation bill. He said it was not the intent to exclude REAAs or "bail out" school districts which were in financial trouble. He said many districts made tremendous reductions as a result of the foundation formula and others did not. He believed the Department of Education only examined those districts in financial trouble.

Senator Binkley discussed his proposal saying each district would receive funds under the DOE mitigation proposal, from PL 874 impact aid payments, or under the combination of the 10% PL 874 deferral plus interim area differential equalization, whichever payment is the highest. He said an additional \$1.2 million would be required in [HB 444](#) to totally fund the proposal.

Representative Davis agreed that some schools made drastic cuts and others did not, however, he felt there are schools in need of immediate assistance which have patiently been waiting for their applications to be approved. Representative Zawacki did not believe the Committee desired to deprive the ten schools recommended for funding, however, he felt there is a need to find another formula to address the needs of other schools requiring assistance.

Senator Binkley MOVED to withhold the expenditure of \$2,000,000 appropriated under Section 154, Chapter 3, FSSLA 1987, and examine it in context of the other proposed recommendations regarding PL 874 impact aid payments, 10% PL 874 deferral plus interim area differential equalization, and the Department of Education's recommendations for supplemental funding. The department would be allowed the flexibility to expend up to a total of \$500,000 of the \$2,000,000 for districts in column 4 (attachment 2) not to exceed any individual amount recommended by the Department of Education to a particular district.

Members were advised that Hoonah and Yakutat appear to have significant immediate cash flow problems. It was noted that the Iditarod District and Kuspuk District would receive funding although they have projected fund balances and the Yukon-Koyukuk District would receive funding with a zero balance currently projected.

Senator Binkley discussed the method whereby the FY 88

appropriation would be reappropriated. Chairman Larson referenced [SB 408](#) and questioned the legality of utilizing funds for the PL 874 settlement for mitigating problems found with the foundation formula. Senator Binkley said the proposal would meet the disparity test. He did not believe the federal government would have a problem so long as the disparity test is met. Mr. Hole said it is correct that the proposal meets the disparity test, however, the disparity test was not a part of the settlement for PL 874 in FY 87.

Senator Duncan acknowledged the complexity of the issues to be addressed by the proposal. He recommended that the Committee recess to allow members an opportunity to review the proposal in detail.

Chairman Larson advised members that the meeting would recess until 7:30 a.m., March 9.

#### RECESS

The meeting recessed at 9:15 a.m. on March 8, 1988 and reconvened at 7:45 a.m. on March 9, 1988.

Joint  
88  
JLBA

88/03/09

0745

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
March 9, 1988  
7:45 a.m.

(Tape LBA 88-4, Side 2, #016-end)  
(Tape LBA 88-5, Side 1 and 2)

#### CALL TO ORDER

Chairman Larson recalled the meeting of the Budget and Audit Committee to order at 7:45 a.m.

PRESENT

The following members of the Committee were present:

Representative Hoffman  
Representative Larson  
Representative Pourchot  
Representative Zawacki  
Representative Davis (alternate)  
Senator Binkley  
Senator Duncan  
Senator Fischer  
Senator Halford  
Senator Jones

ALSO PRESENT: Senator Josephson; Representative Herrmann;

Tamara Cook, Director, Legal Services; Commissioner Demmert, Department of Education; Tom Wagner, Department of Law; Mike Greany, Director, Legislative Finance; and Randy Welker, Legislative Auditor.

DEPARTMENT OF EDUCATION-SECTION 154, CHAPTER 3, FSSLA 1987

Chairman Larson advised members that a motion by Senator Binkley was under consideration for approval. He asked Senator Binkley to review his motion with members of the Committee.

Senator Binkley referenced a handout entitled, "Proposed supplementary funding and FY 87 impact aid adjustment" (Attachment 2). He advised members that his motion would provide funding at the highest amount as contained in col. 3, or 4, or 6. He indicated his desire that funding be included in the legislation to be introduced by the governor for the proposed FY 87 impact aid adjustment. The Department of Education would be allowed the discretion to utilize up to \$500,000, for any district which appeared in col. 4 and had an immediate cash flow problem, until such time the legislation passed.

Chairman Larson advised members that the following amounts have been included in [HB 444](#), or are issues which may need to be considered:

Sec. 9, \$3,379,800 - fully fund the foundation program for FY

88 shortages in part due to the governor's veto

Sec. 10, \$800,000 - fully fund tuition students

Sec. 44, \$3,000 - state warrants "clean up"

\$9,153,619 - full funding of school debt reimbursement-FY 88

\$2,515,570 - full funding of pupil transportation-FY 88

\$350,000 - Galena School District supplemental proposal

\$127,800 - Kake School District supplemental proposal

\$9,583,564 - settlement for FY 87 foundation/PL 81-874

\$431,500 - foundation funds for FY 88 to pay hold harmless obligation resulting in distribution of additional foundation funding for FY 87 per PL 81-874 settlement

\$248,400 - foundation funds for FY 88 to pay for student increase as determined by second student count

\$2,580,100 - settlement for repayment of PL 81-874 special education for FY 84.

Chairman Larson said the total of the above listed items is \$25.1 million. In response to a question from Senator Halford, Chairman Larson understood that there are three districts which would receive funding under the department's recommendations which would then be deducted from their PL 874 adjustment in the amount of \$218,000.

Senator Binkley said he had been concerned with the gross inequities which were apparent in the new foundation formula, specifically within the formula for small, single site school districts and area differentials. He reiterated the actions taken by the Senate Finance Committee, Senator Zharoff and himself with regard to the bill immediately prior to its passage last year. Senator Binkley discussed the disparities with the geographic differential, as contained in the Homan McDowell study and used in the formula, and the agreement that \$2 million be included to specifically address these inequities. He said col. 3 addressed the area differential problems as well as the 10% PL 874 hold back. He advised members that some districts could not use 10% of their PL 874

funding in FY 88 which created a gap. He said this gap was not considered by the Department in formulation of the foundation formula or in regulations. Consequently, col. 3 would address this inequity so that all districts could use 10% of the PL 874 in FY 88.

Chairman Larson cited those school districts which would receive funding under col. 3 and the amount of their fund balances. These schools included Haines, Hydaburg, Iditarod, Kuspuk, Skagway, Nenana, S.E. Island, St. Marys, Yukon Koyukuk, and Yupiit. He said a district is not allowed to carry forward more than 10% of their total budget from a previous fiscal year. He said several schools included in col. 3 would have a balance in excess of 10%.

Senator Binkley acknowledged this policy to be one of the fundamental differences in the Department's approach to distribution of the \$2 million as opposed to what he believed to be the legislative intent concerning distribution of the funds. Senator Binkley said the money was not to serve as an emergency bail out for school districts which were out of money. Instead, it was to address imbalances or inequities in the formula fund. Senator Binkley said a number of districts had been prudent with their budgets and made reductions so that a fund balance could be maintained to address any unforeseen expenditures. However, as a result of the regulations adopted by the department for disbursement of the \$2 million, these districts are penalized for those fund balances. Senator Binkley strongly objected to this policy saying it was contrary to legislative intent.

Representative Davis did not feel that the Committee could address the totality of the inequities of the foundation formula. He felt the Committee should assist those communities which are in a deficit situation by following the Department of Education's recommendations for distribution of the \$2 million. He felt that any PL 874 funding which might be available could be used to reduce the amount to be received by a district under this section. He did not feel comfortable with providing funding to schools with a fund balance.

Senator Binkley argued that his proposal would address the Department of Education's recommendations for school districts with a deficit as well as those with an immediate cash flow problem.

There was discussion concerning the totals of the columns as contained in Attachment 2 and additional general fund which would be required to fund the proposal.

Senator Binkley MOVED to amend his motion to fund approximately 20%, or \$3 million, of the FY 88 school debt reimbursement shortfall. (Attachment 2). Senator Halford said the \$3 million would offset the PL 874 adjustment. He said Anchorage would have a zero net effect since there is not enough to offset the PL 874 adjustment. He questioned whether the Committee had any authority other than an advisory dispersal role.

(Tape change, LBA 88-5, Side 1)

Chairman Larson asked Tamara Cook, Director, Legal Services, to advise the Committee with regard to her opinion should the Committee not accept the Department of Education's recommendations and accept Senator Binkley's proposal that alternatives be examined for disbursement of the funds.

TAMARA COOK, DIRECTOR, LEGAL SERVICES, felt that regardless of the actions taken by the Committee, there would be a philosophical potential for a lawsuit. She said there could be a district which would feel that the Department of Education had not properly interpreted the original appropriation. She said the Committee can not distribute the funding and the only way the funds can be disbursed is when the Department takes action. It was determined that should the Committee agree with the Department of Education's recommendation, the disbursement could later be deducted from future impact aid entitlement. A second appropriation would be necessary and the intended distribution would have to be made clear in the appropriation. Ms. Cook said to the extent that a second appropriation might set up a complex formula, it might be necessary to enact substantive law which would set out the distribution formula which would be funded through the appropriation bill. There was discussion concerning whether appropriations fall under the general severability statute.

Ms. Cook believed they did.

Senator Duncan said it was decided in court years ago that the Budget and Audit Committee only has advisory capacity. He believed that Senator Binkley's motion would only be a recommendation to the Finance Committees and the Department of

Education regarding disbursement of the \$2 million and the need for an additional \$12 million. Senator Duncan expressed concern with the possibility of a challenge by a district should the Committee agree with the Department's recommendations for dispersal of the funds. He felt that the "cleanest" method would be to handle the issue through the legislative process which is known to be constitutional.

Chairman Larson asked if section 154, ch. 3, FSSLA 1987, were legal. Ms. Cook felt it highly questionable as the language setting out the purpose of the appropriation is vague. She said the courts require as a minimum that an appropriation establish an exact idea of the amount to be appropriated and a clear idea of the purpose. She said this appropriation leaves open such questions as "what mitigation means", "what small means", "what single site school means", etcetera. She said the Department has no statutory authority to administer these funds. She said a mitigation program should have been adopted in substantive law, giving the department direction, and then an appropriation made to the mitigation fund. Currently, the Department is given a sum of money with a lack of guidance regarding its distribution. Consequently, there is a question about whether the legislature is attempting in an appropriation act to convey upon the department the power to work these questions out. She said an appropriation act can not grant power to administer without violating the confinement requirements.

It was noted that the state could be sued by a district not receiving funding under the department's recommendations, or should the Committee not accept the department's recommendations, by those districts which would have received funding under those recommendations. Ms. Cook felt the "best shot" this appropriation now has is to be distributed in accordance with the department regulations as it is the only structure to point to. She said another possibility would be for the Legislature to reappropriate the funds out of this program. Senator Binkley said that was his proposal.

There was discussion concerning substantive law which would be needed and the method for providing a direct grant to a named recipients of any mitigation funding.

Senator Fischer asked what actions the department would take absent legislative approval. COMMISSIONER DEMMERT, DEPARTMENT OF EDUCATION, felt they had made a good faith effort to

regulate the distribution of the money and provide districts with an opportunity to respond. He felt their recommendations, based on what information they had, fairly distributed the funds. Commissioner Demmert felt they had designed a compromise in accordance with concerns expressed by legislators. He encouraged a speedy resolution to the issue so that funds could be distributed to assist districts which are in financial distress. He said if the Legislature failed to reach a compromise he would meet with the governor to discuss the issue. He said they do not wish to present a proposal which is not supported by the Legislature and he hoped that a compromise by the Legislature could be reached.

If not, it would be his inclination to disburse the appropriation under their current proposal.

Senator Binkley informed members of the advantages of his proposal in precluding the state from being sued. Senator Duncan could not recall a time when a department had not followed the recommendations of the Committee and felt the Administration would heavily weigh the advice of the Committee.

In response to a question from Senator Fischer, Commissioner Demmert advised members that the notice of the proposed regulations went out to all school districts.

Chairman Larson asked for a legal opinion regarding the legality of the inclusion of the PL 874 settlement monies, \$9.5 million, in any compromise. MR. TOM WAGNER, DEPARTMENT OF LAW, said the proposed impact aide settlement deals with FY 87. He said the area differentials, which were going to be used in the settlement, did not take PL 874 into account. Mr. Wagner believed the state's program is going to fit within the disparity guidelines surrounding PL 874 therefore the state is entitled to take PL 874 into account in a "certain way". He said the Legislature would need to be very clear regarding the purpose of appropriations by separating other issues, such as mitigation or adjusting area differentials, from the PL 874 issue. Mr. Wagner said one of the criteria for being allowed to take PL 874 into account is that there be an equalization program. He discussed the importance of any "add on" money meeting the disparity range as not to skew an equalization program. Mr. Wagner felt two separate pieces of legislation, one for the impact aid and a line item appropriation, would be best to clearly identify that one is not offsetting the other.

Senator Binkley advised members that his proposal did meet the disparity guidelines.

A roll call vote was taken on Senator Binkley's motion to amend his motion to provide 20% of the FY 88 school debt reimbursement shortfall.

IN FAVOR: Hoffman, Binkley, Duncan

OPPOSED: Larson, Pourchot, Zawacki, Fischer, Halford, Jones, Davis

The MOTION FAILED (3-7).

(Tape change, Side 2)

Senator Binkley MOVED to amend his motion to provide 60% of the FY 88 school debt reimbursement shortfall which would represent an additional amount to be added to districts and not in combination with any other columns as contained in Attachment 2. (Attachment 3). He said the amount for Anchorage would be approximately \$2 million.

Following discussion by members, Senator Binkley WITHDREW HIS AMENDMENT TO HIS MOTION, saying he had not checked to see that it would meet the disparity test. Senator Binkley WITHDREW HIS MAIN MOTION.

Senator Jones MOVED that the Budget and Audit Committee advise the Department of Education to proceed with the disbursement of funds under Section 154, Ch. 3, FSSLA 1987, as proposed.

Senator Binkley OBJECTED feeling there are serious legal problems. He felt it prudent to proceed with a supplemental piece of legislation clearly identifying recipients of the funds in an attempt to preclude the department and state from any legal action.

Senator Binkley suggested that a school district could file an injunction to preclude the department from distributing any of the \$2 million until such time the district felt they had received that portion which they believed fair for their district. Senator Duncan felt the prudent action at this time would be to disburse the \$2 million and address the other identified problems through supplemental legislation. He

encouraged the Administration to immediately submit legislation to correct the PL 874 issue. Senator Halford agreed that a supplemental should go forward. Representative Hoffman discussed the inability of St. Marys, which had a fund balance for school construction, to apply for funding. He urged the Committee to use its influence in putting forth a supplemental. He urged defeat of the motion and asked the Committee to come forward with a positive solution as recommended by legal counsel.

A roll call vote was taken on the motion to advise the Department of Education to proceed with the disbursement of funds under Section 154, Ch. 3, FSSLA 1987, as proposed.

IN FAVOR: Larson, Pourchot, Zawacki, Davis, Duncan, Fischer, Halford, Jones

OPPOSED: Hoffman, Binkley

The MOTION PASSED (8-2).

Members acknowledged their varying concerns with regard to the mitigation account, supplemental funding, area differential disparity, PL 874 settlement, etcetera.

Senator Duncan MOVED to direct the Department of Education to address the concerns expressed by the Budget and Audit Committee in a piece of legislation for introduction in both bodies.

ADJOURNMENT

The meeting adjourned at 10:00 a.m.

Approved by:

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Representative Ron Larson  
Chair  
Budget and Audit Committee

Joint  
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0735

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
March 15, 1988  
Juneau, Alaska  
7:35 a.m.

Tape LBA 88-6, Sides 1 and 2  
Tape LBA 88-7, Side 1 (000-176)

#### CALL TO ORDER

Chairman Ron Larson convened the meeting at approximately 7:35 a.m., in the House Finance Committee Room, State Capitol, Juneau, Alaska.

#### PRESENT

The following committee members were present:

Representative Hoffman  
Representative Larson  
Representative Zawacki  
Representative Davis (Alternate)  
Senator Duncan  
Senator Fischer  
Senator Jones

Representative Pourchot and Senators Binkley and Halford arrived shortly after the meeting began. Representative Adams did not attend.

ALSO ATTENDING: Representative Martin; Commissioner of Administration John Andrews; Daniel Humphrey, of Daniel R.

Humphrey, CPA, consultant to the Dept. of Administration; Bob Maynard, Assistant Attorney General, Dept. of Law; Mary Jo Jeans, Director, Division of Pioneer Benefits; Randy Welker, Legislative Auditor; Eric McDowell of McDowell Group/Data Decision Group, Inc.; Niles Cesar, Executive Vice President, Southeast Alaska Regional Health Corporation (SEARHC); Carolyn Burg, representing the Pioneers of Alaska; Joe Alter, representing the Pioneer Homes Advisory Board; Henrietta Sievenpiper; Mike Greany, Director,

Legislative Finance Division; Jim Slocum and Karen Rehfeld, Fiscal Analysts, Legislative Finance Division; and aides to committee members and other members of the legislature.

#### MINUTES OF PREVIOUS MEETINGS

Chairman Larson noted that minutes of the meetings of March 8 and 9, 1988, were being distributed for committee review prior to approval at the next meeting.

#### PURPOSE OF THE MEETING

Chairman Larson advised that the meeting was convened to address questions relating to the proposed area cost differential study and management of the Juneau Pioneers' Home. He explained that discussion would commence with the cost differential study, and noted that if the committee was unable to conclude discussion at this time, further consideration would be postponed until later in the week.

#### AREA COST DIFFERENTIAL STUDY

Chairman Larson explained that the proposed study relates to the area cost differential for formula funding of school districts in Alaska. He noted that a copy of the contract for the study had been distributed to members for review.

ERIC McDOWELL, President, DATA DECISIONS GROUP, INC., came before committee. Senator Fischer noted references to "The McDowell Group" contained within the Work Plan Summary attached to the proposed contract and advised of his understanding that there was no such company. Mr. McDowell explained that The McDowell Group is part of Data Decisions Group, Inc. The McDowell Group has been in business in Alaska for sixteen years and has performed 200 to 300 economic studies. As part of the Data Decisions Group, it has access to sophisticated survey research expertise.

The merger between the two groups was formed last year.

(Representative Pourchot arrived at the meeting at this time.)

Senator Fischer next asked if the purpose of the study would be to establish appropriate differential elements and factors for instructional units. Mr. McDowell explained that as a result of the study the committee would have three things:

1. A cost differential for non-personnel school operations in all 55 districts.
2. An update of the cost of living differential for the personnel portion of school budgets.
3. A data base involving enrollment, professional staff, and geographic facilities.

(Senators Binkley and Halford arrived at the meeting at this time.)

The committee will thus have two differentials (one for operations, the other relating to personnel) and a complete data base for each of the 55 districts. The study proposes to provide as much decision making information as possible rather than to make decisions for the committee based on predetermined numbers.

Senator Fischer then asked why the committee should enter a sole source, \$180.0 contract with Data Decisions Group instead of offering the contract to a number of companies through the RFP process. Mr. McDowell answered that while other companies might be available, none have the degree of expertise Data Decisions has in the differential field. Data Decisions is the only firm in Alaska to have conducted a comprehensive cost of living differential study. While other studies have been done, none were as complete nor were they conducted with methodology developed especially for Alaska.

Referring to a previous, \$216.0 study by The McDowell Group, Senator Fischer questioned need for the upcoming contract, asking if performance of the contract would ensure that the state would not be facing the same problem and need for an additional study next year. Mr. McDowell explained that while the "political decision making problem" would always exist, the current information problem would be solved for next year.

Chairman Larson further explained that when the legislature dealt with [HB 126](#) (Public School Foundation Program and T.R.S), the area cost differential from which it worked was based on the cost of living in 19 regions of Alaska. Legislators were uncomfortable with the numbers and felt that a profile on the cost of education in Alaska's 55 school districts was needed.

Senator Fischer inquired concerning how the dollar amount of the proposed \$180.0 contract had been ascertained. Mr. McDowell

answered that he, his staff, and his associate, Dr. Nat Cole, did an analysis of the amount of professional time needed to accomplish the three tasks covered by the study. The price of the contract is based on that analysis.

In response to further questions from Senator Fischer, Mr. McDowell explained that in conducting the study, staff would not be visiting all 55 school districts. The cost of that kind of effort would be prohibitive. Staff will take advantage of existing information, information obtained through surveys within the districts, and supplemental research on items such as housing. He stressed that his firm had previously conducted two landmark studies. One related to the cost of living. For that study, the firm surveyed 2,500 households and 2,000 retail outlets. Duplication of that effort would be extremely expensive. Secondly, in the early 1980s, the firm performed the only comprehensive study of the cost of education (the area cost differential study for the instructional unit allotment). In terms of expertise, the firm has conducted major studies in Alaska. Senator Fisher asked if both studies were performed for the state, and Mr. McDowell answered affirmatively. The Senator then noted that since the studies are public documents, other firms would have access to them as well, and Mr. McDowell concurred in that understanding.

Senator Fischer next inquired concerning the \$15.0 budgeted for expenses. Mr. McDowell explained that his firm had presented its proposal in two fashions. It originally detailed all expenses anticipated to be incurred by the study. In the final contract, these expenses (many of which are expected to be telephone costs) were presented as a lump sum so that the committee would not be subject to costs should overruns occur. He noted that he was agreeable to proceeding via the lump sum method or per individual cost item. Senator Fischer then inquired concerning underruns.

Will the contract cost a flat \$180.0, or "up to \$180.0?" Mr. McDowell answered that the contract proposes a flat \$180.0 amount. He advised that he would be agreeable to performance of the contract on an hourly and cost basis if the committee preferred. Senator Fischer voiced concern regarding \$15.0 in anticipated expenses for a study which does not anticipate "going out into the field . . . ."

Referring to the method of payment, Senator Fischer asked if it is normal for 17% of the contract price to be paid "up front." Mr. McDowell answered that payment varies per contract.

Something is usually provided up front. Sometimes it is half, a monthly amount, etc. Senator Fischer asked if Mr. McDowell would agree to performance on a cost basis whereby the firm submits bills to the committee under a contract price up to \$180.0. The Senator advised that since the contract is sole source and there is nothing to evaluate it against, the committee would then have a certified payroll to provide an understanding of how funds are spent and to provide guidance for handling future sole source contracts. Mr. McDowell answered that he would be agreeable to that arrangement.

Senator Fischer next asked if a performance bond was required for the contract, and Mr. McDowell answered negatively.

Senator Fischer then asked if Dept. of Education staff could perform the contract in house since the department has access to study material. Mr. McDowell explained that while the department has some, it does not have most of the material. He added that "once a system is set up, and if they generated the information in house," the department could perform the task. He noted, however, lack of department expertise in the differential and professional research areas. It is this expertise that the contract would be purchasing from Data Decisions.

Senator Fischer next queried Mr. McDowell concerning possible retention of a portion of the contract as security pending committee approval of the study effort. Mr. McDowell expressed hesitation at being subject to committee information needs a year and a half hence. He advised, however, "If you had a chance to review in detail the document for as long as you would like, I would be glad to wait for the last payment until you're happy."

Chairman Larson acknowledged that because of the sole source nature of the contract, all questions must be answered. He noted, however, that in light of time constraints, further discussion of the contract would be postponed to the next meeting in the hope of finalizing it at that time. He then directed that the committee proceed to the next agenda item.

### **JUNEAU PIONEERS' HOME**

Chairman Larson spoke briefly to concerns for quality care and need to open the Juneau home as soon as possible. He advised that the issue before committee at this time relates to the type of management for the home. He further directed attention to an

opinion from the Attorney General regarding budget intent language for the Juneau facility, and asked that Commissioner of Administration John Andrews come before committee.

JOHN ANDREWS, Commissioner of Administration, and DANIEL R.

HUMPHREY, consultant to the Department of Administration, came before committee. Chairman Larson noted problems surrounding the opening of the home stemming from intent language included in the FY 88 operating budget. He explained that earlier discussion of the issue centered on privatization of Juneau home operations and the drafting of an RFP proposal to place management of the home out to bid. He acknowledged sentiments that the home should be operated as a state facility like other pioneer homes, as well as an opposing belief that the state has a unique opportunity to attempt cost savings by operating the new home through private contract. The Chairman then asked that Commissioner Andrews speak to problems surrounding the RFP process and why the bids were not acceptable.

Commissioner Andrews explained that the RFP was issued the middle of December. The deadline for receipt of proposals was the last day of February. The department held a pre-proposal conference with prospective bidders, and five vendors were present at the question and answer session. The department subsequently received correspondence from several of the five, expressing the belief that minimum criteria contained in the RFP was not well founded and requesting that it be withdrawn. The department declined to do so. On the last day of February, two proposals were received by the state. At that time, a pre-selected proposal evaluation committee met and evaluated the proposals in terms of compliance with the terms of the RFP. Neither bidder met the minimum requirements. One had an insufficient number of years of experience in like work; the other did not fill out a complete proposal package.

At the present time, the department has reached a decision point.

For purposes of the procurement code (AS 36.30), the procurement effort has been completed. The department does not have legal authority to grant a contract for either of the above-noted bids because they are not in compliance with the terms of the RFP. To do so would disenfranchise other vendors who might have offered proposals had the criteria been different.

Chairman Larson inquired concerning who had drafted the RFP and

why it was drafted in the manner it was. Commissioner Andrews explained that Daniel Humphrey had been hired as a consultant for the purpose of drafting both the minimum criteria and the RFP.

Chairman Larson asked if the RFP was drafted in such a manner that requirements for bidders were beyond those which the state places upon itself.

DANIEL HUMPHREY, of Daniel R. Humphrey, CPA, consultant to the Dept. of Administration, advised members of his 18 years of experience in different aspects of long-term care. He explained that the department requested that he take a look at the existing pioneer home program. He noted that the pioneer home system is a good program. It enjoys a good community relationship and is sensitive to the needs of people in Alaska. Since the program has been successful, it is important that if privatization occurs, a situation is not created whereby somebody gains access to the system and rather than delivering quality care actually cuts the level of care. Mr. Humphrey cautioned that this could happen. In a number of instances long-term care or retirement and nursing facilities have been acquired by individuals who speak of quality but in reality allow deterioration to occur when they assume management. With this in mind, Mr. Humphrey advised of his belief that RFP criteria should "serve as a gate to the evaluation process." He cautioned that once the gate is opened and private firms admitted, the state would have to go with the most cost-effective bid. If cost effectiveness is achieved at the expense of patient care, it is not in the best interest of the state. Mr. Humphrey advised that within that set of parameters, he attempted to develop reasonable criteria for basic eligibility requirements. One item of that criteria is experience. The pioneer home system encompasses both retirement homes and skilled, long-term care facilities. The homes are not the same as clinics or other types of health-related activities.

The state must recognize that the population is aging, and those in pioneer homes today are probably "sicker" than those in residence fifteen years ago. This situation will continue to accelerate. One must also recognize that the facilities provide a home-like atmosphere. They are not strictly institutions.

Managers must be sensitive to that fact. The successful applicant should have practical experience in this field in order to be sensitive to the adequate rendering of services. The first minimum qualification thus required five years' experience. Mr. Humphrey acknowledged that the five-year requirement reflects a

judgment call (it could have been three). He advised, however, that he felt five was "reasonable under the circumstances."

The second criteria relates to the quality of the bidder's delivery of care elsewhere. Many of the anticipated applicants would have been "multi-facility operators" (nursing home chains or nursing home management companies). Mr. Humphrey stressed the importance of ensuring that if other facilities operated by an applicant had had serious quality control problems, the applicant would not be eligible under the RFP. The attempt here was to deny access to firms which had been decertified under the medicaid/medicare program, had had licenses revoked, or had received consecutive notices of noncompliance with standards.

Mr. Humphrey acknowledged that it is easy for even a good quality provider to "have a standard out, because the federal government changes them all the time." Consecutive noncompliance, however, means that deficiencies were noted, and the firm failed to correct them by the next survey. A firm which has had that sort of problem is probably not managing its current operations well and should not assume responsibility for additional health care facilities.

Mr. Humphrey stressed the importance of criteria in the wake of a management agreement. Should a dispute between the state and care provider arise and litigation follow, nobody generally wins.

It is better to be a bit "tougher" on the front end and select from firms with proven track records.

Mr. Humphrey further stressed that the firm selected to manage the Juneau home--a \$10 million physical plant caring for 52 residents--should have a management team capable of continuing operations should one of the team members leave or die. A team of three was thus selected. Mr. Humphrey advised that poor maintenance and management of an expensive physical plant could quickly jeopardized the value of the plant.

The fourth criteria relates to a performance bond. This requirement is implicit in basic state acquisition documents and is appropriate in light of the multimillion dollar contract which will extend over a number of years.

The fifth criteria required that if one of the management team had had his or her professional license suspended or revoked, the firm's proposal would not be accepted.

In summary, Mr. Humphrey stated that the idea behind establishment of minimum criteria was "to try to create a gate." He acknowledged that it may have been "a little bit tighter than some people liked," but it was done objectively based on a desire that viable applicants engender a high degree of confidence and evidence ability to perform well.

Chairman Larson asked that Mr. Humphrey provide information on his background. Mr. Humphrey advised that he is a CPA with his own firm located in Seattle, Washington. He has been in practice for approximately 18 years. More recently, he explained that he had increasingly been working in the area of consulting. He further explained that he is currently part owner of two nursing homes in Washington, and has had experience as an expert witness in multimillion dollar class action court cases. He added that he had worked with many different types of nursing homes and could "tell a good one from a bad one pretty quickly." Mr. Humphrey further explained that he had also worked with those in the management area of health care. In response to further inquiry from Chairman Larson, Mr. Humphrey advised that he was hired as a consultant by the Dept. of Administration.

Chairman Larson asked how care at current state-operated pioneer homes would compare with criteria for the RFP. Mr. Humphrey answered that the criteria is essential for all pioneer homes.

He acknowledged that he was not familiar with the operation of all of the state's homes, but advised that he had met some of the managers who appeared to be very knowledgeable. He stressed that the ultimate strength of the homes rests in employees and community input. Mr. Humphrey voiced his belief that established criteria is inevitable because of rising care levels for residents. The aging process is levying a heavier care requirement on pioneer homes in terms of the differing care levels currently being provided.

Representative Zawacki asked if current managers and operations at pioneer homes would qualify under RFP criteria. Mr. Humphrey answered that he was not sufficiently familiar with managers and home operations to respond.

Senator Duncan noted that in evaluating state versus private operation, the committee is "looking at two different situations." He explained that while current managers of pioneer homes might not be able to meet the five-year criteria, the

relationship between a public employee and the state is quite different from that under a private contractor. Should the state have problems with an existing manager, the system can rapidly dismiss the individual and replace him or her with someone who is qualified. The state would not have that flexibility under a five-year contract with the private sector.

Representative Pourchot noted time limitations surrounding the writing of the RFP, and asked if a pre-bid conference had been held to solicit input from those interested in the RFP in order to weigh criteria against the reality of bidding. Commissioner Andrews acknowledged that the time frame was indeed short. He stated that in weighing recommended criteria (bearing in mind the procurement code) it was his judgment that the inquiry suggested by Representative Pourchot would be "dangerous to this process." It might open the state to charges of pre-arrangement and tailoring of the RFP to satisfy one bidder over another.

Commissioner Andrews advised that he therefore sought to isolate himself from information regarding how the proposed criteria might affect bidders.

Senator Fischer asked if medicare and medicaid applied to the pioneer home system. Mr. Humphrey answered that while they do not directly apply, both are pertinent in terms of licensing. It was not the intent of the RFP to bring those programs into the existing system. Over the last fifteen to twenty years, medicare and medicaid programs have, however, developed good guidelines and definitions of basic quality care issues (proper infection control techniques, feeding, turning, positioning, and transferring of patients, etc.) This body of knowledge has in some instances been litigated. It was thus felt that, as a minimum, the care provider should be capable of meeting those standards of performance.

Senator Fischer expressed concern that under RFP criteria even if a private contractor such as SEARHC were to hand pick the very best, long-term employees from existing pioneer homes to staff the Juneau home, SEARHC would still be disqualified under the criteria. Mr. Humphrey concurred.

Representative Zawacki asked if the RFP had been distributed both inside and outside of Alaska. Commissioner Andrews answered that it was advertised in newspapers within the state and mailed to anyone who requested it, regardless of whether the requestor was located inside or outside of the state. Representative Zawacki

voiced concern that the department had hired an out-of-state consultant to develop the RFP yet failed to advertise the RFP outside of Alaska. Chairman Larson voiced need for a neutral person to draft the RFP, and noted that out-of-state advertising would be extremely costly.

MARY JO JEANS, Director, Division of Pioneer Benefits, Dept. of Administration, advised that the department maintains a list of individuals and firms interested in bidding on state projects.

Based on that list, the division sent out over 400 informational letters nationwide. Those who were interested in the RFP thus had an opportunity to respond.

Senator Duncan concurred in comments by the Chairman regarding need for an unbiased approach to drafting the RFP. He advised that an objective point of view is extremely important since the state was proposing a major step in terms of operation of the Juneau home.

(End, LBA-88, #6, Side 1)  
(Begin LBA-88, #6, Side 2)

Senator Duncan stressed again the difference in relationship between the state and its employees in state-operated homes versus a private contractor. He spoke to Senator Fischer's earlier statement that even with hand-picked employees from current Pioneer Homes, SEARHC would not qualify under terms of the RFP, advising that here again the reason the firm would not qualify relates to the difference in relationship between it and the state. He stressed that under a five-year private contract, the state could easily lose control.

Senator Duncan next queried Commissioner Andrews concerning anticipated savings to be derived from the private contract. The Commissioner concurred in Senator Duncan's above statements concerning the crucial difference between the state's relationship to its employees versus the situation under private contract. That difference represents "an element of risk." When dealing with state employees as inevitable differences and complaints arise, the state can intervene effectively. State ability to react is hindered in a contractual relationship.

Minimum criteria was thus developed to diminish the element of risk and provide assurances that inordinate problems do not arise. The Commissioner acknowledged that RFP requirements are

more strict than those applied to state home operations, but he added that that is appropriate in light of the element of risk associated with a private contract.

Senator Halford noted that the RFP process appears to have been a futile exercise designed to say, "We can't get there from here," since no one could meet the criteria. Speaking to an earlier question relating to the fact that even with hand picked state employees SEARHC would not meet minimum requirements, Commissioner Andrews explained that SEARHC would still not satisfy the first requirement that the organization have five years' experience in like work, nor the third requirement that the organization have a long-established management team with proven ability to work successfully together.

Senator Duncan stressed that the fact that SEARHC did not meet criteria does not mean that there are no other contractors who would qualify. He noted that SEARHC provides very good services in other health-related fields but has not been involved in nursing home-type operations. Even with the best employees, the firm would not have qualified because it lacked five years' experience in nursing home care.

Responding to an earlier question concerning costs to be saved through privatization of Juneau home operations, Commissioner Andrews answered that the situation is mixed. The budget proposal placed before the legislature in January seeks \$2.218 for the Juneau home. Private contractors submitted proposals for \$2.040 and higher. The Commissioner further advised that prior to receipt of the bids, he had asked staff to "rethink one more time for cost comparison purposes," the cost of a state-operated facility. The Governor's amended budget contains that reevaluation (\$2.170--a \$44.0 decrease from the original budget).

The revised budget contains assumptions that portions of home operation (physician's services, pharmaceutical services, and supervision of housekeeping and food service) could be contracted out. It is now the department's intent to pursue entire contractual operation of housekeeping and food services. That should further reduce the cost of state operation by an estimated \$100.0. That additional reduction is not "embedded" in the amended budget since questions arise concerning the accuracy of the estimate. The current proposal for operation of the Juneau home as a state facility (with the four, above-noted functions contracted out) is \$2.070. The lowest private offer was \$2.040.

Senator Duncan voiced his understanding that approximately \$30.0 to \$40.0 would be saved through private contract for operation of the home.

Senator Fischer noted the foregoing state estimates and advised that the private sector is disadvantaged in that it must provide a "true estimate" to which it will be held. He then suggested that if the home is state operated and funded at \$2.070, the department will request incremental increases in future years which might increase the budget to \$2.5 or \$3.0. Speaking to risk involved in private contracts, Senator Fischer noted that Lutheran Homes has done an excellent job of running both the Central Peninsula General Hospital in the Kenai/Soldotna area and Heritage Place (a long-term care facility for senior citizens).

Senator Fischer advised that he would match the care at Heritage Place with the level of care at any of the state-operated homes.

Senator Fischer next asked if the Commissioner was personally opposed to privatizing operation of pioneer homes. Commissioner Andrews stated that he was not against privatization. In this particular instance, and for this particular procurement effort, he advised that his recommendation to the Governor would be that the Juneau home be operated as a state facility. The Commissioner explained that at several times during the procurement effort he became "fairly enthusiastic" about a potential private contract. He advised that it appeared to be a positive move which would bring fresh perspective, insight, and renewed vigor to operation of the homes. In the end the procurement effort did not work. The state is now in a position where it must make a decision among available alternatives:

1. Begin again with another request for proposals worded or advertised more broadly.
2. Leave a \$10 million facility vacant.
3. Operate the home as a state facility.

Chairman Larson noted that July 1, 1988, is now the scheduled opening date for the Juneau home. He further noted a legal opinion from Bob Maynard, Assistant Attorney General, Dept. of Law, indicating that legislative intent language contained in the FY 88 budget was ambiguous and left open the question of whether or not it had to be followed. The Chairman voiced his interpretation of the opinion to be that the department does not

have to follow the intent because of its broad range. The Chairman then restated alternatives for the home to be:

1. Redraft the RFP

2. Operate the Juneau Home as a state facility

3. Address the question in the FY 89 budget by appropriating funding and then specifically stating intent as to how the dollars should be spent.

Representative Pourchot advised that issues surrounding the home had reached the current point as a result of legislative concern over the cost of opening a new facility. Discussion did not center so much on the philosophy of privatization versus state operation as upon ways to minimize those costs. The same discussion has been had regarding the Spring Creek prison facility, the Anchorage Court House, etc. These facilities have not been privatized. Representative Pourchot noted that by going ahead with state operation, the committee knows what it will get--the same quality of care provided at existing homes. In reshaping the RFP, the state would be exposed to risks relating to the level of care, and the bid price would remain an unknown.

He advised that estimated monetary savings do not appear to equate to the risk involved, and suggested that the committee direct that the department proceed with state operation.

Chairman Larson concurred, advising that a portion of the \$500.0 appropriated for the current fiscal year would be utilized regardless of the resulting management approach.

Representative Zawacki quoted from the following Juneau Empire newspaper article:

Mr. Cladouhos, administrator of SEARHC medical and dental clinics, said the SEARHC bid for operating the Juneau Pioneers' Home was \$1.79 million a year, about \$500.0 less than the estimated cost of running a home by the state. The savings would be achieved because of lower salaries than with state employees, and incorporating some of the Pioneer Home's costs in the rest of the corporation's.

Representative Zawacki referred to department estimates that costs savings would be approximately \$30.0 to \$40.0, and asked

for an explanation of the difference. He further advised that he was puzzled by statements that the Commissioner was "enthusiastic" about privatizing the home, noting that in December the Commissioner had advised that he would not pursue privatization since it was not in the best interest of the state.

At this point in the meeting, Chairman Larson noted an attendance conflict for some members since the Senate Finance Committee was about to begin its meeting. He stated that he hoped to bring the issue of operation of the Juneau home to "some type of a satisfactory conclusion" during the current meeting, and suggested that remaining committee members continue the meeting as a committee of the whole for the purpose of taking public testimony, but that a quorum be reconvened prior to taking final action on the issue.

Senator Duncan referred to the difference in estimated savings noted earlier by Representative Zawacki and explained that in arriving at its figures SEARHC had netted out program receipts.

Should the state do the same with its \$2.1 million budget, it would be close to the same level.

Representative Zawacki requested that representatives from SEARHC be allowed to speak to the RFP. He further voiced his belief that a committee vote on the matter during the current meeting would be a disservice to bidders. Chairman Larson noted a larger disservice stemming from delayed opening of the home.

Senator Fischer stressed need for testimony from the Dept. of Law regarding the validity of legislative intent, suggesting that if intent means nothing, a vote would also be meaningless, and the department would proceed per the original plan.

Representative Davis voiced need for committee direction to the department. He noted previous consideration by the administration for turning all pioneer homes over to private contract and advised of legislative concern. As a compromise, private operation of the Juneau home was suggested as a test.

Representative Davis stated that he was comfortable with the way the RFP was drafted, noting that the process was not in vain since it generated careful consideration.

At this point, Chairman Larson requested that a motion be made regarding operation of the home, noting that public testimony

would then be had followed by a determinative vote.

Senator Duncan MOVED to direct the Dept. of Administration to proceed with operation of the Juneau Pioneers' Home under state operation and proceed with the hiring of necessary personnel in order to move ahead. Senator Jones MOVED to AMEND THE MOTION, directing the department to contract the "entire food service and housekeeping function." Senator Fischer OBJECTED for the purpose of clarifying the impact of legislative intent, asking if the amendment to the motion would be binding on the administration.

BOB MAYNARD, Assistant Attorney General, Dept. of Law, responded negatively. Chairman Larson noted the difference between that which is legally and that which is morally binding.

Senator Binkley addressed questions to Mr. Humphrey, asking if privatization of long-term care represents a novel concept. Mr. Humphrey answered that it was unique, that he had not before "run across it." He qualified his response by advising that other states "don't have the pioneer homes." Senator Binkley next inquired concerning how other states care for the elderly, and Mr. Humphrey explained that "they are at the tender mercy of the system." He added that that is not always comforting. Elderly persons needing care usually end up on the medicaid welfare program in less desirable facilities. Private, high quality facilities are expensive. Those who are not doing well financially end up in less desirable nursing homes. In response to a further question from Senator Binkley asking if such homes are state operated, Mr. Humphrey answered negatively, explaining that state medicaid agencies provide a fixed amount for patient care, and the patient must then "go out and try to locate a nursing home in which to reside . . . ." These homes are all privately operated. Mr. Humphrey explained that "a lot of large nursing home chains--multiple care facilities have specialized in the medicaid market."

Senator Binkley voiced his understanding that the RFP for pioneer home services was unique, that Mr. Humphrey had not before had a similar experience, and that the two-week time period for drafting was short. Mr. Humphrey concurred, advising of an additional consideration in that he believed the existing pioneer home system to be a good program. He voiced apprehension over being "too loose on the criteria" because of the danger involved in ending up with a successful bidder who might not continue the program. He acknowledged that he had freedom to make decisions, and was not asked to nor did he "stack any decks." He advised

that he simply did the best he could to develop criteria.

Senator Binkley noted comments by Mr. Humphrey that two weeks was a short time period within which to draft the unique RFP proposal, and asked why the time crunch had occurred since legislative intent had issued in May. Commissioner Andrews provided background information on the issue, explaining that after the budget was passed, the department spent ensuing months determining how it would carry out the proposed contract. It contacted the Council of State Governments in an attempt to speak with knowledgeable individuals in Delaware and other East Coast states which had made experimental moves in a similar direction.

The Commissioner referred to studies relating to potential problems and noted policy implications "in the political scene." He further advised that after talking with those involved, the most significant underlying consideration was "to go slow and be careful." This area is fraught with difficulties. At this point the undertaking was subjected to reappraisal in terms of risks and whether the move was prudent. Reconsideration led to the conclusion expressed in October correspondence to the committee.

The committee met in November, reaffirmed and restated legislative intent, and issued a directive and time table for proceeding to private contract.

Chairman Larson directed that the committee proceed to public testimony and advised that later in the morning the meeting would be briefly recessed to gather a quorum and vote on the motion.

He then requested that representatives from SEARHC speak before committee.

NILES CESAR, Executive Vice President, Southeast Regional Health Corporation (SEARHC), came before committee voicing his belief that throughout the process SEARHC had responded in appropriate fashion. He explained that the corporation was approached by the legislature and asked to examine privatization. SEARHC responded with an unsolicited proposal in April and waited until October when the department advised that operation would not be privatized. SEARHC then appeared before Legislative Budget and Audit, and the committee subsequently mandated that the department seek private contract for operation of the home.

Mr. Cesar questioned statements by Commissioner Andrews that he was committed to privatization and suggested that the RFP was

constructed to exclude private parties. He further noted that the SEARHC proposal was not evaluated. The corporation was evaluated only in terms of minimum criteria. The proposal itself as well as levels and standards of care were not evaluated.

Mr. Cesar advised of a series of letters between SEARHC and the department regarding minimum qualifications. While the corporation did not receive positive feeling that qualifications would be waived, it nonetheless wrote a proposal. He advised of discussions with Senator Duncan concerning costs and funding, but further advised that he would stand by the fact that the state would save "several hundred thousand dollars" through private operation. He further noted that the state does not address many items in its proposal for operation of the home such as premium pay, travel, hire, etc. Much will not come to light until next year when the legislature is asked to increase the budget.

In deference to Mr. Humphrey's experience in Washington state, Mr. Cesar stressed that SEARHC has experience in Alaska and has dealt with issues of concern addressed by the RFP. Mr. Cesar explained that SEARHC did not expect to receive the contract for operation of the home since it believed that the administration was "so dead set against it that they (sic) would do everything in their (sic) power to see that we didn't get it." SEARHC continues to believe that the department's cavalier approach to privatization should be brought to legislative attention.

Speaking to the level of care at pioneer homes, Mr. Cesar advised that Mr. Humphrey had not evaluated the care. He further advised that SEARHC had received "many calls" regarding pioneer home care, and noted that not "everyone in the State of Alaska feels that they are operated in a grand fashion." Like any system, it has problems. Mr. Cesar stated that SEARHC had essentially written the standards for the Juneau home. The document weighs seven pounds, is over 1,000 pages long, and represents an excellent job written by professional Juneau-based people.

Mr. Cesar stated that he did not expect his testimony to make a difference, but expressed need to voice frustration with the system and request that the legislature oversee the administration and Division of Pioneers' Benefits in order to make both more responsive to privatization. An outside entity should review the issue of privatization.

In his closing statement, Mr. Cesar expressed concern that existing pioneer homes will not continue in the future in that

there will likely be court challenges to the system. The system must respond to these challenges today, or pioneers the administration seeks to care for will be hurt when residency requirements no longer exist, the homes are overcrowded, and the state discovers that it costs twice as much for a nursing bed in the pioneer home system as it does in the private sector.

Chairman Larson and Representative Davis agreed that the legislature would have to face many of the challenges outlined by Mr. Cesar.

Representative Zawacki asked if, aside from compliance with minimum criteria for the RFP, the proposal offered by SEARHC far exceeded current pioneer home requirements. Mr. Cesar answered affirmatively, explaining that medicare has several levels of standards. Acute care facilities--hospitals--are the highest level of care. Nursing homes are below that. One of the staff executives at SEARHC is the western regional representative to American health care executives. He has 30 years experience.

SEARHC has a number of graduate degree employees (geriatric nurses and nurse practitioners) on staff.

When queried by Representative Zawacki concerning the \$500.0 in cost savings estimated by SEARHC to be gained through private contract, Mr. Cesar acknowledged the recovery of costs through program receipts earlier noted by Senator Duncan. SEARHC estimates recovery at 80%. That brings the private contract closer to the state. The private sector should be given an opportunity to back out these costs as has the state. Mr. Cesar advised that he would stand by estimates that the SEARHC proposal would save the state \$150.0 to \$200.0.

(End LBA #6, Side 2)  
(Begin LBA #7, Side 1)

Senator Duncan made reference to earlier conversations with personnel from SEARHC, acknowledged that privatization of pioneer home operations could perhaps reduce costs, and advised of his intent to provide funds within the operating budget for a comprehensive review of the pioneer home system. He stressed need to open the home as soon as possible in order to benefit seniors in the Juneau community. Mr. Cesar stated that SEARHC had written a proposal which could have opened the home in May, and he advised that he was skeptical of the new July 1 target for state operation. Chairman Larson concurred in need to evaluate

the process under which care for seniors is provided.

BOB MAYNARD, Assistant Attorney General, Dept. of Law, next came before committee. He advised of an opinion issued by the Office of the Attorney General, indicating that intent language relating to operation of the Juneau Pioneer Home was not binding on the administration because of form. The problem is that the language not only qualifies funding flowing to the Juneau Pioneer Home, it also applies to the entire appropriation for all pioneer homes.

What the legislature essentially said to the Governor was, "You either contract out the Juneau home to private operation, or "you don't operate any pioneer home in the state." Had the legislature simply applied the intent to funding for the Juneau home, the matter would have been much different. By applying the intent in the manner used by the legislature, it appears that the legislature sought to hide something from the Governor's line item veto authority. The intent language swept too broadly. It conditioned the entire Pioneer Home appropriation and violated the "germaneness" condition.

Discussion followed between Representative Zawacki and Mr. Maynard concerning use of appropriations versus allocations when constructing the operating budget. Mr. Maynard explained that intent may only be applied to appropriations (which are binding upon the administration), while allocations merely provide guidelines for the use of funding.

CAROLYN BURG, representing the Pioneers of Alaska, next came before committee. She explained that in a conversation with the grand president of the Pioneers, Edwin Klopp of Homer, he indicated that pioneers do not want privatization of the homes.

Mrs. Burg further spoke favorably concerning proposed legislation which would provide an ombudsman for pioneers, advising that the service would alleviate lawsuits. She explained that many complaints from seniors are minor and could easily be handled by an ombudsman. Mrs. Burg advised that "a lot of the things that the pioneers want don't cost any money at all." They relate to courtesy, the way pioneers are treated, and the attitudes of those who treat them. She stressed need for training for staff members who work with senior citizens.

Mrs. Burg further spoke to need for a coordinator to deal with older people, make them and their families aware of available services, and provide direction.

In her closing remarks, Mrs. Burg expressed hope that the Juneau home would be operated under state care, noting the uniqueness of the home system, and voicing compliments concerning the level of care. She expressed thanks to committee members for support of state-operation of the Juneau home.

JOE ALTER next came before committee, advising that he was approaching his fifth decade of Alaskan living and nearing the time when he might consider residency in a pioneer home. He voiced support for the motion pending before committee. He explained that as a member of the Pioneer Home Advisory Board he had attended hearings in communities which currently have pioneer homes. Comments from both residents of the homes and community members offered at the September meetings are contained in an executive summary of board findings. The comments reflect the fact that:

1. There is a very, very appreciative group of people out there who think the state is doing a marvelous job.
2. There is also deep apprehension and concern regarding what might occur if someone else was operating the system.
3. There is deep concern for containment of costs.

Discussion indicated that:

- a. Many people who are not pioneers need the same quality of service the homes provide.
- b. Many people currently in the homes would not qualify for medicaid assistance.
- c. Many people are able and "fully willing" to pay their own way if given the opportunity.

With the foregoing thoughts in mind, members suggested that a cooperative effort between local communities and the state could retain the dignity of senior citizens in their own home settings as long as possible. When necessary, seniors could enter a home in the local community which would be largely paid for by the predominance of people willing to pay for frail, elderly care.

Mr. Alter noted that many seniors do not want the costly care of

a nursing home. They prefer "some measured help in their own community." Mr. Alter further noted that the foregoing proposal would tap a new source of revenue. It would also provide for those who are not now being served as well as provide an alternative for those who are currently residing in pioneer homes but do not need "the full care a pioneer home provides."

At the other end of the scale, Mr. Alter advised that the state is currently subsidizing empty hospital beds and empty private nursing care beds. These are not being filled because when an individual reaches a point where he or she needs critical care, there is no mechanism for placing the individual in such a facility.

Mr. Alter explained that he mentioned the foregoing proposals to demonstrate "that there is a lot of thought going on in cost containment." Through cooperative effort with state agencies, the legislature, and the public a means for containing and possibly reducing cost may be achieved and a broader spectrum of care provided.

In his closing remarks, Mr. Alter again voiced support for the motion pending before committee.

HENRIETTA SIEVENPIPER next came before committee, advising that she and her husband had visited the Sitka Pioneers' Home, and had spent fourteen months in the Anchorage home. She stated that the Anchorage home was truly a "home away from home." She further spoke to the excellent level of service rendered by kind, caring staff members. She voiced her hope that the state would continue to operate the system, advising that it "is doing a wonderful job . . . ."

Chairman Larson advised that the meeting of the committee of the whole would be briefly recessed at this time in order to reassemble members for a vote on the pending motion.

RECESS - 9:30 A.M.

RECONVENE - 9:40 A.M.

Upon reconvening Chairman Larson asked that Senator Duncan restate his motion. Senator Duncan MOVED to approve the department's recommendation that it proceed with necessary steps to operate the Juneau Pioneers' Home as a state-operated facility, taking into consideration the contracting out of food

service and maintenance items mentioned in department correspondence. Representative Davis inquired concerning items to be contracted, and Senator Duncan explained that the Juneau home would be operated in the same manner as other pioneer homes.

He further advised of his understanding that food service and maintenance are, for the most part, contracted out at other homes.

Correspondence from the department indicates intent to proceed through the RFP process in soliciting proposals for those services. Representative Davis asked if the proposed contracting of housekeeping and maintenance would slow the process of opening the home. Senator Duncan advised of his understanding that the process would not be slowed.

A roll call vote was taken on Senator Duncan's motion for operation of the Juneau Pioneers' Home as a state facility with food and maintenance services to be contracted out.

YEA: Senator Duncan, Representative Hoffman,  
Senator Jones, Representative Larson,  
Representative Pourchot, Representative Davis

NAY: Representative Zawacki

**The MOTION CARRIED WITH A MAJORITY OF AFFIRMATIVE VOTES (6-1).**

Chairman Larson advised that the meeting would be recessed until a time uncertain when it would be reconvened to continue consideration of the McDowell contract and to review audit reports.

RECESS

The meeting was recessed at approximately 9:50 a.m.

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Approved:

Representative Ron Larson, Chairman  
Legislative Budget and Audit Committee

Joint  
88  
JLBA

88/03/18

0745

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
March 18, 1988  
7:45 a.m.

(Tape LBA 88-8, Side 1, #000-#155)

#### CALL TO ORDER

Chairman Larson called the meeting of the Budget and Audit Committee to order at 7:45 a.m., in the Senate Finance Committee Room, State Capitol Building, Juneau, Alaska.

#### PRESENT

The following Committee members were present:

Representative Larson  
Representative Pourchot  
Representative Davis (Alternate)  
Senator Binkley  
Senator Duncan  
Senator Fischer  
Senator Halford

ALSO PRESENT: Eric McDowell, Data Decision Group, Inc.; Randy Welker, Legislative Auditor; Merle Jensen, Legislative Audit Division; and Mike Greany, Director, Legislative Finance.

#### CONTRACT WITH MCDOWELL GROUP - AREA COST DIFFERENTIAL

Chairman Larson advised members that changes had been made to the proposed contract with Data Decisions Group, Inc., which would provide a three-phase study of the cost of education in Alaska's fifty-five school districts, and a prototype data collection model to be maintained by the Department of Education on an ongoing basis. He said there would be an advance payment of \$30,000 upon signing of the contract, monthly progress billings and documentation, and a final payment of \$30,000 upon receipt and acceptance of the final

written report. He asked members to approve a change to the draft which would provide that procurement officer read procurement officers. He advised members that Senator Binkley and himself would serve as procurement officers.

Senator Fischer felt it appropriate that payment occur after the rendering of a service. He clarified the documentation and monthly billing process to be used to satisfy payments under the contract.

Senator Fischer MOVED to change the draft contract to read procurement officers rather than procurement officer. There being NO OBJECTION, it was so ordered.

Senator Binkley MOVED AND ASKED UNANIMOUS CONSENT that the Committee enter into a contract with Data Decisions Group, Inc. not to exceed \$180,000 (Copy of contract on file). There being NO OBJECTION, it was so ordered.

#### EXECUTIVE SESSION

The Committee met in EXECUTIVE SESSION from 7:55 a.m. to 8:20 a.m. for the purpose of consideration of final and preliminary audits.

#### REGULAR SESSION

The meeting reconvened in REGULAR SESSION at 8:20 a.m.

#### PRELIMINARY AUDIT

Senator Halford MOVED that the PRELIMINARY AUDIT on the Department of Public Safety be released to the agency for response. There being NO OBJECTION, it was so ordered.

#### FINAL AUDITS

Senator Halford MOVED that the following FINAL AUDITS be released to the public:

Department of Transportation and Public Facilities  
Anchorage International Airport  
Letter report on the Office of the Governor, Super  
Collider Project Site Proposal

There being NO OBJECTION, it was so ordered.

## LEGISLATIVE AUDITOR PAY

Senator Halford MOVED that the Committee approve the recommendation, as contained in the memorandum from Chairman Larson to members dated 3/17/88, regarding the level of pay to be authorized for the Legislative Auditor, Mr. Randy Welker.

(Copy of memorandum on file). There being NO OBJECTION, it was so ordered.

## ADJOURNMENT

The meeting adjourned at 8:21 a.m.

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Representative Ron Larson, Chair  
Budget and Audit Committee

Joint  
88  
JLBA

88/03/24

0810

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
March 24, 1988  
8:10 a.m.

(Tape LBA 88-8, Side 1, #155-#233)

## CALL TO ORDER

Chairman Larson called the meeting of the Budget and Audit Committee to order at 8:10 a.m. in the Senate Finance Committee Room, State Capitol Building, Juneau, Alaska.

## PRESENT

The following Committee members were present:

Representative Adams  
Representative Hoffman  
Representative Larson  
Representative Pourchot  
Representative Davis (Alternate)  
Senator Binkley  
Senator Fischer  
Senator Halford  
Senator Jones

(Representative Zawacki and Senator Duncan were not present.)

ALSO PRESENT: Mike Greany, Director, Legislative Finance;  
Randy Welker, Legislative Auditor; and staff to members.

#### APPROVAL OF MINUTES

Representative Adams MOVED to approve the minutes of the meetings held March 8, 1988 and March 9, 1988. There being NO OBJECTION, it was so ordered.

#### CONTRACT - JOHN BITNEY

Representative Adams MOVED that the Committee approve an extension of the personal services contract with John Bitney.

The contract would be extended to May 28, 1988. There being NO OBJECTION, it was so ordered.

#### EXECUTIVE SESSION

Representative Adams MOVED that the Committee meet in EXECUTIVE SESSION for the purpose of consideration of an audit. There being NO OBJECTION, it was so ordered and the Committee met in EXECUTIVE SESSION from 8:10 a.m. to 8:25 a.m.

#### REGULAR SESSION

The Committee reconvened in REGULAR SESSION at 8:25 a.m.

#### FINAL AUDIT

Representative Adams MOVED that the special report on the Department of Natural Resources, Point MacKenzie Agriculture project, Matanuska Maid Dairy, be released to the public.

There being NO OBJECTION, it was so ordered.

#### SPECIAL AUDIT REQUEST

Representative Adams MOVED AND ASKED UNANIMOUS CONSENT that the Committee approve a request by Senator Binkley for an audit of the Alaska Court System and any contracts with Space Management Consultants, Inc. or Dr. F. Michael Wong, and McCool-McDonald of Alaska, Inc. or John McCool, Michael Carlson, Douglas Green or Allen McDonald. There being NO OBJECTION, it was so ordered.

#### ADJOURNMENT

The meeting adjourned at 8:27 a.m.

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Approved by:

Representative Ron Larson, Chair  
Budget and Audit Committee

Joint  
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JLBA

88/04/06

0810

ALASKA STATE LEGISLATURE  
BUDGET AND AUDIT COMMITTEE  
April 6, 1988  
8:10 a.m.

(Tape LBA 88-8, Side 1, #233-end)



## The making of a Pioneers' Home, 1988

In its 75-year history, the Pioneers' Homes network has been state-run. But now there's the Juneau "experiment" and the first move to private-sector management. What's on the horizon for Juneau and the other homes?

Stories and photos by Rebecca Goodman



Juneau's first 54-bed Pioneers' home is due to open in May.

### State embarks on complex 'experiment'

It'll be a rare day in February — Leap Day, February 29, 1988, to be exact — when Alaska's state-run Pioneers' Home system officially embarks on a complex experiment of cost-containment at its newest site, the \$7.3 million Juneau Pioneers' Home.

The Juneau "experiment" — hailed by some, scorned by others — marks the Pioneers' Homes' first major move to total private sector management.

In the past the five-home system has occasionally subcontracted meal, laundry and some medical services to private contractors. But never has a private contractor managed all operations at one of the nursing/residential facilities for pioneers.

Now, spurred by some lawmakers and an administration eager to trim the homes' yearly operating costs of

#### Private management could be the future course for other Pioneers' Homes

\$20 million-plus, the state is on a fast-track to privatize operation of Juneau's about-to-be-opened 54-bed home.

If all goes according to the state's timeline, private contractors interested in operating Juneau's home will have

until the close of the working day February 29 to submit detailed management proposals to the Division of Pioneers' Benefits.

Once those proposals are reviewed and evaluated by a six-member panel, state officials expect to award the home's management contract in mid-March. The new contractor will have just over a month to recruit and train some 50 to 60 staff members, as well as interview and admit at least a few of the 52 new residents by May 1.

If private management "works right" at the Juneau home, it could be the future course for other Pioneers'

Homes in Sitka, Palmer, Fairbanks, Anchorage and Ketchikan, said one  
*page 12 please*

# High noon at the Pioneers' Homes

## State officials face showdown on variety of fronts

Ever since the 1988 Rodney Vest litigation successfully challenged the 25-year residency requirement of Alaska's \$250-per-month Longevity Bonus program for seniors, state officials have nervously awaited a similar showdown over the Pioneers' Homes 15-year residency requirement.

But so far, the expected legal showdown hasn't happened.

Instead, showdowns on a variety of other fronts have forced state officials on the defensive to re-assess the Pioneers' Homes, which provide nursing and residential care to some 600 older Alaskans.

"The homes have long been the subject of intense debate," said one state official who asked that his name not be used. "But now it seems more Alaskans are questioning the purpose, the fairness, the direction of the homes. The state has its view of the system, the Pioneers have their view, legislators have their own ideas of where it should be headed. I hope we can head off a big battle."

One particularly sharp onslaught of criticism aimed at the homes is contained in a draft of a soon-to-be-released audit by the state's Office of Management and Budget.

The draft audit recommends that the Division of Pioneers' Benefits:

- change its 15-year residency admissions requirements in order to

capture federal Medicaid reimbursement;

- decrease or eliminate nursing care and provide only residential care at the homes; and

- change its present rate structure of \$525 per month for nursing care and \$425 per month for residential care to reflect the higher rates (aver-

### A draft audit recommends the Division of Pioneers' Benefits change eligibility requirements and rate structure, and eliminate nursing care at the homes

age of \$6,000 per month) charged at Alaska's private nursing facilities.

Officials in both the Department of Administration, which oversees the Pioneers' Homes, and the Department of Health and Social Services reacted swiftly and negatively to the audit.

At *Senior Voice* press time departmental concerns over the audit had not been officially released. However, several state officials complained that authors of the audit "had done a poor job of interpreting data."

But audit or no audit, officials already are asking questions and testing new ideas which closely parallel some of the audit's recommendations.

During a recent interim Health Care Commission meeting in Anchorage, Jim Fox, deputy commissioner of the Department of Administration, outlined several cost-containment ideas in the works for the Pioneers' Homes.

"Right now we have no valid comparisons to go on to determine the criteria for Medicaid eligibility in the homes," Fox explained.

"We don't have any exact data on the incomes of the seniors in the nursing wings, so determining Medicaid eligibility is difficult. But using very rough figures we've estimated that perhaps 30 percent of those nursing wing patients would never be eligible for the Medicaid program."

Fox said any talk about instituting Medicaid in the homes would be incomplete unless it included some solution of what to do about the Pioneers' Home residents ineligible for the Medicaid program.

And eligibility for Medicaid isn't the only concern. There are many other barriers to obtaining Medicaid payment for the homes, Fox said. The state would have to address licensing and certification standards, admissions policies, income and resource

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## Juneau 'experiment' marks first move to privatization

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state official who requested his name not be used.

It's a sensitive issue. Will the Juneau experiment "work right" for residents and for the state?

It's too early to predict the outcome, but state officials are convinced the experiment can work successfully if the right contractor is chosen.

### It's still too early to predict the outcome, but state officials are convinced the experiment can work successfully.

Many older Alaskans, though, remain skeptical, even fearful, of private operation of the Juneau home. Some are worried that quality of care at the Juneau home will suffer as a result of privatization.

"My biggest question, my biggest fear," said a Juneau woman who has been on the home's waiting list for several years, "is where will those private

contractors make their profits?"

Speaking on condition of anonymity for fear of being labeled a "trouble-maker," she said, "We need to face the facts: If the state gives a contract to a profit-making company, they will make a profit, count on it. Will it mean less quality of care? Probably. Or less nutrition? That's likely, too. They'll cut something and what will it be?"

"I realize that any private contractor would have to follow certain rules and regulations, but I also know owners will be cut somewhere to make a profit. It worries me a great deal because the state's overriding concern seems now to be money and how to save it. There's a lot more to consider here than just money," she said.

Maty Jo Jeans, director of the Division of Pioneers' Benefits, which oversees the homes, said she shares the same worries.

"My main concern is rendering quality health care services to those residents," Jeans said. "Certainly, opening the home and keeping it cost-efficient are important, but quality of care comes first. Those seniors deserve nothing less," she explained.

Jeans also said the Juneau home would be operated as a regular Pioneers' Home, following the same admissions policies and 15-year residency requirement, collecting the same

monthly rates (\$525 for nursing, \$425 for residential), and maintaining the same traditions of a typical home.

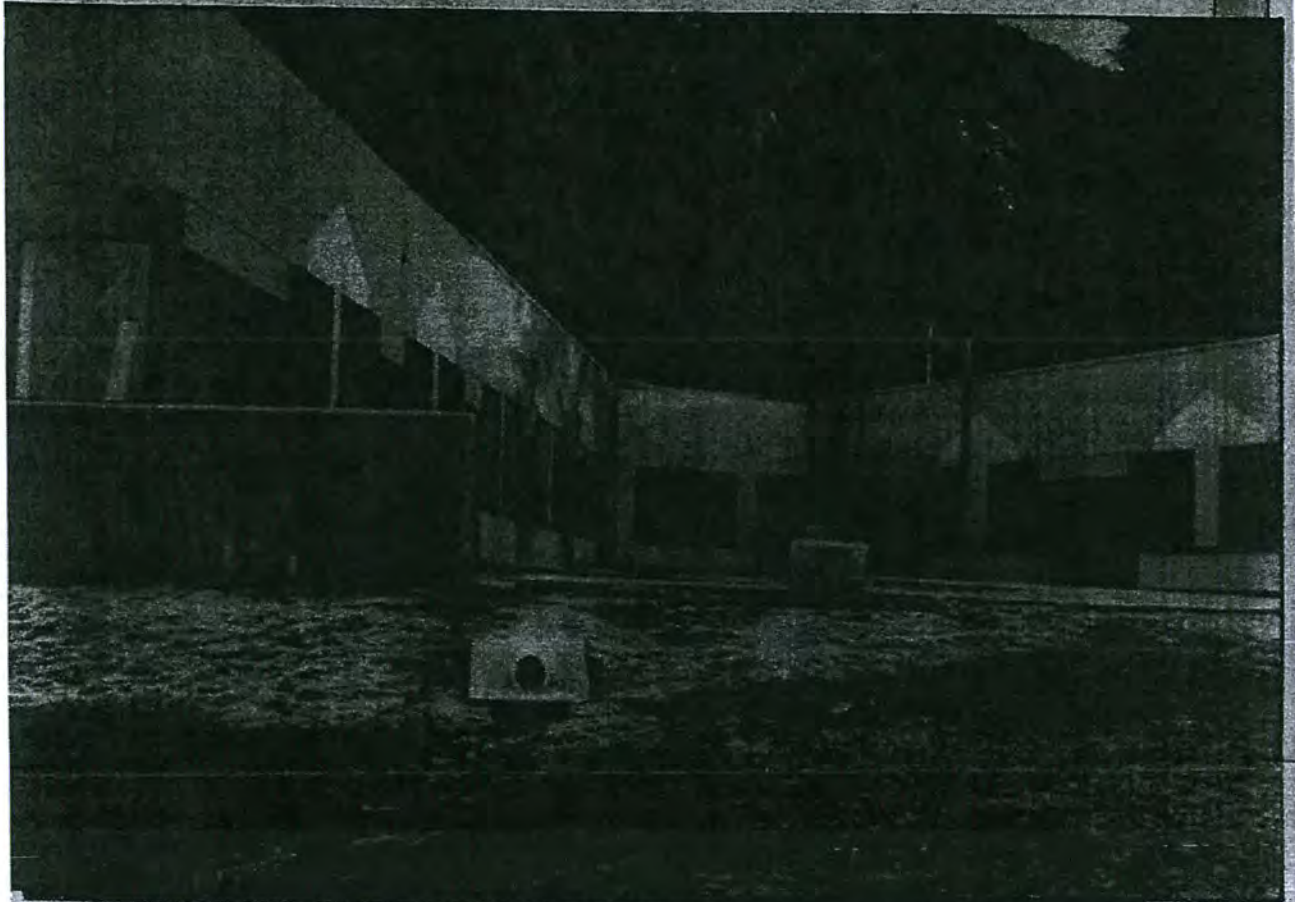
"We've asked contractors to give us written assurances and detailed plans for assuring both professional compe-

tence as well as seniors' Home tradi-

tion. However, despite the state, some are convinced that the state



Rooms along both the north and south wings of the Juneau home take advantage of views of the Mendenhall Wetlands area and surrounding mountain ranges.



tivity to Pigs," Jeans said. assurances by 's remain uncon- has done enough

to assure quality of care at the new home.

Freda Borchick, a retired administrative officer formerly employed by the Division of Family and Youth Services, expressed dismay with sev-

eral sections of the state's request for proposal (RFP) document, the "guideline" which outlines requirements, qualifications and expectations of private contractors who submit plans to run the Juneau home.

Borchick, who for years reviewed and evaluated proposals for the state and is familiar with the operation of most of the Pioneers' Homes, called the Juneau RFP "poorly written and lax in some areas."

"I fully expected to see in this document some well-defined guidelines on the budget and several phase-in stages for the operation of the home," Borchick said. "The RFP is silent on these matters."

But Jim Fox, deputy commissioner for the Department of Administration, who helped oversee the creation of the RFP, said much was left "open" intentionally.

The RFP was written under a \$35,000 contract (just over \$5,000 has been spent so far) by Seattle consultant Daniel R. Humphrey, a certified public accountant. It is structured to allow the state to take advantage of the best ideas and innovations proposed by contractors, Fox said.

"Our push was to leave it open for

offerors to provide comprehensive management plans to us," Fox said.

"We tried not to hinder their flexibility. We asked contractors to address quality of care issues and cost-containment and outline detailed plans for how they would accomplish this."

**'My biggest question is where will those private contractors make their profits?'**

But Borchick disagrees with the "open" approach.

"If the state really wants that facility to be operated as a Pioneers' Home, then they should be giving out clearer guidelines in their RFP. My view is that RFPs should set the framework, the conditions for what's expected. The state's responsibility for defining what standards should be imposed and what services are to be offered simply cannot be passed on to a private contractor."

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Lorraine Beyer of Juneau checks the view from the south wing solarium of the new Pioneers' Home.

## The road to privatization

Until last fall, Department of Administration officials had wanted to hold off on private-sector management of the new Juneau Pioneers' Home in order to first resolve some of the larger issues including residency, rates and quality of care facing the homes.

But as a result of earlier actions by the governor and key legislators, department officials had no choice but to speed toward private management. Events that led to decision to use private management in the Juneau home began over a year ago.

Convinced that the state did not have enough operating funds to open and run the Juneau home, Cowper called a halt to its construction soon after he took office in December 1988.

Juneau legislators, anxious to have the home built, aimed for a compromise and, in the end, Cowper agreed to allocate

\$500,000 for operation of the Juneau Pioneers' Home, but only on the condition that the home be privately managed.

Many lawmakers liked the idea of privatizing the home. As a result, they included legislative intent language in the budget which stated that the appropriation for the Juneau home be contingent upon the issuance of a request for proposals for the private operation of the Juneau home.

By late summer, administration and department officials began balking at rushing into privatization.

They also questioned the legality of the legislative intent and announced in September that the Juneau home would be run by the state, not privately operated.

The state's announcement prompted a heated debate between state officials and lawmakers during an October public hearing in Juneau.

Lawmakers, irritated that state officials would ignore a legislative intent, brought out their legislative counsel, George Utermohle, to explain why their intent was legal and valid.

Acknowledging that the language of the intent was "not perfect," Utermohle said it was the minimum necessary to convey the intent of the legislature; was germane to the subject; did not enact new law or have an effect beyond the appropriation. In other words, he said, it is valid language.

Rather than risk the continued wrath of legislators and jeopardize Pioneers' Homes' 1988 funding, state officials speeded toward privatization to comply with legislators' wishes.

By mid-March state officials expect to award the contract for operation so that new residents may be admitted into the home by May.

## High noon: State faces showdown . . .

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standards, as well as the residency requirement issue.

As far as nursing services are concerned, the state is not actively considering elimination of the homes' nursing services as suggested in the audit.

However, it is exploring ways to institute a middle level of care called "residential level II" services which offer more personal care services than in the current residential wings of the homes. The majority of residents in the homes could benefit from this level of

care, according to state officials.

"We're planning to test the development of this care in one of the homes (Anchorage) as a benchmark for defining those services," Fox said. At present, the Department of Health and Social Services is reviewing the regulations for residential level II services and expects to finalize work this spring.

And what about increasing monthly rates as suggested in the audit?

"Our feeling is that nearly everyone agrees that the homes' rate structures

need to be looked at," Fox said.

"When we reviewed it last year we concluded that we could probably get a fair gain in revenue if those rates were changed."

But for now, Fox said, the department would prefer to "back off" on the rates issue until this summer when the state may hold public hearings on the matter.

"We have enough to handle now with the privatization issue in Juneau, and we'd prefer not to cloud the long-term picture."

## Juneau 'experiment' in privatization . . .

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Pioneers' Homes advisory board member Joe Aller of Juneau echoed some of Borchick's comments and expressed concern that the state may be trying to push too quickly to privatize.

"I realize the state was under considerable strain to put together an RFP very quickly after some legislators ordered the Department of Administration to follow their legislative intent to privatize.

"And really, it must be said that under those conditions, the division did the best job it could," Aller pointed out. "But still, one cannot help but feel that the state is rushing into privatization too rashly. What possible good can come of rushing into this venture?" he asked.

Other problems also disturb Borchick.

"If the money to operate the Juneau home for the last two months of this fiscal year (May and June) is not released until May 1, and if the contract is not even effective until May 1, how can the state expect a private agency to come in, hire, train, place and admit residents into the home by May 1? It's unrealistic," Borchick said.

Of all her concerns about the RFP, though, Borchick's biggest

gripe has to do with the state's built-in incentives allowing private contractors to keep 25 percent of any cost savings as an additional management fee. Any savings beyond that amount would be funneled back into the state's general fund along with monthly residential and nursing care fees collected from residents of the home.

"This profit-taking goes completely against seniors' wishes and, even worse, it's a license to pinch where pinching shouldn't be done," Borchick said.

But state officials argued that the small incentives for saving money were included not as a license to pinch, but as a way for the state to make the management package more attractive to potential contractors.

Aside from disagreements about the RFP, some seniors and even some state officials question whether a private contractor can run a more cost-effective operation than the state.

"We really won't know the answer to that question until we open those proposals, jeans said. "That's part of what this private contracting experiment is all about. Can it be done and done well?"

About \$2.2 million has been set

aside for the Juneau home in the proposed fiscal year 1989 budget (which begins July 1). State officials said they expect most contractors' proposals will "come in under" that budget figure.

Private contractors who have expressed interest in operating Juneau's home include Southeast Alaska Regional Health Corporation (SEARHC); Lutheran Hospitals and Homes, ARA Services; Statewide Services; and St. Ann's Nursing Home.

Niles Cesar, executive vice president of SEARHC, speculated in a public hearing recently that his nonprofit organization could "operate the Pioneers' Home \$100,000 to \$200,000 under the state operation."

But Cesar's group may not be given the opportunity to try because the RFP's minimum qualification of five years' experience operating a skilled care facility precludes SEARHC from competing.

In a letter to commissioner John Andrews of the Department of Administration, Cesar said: "Focusing on skilled nursing care favors large national for-profit health care corporations. This is inconsistent with the desire to maintain the home-like atmosphere and special nature of the

Pioneers' Homes."

Questions raised by SEARHC and other private contractors are now under consideration by the department, said deputy commissioner Fox. Any clarifications or changes to the RFP will be announced in early February.

"None of us believes that this RFP is a perfect document," Fox said. "We expect changes will be necessary."

"This is the first time we've tried this, but I'm optimistic that we'll learn quite a bit from this process and obtain better management plans for our homes as a result," he added.

"Contracting out the Juneau home may turn out to be a good thing because it'll allow us a clear look at our options before we commit the whole system to privatization."

Even Borchick admits the state eventually could have a better Pioneers' Home operation through a contractor.

"It could well be that this home could set an example for the others by instituting better standards and quality of care," she said.

"But frankly, I just don't believe the state will accomplish it through these means; they're going about it the wrong way."



# TRICARE® Survivor Benefits

Continuing medical, pharmacy, and dental benefits for surviving family members

TRICARE continues to provide benefits to eligible family members following the death of their sponsor. The type of coverage and costs depend on your sponsor's military status at the time of his or her death. You are automatically eligible for TRICARE survivor benefits as long as your information in the Defense Enrollment Eligibility Reporting System (DEERS) is current and you are one of the following:

- A surviving spouse who has not remarried (*eligibility cannot be regained later, even if you divorce or your new spouse dies*)
- A surviving unmarried child under age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support*)

**Note:** Children with disabilities may remain eligible beyond normal age limits. Check with your sponsor's service for eligibility criteria.

## SURVIVORS OF ACTIVE DUTY SERVICE MEMBERS

As a surviving spouse, if your sponsor dies while serving on active duty for a period of more than 30 consecutive days (*including eligible National Guard and Reserve members*), you remain eligible as a transitional survivor for three years, and have active duty family member (ADFM) benefits and costs. Eligibility includes survivors of sponsors who die while on delayed-effective-date active duty orders. Transitional survivors remain eligible for TRICARE Prime, TRICARE Prime Remote for Active Duty Family Members (TPRADFM), and TRICARE Standard and TRICARE Extra in the United States, and TRICARE Overseas Program (TOP) Prime, TOP Prime Remote, and TOP Standard overseas.

After three years, you remain eligible as a survivor and have retiree family member benefits and costs. You pay retiree rates under TRICARE Prime, if available in your area (*you will need to reenroll*), TRICARE Standard and TRICARE Extra in the

United States, or TOP Standard overseas. As a survivor, you are not eligible for TPRADFM, TOP Prime, or TOP Prime Remote. If you do not enroll in TRICARE Prime, coverage automatically continues under TRICARE Standard.

Surviving children remain eligible for TRICARE benefits as ADFMs. Unlike spouses, eligibility will not change after three years, and children remain covered as ADFMs until eligibility ends due to age limits or for another reason (*e.g., marriage*). After aging out of TRICARE, surviving children may qualify to maintain TRICARE coverage until reaching age 26 by purchasing a TRICARE Young Adult (TYA) program option. For more information on TYA, visit [www.tricare.mil/tya](http://www.tricare.mil/tya).

## TRICARE PRIME® COVERAGE GUIDELINES

Transitional survivors enrolled in a stateside or overseas TRICARE Prime option at the time of the sponsor's death will not be disenrolled. Coverage continues as long as your information in DEERS is up to date or until your eligibility ends (*i.e., after three years from the sponsor's death or earlier if a spouse remarries*). If you are not enrolled in a TRICARE Prime option and you are eligible, you may enroll after your sponsor's death. Normal TRICARE Prime enrollment rules apply; there is no retroactive enrollment. Transitional survivors not enrolled in a TRICARE Prime option will be covered as ADFMs under TRICARE Standard and TRICARE Extra in the United States or TOP Standard overseas. TPRADFM, TOP Prime, and TOP Prime Remote are not available to surviving spouses after the three-year transitional survivor period. For cost details, visit [www.tricare.mil/costs](http://www.tricare.mil/costs).

**Note:** Surviving beneficiaries in the United States will have their TRICARE Prime enrollment fees frozen at the rate in effect at the time they become survivors and are enrolled in a TRICARE Prime option. Beneficiaries in this category will not be charged a fee increase as long as at least one family member remains enrolled.

*This fact sheet is not all-inclusive. For additional information, please visit [www.tricare.mil](http://www.tricare.mil).*

## **SURVIVORS OF NATIONAL GUARD AND RESERVE MEMBERS**

### **Non-Activated Sponsor**

If you are a survivor of a non-activated National Guard or Reserve member who had TRICARE Reserve Select (TRS) or Transitional Assistance Management Program (TAMP) coverage at the time of his or her death, you may qualify for TRICARE survivor coverage. Former spouses and remarried surviving spouses do not qualify to purchase coverage.

If TRS coverage was in effect, qualified survivors may purchase or continue coverage under TRS for up to six months from the date of their sponsor's death. Surviving family members who are eligible for or enrolled in the Federal Employees Health Benefits (FEHB) Program may purchase TRS coverage. For more information about the TRS survivor benefit, see the *TRICARE Reserve Select Coverage Guidelines* section of this fact sheet.

If TAMP coverage was in effect, eligible survivors remain covered until the end of the 180-day TAMP period.

### **Sponsor Active 30 Days or Less**

If your sponsor dies while serving on active duty for a period of 30 days or less, to include active duty training/drill, annual training, and individual duty training, family members remain eligible as survivors and have retiree benefits and costs.

**Note:** Surviving spouses remain eligible for survivor benefits unless they remarry and surviving children remain eligible until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support*).

### **Sponsor Active More Than 30 Days**

If your sponsor dies while serving on active duty for a period of more than 30 consecutive days, family members remain eligible as transitional survivors, and have ADFM benefits and costs. After three years, surviving spouses remain eligible as survivors and have retiree family member benefits and costs. Surviving children do not have a status change after three years; they remain eligible for ADFM benefits and costs until they lose TRICARE eligibility due to age limits or for another reason (*e.g., marriage*).

### **TRICARE Reserve Select® Coverage Guidelines**

Survivors enrolled in TRS at the time of their sponsor's death will automatically transition to TRS survivor coverage. Coverage continues as long as your information in DEERS is up to date or until your qualification ends (*i.e., six months from the sponsor's death or earlier if a spouse remarries*). If you are not enrolled in TRS at the time of your sponsor's death and you qualify, you may purchase TRS survivor coverage after your sponsor's death.

Survivors wishing to enroll in TRS survivor coverage must submit a completed *Reserve Component Health Coverage Request* form (DD Form 2896-1) to their regional contractor.

To access *DD Form 2896-1*, log on to the DMDC Reserve Component Purchased TRICARE Application at [www.dmdc.osd.mil/appj/reservetricare](http://www.dmdc.osd.mil/appj/reservetricare). This form must be postmarked or received by the regional contractor no later than 60 days after the date of the sponsor's death.

To use the website, you will need a Department of Defense (DoD) Common Access Card, Defense Finance and Accounting Service (DFAS) myPay PIN, or a DoD Self-Service Logon (DS Logon). For more information on signing up for a DS Logon, visit <https://myaccess.dmdc.osd.mil>.

Survivors wishing to disenroll from TRS survivor coverage must submit a written letter or completed *DD Form 2896-1* to their regional contractor. This form must be postmarked or received by the regional contractor no later than 60 days after the date of the sponsor's death. Premiums will be refunded if no claims were submitted during this 60-day period. For more information, visit [www.tricare.mil/trs](http://www.tricare.mil/trs).

Surviving children may continue their existing TRS survivor benefit for six months or until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support*), whichever comes first. Surviving children who have aged out of TRICARE may qualify for TYA coverage until reaching age 26, during the six-month period of TRS survivor coverage. For more information, visit [www.tricare.mil/tya](http://www.tricare.mil/tya).

## **SURVIVORS OF RETIRED RESERVE MEMBERS**

If you are a survivor of a Retired Reserve member who had TRICARE Retired Reserve (TRR) coverage at the time of his or her death, you may qualify for TRICARE survivor coverage. Surviving spouses and children remain qualified for TRR survivor coverage until the day the sponsor would have turned age 60, at which point they may become eligible for premium-free TRICARE Standard and TRICARE Extra, or may enroll in TRICARE Prime (*if available*). Surviving family members who are eligible for or enrolled in the FEHB Program may purchase TRR. For more information, visit [www.tricare.mil/trr](http://www.tricare.mil/trr).

### **TRICARE Retired Reserve® Coverage Guidelines**

Survivors enrolled in TRR at the time of their sponsor's death will automatically transition to TRR survivor coverage. Coverage continues as long as DEERS information is up to date or until eligibility ends (*i.e., at the time your sponsor would have reached age 60 or earlier if a spouse remarries*). If you are not enrolled in TRR at the time of your sponsor's death and you qualify, you may purchase TRR survivor coverage after your sponsor's death. Coverage may be purchased at any time after the sponsor's death, provided the sponsor would not have reached age 60 at the time of purchase.

Survivors wishing to enroll in TRR survivor coverage must submit a completed *DD Form 2896-1* to their regional contractor. To access the *DD Form 2896-1*, log on to the

DMDC Reserve Component Purchased TRICARE Application at [www.dmdc.osd.mil/appj/reservetricare](http://www.dmdc.osd.mil/appj/reservetricare). You will need a Common Access Card, DFAS myPay PIN, or DS Logon to access this website and form. This form must be postmarked or received by the regional contractor no later than 60 days after the date of the sponsor's death. Survivors wishing to disenroll from TRR survivor coverage must submit a written letter or *DD Form 2896-1* to their regional contractor and it must be postmarked or received no later than 60 days after the date of the sponsor's death. Premiums will be refunded if no claims were submitted during this 60-day period.

Surviving children are eligible for TRR until their sponsor would have reached age 60 or until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning and if the sponsor provided over 50 percent of the financial support*), whichever comes first. If the sponsor was enrolled in TRR at the time of death, surviving children who age out of TRICARE may qualify to purchase TYA coverage until reaching age 26. For more information, visit [www.tricare.mil/tya](http://www.tricare.mil/tya).

## **SURVIVORS WHO ARE ENTITLED TO MEDICARE**

Surviving family members who are already entitled to premium-free Medicare Part A at the time of the sponsor's death should sign up for Medicare Part B within eight months of the date of the sponsor's death to avoid the Medicare Part B late-enrollment monthly premium surcharge (*10 percent for each 12-month period you could have had Medicare Part B, but did not*). To sign up for Medicare Part B during this special enrollment period (*if it applies to you*) and waive the Medicare Part B late-enrollment premium surcharge, you will need proof of your eligibility for the special enrollment period. You can call the Defense Manpower Data Center at **1-800-538-9552 (TDD/TTY: 1-866-363-2883)** and ask for a *Verification of Military Health Care Benefits* letter, which you should present to the Social Security Administration to prove your eligibility for the special enrollment period.

Surviving family members who become entitled to premium-free Medicare Part A after the date of the sponsor's death should sign up for Medicare Part B immediately upon becoming entitled to Medicare Part A to avoid the Part B late-enrollment premium surcharge.

If you do not sign up for Medicare Part B when you first become eligible, you may sign up during the general enrollment period (GEP), which occurs each year, January 1–March 31. If you sign up during the GEP, your Medicare Part B will begin July 1 of the year in which you sign up. The Part B late-enrollment premium surcharge will apply for each 12-month period you could have had Medicare Part B, but did not.

It is important to note that in general, TRICARE beneficiaries who are entitled to premium-free Medicare Part A must have Medicare Part B to remain TRICARE-eligible. If you are a surviving family member who is entitled to premium-free

Medicare Part A, and you do not have Medicare Part B, you will be ineligible for TRICARE after your three-year transitional survivor period ends. Surviving family members of Retired Reserve members become eligible for premium-free TRICARE Standard and TRICARE Extra, or may enroll in TRICARE Prime (*if available*), beginning on the date their sponsor would have turned age 60. To be eligible for TRICARE at that point, beneficiaries entitled to Medicare Part A must also have Medicare Part B.

## **PHARMACY COVERAGE**

As a survivor, your pharmacy benefit remains the same regardless of your TRICARE program option. In the United States and U.S. territories (*American Samoa,\* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), you may fill prescriptions through military pharmacies, TRICARE Pharmacy Home Delivery, TRICARE retail network pharmacies, or non-network pharmacies. Using a non-network pharmacy is your most costly option. The TRICARE pharmacy benefit in the United States and U.S. territories is administered by Express Scripts, Inc. For more information, visit [www.tricare.mil/pharmacy](http://www.tricare.mil/pharmacy) or [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE).

Outside the United States and U.S. territories, you may fill prescriptions at military pharmacies, through TRICARE Pharmacy Home Delivery,<sup>†</sup> at TRICARE retail network pharmacies in some locations, or at host nation pharmacies. Host nation pharmacies are non-network; therefore, when filling a prescription at a host nation pharmacy, you will pay the full cost up front and file a claim with the TOP claims processor for reimbursement. You must submit proof of payment with all overseas pharmacy claims. For more information about how to file claims for prescriptions filled overseas, visit [www.tricare.mil/claims](http://www.tricare.mil/claims).

**Note:** In the Philippines, you are required to use certified pharmacy providers. For more information, visit [www.tricare-overseas.com/philippines.htm](http://www.tricare-overseas.com/philippines.htm).

\* Currently, there are no TRICARE retail network pharmacies in American Samoa.

† Outside the United States and U.S. territories, you can only use the TRICARE Pharmacy Home Delivery option if you have an APO/FPO address or are assigned to a U.S. Embassy or Consulate. Beneficiaries residing in Germany cannot use the home delivery option due to country-specific legal restrictions. If you live in Germany, you should fill prescriptions at military pharmacies or host nation pharmacies.

## **DENTAL OPTIONS**

### **TRICARE Dental Program Survivor Benefit**

When a sponsor dies while on active duty, surviving family members are eligible for the TRICARE Dental Program (TDP) Survivor Benefit whether or not the family members were enrolled in the TDP prior to the sponsor's death. Eligible surviving family members do not pay TDP premiums; these costs are covered 100 percent (*family members are still*

responsible for any applicable cost-shares). The TDP Survivor Benefit also applies to family members of the Selected Reserve and the Individual Ready Reserve (*special mobilization category*), regardless of whether the sponsor was on active duty orders or enrolled in the TDP at the time of his or her death. Former spouses and remarried surviving spouses are not eligible for TDP benefits.

The surviving spouse is eligible to receive survivor benefits for up to three years from the sponsor's date of death, regardless of the TDP Survivor Benefit enrollment coverage start date.

Surviving children are eligible to receive the TDP Survivor Benefit until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support*).

Eligible surviving family members enrolled in the TDP at the time of their sponsor's death will be automatically enrolled in the TDP Survivor Benefit. Survivors will be notified of this enrollment change and the terms of the TDP Survivor Benefit. Eligible surviving family members not enrolled in the TDP at the time of the sponsor's death will be notified of their TDP eligibility. If eligible, surviving spouses, parents, or legal guardians may elect to enroll in the TDP Survivor Benefit. For more information, visit [www.tricare.mil/tdp](http://www.tricare.mil/tdp).

## TRICARE Retiree Dental Program

When your TDP Survivor Benefit ends, surviving spouses whose sponsor died while on active duty (*including National Guard and Reserve sponsors who were on active duty for more than 30 days*) may be eligible for the TRICARE Retiree Dental Program. For more information, visit [www.trdp.org](http://www.trdp.org).

Surviving spouses whose sponsor died while on active duty orders for 30 days or less have no TRICARE dental insurance after the TDP Survivor Benefit ends.

## MINIMUM ESSENTIAL COVERAGE

Under the Affordable Care Act (ACA), individuals must have health care coverage that meets a minimum standard called minimum essential coverage; otherwise, they must qualify for an exemption. TRICARE coverage meets the minimum essential coverage requirement under the ACA. Most people who do not meet this provision of the law will be required to pay a penalty for each month they do not have adequate coverage. The penalty will be collected each year with federal tax returns. You can find other health care coverage options at [www.healthcare.gov](http://www.healthcare.gov).

## FOR INFORMATION AND ASSISTANCE

<p><b>N</b> TRICARE North Region</p> <p>Health Net Federal Services, LLC 1-877-TRICARE (1-877-874-2273) <a href="http://www.hnfs.com">www.hnfs.com</a></p>	<p><b>S</b> TRICARE South Region</p> <p>Humana Military, a division of Humana Government Business 1-800-444-5445 <a href="http://HumanaMilitary.com">HumanaMilitary.com</a></p>	<p><b>W</b> TRICARE West Region</p> <p>UnitedHealthcare Military &amp; Veterans 1-877-988-WEST (1-877-988-9378) <a href="http://www.uhcilitarywest.com">www.uhcilitarywest.com</a></p>
<p><b>O</b> TRICARE Overseas Program (TOP) Regional Call Center—Eurasia-Africa<sup>1</sup></p> <p>+44-20-8762-8384 (<i>overseas</i>) 1-877-678-1207 (<i>stateside</i>) <a href="mailto:tricarelon@internationalsos.com">tricarelon@internationalsos.com</a></p>	<p><b>O</b> TOP Regional Call Center—Latin America and Canada<sup>1</sup></p> <p>+1-215-942-8393 (<i>overseas</i>) 1-877-451-8659 (<i>stateside</i>) <a href="mailto:tricarephl@internationalsos.com">tricarephl@internationalsos.com</a></p>	<p><b>O</b> TOP Regional Call Centers—Pacific<sup>1</sup></p> <p>Singapore: +65-6339-2676 (<i>overseas</i>) 1-877-678-1208 (<i>stateside</i>) <a href="mailto:sin.tricare@internationalsos.com">sin.tricare@internationalsos.com</a></p> <p>Sydney: +61-2-9273-2710 (<i>overseas</i>) 1-877-678-1209 (<i>stateside</i>) <a href="mailto:sydricare@internationalsos.com">sydricare@internationalsos.com</a></p>
<p>milConnect Web Site—Update DEERS Information <a href="http://milconnect.dmdc.osd.mil">http://milconnect.dmdc.osd.mil</a></p>	<p>TRICARE Dental Program 1-855-MET-TDP1 (1-855-638-8371) (<i>stateside</i>) 1-855-MET-TDP2 (1-855-638-8372) (<i>overseas</i>) 1-855-MET-TDP3 (1-855-638-8373) (<i>TDD/TTY</i>) <a href="http://www.metlife.com/tricare">www.metlife.com/tricare</a></p> <p>TRICARE Retiree Dental Program 1-888-838-8737 <a href="http://www.trdp.org">www.trdp.org</a></p>	<p>TRICARE Pharmacy Program 1-877-363-1303 <a href="http://www.tricare.mil/pharmacy">www.tricare.mil/pharmacy</a> <a href="http://www.express-scripts.com/TRICARE">www.express-scripts.com/TRICARE</a></p>

1. For toll-free contact information, visit [www.tricare-overseas.com](http://www.tricare-overseas.com).

### An Important Note About TRICARE Program Information

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. **Military hospital and clinic guidelines and policies may be different than those outlined in this publication.** For the most recent information, contact your TRICARE regional contractor or local military hospital or clinic. The TRICARE program meets the minimum essential coverage requirement under the Affordable Care Act.

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May 24, 2016

Ms. Michele Michaud  
Department of Administration  
State of Alaska  
333 Willoughby Avenue  
6<sup>th</sup> Floor State Office Building  
Juneau, AK 99811-0208

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**Re: Fiscal Note for HB4002 – Occupational Death Benefits for the PERS  
Peace/Fire Defined Benefit (DB) and Defined Contribution (DCR) Retiree Medical  
Plans**

Dear Michele:

As requested, we are providing the following information for a Fiscal Note on HB4002 which changes spousal and dependent coverage upon an occupational death of a member of the Defined Benefit Retiree Medical Plans for the Public Employee's Retirement System (PERS) for peace/fire members only and the Defined Contribution Retiree Medical Plans PERS for peace/fire members only.

**Summary of Provisions**

The purpose of the bill is to provide system-paid major medical coverage for survivors of a PERS member who was employed by the State or a participating political subdivision as a peace officer or firefighter and whose death occurs before the member's retirement and while in the performance and within the scope of the member's duties (occupational deaths). In addition, HB4002 in the case of occupational death removes the requirement that a peace officer or firefighter retire directly from the plan for the Defined Contribution (DCR) Retiree Medical Plan. HB4002 is proposed to include the following:

- Extension of existing PERS occupational death benefits which provide retiree benefits including system-paid major medical benefits to survivors of Tier I members whose deaths occur as a result of their job duties. This bill extends the benefit to Tiers II and III members.
- Under the existing PERS DCR plan, no person is eligible for system-paid major medical benefits. The draft bill would allow for a 100% premium subsidy for major medical benefits for eligible persons who are survivors of employees who were peace officers or firefighters and whose death was occupational. The 100% premium subsidy changes to a normal premium subsidy at Medicare age (e.g., 65). The HRA can then be used to fund the portion of the premium for which the spouse is responsible.

- The PERS DCR plan requires members to "retire directly from the plan" in order to be eligible for medical benefits. To effectuate the goals of the legislation, the draft bill removes that language from the plan only as it applies to eligible survivors of a peace officer and firefighter whose death occurs as a result of the job.
- Corrects the PERS peace officer or fire fighter occupational death benefit statute to extend benefits to the dependent children, in those instances when there is no surviving spouse, of peace officers and firefighters whose deaths occur while in the performance and within the scope of their duties.

The bill would have a retroactive effective date, January 1, 2013. The impact due to the timing difference is not significant as only two participants are with the plan and others have elected COBRA or gone to the exchange.



**Financial Impact of Bill**

The table below shows the change in Actuarial Accrued Liability, Normal Cost Rate and Total Actuarial Required Contribution Rate, as a percentage of covered payroll:

(\$000s)	Defined Benefit			Defined Contribution		
	PERS Others	PERS P/F	PERS Total	PERS Others	PERS P/F	PERS Total
<b>2015 Valuation Results</b>						
Actuarial Accrued Liability	\$6,553,679	\$796,504	\$7,350,183	\$53,844	\$4,839	\$58,683
Normal Cost Rate*	2.93%	2.44%	2.86%	0.95%	0.69%	0.92%
Total Actuarial Required Contribution Rate*	3.24%	2.69%	3.16%	1.06%	0.77%	1.03%
<b>2015 Valuation Results –HB4002</b>						
Actuarial Accrued Liability	\$6,553,679	\$796,769	\$7,350,448	\$53,844	\$5,131	\$58,975
Normal Cost Rate *	2.93%	2.45%	2.86%	0.95%	0.77%	0.93%
Total Actuarial Required Contribution Rate*	3.24%	2.70%	3.17%	1.06%	0.87%	1.04%

\*Rounded

(\$000s)	Defined Benefit			Defined Contribution		
	PERS Others	PERS P/F	PERS Total	PERS Others	PERS P/F	PERS Total
<b>2015 Valuation Results – HB4002 Impact</b>						
Actuarial Accrued Liability	\$0	\$265	\$265	\$0	\$292	\$ 292
Normal Cost Rate	0.00%	0.01315%	0.00175%	0.00%	0.08262%	0.00950%
Total Actuarial Required Contribution Rate	0.00%	0.01874%	0.00250%	0.00%	0.09897%	0.01138%

The data, assumptions, plan provisions and methods used for the costs are described in the draft actuarial valuation reports as of June 30, 2015, unless otherwise noted.

The tables below show the estimated cost of the bill for Fiscal Years 2017 through 2022. Dollars are in thousands.

(\$000s)	FY17	FY18	FY19	FY20	FY21	FY22
<b>PERS – Defined Benefit – Occupational Death Benefit Changes for Peace / Fire members</b>						
Increase In Normal Cost Amount	\$41	\$42	\$44	\$45	\$46	\$48
Increase in Past Service Cost Amortization Payment	\$17	\$18	\$18	\$19	\$20	\$20
Total Increase in Annual Employer Contribution	\$58	\$60	\$62	\$64	\$66	\$68
<b>PERS – Defined Contribution – Occupational Death Benefit Changes for Peace / Fire members</b>						
Increase In Normal Cost Amount	\$97	\$103	\$110	\$117	\$124	\$132
Increase in Past Service Cost Amortization Payment	\$19	\$20	\$22	\$23	\$25	\$26
Total Increase in Annual Employer Contribution	\$116	\$123	\$132	\$140	\$149	\$158
<b>PERS – Total – Occupational Death Benefit Changes for Peace / Fire members</b>						
Increase In Normal Cost Amount	\$138	\$145	\$154	\$162	\$170	\$180
Increase in Past Service Cost Amortization Payment	\$36	\$38	\$40	\$42	\$45	\$46
Total Increase in Annual Employer Contribution	\$174	\$183	\$194	\$204	\$215	\$226

### Impact and Methodology

Surviving spouses and dependents would be allowed to commence subsidized medical coverage immediately upon the occupational death of a current member. This change did not impact Tier 1 members of PERS nor any members of PERS Others or Teachers.

The impact to the normal cost rate for the DB plan for this change was 0.01315% for peace/fire only and 0.00175% overall; the impact did increase the past service cost amortization resulting in a 0.00250% impact to the total rate. Similarly for the DCR plan this change was a 0.08262% increase to the normal cost rate for peace/fire members and 0.00950% overall. The total contribution rate increased 0.09897% for peace/fire and 0.01138% overall. These results are slightly lower than the estimates in 2015 and reflect June 30, 2015 valuation results and the premium cost-sharing upon Medicare eligibility in the DCR plan.

We assumed 100% of eligible individuals would initially elect this subsidized coverage for all plans except where contributions are required for Medicare-eligible survivors in the DCR plan. Retiree contribution provisions and health plan participation are assumed to apply according to DCR valuation assumptions upon Medicare eligibility. In addition, we assumed that surviving spouses and dependents would be eligible for coverage under their current respective DB or DCR retiree medical plan.

For this study, we have assumed the proposed changes will be effective as of January 1, 2013. This retroactive applicability date is de minimis and does not materially impact our calculations below. In addition, we have assumed that on average 45% of survivors will be employed or re-married with primary coverage and the plan will pay secondary. We have assumed that the value after coordination of benefits is 20% of the benefit for valuation purposes.

Future actuarial measurements may differ significantly from current measurements due to plan experience differing from that anticipated by the economic and demographic assumptions, increases or decreases expected as part of the natural operation of the methodology used for these measurements, and changes in plan provisions or applicable law. In particular, retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. An analysis of the potential range of such future differences is beyond the scope of this study.

Melissa Bissett is a Fellow of the Society of Actuaries and Member of the American Academy of Actuaries, and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained in this report.

Please let us know if you need any further information.

BUCK CONSULTANTS, LLC



Melissa A. Bissett, F.S.A., M.A.A.A.  
Senior Consultant, Healthcare Actuary

cc: John Boucher, State of Alaska  
Larry Langer, Buck Consultants  
David Kershner, Buck Consultants  
Bob Besenhofer, Buck Consultants  
Todd Kanaster, Buck Consultants

## Helen Phillips

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**From:** Brodie Anderson  
**Sent:** Wednesday, June 15, 2016 12:29 PM  
**To:** Helen Phillips  
**Subject:** FW: HB 4002 - Responses to House Finance Committee Questions  
**Attachments:** Tricare Military Survivor\_FS.PDF; HB4002 Supporting Documents-Actuarial letter 5.24.16.pdf

HB 4002 response from department....

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**From:** Mills, Cori M (LAW) [mailto:cori.mills@alaska.gov]  
**Sent:** Wednesday, June 15, 2016 11:53 AM  
**To:** Brodie Anderson <Brodie.Anderson@akleg.gov>  
**Cc:** Peterson, Darwin R (GOV) <darwin.peterson@alaska.gov>; Boucher, John L (DOA) <john.boucher@alaska.gov>; Michaud, Michele M (DOA) <michele.michaud@alaska.gov>  
**Subject:** HB 4002 - Responses to House Finance Committee Questions

Brodie, the following are the questions that came up in committee yesterday and the administration's responses.

- 1) Who are included in State firefighters? There are 86 State of Alaska firefighters. These are with Public Safety Division of Fire Prevention and with DNR, Wildland Firefighters.
- 2) What types of benefits are provided to Village Public Safety Officers (VPSO)? All VPSO programs offer some form of Private Health Insurance - this a large part of the charges in the fringe benefits costs of the grants. Retirement benefits vary among the various grantees. Many do not have policies that deal specifically with VPSOs for such matters as line of duty death because the majority of the grantees' employees are administrative and low risk for occupational death or injury. For more information, please contact DPS.
- 3) What is the difference between a Regional Public Safety officer and a VPSO? Regional public safety officers (defined in statute at AS 18.65.680) were employees of the Department of Public Safety. The RPSO was designed to live in the village, be a department member/state employee, have limited enforcement responsibilities, and be a midlevel enforcement officer. Through collective bargaining, all RPSOs were converted to Troopers due to similar work and pay issues. DPS currently does not have any RPSOs. For more information, please contact DPS.
- 4) What, if any, medical death benefits are survivors of National Guard members entitled to? The attached brochure describes medical benefits for survivors of active duty military (including National Guard) who die in the line of duty.
- 5) Total number of PERS employees.

**PERS: Total:** 35,785

Total DB Tiers: 17,047

Tier I: 2,018

Tier II: 4,590

Tier III: 10,439

Total DCR Tier IV: 18,738

**TRS: Total:** 10,586

Total DB Tiers: 5,590

Tier I: 668

Tier II: 4,922

- 6) What was the amount of the prior fiscal note that covered all employees? The department asked Buck Consultants to prepare a fiscal analysis in April of 2015 based on the initial version of the bill but excluding changing the provision that requires DCR employees to retire directly from the plan. At that time, projected costs were beginning in FY16 \$2.3 million, increasing to \$3.1 by FY20. A new actuarial analysis would have to be performed to get updated estimates.
- 7) What is the occupational death rate of the peace officers/firefighters vs. other occupations? .5/1,000 lives exposed in Peace Officer and Firefighter and .05/1,000 lives exposed in "All Others"
- 8) What does SO stand for? "SO" is short for significant other. A significant other is not eligible for benefits under PERS. All couples must be married in order to be eligible for medical benefit coverage for the spouse under the retiree medical plan.
- 9) Bill limits coverage to 3 families, what about the others on the list?
  - 4 peace officer/firefighter deaths that occurred since January 1, 2013 – covered by the bill
  - 5 peace officer/firefighter deaths that occurred prior to January 1, 2013 – survivors are not currently receiving system-paid medical benefits and are not covered by the bill
  - 9 peace officer/firefighter deaths that occurred prior to January 1, 2013 – survivors are receiving system paid benefits or had no survivor
  - 3 "all other" PERS occupational deaths that occurred since January 1, 2013 – survivors are not currently receiving system-paid medical benefits
  - 6 "all other" PERS occupational deaths occurred before January 1, 2013: survivors are not currently receiving system-paid medical benefitsThe remaining "all other" are either Tier I, have no survivor, or the survivor is currently receiving system-paid medical benefits, but had a period of time where they were required to self-pay
- 10) Breakdown of how the fiscal note was calculated. The attached letter from Buck Consultants explains the actuarial analysis.

I'm helping out coordinating this bill while Minta is out of the office. Feel free to contact me if you need anything else.

Thanks!

Cori Mills  
Assistant Attorney General  
Department of Law  
(907) 465-2132  
[cori.mills@alaska.gov](mailto:cori.mills@alaska.gov)

# UPDATED

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## OIG Guidelines for Evaluating State False Claims Acts

Note: These guidelines are effective March 15, 2013, and replace the guidelines effective on August 21, 2006, found at 71 FR 48552.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



# UPDATED OIG GUIDELINES FOR EVALUATING STATE FALSE CLAIMS ACTS

Note: These guidelines are effective March 15, 2013, and replace the guidelines effective on August 21, 2006, found at 71 FR 48552.

## ***Purpose of Updating Guidance***

On August 21, 2006, the Office of Inspector General (OIG) issued guidelines on how the Inspector General would determine whether a State law meets the requirements of section 1909(b) of the Social Security Act (Act). See 71 FR 48552, Aug. 21, 2006. These guidelines replace those 2006 guidelines to reflect the amendments to the Federal False Claims Act (FCA) that have gone into effect since the effective date of section 1909 of the Act. These new guidelines provide more specificity regarding OIG's reviews when evaluating a State law and are based on OIG's experience in reviewing over 28 different State laws. The guidelines in this notice are based on the FCA in effect on the date of the publication of this notice. Future amendments to the FCA could further affect OIG's evaluation of State laws.

## ***OIG Procedures for Reviewing State False Claims Acts***

OIG will accept requests for review of State laws that have been enacted and that are in effect to determine whether they meet the requirements of section 1909 of the Act. To request OIG review of a State law, the State Attorney General's office should submit a complete copy of the State law and any other relevant information to the following address: Assistant Inspector General for Legal Affairs, Office of Inspector General, Office of Counsel to the Inspector General, Cohen Building, Mail Stop 5527, 330 Independence Avenue, SW, Washington, DC 20201. Submissions by telecopier, facsimile, or other electronic media will not be accepted. OIG will review the State law under these guidelines and in consultation with the U.S. Department of Justice (DOJ) and will inform the State Attorney General's office in writing whether the State law meets the requirements of section 1909 of the Act. OIG will also accept submissions of draft legislation for informal review and discussion.

For Further Information Contact: **Katie A. Arnholt** or **Susan E. Gillin**, Office of Counsel to the Inspector General, (202) 619-2078.

### ***Background***

Section 1909 of the Act, added by section 6031 of the Deficit Reduction Act of 2005 (Pub. L. 109-171), creates a financial incentive for States to enact legislation that establishes liability to the State for false or fraudulent claims to the State Medicaid program. This incentive takes the form of a decrease in the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under a qualifying law. For a State to qualify for this incentive, the State law must meet certain requirements listed in section 1909 of the Act, as determined by the Inspector General of the Department of Health and Human Services in consultation with the U.S. Attorney General.

Medicaid, authorized under Title XIX of the Act, 42 U.S.C. 1396-1396w-5, is a joint Federal and State program that pays for medical and related benefits provided to certain low-income families and individuals. States that participate in Medicaid administer their own programs within broad Federal guidelines and receive matching funds from the Federal Government, called the Federal medical assistance percentage. The Federal medical assistance percentage for a State generally varies between 50 and 83 percent, depending on the State's per capita income for a particular year.

Individuals or entities that submit false or fraudulent claims under State Medicaid programs may be civilly liable under the FCA, 31 U.S.C. 3729-3733. Under the FCA, any person who knowingly submits, or causes to be submitted, a false or fraudulent claim for payment or approval under the State Medicaid program is liable to the Federal Government for three times the amount of the Federal Government's damages plus penalties of \$5,500 to \$11,000 for each false or fraudulent claim. Under the qui tam provisions of the FCA, private persons, known as relators, may file lawsuits in Federal court against individuals and entities that defraud the Federal Government by submitting false or fraudulent claims under State Medicaid programs. DOJ is required to investigate the relator's allegations and may

intervene and take over the prosecution of the action. If DOJ chooses not to intervene, the relator has the right to conduct the action. With respect to recoveries in cases in which DOJ has intervened, the relator is generally entitled to between 15 and 25 percent of the proceeds of the action or settlement of the claim depending on the extent to which the relator substantially contributed to the case. In cases in which DOJ has declined to intervene, the relator is generally entitled to between 25 and 30 percent of the proceeds of the action or settlement of the claim.

Many States have enacted their own false claims acts that establish civil liability to the States for individuals and entities that submit false or fraudulent claims under the State Medicaid programs. Generally, these laws include qui tam provisions that reward relators with a share of the recovery in cases of Medicaid fraud. If a State obtains a recovery as a result of a State action relating to false or fraudulent claims under the State Medicaid program, it must share the recovery with the Federal Government in the same proportion as the Federal medical assistance percentage. For example, if the Federal medical assistance percentage for a State is 60 percent, then the State would retain 40 percent of the recovery and the Federal Government would be entitled to the remaining 60 percent of the recovery.

### ***Section 1909 of the Social Security Act***

To encourage States to pursue civil Medicaid fraud, Congress added section 1909 to the Act, effective on January 1, 2007. Under this section, if a State has in effect a State false claims act that meets certain enumerated requirements, as determined by the Inspector General in consultation with the Attorney General, ~~the Federal medical assistance percentage will be decreased by 10 percentage points with respect to any amount recovered under a State action brought under such a law.~~ Under section 1909(a) of the Act, if a State has a qualifying law, the State's share of any recovery in an action under such a law will be increased by 10 percentage points. For example, if the State's Medicaid share is 50 percent, the State would be entitled to 60 percent of the amount of the recovery, while the Federal Government would be entitled to 40 percent.

Section 1909(b) of the Act sets forth the requirements that a State law must meet to qualify for the incentive. Under this section, the Inspector General must determine, in consultation with the U.S. Attorney General, whether a State has in effect a false claims act that meets the following requirements:

1. The law must establish liability to the State for false or fraudulent claims described in 31 U.S.C. 3729 with respect to any expenditure described in section 1903(a) of the Act.
2. The law must contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in 31 U.S.C. 3730-3732.
3. The law must contain a requirement for filing an action under seal for 60 days with review by the State Attorney General.
4. The law must contain a civil penalty that is not less than the amount of the civil penalty authorized under 31 U.S.C. 3729.

Section 1909(c) of the Act provides that a State that has a law in effect that meets the requirements of section 1909(b) of the Act will be considered in compliance with such requirements so long as the law continues to meet such requirements. A State will not qualify for the 10-percentage-point increase in its share of recoveries until after the Inspector General, in consultation with the U.S. Attorney General, has determined that the State's law satisfies the requirements of section 1909(b) of the Act.

Section 1909 of the Act does not require a State to have in effect a false claims act or to enact a false claims act. A State may choose not to enact a false claims act or may choose to enact a false claims act that does not meet the enumerated requirements. However, a State that does not have a qualifying law in effect will not be eligible for the 10-percentage-point increase in its share of Medicaid fraud recoveries.

### ***Amendments to the FCA***

Congress has amended the FCA three times since the enactment of section 1909 of the Act: on May 20, 2009, in the Fraud Enforcement and Recovery Act of 2009; on March 23, 2010, in the Patient Protection and Affordable Care Act; and on July 21,

2010, in the Dodd-Frank Wall Street Reform and Consumer Protection Act. These three acts, among other things, amended the bases for liability in the FCA, expanded the rights of *qui tam* relators, and added an express requirement that civil penalties include adjustments under the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Pub. L. 104-410).

For purposes of OIG's review of State false claims acts, OIG will interpret the references in section 1909 of the Act with reference to the FCA to incorporate the amendments in the Fraud Enforcement and Recovery Act, the Patient Protection and Affordable Care Act, and the Dodd-Frank Wall Street Reform and Consumer Protection Act, as well as any future amendments to the FCA. Therefore, to qualify for the incentive, a State false claims act must fulfill the requirements of section 1909 of the Act with reference to the FCA as amended at the time of OIG's review.

For States with false claims acts approved by OIG before the amendments to the FCA in the Fraud Enforcement and Recovery Act, the Patient Protection and Affordable Care Act, and the Dodd-Frank Wall Street Reform and Consumer Protection Act, OIG provided a 2-year grace period during which the approved States would continue to be deemed compliant with the requirements of section 1909 of the Act and the States would continue to qualify for the incentive. The date of the expiration of the 2-year grace period was set forth in individual letters to each affected State. After the expiration of its 2-year grace period, a State will no longer qualify for the incentive unless its law: (1) is amended and resubmitted to OIG for review and (2) either is approved by OIG or is pending review by OIG.

OIG anticipates that if any provision of the FCA relevant to OIG's reviews under section 1909 of the Act is amended in the future, it will grant similar 2-year grace periods to any States with laws approved by OIG at the time of such amendment. In such event, OIG would review each OIG-approved State law and then notify in writing any State that, as a result of the amendment to the FCA, no longer satisfies the requirements of section 1909 of the Act. The specific dates for the grace period would be in the written notice.

## ***OIG Guidelines for Evaluating State False Claims Acts***

Section 1909 of the Act sets forth four requirements a State law must meet to qualify for the 10-percentage-point decrease in the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under the State law. After consulting with DOJ, OIG has developed guidelines to use in determining whether a State law meets the enumerated requirements. The guidelines are intended to highlight the FCA provisions relevant to OIG's determination of whether a State law meets the requirements of section 1909 of the Act. OIG will closely review any variation from these provisions of the FCA in the State law.

### ***A. Liability for False or Fraudulent Claims***

Under section 1909(b)(1) of the Act, the State law must establish liability to the State for false or fraudulent claims described in 31 U.S.C. 3729, with respect to expenditures related to State Medicaid plans. When evaluating a State law to determine whether it meets the requirements of section 1909(b)(1) of the Act, OIG will consider whether the law provides for the following:

1. Liability to the State for false or fraudulent claims with respect to Medicaid program expenditures, including:
  - knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;
  - knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
  - knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the State; and conspiring to commit any of the violations described above.
2. Definitions for the terms "knowing" and "knowingly" meaning that a person, with respect to information: (a) has actual knowledge of the information, (b) acts in deliberate ignorance of the truth or falsity of the information, or (c) acts in reckless disregard of the truth or falsity of the information. In addition, no specific intent to defraud should be required.

3. A definition for the term "claim" meaning, with respect to any Medicaid program expenditure, any request or demand, whether under contract or otherwise, for money or property and whether or not the State has title to the money or property, that (a) is presented to an officer, employee, or agent of the State, or (b) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the State's behalf or to advance a State program or interest and if the State (i) provides or has provided any portion of the money or property requested or demanded or (ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
4. A definition of the term "obligation" meaning an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship; from a fee-based or similar relationship; from statute or regulation; or from the retention of any overpayment.
5. A definition of the term "material" meaning to have a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

If a State law includes provisions that limit the application of the above-described liability provisions and definitions, OIG will consider whether, because of those limitations, the State law fails to fully establish liability to the State for the false or fraudulent claims described in 31 U.S.C. 3729.

#### *B. Rewarding and Facilitating Qui Tam Actions*

Under section 1909(b)(2) of the Act, a State law must contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in 31 U.S.C. 3730-3732. When evaluating a State law to determine whether it meets these requirements, OIG will consider whether the law provides for the following:

1. A relator may bring a civil action for a violation of the State law for the relator and for the State, which shall be brought in the name of the State.
2. When a relator brings an action under the State law, no person other than the State may intervene or bring a related action based on the facts underlying the pending action.
3. If the State proceeds with the action, the relator shall have the right to continue as a party to the action.

4. If the State elects not to proceed with the action, the relator shall have the right to conduct the action. When the relator proceeds with the action, the court, without limiting the status and rights of the relator, may permit the State to intervene at a later date.
5. If the State is authorized to elect to pursue its claim through an alternative remedy available to the State, the relator shall have the same rights in such alternative proceeding as the relator would have had if the action had continued under the State false claims act.
6. If the State proceeds with the action, the relator shall receive at least 15 to 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action. Such payment shall be made from the proceeds of the action or settlement of the claim.
7. If the State does not proceed with the action, the relator bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages, which shall be least 25 to 30 percent of the proceeds of the action or settlement of the claim. Such payment shall be made from the proceeds of the action or settlement of the claim.
8. A relator who receives a percentage of the proceeds of the action or settlement of the claim shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.
9. If the State law limits *qui tam* actions as a result of public disclosures, such limitation must not be broader than the following: The court shall dismiss an action or a claim under the State law, unless opposed by the State, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed (a) in a State criminal, civil, or administrative hearing in which the State or its agent is a party; (b) in a State legislative or other State report, hearing, audit, or investigation; or (c) from the news media; unless the action is brought by the State Attorney General or the relator is an original source of the information.
10. If the State law limits *qui tam* actions as a result of public disclosures, it must provide a definition of "original source" that is not narrower than the following: an individual who either (a) prior to a public disclosure, has voluntarily disclosed to the State the information on which allegations or transactions in a claim are based, or (b) has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the State before filing an action.

11. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action under the State law or other efforts to stop one or more violations of the State law. Relief shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination; two times the amount of back pay; interest on the back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. The relator must be allowed to initiate a civil action for such retaliation for at least 3 years after the date when the retaliation occurred.
12. A statute of limitations not shorter than the following, whichever is later: (a) 6 years after the date on which the violation of the State law was committed or (b) 3 years after the date when facts material to the right of action are known, or reasonably should have been known, by the office of the State charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation occurred.
13. If the State elects to intervene and proceed with an action brought by a relator, the State may file its own complaint or amend the complaint of the relator to clarify or add detail to the claims in which the State is intervening and add any claims with respect to which the State contends it is entitled to relief. For statute of limitations purposes, any such State pleading shall relate back to the filing date of the complaint of the relator, to the extent that the claim of the State arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that relator.
14. In any action brought under the State law, the State shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

The State law may include additional restrictions on the relator's procedural rights, limitations on or reductions in the relator's award, jurisdictional bars, and other *qui tam* provisions that do not conflict with the requirements of section 1909(b)(2) of the Act. If such provisions are more restrictive than the provisions of the FCA, OIG may determine that a State law is not as effective in rewarding and facilitating *qui tam* actions as the FCA. OIG will make such determinations on a case-by-case

basis and in consultation with DOJ. Examples of such provisions OIG may consider include:

- any limitation on the rights of the relator that is broader than the limitations on the rights of the relator in the FCA,
- any limitation on or reduction in the relator's share of the proceeds of the action or settlement that is broader than the limitations on or greater than the reductions in the relator's share under the FCA,
- any requirements placed on the relator that are more onerous than the requirements placed on the relator under the FCA,
- any requirement that the relator pay defendant's attorneys' fees and expenses that is broader than the requirement under the FCA, and
- any jurisdictional bar that is broader than the jurisdictional bars under the FCA.

#### *C. Seal Provisions*

Under section 1909(b)(3) of the Act, a State law must contain a requirement for filing an action under seal for 60 days with review by the State Attorney General. When evaluating whether a State law meets the requirements of section 1909(b)(3) of the Act, OIG will consider whether the law requires the complaint to be filed in camera and to remain under seal for at least 60 days.

#### *D. Civil Penalty Provisions*

Under section 1909(b)(4) of the Act, the State law must contain a civil penalty that is not less than the amount of the civil penalty authorized under 31 U.S.C. 3729. When determining whether a State law meets the requirements of section 1909(b)(4) of the Act, OIG will consider whether the law establishes liability for (1) at least treble damages and (2) civil penalties of at least \$5,000 to \$10,000 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Pub. L. 104-410). As of the date of this Notice, the civil penalties under the FCA, as adjusted by the Federal Civil Penalties Inflation Adjustment Act, are \$5,500 to \$11,000. Therefore, a State law must provide for civil penalties of at

least \$5,500 to \$11,000. If the civil penalties under the FCA are further adjusted by the Federal Civil Penalties Inflation Adjustment Act at a future date, then a State law must provide for civil penalties of at least those adjusted amounts to satisfy the requirements of section 1909(b)(4) of the Act.

## Kraly, Stacie L (LAW)

**From:** Brodie Anderson <Brodie.Anderson@akleg.gov>  
**Sent:** Monday, March 21, 2016 5:54 PM  
**To:** Pierson, Jane (LAA); Shadduck, Heather R (LAA); Phillips, Helen (LAA); Newman, Anthony (HSS); Kraly, Stacie L (LAW)  
**Subject:** SB 74 Medicaid Reform schedule and presenters  
**Attachments:** SB 74 Medicaid Schedule.docx

<i>Date/Time</i>	<i>Topic</i>	<i>Presenter</i>	<i>Organization</i>
<b>Monday, Mar 21</b>	Introduction	Heather Shadduck	Sponsor's Office
		Stacie Kraly	Dept. of Law
<b>Tuesday, Mar 22</b>	Fraud, False Claims, Penalties	Andrew Peterson	Medicaid Fraud Control Unit
		Doug Jones	Health Care Services
		Stacie Kraly	Dept. of Law
		Lynne Keilman-Cruz	DHSS (SDS)
<b>Wednesday, Mar 23</b>	Super-utilizers, Emergency Room Management	Anne Zink, M.D.	MatSu ER doc; President, American College of Emergency Physicians Alaska Chapter
		Becky Hultberg	Alaska State Hospital & Nursing Home Assoc.
		Carl Heine, MD	Juneau ER Doc; Past President, American College of Emergency Physicians Alaska Chapter
		Margaret Brodie	DHSS (Update re current Super Utilizers Program)
<b>Thursday, Mar 24</b>	Managed Care, Accountable Care and Organizations	LeAnn Behrens	President, Medical Health Plan, Texas, Amerigroup
		Sabrina Gibson	Chief Medical Actuary, Well Care Health Plans, Inc.
		Jocelyn Pemberton, MBA, CMPE	E.D. Alaska Hospitalist Group, LLC
		Nancy Merriman	Alaska Primary Care Associates
		Rich Davis	Central Peninsula Hospital

Monday, Mar 28

	Thea Agnew Bemben	Agnew Beck
Behavioral Health	Charlie Curie	CEO, The Curie Group (AMHTA expert)
	Jeff Jessee	AMHT
	Karen Forrest	DHSS
	Randall Burns	DHSS
	Thea Agnew Bemben	Agnew::Beck
	Kate Burkhardt	ED, Advisory Board on Alcoholism & Drug Abuse
	Tom Chard	ED, Alaska Behavioral Health Associates

Monday, Mar 28

Federal Overview, Waivers, and Options	Jerry Moses	Contact Alaska Native Tribal Health Consortium
	Shane Spotts	Health Management Associates (contractor for 1915 i/k)
	Valerie Davidson	DHSS
	Jon Sherwood	DHSS
	Duane Mayes	DHSS - 1915 i/k

Tuesday, Mar 29

Fiscal Notes	Jon Sherwood	
Public Testimony	5:00 PM- 7:00 PM	

Wednesday, Mar 30

Telemedicine	Stewart Ferguson	Chief Technology Officer, ANTHC
	Rebecca Madison	Board Member of Northwest Telehealth/ Alaska eHealth Network
	Henry DePhillips	Medical Director, Teledoc
	Wallace Adamson	Strategic Partnership
Prescription Drug Database	Jay Butler	Chief Medical Officer
	Dr. Erin Narus	State Medical Pharmacist
	Janey Hovington	Boards & Commission
	Carl Heine, MD	Juneau ER Doc; Past President, American College of Emergency Physicians Alaska Chapter
	Brian Howes	Senior Investigator, AK CCED Div of Corp Business

29-LS0692\T  
Glover  
4/5/16

**ADOPTED**  
4-7-16

**HOUSE CS FOR CS FOR SENATE BILL NO. 74(FIN)**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-NINTH LEGISLATURE - SECOND SESSION**

**BY THE HOUSE FINANCE COMMITTEE**

**Offered:**  
**Referred:**

**Sponsor(s): SENATORS KELLY, Giessel, Micciche, Bishop, MacKinnon, Hoffman, Costello, McGuire, Stedman, Stevens, Coghill, Egan, Meyer**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to diagnosis, treatment, and prescription of drugs without a physical**  
2 **examination by a physician; relating to the delivery of services by a licensed audiologist,**  
3 **speech-language pathologist, professional counselor, marriage and family therapist,**  
4 **psychologist, psychological associate, social worker, physical therapist, occupational**  
5 **therapist, and registered speech-language pathologist assistant by audio, video, or data**  
6 **communications; relating to the duties of the State Medical Board; relating to**  
7 **limitations of actions; establishing the Alaska Medical Assistance False Claim and**  
8 **Reporting Act; relating to medical assistance programs administered by the Department**  
9 **of Health and Social Services; relating to the controlled substance prescription**  
10 **database; relating to the duties of the Board of Pharmacy; relating to the duties of the**  
11 **Board of Dental Examiners; relating to the duties of the Board of Nursing; relating to**  
12 **the duties of the Board of Examiners in Optometry; relating to the duties of the**

1 **Department of Commerce, Community, and Economic Development; relating to the**  
2 **duties of the Department of Corrections; relating to accounting for program receipts;**  
3 **relating to public record status of records related to the Alaska Medical Assistance False**  
4 **Claim and Reporting Act; establishing a telemedicine business registry; relating to**  
5 **competitive bidding for medical assistance products and services; relating to verification**  
6 **of eligibility for public assistance programs administered by the Department of Health**  
7 **and Social Services; relating to annual audits of state medical assistance providers;**  
8 **relating to reporting overpayments of medical assistance payments; establishing**  
9 **authority to assess civil penalties for violations of medical assistance program**  
10 **requirements; relating to the duties of the Department of Health and Social Services;**  
11 **establishing medical assistance demonstration projects; relating to Alaska Pioneers'**  
12 **Homes and Alaska Veterans' Homes; relating to the duties of the Department of**  
13 **Administration; relating to the Alaska Mental Health Trust Authority; relating to**  
14 **feasibility studies for the provision of specified state services; relating to a report by the**  
15 **Board of Pharmacy, Board of Examiners in Optometry, Board of Dental Examiners,**  
16 **Board of Nursing, and State Medical Board; amending Rules 4, 5, 7, 12, 24, 26, 27, 41,**  
17 **77, 79, and 82, Alaska Rules of Civil Procedure; and providing for an effective date."**

18 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

19 \* **Section 1.** AS 08.11.080 is amended by adding new subsections to read:

20 (b) The department may not impose disciplinary sanctions on an audiologist  
21 for the evaluation, diagnosis, or treatment of a person through audio, video, or data  
22 communications when physically separated from the person if the audiologist

23 (1) or another licensed health care provider is available to provide  
24 follow-up care;

25 (2) requests that the person consent to sending a copy of all records of

1 the encounter to a primary care provider if the audiologist is not the person's primary  
2 care provider and, if the person consents, the audiologist sends the records to the  
3 person's primary care provider; and

4 (3) meets the requirements established by the department in regulation.

5 (c) The department shall adopt regulations restricting the evaluation,  
6 diagnosis, supervision, and treatment of a person as authorized under (b) of this  
7 section by establishing standards of care, including standards for training,  
8 confidentiality, supervision, practice, and related issues.

9 \* **Sec. 2.** AS 08.11.083 is amended by adding new subsections to read:

10 (b) The department may not impose disciplinary sanctions on a speech-  
11 language pathologist assistant for the evaluation, diagnosis, or treatment of a person  
12 through audio, video, or data communications when physically separated from the  
13 person if the speech-language pathologist assistant

14 (1) or another licensed health care provider is available to provide  
15 follow-up care;

16 (2) requests that the person consent to sending a copy of all records of  
17 the encounter to a primary care provider if the speech-language pathologist assistant is  
18 not the person's primary care provider and, if the person consents, the speech-language  
19 pathologist assistant sends the records to the person's primary care provider; and

20 (3) meets the requirements established by the board in regulation.

21 (c) The department shall adopt regulations restricting the evaluation,  
22 diagnosis, supervision, and treatment of a person as authorized under (b) of this  
23 section by establishing standards of care, including standards for training,  
24 confidentiality, supervision, practice, and related issues.

25 \* **Sec. 3.** AS 08.11.085 is amended by adding new subsections to read:

26 (b) The department may not impose disciplinary sanctions on a speech-  
27 language pathologist for the evaluation, diagnosis, or treatment of a person through  
28 audio, video, or data communications when physically separated from the person if the  
29 speech-language pathologist

30 (1) or another licensed health care provider is available to provide  
31 follow-up care;

1 (2) requests that the person consent to sending a copy of all records of  
2 the encounter to a primary care provider if the speech-language pathologist is not the  
3 person's primary care provider and, if the person consents, the speech-language  
4 pathologist sends the records to the person's primary care provider; and

5 (3) meets the requirements established by the board in regulation.

6 (c) The department shall adopt regulations restricting the evaluation,  
7 diagnosis, supervision, and treatment of a person as authorized under (b) of this  
8 section by establishing standards of care, including standards for training,  
9 confidentiality, supervision, practice, and related issues.

10 \* **Sec. 4.** AS 08.29.400 is amended by adding new subsections to read:

11 (b) The board may not impose disciplinary sanctions on a licensee for the  
12 evaluation, diagnosis, or treatment of a person through audio, video, or data  
13 communications when physically separated from the person if

14 (1) the licensee or another licensed health care provider is available to  
15 provide follow-up care;

16 (2) the licensee requests that the person consent to sending a copy of  
17 all records of the encounter to a primary care provider if the licensee is not the  
18 person's primary care provider and, if the person consents, the licensee sends the  
19 records to the person's primary care provider; and

20 (3) the licensee meets the requirements established by the board in  
21 regulation.

22 (c) The board shall adopt regulations restricting the evaluation, diagnosis,  
23 supervision, and treatment of a person as authorized under (b) of this section by  
24 establishing standards of care, including standards for training, confidentiality,  
25 supervision, practice, and related issues.

26 \* **Sec. 5.** AS 08.36.070(a) is amended to read:

27 (a) The board shall

28 (1) provide for the examination of applicants and the credentialing,  
29 registration, and licensure of those applicants it finds qualified;

30 (2) maintain a registry of licensed dentists, licensed dental hygienists,  
31 and registered dental assistants who are in good standing;

1 (3) affiliate with the American Association of Dental Boards and pay  
2 annual dues to the association;

3 (4) hold hearings and order the disciplinary sanction of a person who  
4 violates this chapter, AS 08.32, or a regulation of the board;

5 (5) supply forms for applications, licenses, permits, certificates,  
6 registration documents, and other papers and records;

7 (6) enforce the provisions of this chapter and AS 08.32 and adopt or  
8 amend the regulations necessary to make the provisions of this chapter and AS 08.32  
9 effective;

10 (7) adopt regulations ensuring that renewal of a license, registration, or  
11 certificate under this chapter or a license, certificate, or endorsement under AS 08.32  
12 is contingent upon proof of continued professional competence;

13 (8) at least annually, cause to be published on the Internet and in a  
14 newspaper of general circulation in each major city in the state a summary of  
15 disciplinary actions the board has taken during the preceding calendar year;

16 (9) issue permits or certificates to licensed dentists, licensed dental  
17 hygienists, and dental assistants who meet standards determined by the board for  
18 specific procedures that require specific education and training;

19 **(10) require that a licensed dentist who has a federal Drug**  
20 **Enforcement Administration registration number register with the controlled**  
21 **substance prescription database under AS 17.30.200(o).**

22 \* **Sec. 6.** AS 08.63.210 is amended by adding new subsections to read:

23 (c) The board may not impose disciplinary sanctions on a licensee for the  
24 evaluation, diagnosis, supervision, or treatment of a person through audio, video, or  
25 data communications when physically separated from the person if

26 (1) the licensee or another licensed health care provider is available to  
27 provide follow-up care;

28 (2) the licensee requests that the person consent to sending a copy of  
29 all records of the encounter to a primary care provider if the licensee is not the  
30 person's primary care provider and, if the person consents, the licensee sends the  
31 records to the person's primary care provider; and

1 (3) the licensee meets the requirements established by the board in  
2 regulation.

3 (d) The board shall adopt regulations restricting the evaluation, diagnosis,  
4 supervision, and treatment of a person as authorized under (c) of this section by  
5 establishing standards of care, including standards for training, confidentiality,  
6 supervision, practice, and related issues.

7 \* Sec. 7. AS 08.64.101 is amended to read:

8 **Sec. 08.64.101. Duties.** The board shall

9 (1) examine and issue licenses to applicants;

10 (2) develop written guidelines to ensure that licensing requirements are  
11 not unreasonably burdensome and the issuance of licenses is not unreasonably  
12 withheld or delayed;

13 (3) after a hearing, impose disciplinary sanctions on persons who  
14 violate this chapter or the regulations or orders of the board;

15 (4) adopt regulations ensuring that renewal of licenses is contingent on  
16 [UPON] proof of continued competency on the part of the licensee; and

17 (5) under regulations adopted by the board, contract with private  
18 professional organizations to establish an impaired medical professionals program to  
19 identify, confront, evaluate, and treat persons licensed under this chapter who abuse  
20 alcohol, other drugs, or other substances or are mentally ill or cognitively impaired;

21 **(6) adopt regulations that establish guidelines for a physician who**  
22 **is rendering a diagnosis, providing treatment, or prescribing, dispensing, or**  
23 **administering a prescription drug to a person without conducting a physical**  
24 **examination under AS 08.64.364; the guidelines must include a nationally**  
25 **recognized model policy for standards of care of a patient who is at a different**  
26 **location than the physician;**

27 **(7) require that a licensee who has a federal Drug Enforcement**  
28 **Administration registration number register with the controlled substance**  
29 **prescription database under AS 17.30.200(o).**

30 \* Sec. 8. AS 08.64.364(a) is amended to read:

31 (a) The board may not impose disciplinary sanctions on a physician for

1 rendering a diagnosis, providing treatment, or prescribing, dispensing, or  
2 administering a prescription drug that is not a controlled substance to a person  
3 without conducting a physical examination if

4 (1) [THE PRESCRIPTION DRUG IS

5 (A) NOT A CONTROLLED SUBSTANCE; OR

6 (B) A CONTROLLED SUBSTANCE AND IS PRESCRIBED,  
7 DISPENSED, OR ADMINISTERED BY A PHYSICIAN WHEN AN  
8 APPROPRIATE LICENSED HEALTH CARE PROVIDER IS PRESENT  
9 WITH THE PATIENT TO ASSIST THE PHYSICIAN WITH  
10 EXAMINATION, DIAGNOSIS, AND TREATMENT;

11 (2) THE PHYSICIAN IS LOCATED IN THIS STATE AND] the  
12 physician or another licensed health care provider or physician in the physician's  
13 group practice is available to provide follow-up care; and

14 (2) the physician requests that [(3)] the person consent  
15 [CONSENTS] to sending a copy of all records of the encounter to the person's primary  
16 care provider if the prescribing physician is not the person's primary care provider,  
17 and, if the patient consents, the physician sends the records to the person's primary  
18 care provider.

19 \* **Sec. 9.** AS 08.64.364 is amended by adding new subsections to read:

20 (c) The board may not impose disciplinary sanctions on a physician for  
21 prescribing, dispensing, or administering a prescription drug that is a controlled  
22 substance or botulinum toxin if the requirements under (a) of this section are met and  
23 the physician prescribes, dispenses, or administers the controlled substance or  
24 botulinum toxin when an appropriate licensed health care provider is present with the  
25 patient to assist the physician with examination, diagnosis, and treatment.

26 (d) Notwithstanding (a) and (c) of this section, a physician may not

27 (1) prescribe, dispense, or administer an abortion-inducing drug under  
28 (a) of this section unless the physician complies with AS 18.16.010; or

29 (2) prescribe, dispense, or administer a prescription drug in response to  
30 an Internet questionnaire or electronic mail message to a person with whom the  
31 physician does not have a prior physician-patient relationship.

1     \* **Sec. 10.** AS 08.68.100(a) is amended to read:

2             (a) The board shall

3                     (1) adopt regulations necessary to implement this chapter, including  
4             regulations

5                             (A) pertaining to practice as an advanced nurse practitioner and  
6             a certified registered nurse anesthetist;

7                             (B) necessary to implement AS 08.68.331 - 08.68.336 relating  
8             to certified nurse aides in order to protect the health, safety, and welfare of  
9             clients served by nurse aides;

10                            (C) pertaining to retired nurse status; and

11                            (D) establishing criteria for approval of practical nurse  
12             education programs that are not accredited by a national nursing accrediting  
13             body;

14                     (2) approve curricula and adopt standards for basic education programs  
15             that prepare persons for licensing under AS 08.68.190;

16                     (3) provide for surveys of the basic nursing education programs in the  
17             state at the times it considers necessary;

18                     (4) approve education programs that meet the requirements of this  
19             chapter and of the board, and deny, revoke, or suspend approval of education  
20             programs for failure to meet the requirements;

21                     (5) examine, license, and renew the licenses of qualified applicants;

22                     (6) prescribe requirements for competence before a former nurse may  
23             resume the practice of nursing under this chapter;

24                     (7) define by regulation the qualifications and duties of the executive  
25             administrator and delegate authority to the executive administrator that is necessary to  
26             conduct board business;

27                     (8) develop reasonable and uniform standards for nursing practice;

28                     (9) publish advisory opinions regarding whether nursing practice  
29             procedures or policies comply with acceptable standards of nursing practice as defined  
30             under this chapter;

31                     (10) require applicants under this chapter to submit fingerprints and the

1 fees required by the Department of Public Safety under AS 12.62.160 for criminal  
2 justice information and a national criminal history record check; the department shall  
3 submit the fingerprints and fees to the Department of Public Safety for a report of  
4 criminal justice information under AS 12.62 and a national criminal history record  
5 check under AS 12.62.400;

6 **(11) require that a licensed advanced nurse practitioner who has a**  
7 **federal Drug Enforcement Administration registration number register with the**  
8 **controlled substance prescription database under AS 17.30.200(o).**

9 \* Sec. 11. AS 08.72.060(c) is amended to read:

10 (c) The board shall

11 (1) elect a chair and secretary from among its members;

12 (2) order a licensee to submit to a reasonable physical examination if  
13 the licensee's physical capacity to practice safely is at issue;

14 **(3) require that a licensee who has a federal Drug Enforcement**  
15 **Administration registration number register with the controlled substance**  
16 **prescription database under AS 17.30.200(o).**

17 \* Sec. 12. AS 08.80.030(b) is amended to read:

18 (b) In order to fulfill its responsibilities, the board has the powers necessary  
19 for implementation and enforcement of this chapter, including the power to

20 (1) elect a president and secretary from its membership and adopt rules  
21 for the conduct of its business;

22 (2) license by examination or by license transfer the applicants who are  
23 qualified to engage in the practice of pharmacy;

24 (3) assist the department in inspections and investigations for  
25 violations of this chapter, or of any other state or federal statute relating to the practice  
26 of pharmacy;

27 (4) adopt regulations to carry out the purposes of this chapter;

28 (5) establish and enforce compliance with professional standards and  
29 rules of conduct for pharmacists engaged in the practice of pharmacy;

30 (6) determine standards for recognition and approval of degree  
31 programs of schools and colleges of pharmacy whose graduates shall be eligible for

1 licensure in this state, including the specification and enforcement of requirements for  
2 practical training, including internships;

3 (7) establish for pharmacists and pharmacies minimum specifications  
4 for the physical facilities, technical equipment, personnel, and procedures for the  
5 storage, compounding, and dispensing of drugs or related devices, and for the  
6 monitoring of drug therapy;

7 (8) enforce the provisions of this chapter relating to the conduct or  
8 competence of pharmacists practicing in the state, and the suspension, revocation, or  
9 restriction of licenses to engage in the practice of pharmacy;

10 (9) license and regulate the training, qualifications, and employment of  
11 pharmacy interns and pharmacy technicians;

12 (10) issue licenses to persons engaged in the manufacture and  
13 distribution of drugs and related devices;

14 (11) establish and maintain a controlled substance prescription  
15 database as provided in AS 17.30.200;

16 (12) establish standards for the independent administration by a  
17 pharmacist of vaccines and related emergency medications under AS 08.80.168,  
18 including the completion of an immunization training program approved by the board;

19 **(13) require that a licensed pharmacist who has a federal Drug**  
20 **Enforcement Administration registration number register with the controlled**  
21 **substance prescription database under AS 17.30.200(o).**

22 \* **Sec. 13.** AS 08.84.120 is amended by adding new subsections to read:

23 (c) The board may not impose disciplinary sanctions on a licensee for the  
24 evaluation, diagnosis, or treatment of a person through audio, video, or data  
25 communications when physically separated from the person if the licensee

26 (1) or another licensed health care provider is available to provide  
27 follow-up care;

28 (2) requests that the person consent to sending a copy of all records of  
29 the encounter to a primary care provider if the licensee is not the person's primary care  
30 provider and, if the person consents, the licensee sends the records to the person's  
31 primary care provider; and

1 (3) meets the requirements established by the board in regulation.

2 (d) The board shall adopt regulations restricting the evaluation, diagnosis,  
3 supervision, and treatment of a person as authorized under (c) of this section by  
4 establishing standards of care, including standards for training, confidentiality,  
5 supervision, practice, and related issues.

6 \* **Sec. 14.** AS 08.86.204 is amended by adding new subsections to read:

7 (c) The board may not impose disciplinary sanctions on a licensee for the  
8 evaluation, diagnosis, or treatment of a person through audio, video, or data  
9 communications when physically separated from the person if

10 (1) the licensee or another licensed health care provider is available to  
11 provide follow-up care;

12 (2) the licensee requests that the person consent to sending a copy of  
13 all records of the encounter to a primary care provider if the licensee is not the  
14 person's primary care provider and, if the person consents, the licensee sends the  
15 records to the person's primary care provider; and

16 (3) the licensee meets the requirements established by the board in  
17 regulation.

18 (d) The board shall adopt regulations restricting the evaluation, diagnosis,  
19 supervision, and treatment of a person as authorized under (c) of this section by  
20 establishing standards of care, including standards for training, confidentiality,  
21 supervision, practice, and related issues.

22 \* **Sec. 15.** AS 08.95.050 is amended by adding new subsections to read:

23 (b) The board may not impose disciplinary sanctions on a licensee for the  
24 evaluation, diagnosis, or treatment of a person through audio, video, or data  
25 communications when physically separated from the person if

26 (1) the licensee or another licensed health care provider is available to  
27 provide follow-up care;

28 (2) the licensee requests that the person consent to sending a copy of  
29 all records of the encounter to a primary care provider if the licensee is not the  
30 person's primary care provider and, if the person consents, the licensee sends the  
31 records to the person's primary care provider; and

1 (3) the licensee meets the requirements established by the board in  
2 regulation.

3 (c) The board shall adopt regulations restricting the evaluation, diagnosis,  
4 supervision, and treatment of a person as authorized under (b) of this section by  
5 establishing standards of care, including standards for training, confidentiality,  
6 supervision, practice, and related issues.

7 \* **Sec. 16.** AS 09.10 is amended by adding a new section to read:

8 **Sec. 09.10.075. Actions related to claims based on medical assistance**  
9 **payment fraud.** Except as provided in AS 09.58.070, a person may not bring an  
10 action under AS 09.58.010 - 09.58.060, unless the action is commenced by the earlier  
11 of (1) six years after the act or omission was committed, or (2) three years after the  
12 date when facts material to the action were known, or reasonably should have been  
13 known, by the attorney general or the Department of Health and Social Services, but  
14 in no event more than 10 years after the date the violation under AS 09.58.010  
15 occurred.

16 \* **Sec. 17.** AS 09.10.120(a) is amended to read:

17 (a) Except as provided in AS 09.10.075, an [AN] action brought in the name  
18 of or for the benefit of the state, any political subdivision, or public corporation may  
19 be commenced only within six years after [OF] the date of accrual of the cause of  
20 action. However, if the action is for relief on the ground of fraud, the limitation  
21 commences from the time of discovery by the aggrieved party of the facts constituting  
22 the fraud.

23 \* **Sec. 18.** AS 09 is amended by adding a new chapter to read:

24 **Chapter 58. Alaska Medical Assistance False Claim and Reporting Act.**

25 **Sec. 09.58.010. False claims for medical assistance; civil penalty.** (a) A  
26 medical assistance provider or medical assistance recipient may not

27 (1) knowingly submit, authorize, or cause to be submitted to an officer  
28 or employee of the state a false or fraudulent claim for payment or approval under the  
29 medical assistance program;

30 (2) knowingly make, use, or cause to be made or used, directly or  
31 indirectly, a false record or statement to get a false or fraudulent claim for payment

1 paid or approved by the state under the medical assistance program;

2 (3) conspire to defraud the state by getting a false or fraudulent claim  
3 paid or approved under the medical assistance program;

4 (4) knowingly make, use, or cause to be made or used, a false record or  
5 statement to conceal, avoid, increase, or decrease an obligation to pay or transmit  
6 money or property to the medical assistance program;

7 (5) knowingly enter into an agreement, contract, or understanding with  
8 an officer or employee of the state for approval or payment of a claim under the  
9 medical assistance program knowing that the information in the agreement, contract,  
10 or understanding is false or fraudulent.

11 (b) A beneficiary of an intentional or inadvertent submission of a false or  
12 fraudulent claim under the medical assistance program who later discovers the claim is  
13 false or fraudulent shall disclose the false or fraudulent claim to the state not later than  
14 60 days after discovering the false claim.

15 (c) In addition to any criminal penalties under AS 47.05, a medical assistance  
16 provider or medical assistance recipient who violates (a) or (b) of this section shall be  
17 liable to the state in a civil action for

18 (1) a civil penalty of not less than \$5,500 and not more than \$11,000;

19 (2) three times the amount of actual damages sustained by the state;

20 (3) full reasonable attorney fees and costs in a case involving a  
21 fraudulent claim, agreement, contract, or understanding; and

22 (4) reasonable attorney fees and costs calculated under applicable court  
23 rules in a case that does not involve a fraudulent claim, agreement, contract, or  
24 understanding.

25 (d) Liability for actual damages under (c) of this section may be reduced to not  
26 less than twice the amount of actual damages that the state sustains if the court finds  
27 that a person liable for an act under (a) or (b) of this section

28 (1) furnished the attorney general or the Department of Health and  
29 Social Services with all information known to the person about the violation not later  
30 than 30 days after the date the information was obtained;

31 (2) fully cooperated with the investigation of the violation under

1 AS 09.58.020;

2 (3) at the time the person furnished the attorney general with the  
3 information about the violation, no criminal prosecution, civil action, investigation, or  
4 administrative action had been started in this state with respect to the violation, and the  
5 person did not have actual knowledge of the existence of an investigation of the  
6 violation.

7 (e) A corporation, partnership, or other individual is liable under this section  
8 for acts of its agents if the agent acted with apparent authority, regardless of whether  
9 the agent acted, in whole or in part, to benefit the principal and regardless of whether  
10 the principal adopted or ratified the agent's claims, representations, statement, or other  
11 action or conduct unless the evidence shows that the agent or apparent agent acted  
12 with intent to deceive the principal.

13 **Sec. 09.58.015. Attorney general investigation; civil action.** (a) The attorney  
14 general or the Department of Health and Social Services may investigate an alleged  
15 violation of AS 09.58.010. The attorney general may request assistance from the  
16 Department of Health and Social Services in an investigation under this section.

17 (b) The attorney general may bring a civil action in superior court under  
18 AS 09.58.010 - 09.58.060.

19 **Sec. 09.58.020. Private plaintiff; civil action.** (a) Notwithstanding  
20 AS 09.58.015, a person may bring an action under this section for a violation of  
21 AS 09.58.010 in the name of the person and the state.

22 (b) To bring an action under this section, a person shall file a complaint, in  
23 camera and under seal, and serve on the attorney general

24 (1) a copy of the complaint; and

25 (2) written disclosure of substantially all material evidence and  
26 information the person possesses that pertains to the claim.

27 (c) A complaint filed under this section must remain under seal for at least 60  
28 days and may not be served on the defendant until the court so orders. The attorney  
29 general may elect to intervene and proceed with the action within 60 days after the  
30 attorney general receives both the complaint and the material evidence and the  
31 information required under (b) of this section. The attorney general may, for good

1 cause shown, move the court, under seal, for an extension of the time during which the  
2 complaint remains under seal under this subsection.

3 (d) Before the expiration of the 60-day period or an extension of time granted  
4 under (c) of this section, the attorney general shall conduct an investigation and make  
5 a written determination as to whether substantial evidence exists that a violation of  
6 AS 09.58.010 has occurred. After the investigation and determination are complete,  
7 the attorney general shall provide the person who brought the action and the  
8 Department of Health and Social Services with a copy of the determination unless the  
9 action has been referred to the division of the Department of Law that has  
10 responsibility for criminal cases.

11 (e) Before the expiration of the 60-day period or an extension obtained under  
12 (c) of this section, the attorney general shall

13 (1) intervene in the action and proceed with the action on behalf of the  
14 state;

15 (2) notify the court that the attorney general declines to take over the  
16 action, in which case the person bringing the action has the right to conduct the action;  
17 or

18 (3) if the attorney general determines that substantial evidence does not  
19 exist that a violation of AS 09.58.010 has occurred, or that the action is barred under  
20 AS 09.58.050, the attorney general shall move the court to dismiss the action.

21 (f) The named defendant in a complaint filed under this section is not required  
22 to respond to a complaint filed under this section until after the complaint is unsealed  
23 by the court and a copy of the summons and complaint are served on the defendant  
24 under the applicable Alaska Rules of Civil Procedure.

25 (g) When a person brings an action under this section, only the attorney  
26 general may intervene or bring a related action based on similar facts to the underlying  
27 action.

28 **Sec. 09.58.025. Subpoenas.** In conducting an investigation under  
29 AS 09.58.015 or 09.58.020, the attorney general may issue subpoenas to compel the  
30 production of books, papers, correspondence, memoranda, and other records in  
31 connection with an investigation under or the administration of AS 09.58.010 -

1 09.58.060. If a medical assistance provider or a medical assistance recipient fails or  
2 refuses, without just cause, to obey a subpoena issued under this subsection, the  
3 superior court may, upon application by the attorney general, issue an order requiring  
4 the medical assistance provider or medical assistance recipient to appear before the  
5 attorney general to produce evidence.

6 **Sec. 09.58.030. Rights in false or fraudulent claims actions.** (a) If the  
7 attorney general elects to intervene and proceed with an action under AS 09.58.020,  
8 the attorney general has exclusive authority for prosecuting the action and is not bound  
9 by an act of the person bringing the action. The person who brought the action has the  
10 right to continue as a nominal party to the action, but does not have the right to  
11 participate in the action except as a witness or as otherwise directed by the attorney  
12 general. If the attorney general elects to intervene under AS 09.58.020, the attorney  
13 general may file a new complaint or amend the complaint filed by the person who  
14 brought the action under AS 09.58.020(b).

15 (b) Notwithstanding the objections of the person who brought the action, the  
16 attorney general may

17 (1) move to dismiss the action at any time under this chapter if the  
18 attorney general has notified the person who brought the action of the intent to seek  
19 dismissal and the court has provided the person who brought the action with an  
20 opportunity to respond to the motion;

21 (2) settle the action with the defendant at any time, if the court  
22 determines, after a hearing, that the proposed settlement is fair, adequate, and  
23 reasonable under all the circumstances; upon a showing of good cause, the hearing  
24 described in this paragraph shall be held in camera.

25 (c) If the attorney general elects not to proceed under AS 09.58.020 with the  
26 action, the person who brought the action has the right to proceed and conduct the  
27 action. The attorney general may request at any time during the proceedings to be  
28 served with copies of all documents related to the action, including pleadings,  
29 motions, and discovery. The attorney general shall pay for the reasonable copying  
30 charges for documents provided under this subsection. If the person who brought the  
31 action proceeds with the action, the court, without limiting the status and rights of the

1 person who brought the action, shall allow the attorney general to intervene at any  
2 time.

3 (d) Whether or not the attorney general proceeds with the action under this  
4 chapter, on a showing by the attorney general that certain actions of discovery by the  
5 person bringing the action would interfere with pending investigation or prosecution  
6 of a criminal or civil proceeding arising out of the same matter, the court may stay the  
7 discovery for not more than 90 days. The court may extend the 90-day period on a  
8 further showing, in camera, that the state has pursued the criminal or civil  
9 investigation or proceedings with reasonable diligence and that proposed discovery in  
10 the civil action under AS 09.58.010 - 09.58.060 may interfere with the ongoing  
11 criminal or civil investigation or proceedings.

12 **Sec. 09.58.040. Award to false or fraudulent claim plaintiff.** (a) If the  
13 attorney general proceeds with an action brought by a person for a violation of  
14 AS 09.58.010, the person who brought the action shall receive at least 15 percent but  
15 not more than 25 percent of the proceeds of the action or settlement of the claim,  
16 depending on the extent to which the person bringing the action contributed to the  
17 prosecution of the action. The court order or settlement agreement shall state the  
18 percentage and the amount to be received by the person who brought the action. A  
19 payment under this subsection to the person who brought the action may only be paid  
20 from proceeds received from a judgment or settlement under this section.

21 (b) If the attorney general does not proceed with an action brought under  
22 AS 09.58.020, the person bringing the action to judgment or settlement by court order  
23 shall receive an amount that the court decides is reasonable for collecting the civil  
24 penalty and damages based on the person's effort to prosecute the action successfully.  
25 The amount shall be at least 25 percent but not more than 30 percent of the proceeds  
26 of the action or settlement of the claim. A payment under this subsection to the person  
27 who brought the action may only be paid from proceeds received from a judgment or  
28 settlement received under this section. In addition, if the person bringing the action  
29 prevails, the person is entitled to

30 (1) full reasonable attorney fees and court costs in a case involving a  
31 fraudulent claim, agreement, contract, or understanding; or

1 (2) reasonable attorney fees and court costs calculated under applicable  
2 court rules in a case that does not involve a fraudulent claim, agreement, contract, or  
3 understanding.

4 (c) Whether or not the attorney general participates in the action, if the court  
5 finds that the action was brought by a person who planned or initiated the violation  
6 alleged in the action brought under AS 09.58.020, the court may, to the extent the  
7 court considers appropriate, reduce the share of the proceeds of the action that the  
8 person would otherwise receive under (a) or (b) of this section, taking into account the  
9 role of that person in advancing the case to litigation and any relevant circumstances  
10 pertaining to the violation. If the person bringing the action is convicted of criminal  
11 conduct arising from the person's role in the violation of AS 09.58.010, the court shall  
12 dismiss the person from the civil action and the person may not receive any share of  
13 the proceeds of the action or settlement. A dismissal under this subsection does not  
14 prejudice the right of the attorney general to continue the action.

15 (d) In this section, "proceeds of the action or settlement"

16 (1) includes damages, civil penalties, payment for cost of compliance,  
17 and other economic benefits realized by the state as a result of a civil action brought  
18 under AS 09.58.010 - 09.58.060;

19 (2) does not include attorney fees and costs awarded to the state.

20 **Sec. 09.58.050. Certain actions barred.** A person may not bring an action  
21 under AS 09.58.020 if the action is

22 (1) based on evidence or information known to the state when the  
23 action was brought;

24 (2) based on allegations or transactions that are the subject of a civil or  
25 criminal action or an administrative proceeding in which the state is already a party;

26 (3) based on the public disclosure of allegations or actions in a  
27 criminal or civil action or an administrative hearing, or from the news media, unless  
28 the action is brought by the attorney general or the person bringing the action is an  
29 original source of the information that was publicly disclosed; in this paragraph, a  
30 person is an original source of the information that was publicly disclosed if the  
31 person has independent knowledge, including knowledge based on personal

1 investigation of the defendant's conduct, of the information on which the allegations  
2 are based, and has voluntarily provided or verified the information on which the  
3 allegations are based or voluntarily provided the information to the attorney general  
4 before filing an action under AS 09.58.020 that is based on the information; or

5 (4) against the state or current or former state employees.

6 **Sec. 09.58.060. State not liable for attorney fees, costs, and other expenses.**

7 The state, its agencies, current or former officers, and current or former employees, are  
8 not liable for attorney fees, costs, and other expenses that a person incurs in bringing  
9 an action under AS 09.58.020.

10 **Sec. 09.58.070. Employee protection for retaliation.** (a) An employee of a  
11 medical assistance provider who is discharged, demoted, suspended, threatened,  
12 harassed, or discriminated against in the terms and conditions of employment by the  
13 employee's employer because of lawful acts done by the employee on behalf of the  
14 employee or others in furtherance of an action under AS 09.58.010 - 09.58.100,  
15 including investigation for, initiation of, testimony for or assistance in an action filed  
16 or to be filed under AS 09.58.010 - 09.58.100, is entitled to the same relief authorized  
17 under AS 39.90.120.

18 (b) Notwithstanding (a) of this section, a state employee who is discharged,  
19 demoted, suspended, threatened, harassed, or discriminated against in the terms and  
20 conditions of employment because of lawful acts done by the employee on behalf of  
21 the employee or a person who brings an action under AS 09.58.020 or in furtherance  
22 of an action under AS 09.58.010 - 09.58.100, including investigation, initiation of,  
23 testimony for or assistance in an action filed or to be filed under AS 09.58.010 -  
24 09.58.100, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska Whistleblower  
25 Act).

26 (c) A person may not bring an action under this section unless the action is  
27 commenced not later than three years after the date the employee was subject to  
28 retaliation under (a) or (b) of this section.

29 **Sec. 09.58.080. Regulations.** The attorney general may adopt regulations  
30 under AS 44.62 as necessary to carry out the purposes of this chapter.

31 **Sec. 09.58.090. Special provisions.** (a) This chapter does not apply to any

1 controversy involving damages to the state of less than \$5,500 in value.

2 (b) No punitive damages may be awarded in an action brought under  
3 AS 09.58.010 - 09.58.060.

4 **Sec. 09.58.100. Definitions.** In this chapter,

5 (1) "attorney general" includes a designee of the attorney general;

6 (2) "claim" means a request for payment of health care services or  
7 equipment, whether made to a contractor, grantee, or other person, when the state  
8 provides, directly or indirectly, a portion of the money, property, or services requested  
9 or demanded, or when the state will, directly or indirectly, reimburse the contractor,  
10 grantee, or other recipient for a portion of the money, property, or services requested  
11 or demanded;

12 (3) "controversy" means the aggregate of one or more false claims  
13 submitted by the same medical assistance provider or medical assistance recipient  
14 under this chapter;

15 (4) "knowingly" means that a person, with or without specific intent to  
16 defraud,

17 (A) has actual knowledge of the information;

18 (B) acts in deliberate ignorance of the truth or falsity of the  
19 information; or

20 (C) acts in reckless disregard of the truth or falsity of the  
21 information;

22 (5) "medical assistance program" means the federal-state program  
23 administered by the Department of Health and Social Services under AS 47.05 and  
24 AS 47.07 and regulations adopted under AS 47.05 and AS 47.07;

25 (6) "medical assistance provider" has the meaning given under  
26 AS 47.05.290;

27 (7) "medical assistance recipient" has the meaning given under  
28 AS 47.05.290;

29 (8) "obligation" means an established duty, whether or not fixed,  
30 arising from

31 (A) an express or implied contractual grantor or grantee or

1           licensor or licensee relationship;

2                           (B) a fee-based or similar relationship;

3                           (C) a statute or regulation; or

4                           (D) the retention of any overpayment.

5           **Sec. 09.58.110. Short title.** This chapter may be cited as the Alaska Medical  
6           Assistance False Claim and Reporting Act.

7   \* **Sec. 19.** AS 09.58.025, added by sec. 18 of this Act, is amended to read:

8           **Sec. 09.58.025. Subpoenas.** In conducting an investigation under  
9           AS 09.58.015 [OR 09.58.020], the attorney general may issue subpoenas to compel  
10           the production of books, papers, correspondence, memoranda, and other records in  
11           connection with an investigation under or the administration of AS 09.58.010 -  
12           09.58.060. If a medical assistance provider or a medical assistance recipient fails or  
13           refuses, without just cause, to obey a subpoena issued under this subsection, the  
14           superior court may, upon application by the attorney general, issue an order requiring  
15           the medical assistance provider or medical assistance recipient to appear before the  
16           attorney general to produce evidence.

17   \* **Sec. 20.** AS 09.58.070(b), added by sec. 18 of this Act, is amended to read:

18           (b) Notwithstanding (a) of this section, a state employee who is discharged,  
19           demoted, suspended, threatened, harassed, or discriminated against in the terms and  
20           conditions of employment because of lawful acts done by the employee on behalf of  
21           the employee [OR A PERSON WHO BRINGS AN ACTION UNDER AS 09.58.020]  
22           or in furtherance of an action under AS 09.58.010 - 09.58.060, including investigation,  
23           initiation of, testimony for or assistance in an action filed or to be filed under  
24           AS 09.58.010 - 09.58.060, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska  
25           Whistleblower Act).

26   \* **Sec. 21.** AS 17.30.200(a) is amended to read:

27           (a) The controlled substance prescription database is established in the Board  
28           of Pharmacy. The purpose of the database is to contain data as described in this  
29           section regarding every prescription for a schedule [IA, IIA, IIIA, IVA, OR VA  
30           CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III,  
31           or IV [, OR V] controlled substance under federal law dispensed in the state to a

1 person other than those administered to a patient at a health care facility. [THE  
2 DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC  
3 DEVELOPMENT SHALL ASSIST THE BOARD AND PROVIDE NECESSARY  
4 STAFF AND EQUIPMENT TO IMPLEMENT THIS SECTION.]

5 \* **Sec. 22.** AS 17.30.200(b) is amended to read:

6 (b) The pharmacist-in-charge of each licensed or registered pharmacy,  
7 regarding each schedule [IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE  
8 UNDER STATE LAW OR A SCHEDULE I,] II, III, or IV [, OR V] controlled  
9 substance under federal law dispensed by a pharmacist under the supervision of the  
10 pharmacist-in-charge, and each practitioner who directly dispenses a schedule [IA,  
11 IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE LAW OR A  
12 SCHEDULE I,] II, III, or IV [, OR V] controlled substance under federal law other  
13 than those administered to a patient at a health care facility, shall submit to the board,  
14 by a procedure and in a format established by the board, the following information for  
15 inclusion in the database on at least a weekly basis:

16 (1) the name of the prescribing practitioner and the practitioner's  
17 federal Drug Enforcement Administration registration number or other appropriate  
18 identifier;

19 (2) the date of the prescription;

20 (3) the date the prescription was filled and the method of payment; this  
21 paragraph does not authorize the board to include individual credit card or other  
22 account numbers in the database;

23 (4) the name, address, and date of birth of the person for whom the  
24 prescription was written;

25 (5) the name and national drug code of the controlled substance;

26 (6) the quantity and strength of the controlled substance dispensed;

27 (7) the name of the drug outlet dispensing the controlled substance;

28 [AND]

29 (8) the name of the pharmacist or practitioner dispensing the controlled  
30 substance and other appropriate identifying information; and

31 (9) if a prescription is dispensed to a person other than the patient

1 **for whom the prescription was written, the name and date of birth of the person**  
2 **to whom the prescription was dispensed.**

3 \* **Sec. 23.** AS 17.30.200(d) is amended to read:

4 (d) The database and the information contained within the database are  
5 confidential, are not public records, and are not subject to public disclosure. The board  
6 shall undertake to ensure the security and confidentiality of the database and the  
7 information contained within the database. The board may allow access to the  
8 database only to the following persons, and in accordance with the limitations  
9 provided and regulations of the board:

10 (1) personnel of the board regarding inquiries concerning licensees or  
11 registrants of the board or personnel of another board or agency concerning a  
12 practitioner under a search warrant, subpoena, or order issued by an administrative law  
13 judge or a court;

14 (2) authorized board personnel or contractors as required for  
15 operational and review purposes;

16 (3) a licensed practitioner having authority to prescribe controlled  
17 substances **or an agent or employee of the practitioner whom the practitioner has**  
18 **authorized to access the database on the practitioner's behalf,** to the extent the  
19 information relates specifically to a current patient of the practitioner to whom the  
20 practitioner is prescribing or considering prescribing a controlled substance; **the agent**  
21 **or employee must be licensed or registered under AS 08;**

22 (4) a licensed or registered pharmacist having authority to dispense  
23 controlled substances **or an agent or employee of the pharmacist whom the**  
24 **pharmacist has authorized to access the database on the pharmacist's behalf,** to  
25 the extent the information relates specifically to a current patient to whom the  
26 pharmacist is dispensing or considering dispensing a controlled substance; **the agent**  
27 **or employee must be licensed or registered under AS 08;**

28 (5) federal, state, and local law enforcement authorities may receive  
29 printouts of information contained in the database under a search warrant [,  
30 SUBPOENA,] or order issued by a court establishing probable cause for the access  
31 and use of the information; [AND]

1 (6) an individual who is the recipient of a controlled substance  
2 prescription entered into the database may receive information contained in the  
3 database concerning the individual on providing evidence satisfactory to the board that  
4 the individual requesting the information is in fact the person about whom the data  
5 entry was made and on payment of a fee set by the board under AS 37.10.050 that  
6 does not exceed \$10;

7 (7) a licensed pharmacist employed by the Department of Health  
8 and Social Services who is responsible for administering prescription drug  
9 coverage for the medical assistance program under AS 47.07, to the extent that  
10 the information relates specifically to prescription drug coverage under the  
11 program;

12 (8) a licensed pharmacist, licensed practitioner, or authorized  
13 employee of the Department of Health and Social Services responsible for  
14 utilization review of prescription drugs for the medical assistance program under  
15 AS 47.07, to the extent that the information relates specifically to utilization  
16 review of prescription drugs provided to recipients of medical assistance;

17 (9) the state medical examiner, to the extent that the information  
18 relates specifically to investigating the cause and manner of a person's death;

19 (10) an authorized employee of the Department of Health and  
20 Social Services may receive information from the database that does not disclose  
21 the identity of a patient, prescriber, dispenser, or dispenser location, for the  
22 purpose of identifying and monitoring public health issues in the state; however,  
23 the information provided under this paragraph may include the region of the  
24 state in which a patient, prescriber, and dispenser are located and the specialty of  
25 the prescriber; and

26 (11) a practitioner employed by the United States Indian Health  
27 Service.

28 \* Sec. 24. AS 17.30.200(e) is amended to read:

29 (e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to  
30 register or submit information to the database as required under this section is  
31 grounds for the board to take disciplinary action against the license or registration of

1 the pharmacy or pharmacist or for another licensing board to take disciplinary action  
2 against a practitioner.

3 \* **Sec. 25.** AS 17.30.200(h) is amended to read:

4 (h) An individual who has submitted information to the database in  
5 accordance with this section may not be held civilly liable for having submitted the  
6 information. [NOTHING IN THIS SECTION REQUIRES OR OBLIGATES A  
7 DISPENSER OR PRACTITIONER TO ACCESS OR CHECK THE DATABASE  
8 BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING A  
9 MEDICATION, OR PROVIDING MEDICAL CARE TO A PERSON.] Dispensers or  
10 practitioners may not be held civilly liable for damages for accessing or failing to  
11 access the information in the database.

12 \* **Sec. 26.** AS 17.30.200(k) is amended to read:

13 (k) In the regulations adopted under this section, the board shall provide

14 (1) that prescription information in the database [SHALL] be purged  
15 from the database after two years have elapsed from the date the prescription was  
16 dispensed;

17 (2) a method for an individual to challenge information in the database  
18 about the individual that the person believes is incorrect or was incorrectly entered by  
19 a dispenser;

20 **(3) a procedure and time frame for registration with the database;**

21 **(4) that a practitioner review the information in the database to**  
22 **check a patient's prescription records before dispensing, prescribing, or**  
23 **administering a schedule II or III controlled substance under federal law to the**  
24 **patient; the regulations must provide that a practitioner is not required to review**  
25 **the information in the database before dispensing, prescribing, or administering**

26 **(A) a controlled substance to a person who is receiving**  
27 **treatment**

28 **(i) in an inpatient setting;**

29 **(ii) at the scene of an emergency or in an ambulance;**  
30 **in this sub-subparagraph, "ambulance" has the meaning given in**  
31 **AS 18.08.200;**

1 (iii) in an emergency room;

2 (iv) immediately before, during, or within the first

3 48 hours after surgery or a medical procedure;

4 (v) in a hospice or nursing home that has an in-

5 house pharmacy; or

6 (B) a nonrefillable prescription of a controlled substance in

7 a quantity intended to last for not more than three days.

8 \* **Sec. 27.** AS 17.30.200 is amended by adding new subsections to read:

9 (o) A pharmacist who dispenses or a practitioner who prescribes, administers,  
10 or directly dispenses a schedule II, III, or IV controlled substance under federal law  
11 shall register with the database by a procedure and in a format established by the  
12 board.

13 (p) The board shall promptly notify the State Medical Board, the Board of  
14 Nursing, the Board of Dental Examiners, and the Board of Examiners in Optometry  
15 when a practitioner registers with the database under (o) of this section.

16 (q) The board is authorized to provide unsolicited notification to a pharmacist  
17 or practitioner if a patient has received one or more prescriptions for controlled  
18 substances in quantities or with a frequency inconsistent with generally recognized  
19 standards of safe practice.

20 (r) The board shall update the database on at least a weekly basis with the  
21 information submitted to the board under (b) of this section.

22 (s) The Department of Commerce, Community, and Economic Development  
23 shall

24 (1) assist the board and provide necessary staff and equipment to  
25 implement this section; and

26 (2) establish fees for registration with the database by a pharmacist or  
27 practitioner required to register under (o) of this section so that the total amount of  
28 fees collected by the department equals the total operational costs of the database  
29 minus all federal funds acquired for the operational costs of the database; in setting the  
30 fee levels, the department shall

31 (A) set the fees for registration with the database so that the

1 fees are the same for all practitioners and pharmacists required to register; and

2 (B) consult with the board to establish the fees under this  
3 subsection.

4 \* **Sec. 28.** AS 33.30.028 is amended by adding new subsections to read:

5 (c) The commissioner shall apply for medical assistance under AS 47.07 and  
6 for general relief assistance under AS 47.25.120 - 47.25.300 on behalf of a prisoner  
7 incarcerated in a correctional facility to establish medical assistance coverage or  
8 general relief assistance for the prisoner during a period of hospitalization outside of  
9 the correctional facility.

10 (d) The commissioner may obtain information necessary to determine whether  
11 a prisoner incarcerated in a correctional facility is eligible for medical assistance under  
12 AS 47.07 or public assistance under AS 47.25. Information obtained under this  
13 subsection may only be used for the purpose of applying for medical assistance or  
14 public assistance under (c) of this section and may not be disclosed for any other  
15 purpose without the permission of the prisoner. An employee of the commissioner  
16 who discloses a prisoner's social security number in an application for medical  
17 assistance or public assistance under this section is considered to be acting in the  
18 performance of the employee's duties or responsibilities under AS 45.48.400(b).

19 \* **Sec. 29.** AS 40.25.120(a) is amended by adding a new paragraph to read:

20 (15) records relating to proceedings under AS 09.58 (Alaska Medical  
21 Assistance False Claim and Reporting Act).

22 \* **Sec. 30.** AS 44.33 is amended by adding a new section to read:

23 **Article 5A. Telemedicine Business Registry.**

24 **Sec. 44.33.381. Telemedicine business registry.** (a) The department shall  
25 adopt regulations for establishing and maintaining a registry of businesses performing  
26 telemedicine services in the state.

27 (b) The department shall maintain the registry of businesses performing  
28 telemedicine services in the state. The registry must include the name, address, and  
29 contact information of businesses performing telemedicine services in the state.

30 (c) In this section,

31 (1) "department" means the Department of Commerce, Community,

1 and Economic Development;

2 (2) "telemedicine services" means the delivery of health care services  
3 using the transfer of medical data through audio, visual, or data communications that  
4 are performed over two or more locations by a provider who is physically separated  
5 from the recipient of the health care services.

6 \* **Sec. 31.** AS 47.05.015 is amended by adding a new subsection to read:

7 (e) Notwithstanding (c) of this section, the department may enter into a  
8 contract through the competitive bidding process under AS 36.30 (State Procurement  
9 Code) for medical assistance products and services offered under AS 47.07.030 if the  
10 contract is for durable medical equipment or specific medical services that can be  
11 delivered on a statewide basis.

12 \* **Sec. 32.** AS 47.05 is amended by adding a new section to article 1 to read:

13 **Sec. 47.05.105. Enhanced computerized eligibility verification system.** (a)  
14 The department shall establish an enhanced computerized income, asset, and identity  
15 eligibility verification system that uses remote identity proofing through multiple  
16 layers of authentication for the purposes of verifying eligibility, eliminating  
17 duplication of public assistance payments, and deterring waste and fraud in public  
18 assistance programs administered by the department under AS 47.05.010. Nothing in  
19 this section prohibits the department from verifying eligibility for public assistance  
20 through additional procedures or authorizes the department or a third-party vendor to  
21 use data to verify eligibility for a federal program if the use of that data is prohibited  
22 by federal law.

23 (b) The department shall enter into a competitively bid contract with a third-  
24 party vendor for the purpose of developing a system under this section to prevent  
25 fraud, misrepresentation, and inadequate documentation when determining an  
26 applicant's eligibility for public assistance before the payment of benefits and for  
27 periodically verifying eligibility between eligibility redeterminations and during  
28 eligibility redeterminations and reviews under AS 47.05.110 - 47.05.120. The  
29 department may also contract with a third-party vendor to provide information to  
30 facilitate reviews of recipient eligibility and income verification.

31 (c) The annual savings to the state resulting from the use of the system under

1 this section must exceed the cost of implementing the system. A contract under this  
2 section must require the third-party vendor to report annual savings to the state  
3 realized from implementing the system. Payment to the third-party vendor may be  
4 based on a fee for each applicant and may include incentives for achieving a rate of  
5 success established by the department for identifying duplication, waste, and fraud in  
6 public assistance programs.

7 (d) To avoid a conflict of interest, the department may not award a contract to  
8 provide services for the enrollment of public assistance providers or applicants under  
9 this title to a vendor that is awarded a contract under this section.

10 \* **Sec. 33.** AS 47.05.200(a) is amended to read:

11 (a) The department shall annually contract for independent audits of a  
12 statewide sample of all medical assistance providers in order to identify overpayments  
13 and violations of criminal statutes. The audits conducted under this section may not be  
14 conducted by the department or employees of the department. The number of audits  
15 under this section **may not be less than 50** each year [, AS A TOTAL FOR THE  
16 MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL  
17 BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE  
18 PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE  
19 DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS  
20 SECTION MAY NOT BE LESS THAN 75]. The audits under this section must  
21 include both on-site audits and desk audits and must be of a variety of provider types.  
22 The department may not award a contract under this subsection to an organization that  
23 does not retain persons with a significant level of expertise and recent professional  
24 practice in the general areas of standard accounting principles and financial auditing  
25 and in the specific areas of medical records review, investigative research, and Alaska  
26 health care criminal law. The contractor, in consultation with the commissioner, shall  
27 select the providers to be audited and decide the ratio of desk audits and on-site audits  
28 to the total number selected. **In identifying providers who are subject to an audit**  
29 **under this chapter, the department shall attempt to minimize concurrent state or**  
30 **federal audits.**

31 \* **Sec. 34.** AS 47.05.200(b) is amended to read:

1 (b) Within 90 days after receiving each audit report from an audit conducted  
2 under this section, the department shall begin administrative procedures to recoup  
3 overpayments identified in the audits and shall allocate the reasonable and necessary  
4 financial and human resources to ensure prompt recovery of overpayments unless the  
5 attorney general has advised the commissioner in writing that a criminal investigation  
6 of an audited provider has been or is about to be undertaken, in which case, the  
7 commissioner shall hold the administrative procedure in abeyance until a final  
8 charging decision by the attorney general has been made. The commissioner shall  
9 provide copies of all audit reports to the attorney general so that the reports can be  
10 screened for the purpose of bringing criminal charges. The department may assess  
11 interest and penalties on any identified overpayment. Interest under this  
12 subsection shall be calculated using the statutory rates for postjudgment interest  
13 accruing from the date of the issuance of the final agency decision to recoup  
14 overpayments identified in the audit. In this subsection, the date of issuance of  
15 the final agency decision is the later of the date of

16 (1) the department's written notification of the decision and the  
17 provider's appeal rights; or

18 (2) if timely appealed by the provider, a final agency decision  
19 under AS 44.64.060.

20 \* Sec. 35. AS 47.05 is amended by adding a new section to read:

21 **Sec. 47.05.235. Duty to identify and repay self-identified overpayments.** (a)  
22 Unless a provider is being audited under AS 47.05.200(a), an enrolled medical  
23 assistance provider shall conduct a biennial review or audit of a statistically valid  
24 sample of claims submitted to the department for reimbursement. If overpayments are  
25 identified, the medical assistance provider shall report the overpayment to the  
26 department not later than 10 business days after identification of the overpayment. The  
27 report must also identify how the medical assistance provider intends to repay the  
28 department. After the department receives the report, the medical assistance provider  
29 and the department shall enter into an agreement establishing a schedule for  
30 repayment of the identified overpayment. The agreement may authorize repayment in  
31 a lump sum, a payment plan, or by offsetting future billings as approved by the

1 department.

2 (b) The department may not assess interest or penalties on an overpayment  
3 identified and repaid by a medical assistance provider under this section.

4 \* **Sec. 36.** AS 47.05 is amended by adding new sections to read:

5 **Sec. 47.05.250. Civil penalties.** (a) The department may assess a civil penalty  
6 against a provider who violates this chapter, AS 47.07, or regulations adopted under  
7 this chapter or AS 47.07.

8 (b) The department shall adopt regulations establishing a range of civil  
9 penalties that the department may assess against a provider under this section. In  
10 establishing the range of civil penalties, the department shall take into account  
11 appropriate factors, including the seriousness of the violation, the service provided by  
12 the provider, and the severity of the penalty. The regulations may not provide for a  
13 civil penalty of less than \$100 or more than \$25,000 for each violation.

14 (c) The provisions of this section are in addition to any other remedies  
15 available under this chapter, AS 47.07, or regulations adopted under this chapter or  
16 AS 47.07.

17 (d) A provider against whom a civil penalty of less than \$2,500 is assessed  
18 may appeal the decision assessing the penalty to the commissioner or the  
19 commissioner's designee. The commissioner shall, by regulation, establish time limits  
20 and procedures for an appeal under this subsection. The decision of the commissioner  
21 or the commissioner's designee may be appealed to the office of administrative  
22 hearings established under AS 44.64.

23 (e) A provider against whom a civil penalty of \$2,500 or more is assessed may  
24 appeal the decision assessing the penalty to the office of administrative hearings  
25 established under AS 44.64.

26 **Sec. 47.05.270. Medical assistance reform program.** (a) The department  
27 shall adopt regulations to design and implement a program for reforming the state  
28 medical assistance program under AS 47.07. The reform program must include

29 (1) referrals to community and social support services, including career  
30 and education training services available through the Department of Labor and  
31 Workforce Development under AS 23.15, the University of Alaska, or other sources;

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

3 (3) expanding the use of telehealth for primary care, behavioral health,  
4 and urgent care;

5 (4) enhancing fraud prevention, detection, and enforcement;

6 (5) reducing the cost of behavioral health, senior, and disabilities  
7 services provided to recipients of medical assistance under the state's home and  
8 community-based services waiver under AS 47.07.045;

9 (6) pharmacy initiatives;

10 (7) enhanced care management;

11 (8) redesigning the payment process by implementing fee agreements  
12 that include one or more of the following:

13 (A) premium payments for centers of excellence;

14 (B) penalties for hospital-acquired infections, readmissions,  
15 and outcome failures;

16 (C) bundled payments for specific episodes of care; or

17 (D) global payments for contracted payers, primary care  
18 managers, and case managers for a recipient or for care related to a specific  
19 diagnosis;

20 (9) stakeholder involvement in setting annual targets for quality and  
21 cost-effectiveness;

22 (10) to the extent consistent with federal law, reducing travel costs by  
23 requiring a recipient to obtain medical services in the recipient's home community, to  
24 the extent appropriate services are available in the recipient's home community;

25 (11) guidelines for health care providers to develop health care  
26 delivery models supported by evidence-based practices that encourage wellness and  
27 disease prevention.

28 (b) The department shall, in coordination with the Alaska Mental Health Trust  
29 Authority, efficiently manage a comprehensive and integrated behavioral health  
30 program that uses evidence-based, data-driven practices to achieve positive outcomes  
31 for people with mental health or substance abuse disorders and children with severe

1 emotional disturbances. The goal of the program is to assist recipients of services  
2 under the program to recover by achieving the highest level of autonomy with the least  
3 dependence on state-funded services possible for each person. The program must  
4 include

5 (1) a plan for providing a continuum of community-based services to  
6 address housing, employment, criminal justice, and other relevant issues;

7 (2) services from a wide array of providers and disciplines, including  
8 licensed or certified mental health and primary care professionals; and

9 (3) efforts to reduce operational barriers that fragment services,  
10 minimize administrative burdens, and reduce the effectiveness and efficiency of the  
11 program.

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

19 (d) On or before November 15 of each year, the department shall prepare a  
20 report and submit the report to the senate secretary and the chief clerk of the house of  
21 representatives and notify the legislature that the report is available. The report must  
22 include

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

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

26 (3) a statement of whether the department has met annual targets for  
27 quality and cost-effectiveness;

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

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

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

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

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

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

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

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

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

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

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

23 (15) the amount of state funds saved as a result of implementing  
24 changes in federal policy authorizing 100 percent federal funding for services  
25 provided to American Indian and Alaska Native individuals eligible for Medicaid, and  
26 the estimated savings in state funds that could have been achieved if the department  
27 had fully implemented the changes in policy.

28 (e) In this section, "telehealth" means the practice of health care delivery,  
29 evaluation, diagnosis, consultation, or treatment, using the transfer of health care data  
30 through audio, visual, or data communications, performed over two or more locations  
31 between providers who are physically separated from the recipient or from each other

1 or between a provider and a recipient who are physically separated from each other.

2 \* **Sec. 37.** AS 47.07.030(d) is amended to read:

3 (d) The department **shall** [MAY] establish as optional services a primary care  
4 case management system or a managed care organization contract in which certain  
5 eligible individuals are required to enroll and seek approval from a case manager or  
6 the managed care organization before receiving certain services. **The purpose of a**  
7 **primary care case management system or managed care organization contract is**  
8 **to increase the use of appropriate primary and preventive care by medical**  
9 **assistance recipients, while decreasing the unnecessary use of specialty care and**  
10 **hospital emergency department services.** The department shall

11 (1) establish enrollment criteria and determine eligibility for services  
12 consistent with federal and state law; **the department shall require recipients with**  
13 **multiple hospitalizations to enroll in a primary care case management system or**  
14 **with a managed care organization under this subsection, except that the**  
15 **department may exempt recipients with chronic, acute, or terminal medical**  
16 **conditions from the requirement under this paragraph;**

17 (2) **define the coordinated care services and provider types eligible**  
18 **to participate as primary care providers;**

19 (3) **create a performance and quality reporting system; and**

20 (4) **integrate the coordinated care demonstration projects**  
21 **described under AS 47.07.039 and the demonstration projects described under**  
22 **AS 47.07.036(e) with the primary care case management system or managed care**  
23 **organization contract established under this subsection.**

24 \* **Sec. 38.** AS 47.07.036 is amended by adding new subsections to read:

25 (d) Notwithstanding (a) - (c) of this section, the department may

26 (1) apply for a section 1915(i) option under 42 U.S.C. 1396n to  
27 improve services and care through home and community-based services to obtain, at a  
28 minimum, a 50 percent federal match;

29 (2) apply for a section 1915(k) option under 42 U.S.C. 1396n to  
30 provide home and community-based services and support to increase the federal match  
31 for these programs from 50 percent to 56 percent;

1 (3) apply for a section 1945 option under 42 U.S.C. 1396w-4 to  
2 provide coordinated care through health homes for individuals with chronic conditions  
3 and to increase the federal match for the services to 90 percent for the first eight  
4 quarters the required state plan amendment is in effect;

5 (4) evaluate and seek permission from the United States Department of  
6 Health and Human Services Centers for Medicare and Medicaid Services to participate  
7 in various demonstration projects, including payment reform, care management  
8 programs, workforce development and innovation, and innovative services delivery  
9 models; and

10 (5) provide incentives for telehealth, including increasing the  
11 capability for and reimbursement of telehealth for recipients.

12 (e) Notwithstanding (a) - (c) of this section, and in addition to the projects and  
13 services described under (d) and (f) of this section, the department shall apply for a  
14 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration  
15 projects focused on innovative payment models for one or more groups of medical  
16 assistance recipients in one or more specific geographic areas. The demonstration  
17 project or projects may include

18 (1) managed care organizations as described under 42 U.S.C. 1396u-2;

19 (2) community care organizations;

20 (3) patient-centered medical homes as described under 42 U.S.C. 256a-  
21 1; or

22 (4) other innovative payment models that ensure access to health care  
23 without reducing the quality of care.

24 (f) Notwithstanding (a) - (c) of this section, and in addition to the projects and  
25 services described under (d) and (e) of this section, the department shall apply for a  
26 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration  
27 projects focused on improving the state's behavioral health system for medical  
28 assistance recipients. The department shall engage stakeholders and the community in  
29 the development of a project or projects under this subsection. The demonstration  
30 project or projects must

31 (1) be consistent with the comprehensive and integrated behavioral

1 health program described under AS 47.05.270(b); and

2 (2) include continuing support for and cooperation with the grant-  
3 funded community mental health clinics and drug and alcohol treatment centers that  
4 have historically provided care to recipients of behavioral health services.

5 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

6 \* **Sec. 39.** AS 47.07 is amended by adding new sections to read:

7 **Sec. 47.07.038. Collaborative, hospital-based project to reduce use of**  
8 **emergency department services.** (a) On or before December 1, 2016, the department  
9 shall collaborate with a statewide professional hospital association to establish a  
10 hospital-based project to reduce the use of emergency department services by medical  
11 assistance recipients. The statewide professional hospital association shall operate the  
12 project. The project may include shared savings for participating hospitals. The project  
13 must include

14 (1) an interdisciplinary process for defining, identifying, and  
15 minimizing the number of frequent users of emergency department services;

16 (2) to the extent consistent with federal law, a system for real-time  
17 electronic exchange of patient information, including recent emergency department  
18 visits, hospital care plans for frequent users of emergency departments, and data from  
19 the controlled substance prescription database;

20 (3) a procedure for educating patients about the use of emergency  
21 departments and appropriate alternative services and facilities for nonurgent care;

22 (4) a process for assisting users of emergency departments in making  
23 appointments with primary care or behavioral health providers within 96 hours after  
24 an emergency department visit;

25 (5) a collaborative process between the department and the statewide  
26 professional hospital association to establish uniform statewide guidelines for  
27 prescribing narcotics in an emergency department; and

28 (6) designation of health care personnel to review successes and  
29 challenges regarding appropriate emergency department use.

30 (b) The department shall adopt regulations necessary to implement this  
31 section, request technical assistance from the United States Department of Health and

1 Human Services, and apply to the United States Department of Health and Human  
2 Services for waivers or amendments to the state plan as necessary to implement the  
3 projects under this section.

4 **Sec. 47.07.039. Coordinated care demonstration projects.** (a) The  
5 department shall contract with one or more third parties to implement one or more  
6 coordinated care demonstration projects for recipients of medical assistance identified  
7 by the department. The purpose of a demonstration project under this section is to  
8 assess the efficacy of a proposed health care delivery model with respect to cost for,  
9 access to, and quality of care for medical assistance recipients. The department may  
10 contract for separate demonstration projects to coordinate care for different groups of  
11 medical assistance recipients to achieve more effective care for recipients at greater  
12 cost savings for the medical assistance program. The department shall request  
13 proposals for at least one project under this section on or before December 31, 2016,  
14 and may annually request proposals for additional projects under this section  
15 thereafter. The department may use an innovative procurement process as described  
16 under AS 36.30.308 to award a contract for a project under this section. A proposal for  
17 a demonstration project under this section must be submitted to the committee  
18 established under (b) of this section and must include three or more of the following  
19 elements:

20 (1) comprehensive primary-care-based management for medical  
21 assistance services, including behavioral health services and coordination of long-term  
22 services and support;

23 (2) care coordination, including the assignment of a primary care  
24 provider located in the local geographic area of the recipient, to the extent practical;

25 (3) health promotion;

26 (4) comprehensive transitional care and follow-up care after inpatient  
27 treatment;

28 (5) referral to community and social support services, including career  
29 and education training services available through the Department of Labor and  
30 Workforce Development under AS 23.15, the University of Alaska, or other sources;

31 (6) sustainability and the ability to achieve similar results in other

1 regions of the state;

2 (7) integration and coordination of benefits, services, and utilization  
3 management;

4 (8) local accountability for health and resource allocation;

5 (9) an innovative payment process, including bundled payments or  
6 global payments.

7 (b) A project review committee is established in the department for the  
8 purpose of reviewing proposals for demonstration projects under this section. The  
9 project review committee consists of

10 (1) the commissioner of the department, or the commissioner's  
11 designee;

12 (2) the commissioner of administration, or the commissioner's  
13 designee;

14 (3) the chief executive officer of the Alaska Mental Health Trust  
15 Authority, or the chief executive officer's designee, who shall serve as chair of the  
16 committee;

17 (4) two representatives of stakeholder groups, appointed by the  
18 governor for staggered three-year terms, as follows:

19 (A) one representative of a stakeholder group who has direct  
20 experience with health plan management and cost control for the medical  
21 assistance population;

22 (B) one representative of a stakeholder group who has direct  
23 experience with health plan management and cost control for a nongovernment  
24 employer of 500 or more employees in the state;

25 (5) a nonvoting member who is a member of the senate, appointed by  
26 the president of the senate; and

27 (6) a nonvoting member who is a member of the house of  
28 representatives, appointed by the speaker of the house of representatives.

29 (c) The department may contract with a managed care organization, primary  
30 care case manager, accountable care organization, prepaid ambulatory health plan, or  
31 provider-led entity to implement a demonstration project under this section. The fee

1 structure for a contract under this subsection may include global payments, bundled  
2 payments, capitated payments, shared savings and risk, or other payment structures.  
3 The department shall work with the division of insurance, Department of Commerce,  
4 Community, and Economic Development, to streamline the application process for a  
5 company to obtain a certificate of authority required under AS 21.09.010 as necessary  
6 to participate in a demonstration project under this section.

7 (d) A proposal for a demonstration project under this section must include, in  
8 addition to the elements required under (a) of this section, information demonstrating  
9 how the project will implement additional cost-saving measures including innovations  
10 to reduce the cost of care for medical assistance recipients through the expanded use  
11 of telehealth for primary care, urgent care, and behavioral health services. The  
12 department shall identify legal or cost barriers preventing the expanded use of  
13 telehealth and shall recommend remedies for identified barriers.

14 (e) The department shall contract with a third-party actuary to review  
15 demonstration projects established under this section. The actuary shall review each  
16 demonstration project after two years of implementation and make recommendations  
17 for the implementation of a similar project on a statewide basis. The actuary shall  
18 evaluate each project based on cost savings for the medical assistance program, health  
19 outcomes for participants in the project, and the ability to achieve similar results on a  
20 statewide basis. On or before December 31 of each year starting in 2018, the actuary  
21 shall submit a final report to the department regarding any demonstration project that  
22 has been in operation for at least two years.

23 (f) The department shall prepare a plan regarding regional or statewide  
24 implementation of a coordinated care project based on the results of the demonstration  
25 projects under this section. On or before November 15, 2019, the department shall  
26 submit the plan to the senate secretary and the chief clerk of the house of  
27 representatives and notify the legislature that the plan is available. On or before  
28 November 15 of each year thereafter, the department shall submit a report regarding  
29 any changes or recommendations regarding the plan developed under this subsection  
30 to the senate secretary and the chief clerk of the house of representatives and notify the  
31 legislature that the report is available.

1 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

2 \* **Sec. 40.** AS 47.07 is amended by adding a new section to read:

3 **Sec. 47.07.076. Reports to legislature.** (a) The department and the attorney  
4 general shall annually prepare a report relating to the medical assistance program  
5 under AS 47.07. The report must include the following information:

6 (1) the amount and source of funds used to prevent or prosecute fraud,  
7 abuse, payment errors, and errors in eligibility determinations for the previous fiscal  
8 year;

9 (2) actions taken to address fraud, abuse, payment errors, and errors in  
10 eligibility determinations during the previous fiscal year;

11 (3) specific examples of fraud or abuse that were prevented or  
12 prosecuted;

13 (4) identification of vulnerabilities in the medical assistance program,  
14 including any vulnerabilities identified by independent auditors with whom the  
15 department contracts under AS 47.05.200;

16 (5) initiatives the department has taken to prevent fraud or abuse;

17 (6) recommendations to increase effectiveness in preventing and  
18 prosecuting fraud and abuse;

19 (7) the return to the state for every dollar expended by the department  
20 and the attorney general to prevent and prosecute fraud and abuse;

21 (8) the most recent payment error rate measurement report for the  
22 medical assistance program, including fee for service programs and pilot or  
23 demonstration projects; the report must also explain the reasons for the payment errors  
24 and the total amount of state and federal funds paid in error during the reporting period  
25 and not recovered by the department at the time of the report;

26 (9) results from the Medicaid Eligibility Quality Control program.

27 (b) On or before November 15 of each year, the department shall submit the  
28 report required under (a) of this section to the senate secretary and the chief clerk of  
29 the house of representatives and notify the legislature that the report is available.

30 (c) On or before December 15 and June 15 of each year, the department shall  
31 prepare a semi-annual report and submit the report to the senate secretary and the chief

1 clerk of the house of representatives and notify the legislature that the report is  
2 available. The report must include

3 (1) updates and status reports on the Medicaid Management  
4 Information System, including progress toward federal certification of the system,  
5 current measurements of the accuracy of the system, timeliness of payment of claims,  
6 and any backlog of claims; and

7 (2) information on the status of an administrative or legal proceeding  
8 relating to resolution of claims against the system contractor and related financial  
9 effects on the state.

10 \* **Sec. 41.** AS 47.07.900(4) is amended to read:

11 (4) "clinic services" means services provided by state-approved  
12 outpatient community mental health clinics [THAT RECEIVE GRANTS UNDER  
13 AS 47.30.520 - 47.30.620], state-operated community mental health clinics, outpatient  
14 surgical care centers, and physician clinics;

15 \* **Sec. 42.** AS 47.07.900(17) is amended to read:

16 (17) "rehabilitative services" means services for substance abusers and  
17 emotionally disturbed or chronically mentally ill adults provided by

18 (A) a drug or alcohol treatment center [THAT IS FUNDED  
19 WITH A GRANT UNDER AS 47.30.475]; or

20 (B) an outpatient community mental health clinic [THAT HAS  
21 A CONTRACT TO PROVIDE COMMUNITY MENTAL HEALTH  
22 SERVICES UNDER AS 47.30.520 - 47.30.620];

23 \* **Sec. 43.** AS 47.25.140(a) is amended to read:

24 (a) Payment under AS 47.25.120 - 47.25.300 may not be made to or on behalf  
25 of an individual who is a resident of a public institution, except as a patient in a public  
26 medical institution, or an individual who is a patient in a public or private institution  
27 for tuberculosis or mental disease, or as provided under AS 33.30.028(c). A resident  
28 of a public institution who is otherwise eligible to receive an allowance under  
29 AS 47.25.120 - 47.25.300 may apply for the allowance instead of the support and  
30 maintenance provided in the public institution.

31 \* **Sec. 44.** AS 47.55.020(e) is amended to read:

1 (e) As a condition for receipt of payment assistance under (d) of this section,  
2 the department, under regulations adopted by the department, **shall** [MAY] require a  
3 person to

4 (1) apply for other state or federally sponsored programs that may  
5 reduce the amount of the payment assistance; **and**

6 (2) **submit to the department a copy of the person's application for**  
7 **medical assistance coverage under AS 47.07 and the decision letter the person**  
8 **receives regarding the application.**

9 \* **Sec. 45.** AS 09.58.020, 09.58.030, 09.58.040, 09.58.050, and 09.58.060 are repealed  
10 July 1, 2019.

11 \* **Sec. 46.** AS 47.07.076(c) is repealed.

12 \* **Sec. 47.** The uncodified law of the State of Alaska is amended by adding a new section to  
13 read:

14 **INDIRECT COURT RULE AMENDMENTS.** (a) AS 09.58.010, added by sec. 18 of  
15 this Act, has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, by  
16 providing that the state is entitled to full reasonable attorney fees and costs if the state prevails  
17 in a civil action under AS 09.58.010 - 09.58.060 that involves fraud, or reasonable attorney  
18 fees and costs if the state prevails in a civil action under AS 09.58.010 - 09.58.060 that does  
19 not involve fraud.

20 (b) AS 09.58.020, added by sec. 18 of this Act, and repealed by sec. 45 of this Act,  
21 has the effect of amending the following court rules in the manner specified from the effective  
22 date of sec. 18 of this Act until July 1, 2019:

23 (1) Rules 4, 5, 7, and 12, Alaska Rules of Civil Procedure, by requiring that a  
24 complaint under AS 09.58 be filed in camera and under seal and may not be served on the  
25 defendant until unsealed and that a copy of the complaint be served on the attorney general;

26 (2) Rules 41 and 77, Alaska Rules of Civil Procedure, by authorizing the  
27 attorney general to move for dismissal of a complaint filed by another person under  
28 AS 09.58.020, added by sec. 18 of this Act and repealed by sec. 45 of this Act, and requiring  
29 court approval for dismissal of the action.

30 (c) AS 09.58.025, added by sec. 18 of this Act, and amended by sec. 19 of this Act,  
31 has the effect of amending Rule 27, Alaska Rules of Civil Procedure, by authorizing the

1 attorney general to issue subpoenas as part of an investigation

2 (1) under AS 09.58.015, added by sec. 18 of this Act, from the effective date  
3 of sec. 18 of this Act; and

4 (2) under AS 09.58.020, added by sec. 18 of this Act, from the effective date  
5 of sec. 18 of this Act until July 1, 2019.

6 (d) AS 09.58.030, added by sec. 18 of this Act, and repealed by sec. 45 of this Act,  
7 has the effect of amending the following court rules in the manner specified from the effective  
8 date of sec. 18 of this Act until July 1, 2019:

9 (1) Rule 24, Alaska Rules of Civil Procedure, by authorizing the attorney  
10 general to intervene in a civil action filed by another person under AS 09.58.020 added by  
11 sec. 18 of this Act, and repealed by sec. 45 of this Act, and limiting the participation of a party  
12 to the litigation;

13 (2) Rules 26 and 27, Alaska Rules of Civil Procedure, by authorizing the  
14 attorney general to request that the court issue a stay of discovery for a 90-day period, or  
15 longer upon a showing by the attorney general.

16 (e) AS 09.58.040, added by sec. 18 of this Act, and repealed by sec. 45 of this Act,  
17 has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, from the  
18 effective date of sec. 18 of this Act until July 1, 2019, by giving a person who brings an action  
19 under AS 09.58.020, added by sec. 18 of this Act, and repealed by sec. 45 of this Act, the  
20 right to reasonable attorney fees and costs in an action prosecuted by the attorney general, and  
21 to full reasonable attorney fees and costs if the person prevails in an action not prosecuted by  
22 the attorney general that involves fraud, or reasonable attorney fees and costs in a case that  
23 does not involve fraud.

24 \* **Sec. 48.** The uncodified law of the State of Alaska is amended by adding a new section to  
25 read:

26 **IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT.**

27 (a) The Department of Health and Social Services shall collaborate with Alaska tribal health  
28 organizations and the United States Department of Health and Human Services to fully  
29 implement changes in federal policy that authorize 100 percent federal funding for services  
30 provided to American Indian and Alaska Native individuals eligible for Medicaid.

31 (b) Within 30 days after the date the Centers for Medicare and Medicaid Services

1 issues a final policy regarding the circumstances in which 100 percent federal funding is  
2 available for medical assistance services received through the United States Indian Health  
3 Service or tribal health facilities, the Department of Health and Social Services shall notify  
4 and submit a report to the co-chairs of the house and senate finance committees of the Alaska  
5 State Legislature that includes an estimate of the savings to the state resulting from the final  
6 policy. Within six months after the date the Centers for Medicare and Medicaid Services  
7 issues the final policy, the Department of Health and Social Services shall fully implement the  
8 policy in the state.

9 (c) In this section, "Alaska tribal health organization" means an organization  
10 recognized by the United States Indian Health Service to provide health-related services.

11 \* **Sec. 49.** The uncodified law of the State of Alaska is amended by adding a new section to  
12 read:

13 HEALTH INFORMATION INFRASTRUCTURE PLAN. (a) The Department of  
14 Health and Social Services shall develop a health information infrastructure plan to strengthen  
15 the health information infrastructure, including health data analytics capability. The purpose  
16 of the health information infrastructure plan is to transform the health care system in the state  
17 by providing

18 (1) data required by health care providers for care coordination and quality  
19 improvement; and

20 (2) the information support required by the Department of Health and Social  
21 Services and health care providers to enable development and implementation of the other  
22 provisions of this Act.

23 (b) To the greatest extent practicable, the health information infrastructure plan will  
24 leverage existing resources, including the health information exchange, and will identify  
25 opportunities for integrating and streamlining health data systems administered by the state.

26 \* **Sec. 50.** The uncodified law of the State of Alaska is amended by adding a new section to  
27 read:

28 FEASIBILITY STUDIES FOR THE PROVISION OF SPECIFIED STATE  
29 SERVICES. (a) The Department of Health and Social Services, in conjunction with the  
30 Alaska Mental Health Trust Authority, shall procure a study analyzing the feasibility of  
31 privatizing services delivered at the Alaska Psychiatric Institute. The Department of Health

1 and Social Services and the Alaska Mental Health Trust Authority shall deliver a joint report  
2 summarizing the conclusions of the Department of Health and Social Services and the Alaska  
3 Mental Health Trust Authority to the senate secretary and the chief clerk of the house of  
4 representatives and notify the legislature that the report is available within 10 days after the  
5 convening of the First Regular Session of the Thirtieth Alaska State Legislature.

6 (b) The Department of Administration shall, in collaboration with the house and  
7 senate finance committees, procure a study to be completed on or before June 30, 2017, to  
8 determine the feasibility of creating a health care authority to coordinate health care plans and  
9 consolidate purchasing effectiveness for all state employees, retired state employees, retired  
10 teachers, medical assistance recipients, University of Alaska employees, employees of state  
11 corporations, and school district employees and to develop appropriate benefit sets, rules,  
12 cost-sharing, and payment structures for all employees and individuals whose health care  
13 benefits are funded directly or indirectly by the state, with the goal of achieving the greatest  
14 possible savings to the state through a coordinated approach administered by a single entity.  
15 In developing the study, the Department of Administration shall seek input from the  
16 Department of Health and Social Services, administrators familiar with managing government  
17 employee health plans, and human resource professionals familiar with self-insured health  
18 care plans. The study must

- 19 (1) identify cost-saving strategies that a health care authority could implement;
- 20 (2) analyze local government participation in the authority;
- 21 (3) analyze a phased approach to adding groups to the health care plans  
22 coordinated by the health care authority;
- 23 (4) consider previous studies procured by the Department of Administration  
24 and the legislature;
- 25 (5) assess the use of community-related health insurance risk pools and the use  
26 of the private marketplace;
- 27 (6) identify organizational models for a health care authority, including private  
28 for-profit, private nonprofit, government, and state corporations; and
- 29 (7) include a public review and comment opportunity for employers,  
30 employees, medical assistance recipients, retirees, and health care providers.

31 (c) In this section, "school district" has the meaning given in AS 14.30.350.

1     \* **Sec. 51.** The uncodified law of the State of Alaska is amended by adding a new section to  
2 read:

3             REPORT TO LEGISLATURE. (a) The Board of Pharmacy, Board of Examiners in  
4 Optometry, Board of Dental Examiners, Board of Nursing, and State Medical Board shall  
5 jointly prepare a report that describes recommended guidelines for the prescription of  
6 schedule II controlled substances listed under federal law. The guidelines must be drafted  
7 with the goal of reducing the over-prescription of pain killers and highly addictive schedule II  
8 controlled substances. The report must include

9                     (1) the following recommended guidelines for each schedule II controlled  
10 substance listed under federal law:

11                             (A) quantity and strength of each dosage;

12                             (B) number of doses for each day;

13                             (C) number of days the drug may be prescribed; and

14                     (2) other recommendations related to reducing the over-prescription of  
15 schedule II controlled substances.

16             (b) On or before January 1, 2017, the Board of Pharmacy, Board of Examiners in  
17 Optometry, Board of Dental Examiners, Board of Nursing, and State Medical Board shall  
18 jointly deliver the report required under (a) of this section to the senate secretary and the chief  
19 clerk of the house of representatives and notify the legislature that the report is available.

20     \* **Sec. 52.** The uncodified law of the State of Alaska is amended by adding a new section to  
21 read:

22             MEDICAID STATE PLAN; WAIVERS; INSTRUCTIONS; NOTICE TO REVISOR  
23 OF STATUTES. The Department of Health and Social Services shall amend and submit for  
24 federal approval a state plan for medical assistance coverage consistent with this Act. The  
25 Department of Health and Social Services shall apply to the United States Department of  
26 Health and Human Services for any waivers necessary to implement this Act. The  
27 commissioner of health and social services shall certify to the revisor of statutes if the  
28 provisions of AS 47.05.270(a)(5), (8), and (10), added by sec. 36 of this Act, and the  
29 provisions of AS 47.07.038, added by sec. 39 of this Act, are approved by the United States  
30 Department of Health and Human Services.

31     \* **Sec. 53.** The uncodified law of the State of Alaska is amended by adding a new section to

1 read:

2 TRANSITION: REGULATIONS. (a) The Department of Health and Social Services  
3 may adopt regulations necessary to implement the changes made by this Act. The regulations  
4 take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date  
5 of the relevant provision of this Act implemented by the regulation.

6 (b) The Department of Commerce, Community, and Economic Development and a  
7 board that regulates an occupation that includes a practitioner who is required to register with  
8 the controlled substances database under AS 17.30.200 shall adopt regulations to implement  
9 the changes made by AS 08.36.070(a), as amended by sec. 5 of this Act, AS 08.64.101(7),  
10 added by sec. 7 of this Act, AS 08.68.100(a), as amended by sec. 10 of this Act,  
11 AS 08.72.060(c), as amended by sec. 11 of this Act, AS 08.80.030(b), as amended by sec. 12  
12 of this Act, AS 17.30.200(a), as amended by sec. 21 of this Act, AS 17.30.200(b), as amended  
13 by sec. 22 of this Act, AS 17.30.200(d), as amended by sec. 23 of this Act, AS 17.30.200(e),  
14 as amended by sec. 24 of this Act, AS 17.30.200(h), as amended by sec. 25 of this Act,  
15 AS 17.30.200(k), as amended by sec. 25 of this Act, and AS 17.30.200(o) - (s), enacted by  
16 sec. 27 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure  
17 Act), but not before the effective date of the relevant provisions of secs. 5, 7, 10, 11, 12, or 21  
18 - 27 of this Act. In this subsection,

19 (1) "board" has the meaning given in AS 08.01.110;

20 (2) "occupation" has the meaning given in AS 08.01.110;

21 (3) "practitioner" has the meaning given in AS 11.71.900.

22 \* **Sec. 54.** The uncodified law of the State of Alaska is amended by adding a new section to  
23 read:

24 CONDITIONAL EFFECT. (a) AS 47.05.270(a)(5), enacted by sec. 36 of this Act,  
25 takes effect only if the commissioner of health and social services certifies to the revisor of  
26 statutes under sec. 52 of this Act, on or before October 1, 2017, that all of the provisions  
27 added by AS 47.05.270(a)(5) have been approved by the United States Department of Health  
28 and Human Services.

29 (b) AS 47.05.270(a)(8), enacted by sec. 36 of this Act, takes effect only if the  
30 commissioner of health and social services certifies to the revisor of statutes under sec. 52 of  
31 this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.270(a)(8)

1 have been approved by the United States Department of Health and Human Services.

2 (c) AS 47.05.270(a)(10), enacted by sec. 36 of this Act, takes effect only if the  
3 commissioner of health and social services certifies to the revisor of statutes under sec. 52 of  
4 this Act, on or before October 1, 2017, that all of the provisions added by  
5 AS 47.05.270(a)(10) have been approved by the United States Department of Health and  
6 Human Services.

7 (d) AS 47.07.038, enacted by sec. 39 of this Act, takes effect only if the commissioner  
8 of health and social services certifies to the revisor of statutes under sec. 52 of this Act, on or  
9 before October 1, 2017, that all of the provisions added by AS 47.07.038 have been approved  
10 by the United States Department of Health and Human Services.

11 (e) AS 09.58.020, added by sec. 18 of this Act, AS 09.58.025, added by sec. 18 of this  
12 Act, AS 09.58.030, added by sec. 18 of this Act, and AS 09.58.040, added by sec. 18 of this  
13 Act, the amendment to AS 09.58.025 by sec. 19 of this Act, and the repeals of AS 09.58.020,  
14 09.58.030, and 09.58.040, by sec. 45 of this Act, take effect only if sec. 47 of this Act receives  
15 the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the  
16 State of Alaska.

17 (f) Section 46 of this Act takes effect only if the commissioner of health and social  
18 services certifies to the revisor of statutes that the Medicaid Management Information System  
19 has been certified by the United States Department of Health and Human Services.

20 \* **Sec. 55.** If AS 47.05.270(a)(5), enacted by sec. 36 of this Act, takes effect, it takes effect  
21 on the day after the date the commissioner of health and social services makes a certification  
22 to the revisor of statutes under secs. 52 and 54(a) of this Act.

23 \* **Sec. 56.** If AS 47.05.270(a)(8), enacted by sec. 36 of this Act, takes effect, it takes effect  
24 on the day after the date the commissioner of health and social services makes a certification  
25 to the revisor of statutes under secs. 52 and 54(b) of this Act.

26 \* **Sec. 57.** If AS 47.05.270(a)(10), enacted by sec. 36 of this Act, takes effect, it takes effect  
27 on the day after the date the commissioner of health and social services makes a certification  
28 to the revisor of statutes under secs. 52 and 54(c) of this Act.

29 \* **Sec. 58.** If AS 47.07.038, enacted by sec. 36 of this Act, takes effect, it takes effect on the  
30 day after the date the commissioner of health and social services makes a certification to the  
31 revisor of statutes under secs. 52 and 54(d) of this Act.

- 1     \* **Sec. 59.** If sec. 46 of this Act takes effect, it takes effect on the day after the date the  
2 commissioner of health and social services makes a certification to the revisor of statutes  
3 under sec. 54(f) of this Act.
- 4     \* **Sec. 60.** Sections 50, 52, 53, and 54 of this Act take effect immediately under  
5 AS 01.10.070(c).
- 6     \* **Sec. 61.** Sections 5, 10 - 12, and 21 - 26 of this Act, AS 08.64.101(7), enacted by sec. 7 of  
7 this Act, and AS 17.30.200(o) - (r), enacted by sec. 27 of this Act, take effect January 1, 2017.
- 8     \* **Sec. 62.** AS 47.07.076(c), enacted by sec. 40 of this Act, takes effect July 1, 2016.
- 9     \* **Sec. 63.** AS 17.30.200(s), enacted by sec. 27 of this Act, takes effect September 1, 2016.
- 10    \* **Sec. 64.** Sections 19 and 20 of this Act take effect July 1, 2019.



THE STATE  
of **ALASKA**  
GOVERNOR BILL WALKER

Department of  
Health and Social Services

ALASKA COMMISSION ON AGING

P.O. Box 110693  
Juneau, Alaska 99811-0693  
Main: 907.465.3250  
Fax: 907.465.1398

April 4, 2016

The Honorable Mark Neuman, Co-Chair  
The Honorable Steve Thompson, Co-Chair  
House Finance Committee  
Alaska State Capitol, Rooms 505 & 515  
Juneau, Alaska 99811-1182

**Subject: Senior Input on Medicaid Reform, CSSB 74**

Dear Co-Chair Neuman and Co-Chair Thompson:

The Alaska Commission on Aging is a Governor-appointed body within the Department of Health and Social Services that serves to ensure the dignity and independence of all older Alaskans by addressing their needs through planning, advocacy, and education through interagency coordination efforts. Home- and community-based long-term support services, such as those provided through the Alaskans Living Independently waiver and Personal Care Assistance Medicaid programs, support seniors who are income-eligible and require assistance with activities of daily living so that they may live in their homes and communities for as long as possible, thus preventing the need for higher cost institutional care. Under the former Administration, the Commission provided recommendations to the Medicaid Reform Advisory Group and serves as a current member of the Department of Health and Social Services Medicaid Redesign Key Partner Committee. We would like to take this opportunity to share with you input that we received from seniors regarding the State's efforts to reform Medicaid.

Based on findings from the 2014-2015 Alaska Senior Survey, access to health care was identified as the most pressing concern for Alaska seniors according to 48% of the 2,280 survey respondents age 55 years and older. Last fall, the Commission conducted four community forums held at senior centers in Anchorage, Fairbanks, Juneau, and the Mat-Su Borough to share information about the proposed Medicaid health care reform efforts and to request input from the senior community regarding them. We used a modified version of the Department of Health and Social Services Medicaid Redesign "Meeting in a Box" power point for these presentations targeting a senior audience. Forty-five participants attended the community forums representing mostly seniors as well as family caregivers, senior providers, and other public members. The following summarizes their recommendations for Medicaid health care reform as they relate to CSSB 74.

- **Improve access to information:** Seniors asked for clear instruction of how public members can access medical assistance health care services and to have this information communicated in multiple media formats such as television, radio, and the newspaper, as well as by electronic means. They also requested to have this information distributed to senior centers, adult day programs, Aging and Disability Resource Centers, and other senior congregate settings. Participants noted that information about Medicaid services is complicated and confusing. Improved access to concise and easy to understand information about Medicaid was a consistent theme identified across all forums and was emphasized as an important element of a "high functioning" health care system.

- **Strengthen access to comprehensive and integrated health care:** Seniors depend on primary care providers for the majority of their health care needs. Forum participants noted their strong desire for a patient-centered health care system that provides medical and behavioral health care services in the primary care setting. This integrated approach has shown to work well for seniors, particularly for those with untreated behavioral health care needs, as older people obtain the majority of their health care services in the primary care setting.
- **Patient case management:** Forum participants identified case management as a vital component of Medicaid health care reform particularly for individuals with multiple chronic care needs, persons with dementia, and those newly discharged from the hospital or nursing home. The role of the patient case manager is critical to ensure that patients and caregivers are following prescribed medical/aftercare discharge instructions, connecting with appropriate home- and community-based services to support health and recovery efforts, and to enhance home safety by inspecting and coordinating modification efforts to reduce the risk for falls and prevent injury. Further, frail seniors, persons with sensory loss, and those with cognitive impairments who do not have a trusted family member or friend to accompany them to medical appointments would benefit from a patient case manager to facilitate an accurate exchange of information between the patient and their doctor and to engage patients in decision-making affecting their care. Forum participants were quick to note that appropriate aftercare promotes a safe, speedy, and less costly recovery following discharge.
- **Family caregivers:** Families and other natural support caregivers provide the foundation of long-term care for seniors and others with disabilities. Without family caregivers, the cost of long-term care would increase astronomically for the State. This care, however, often comes at a high cost to caregiver health and finances, especially for those who care for loved ones at home with dementia. Forum participants observed that targeted training and supports, such as respite and counseling, could reduce personal caregiver costs and extend the amount of time caregivers are able to provide quality care to their loved ones at home. Participants asked that family caregiver supports and training be included as a Medicaid reform strategy to control rising long-term care costs in Alaska.
- **Telehealth:** Forum participants expressed their support for implementing greater use of telehealth in order to address Alaska's shortage of healthcare providers, to enhance access to specialty services such as geriatric health care and dementia care, and to improve access to health care in rural and remote settings utilizing licensed Alaskan health care providers.
- **Reduce Prescription Costs:** The rising cost of prescriptions is a significant financial burden for seniors who take multiple medications as well as Alaska's health care system. To reduce prescription costs, forum participants recommended that the State have the means to purchase commonly used prescriptions by seniors, such as medications for high blood pressure and diabetes, in bulk following the existing practice used for vaccine bulk purchases.
- **Enhance Personal Care Assistance and Waiver Services:** Forum participants underscored the need to increase the availability of these comparatively low cost services to improve senior health and safety as well as preventing the need for more costly institutional care. Many expressed concern that the State was imposing stricter eligibility requirements limiting access to services by those who are in need, increasing their risk for higher cost care.
- **Implement patient incentives to improve health outcomes:** Forum participants also recommended that the State reward Medicaid enrollees who practice health and wellness activities, such as those who quit smoking, reduce alcohol consumption, or engage in regular exercise programs, with reduced

health care premiums. By incentivizing patients, improved health outcomes can be achieved along with a corresponding savings in health care costs.

- **Medicaid State Plan Options:** Forum participants expressed support for implementing Medicaid State Plan options, including the 1915 (i/k), as part of Medicaid Reform efforts to enhance cost savings. The 1915(k), for example, can be used to refinance the Personal Care Assistance program and leverage a 6% higher federal match rate. The 1915(i) is an appropriate state option to serve income-eligible persons with cognitive impairments, such as dementia, who require assistance but do not meet levels of care as required under the 1915 (c). Personal care, adult day, behavioral supports such as cueing and supervision to enhance personal safety, case management, family caregiver training and supports, in addition to assistive and smart home technology are appropriate services that could be provided under the 1915 (i) to enhance the quality of life for an older adult living with dementia. Further, the 1915(i) could also be used to refinance the Pioneer Home's Payment Assistance Program for residents with dementia who do not qualify for the level of care required by the waiver, as well as the State's General Relief program that is used to provide emergency and temporary assisted living home placement for those who meet the Medicaid income threshold but do not qualify for the 1915 (c) waiver.
- **Behavioral Health Care:** Participants noted their appreciation for including mental health/behavioral health care services in Medicaid reform as these services have been long-overlooked in Alaska's health care system.
- **Optional Services:** Forum participants strongly supported the continuation of Medicaid adult optional services for dental, vision, and hearing as these services, not covered by Medicare, are very important for seniors with limited incomes.

We commend the good work of the Legislature, the Department of Health and Social Services, and stakeholders who have collaborated on this draft legislation and for the ongoing commitment to Medicaid health care reform. Please feel free to contact Denise Daniello, ACoA's Executive Director by phone (465-4879) or email ([denise.daniello@alaska.gov](mailto:denise.daniello@alaska.gov)), for further information.

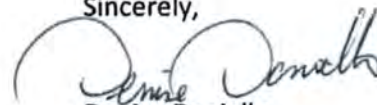
Sincerely,



Mary E. Shields  
Chair, Alaska Commission on Aging

Cc: Representative Dan Sadler  
Representative Tammie Wilson  
Representative Bryce Edgmon  
Representative Lynn Gattis  
Representative Cathy Muñoz

Sincerely,



Denise Daniello  
ACoA Executive Director

Representative Lance Pruitt  
Representative David Guttenberg  
Representative Les Gara  
Representative Scott Kawasaki

3/29/16

To All State Legislators:

I am writing to you on behalf of the physicians of the Family Medicine Department at Alaska Regional Hospital as well as our call group of 14 Family Physicians in Anchorage. Please oppose SB74 (HB344) which passed the Senate March 11, 2016. SB74 unnecessarily increases regulatory burdens on all providers and pharmacists by requiring database entry of controlled medications like testosterone, cough syrups, and medications for weight loss, ADD/ADHD, seizures, sleep, anxiety, and pain control (which are all schedule 2,3,4 substances), before prescribing them to children and adults. This bill causes an unnecessary waste of time (close to an hour a day) for primary care providers who already know what medications their patients are taking. There are 26 medications on this list which are prescribed regularly by primary care. This bill increases government involvement in personal health care, and is an invasion of health privacy for children and adults to be listed on a controlled substance registry for non-narcotic or limited time medications.

SB74 dramatically increases medical care costs to patients. Providers will have to spend time doing this data entry as staff will not know about medications that are listed, and incorrectly entering data could be a liability for the provider and negatively impact patients. This legislation interferes with a provider's ability to prescribe medications in a timely manner to patients, and takes providers away from patients by forcing them to do unnecessary burdensome paperwork. This controlled substance database has a potential to be abused by government or other officials, who will now have access to this list, as it could cause restriction of jobs, gun ownership, future military careers for children, and other potentially negative impacts on people's lives.

\* Sec. 18. AS 17.30.200(k) is amended to read: (k) In the regulations adopted under this section, the board shall provide .....

(4) that a pharmacist or practitioner review the information in the database to check a patient's prescription records before dispensing, prescribing, or administering a controlled substance to the patient;

This bill eliminates the need for physicians to be in state for telemedicine, which may result in substandard care by not requiring providers to do physical exams on patients. These telemedicine physicians will not have the comprehensive records we have on the patients which will result in lower quality of care and potentially serious drug interactions or other serious medical complications. This will dramatically lower the quality of medical care we have in our community, increase fragmentation of care, and result in more instances of malpractice claims and potentially dramatically increasing our liability as practitioners here in Alaska. It will also outsource jobs in a time when we need jobs here in Alaska. It also hinders the state medical board from disciplining providers of telemedicine, and so sets two different standards of care for providers.

The discriminatory clauses in this legislation allow for only Native Americans and Alaskan Natives to get their care paid for with 100% federal reimbursement at ANMC, which is ten times more than they pay private physicians to provide care for people on Medicaid. This also leaves the private providers subject to cuts by the state as they are paid 50% state and 50% federal dollars.

There is also concern about the potential for many unnecessary frivolous lawsuits due to the 15 to 25% recovery for so called Medicaid whistle blowers.

Please oppose SB74 (HB344). This bill will have unintended consequences including the closing of many primary care providers practices due to the provisions in this bill, lowering the quality of medical care, delays in care for patients, increasing regulatory costs, decreasing reimbursement for private providers, and many patients not getting medications they need because of fear of government databases.

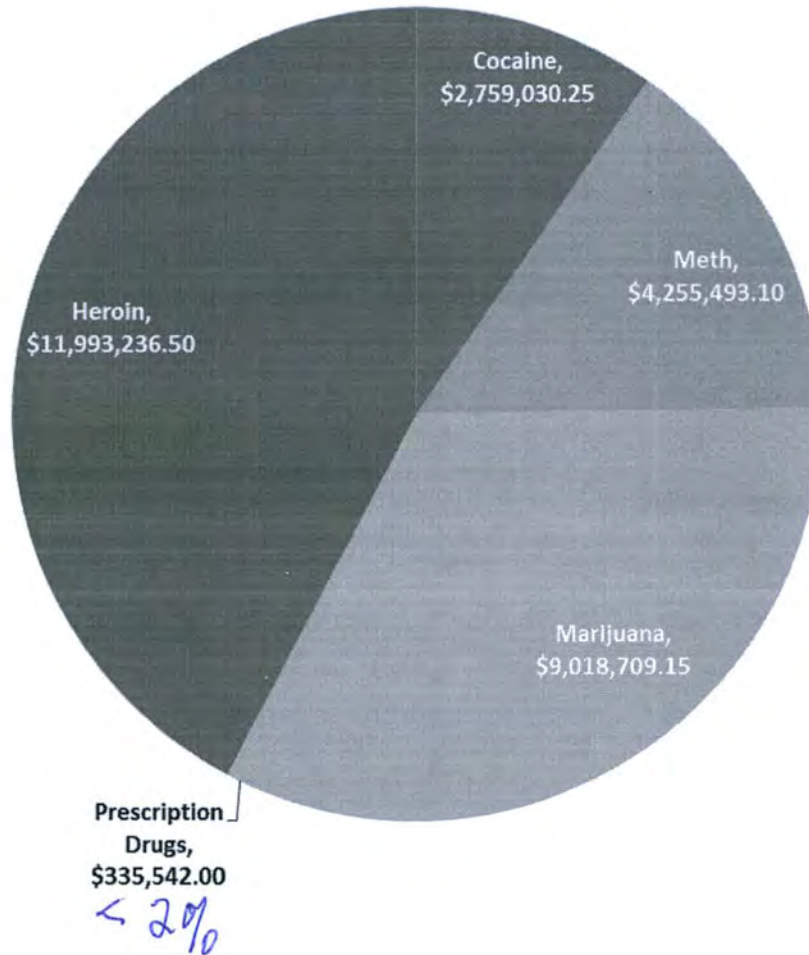
Sincerely yours,



Ilona Farr MD  
Chairman Family Medicine Department Alaska Regional Hospital and  
Representative for 14 Private Practice Family Physicians in Anchorage

**"Drugs of Choice": Total Street Value of Seizures**  
*(Local, State, and Federal Seizures)*

Substance	Street Value*
<b>Cocaine/Crack Cocaine</b>	\$ 2,759,030.25
<b>Methamphetamine</b>	\$ 4,255,493.10
<b>Heroin</b>	\$ 11,993,236.50
<b>Prescription Drugs</b>	\$ 335,542.00
<b>Marijuana</b>	\$ 9,018,709.15



*\*Geographic area street values are estimates only. Street value was determined by the Western States Information Network's Drug Price and Purity Guide 2013, or provided by the local agency. The street value of prescription medications can vary widely depending upon dosage strength. When street value could not be accurately determined, it was not included in this report.*

Drug Schedules

Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs are considered the most dangerous class of drugs with a high potential for abuse and potentially severe psychological and/or physical dependence. As the drug schedule changes-- Schedule II, Schedule III, etc., so does the abuse potential-- Schedule V drugs represents the least potential for abuse. A Listing of drugs and their schedule are located at Controlled Substance Act (CSA) Scheduling or CSA Scheduling by Alphabetical Order. These lists describes the basic or parent chemical and do not necessarily describe the salts, isomers and salts of isomers, esters, ethers and derivatives which may also be classified as controlled substances. These lists are intended as general references and are not comprehensive listings of all controlled substances.

Please note that a substance need not be listed as a controlled substance to be treated as a Schedule I substance for criminal prosecution. A controlled substance analogue is a substance which is intended for human consumption and is structurally or pharmacologically substantially similar to or is represented as being similar to a Schedule I or Schedule II substance and is not an approved medication in the United States. (See 21 U.S.C. §802(32)(A) for the definition of a controlled substance analogue and 21 U.S.C. §813 for the schedule.)

Schedule I

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence. Some examples of Schedule I drugs are:

heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote

Schedule II

Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are:

Combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin

Schedule III

Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are:

Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone

Schedule IV

Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are:

Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol

Schedule V

Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are:

cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin

*Narcotics only 740 pills 7602*

*eliminate*

>> Alphabetical listing of Controlled Substances

# CONTROLLED SUBSTANCES

## - BY CSA SCHEDULE -

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
1-(1-Phenylcyclohexyl)pyrrolidine	7458	I	N	PCPy, PHP, rolicyclidine
1-(2-Phenylethyl)-4-phenyl-4-acetoxypiperidine	9663	I	Y	PEPAP, synthetic heroin
1-[1-(2-Thienyl)cyclohexyl]piperidine	7470	I	N	TCP, tenocyclidine
1-[1-(2-Thienyl)cyclohexyl]pyrrolidine	7473	I	N	TCPy
1-Methyl-4-phenyl-4-propionoxypiperidine	9661	I	Y	MPPP, synthetic heroin
2-(2,5-Dimethoxy-4-(n-propylphenyl) ethanamine (2C-P)	7524	I	N	2C-P
2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine (2C-E )	7509	I	N	2C-E (Positional Isomer: 2,5-Dimethoxy-3,4-dimethylphenethylamine (2C-G))
2-(2,5-Dimethoxy-4-methylphenyl) ethanamine (2C-D)	7508	I	N	2C-D
2-(2,5-Dimethoxy-4-nitro-phenyl) ethanamine (2C-N)	7521	I	N	2C-N
2-(2,5-Dimethoxyphenyl) ethanamine (2C-H)	7517	I	N	2C-H
2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25B-NBOMe)	7536	I	N	25B-NBOMe, 2C-B-NBOMe, 25B, Cimbi-36
2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine (2C-C)	7519	I	N	2C-C
2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25C-NBOMe)	7537	I	N	25C-NBOMe, 2C-C-NBOMe, 25C, Cimbi-82
2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine (2C-T-2 )	7385	I	N	2C-T-2
2-(4-Iodo-2,5-dimethoxyphenyl) ethanamine (2C-I)	7518	I	N	2C-I
2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25I-NBOMe)	7538	I	N	25I-NBOMe, 2C-I-NBOMe, 25I, Cimbi-5
2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine (2C-T-4 )	7532	I	N	2C-T-4 (Positional Isomer: 2,5-Dimethoxy-4-ethylthioamphetamine (Aleph-2))
2,5-Dimethoxy-4-(n-propylthiophenethylamine (2C-T-7)	7348	I	N	2C-T-7 (Positional Isomer: 2,5-Dimethoxy-4-ethylthioamphetamine (Aleph-2))
2,5-Dimethoxy-4-ethylamphetamine	7399	I	N	DOET
2,5-Dimethoxyamphetamine	7396	I	N	DMA, 2,5-DMA
3,4,5-Trimethoxyamphetamine	7390	I	N	TMA (Positional Isomers: 2,4,5-Trimethoxy-amphetamine (TMA-5), 2,4,6-Trimethoxy-amphetamine (TMA-6))
3,4-Methylenedioxyamphetamine	7400	I	N	MDA, Love Drug
3,4-Methylenedioxymethamphetamine	7405	I	N	MDMA, Ecstasy, XTC
3,4-Methylenedioxy-N-ethylamphetamine	7404	I	N	N-ethyl MDA, MDE, MDEA
3-Fluoro-N-methylcathinone (3-FMC)	1233	I	N	1-(3-fluorophenyl)-2-(methylamino)propan-1-one (Positional isomer: 2-FMC)
3-Methylfentanyl	9813	I	Y	China White, fentanyl
3-Methylthiofentanyl	9833	I	Y	Chine White, fentanyl
4-Bromo-2,5-dimethoxyamphetamine	7391	I	N	DOB, 4-bromo-DMA

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

Controlled Substances - by CSA Schedule

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
4-Bromo-2,5-dimethoxyphenethylamine	7392	I	N	2C-B, Nexus, has been sold as Ecstasy, i.e. MDMA
4-Fluoro-N-methylcathinone (4-FMC)	1238	I	N	flephedrone; 1-(4-fluorophenyl)-2-(methylamino)propan-1-one) (Positional isomer: 2-FMC)
4-Methoxyamphetamine	7411	I	N	PMA
4-Methyl-2,5-dimethoxyamphetamine	7395	I	N	DOM, STP (Positional Isomer: 2,5-Dimethoxy-3,4-dimethylphenethylamine (2C-G))
4-Methyl-alpha-pyrrolidinopropiophenone (4-MePPP)	7498	I	N	MePPP, 4-methyl- $\alpha$ -pyrrolidinopropiophenone, 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one)
4-Methylaminorex (cis isomer)	1590	I	N	U4Euh, McN-422
4-Methyl-N-ethylcathinone (4-MEC)	1249	I	N	2-(ethylamino)-1-(4-methylphenyl)propan-1-one)(Positional Isomers:3-methylethcathinone (3-MEC), 4-ethylmethcathinone (4-EMC), 4-methylbuphedrone (4-MeMABP;4-MeBP), 3,4-dimethylmethcathinone(3,4-DMMC),N-ethylbuphedrone (NEB),N-ethyl-N-methylcathinone(EMC))
5-Flouro-UR-144 and XLR11 [1-(5-Fluoro-pentyl)1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl)methanone	7011	I	N	5-Flouro-UR-144, XLR-11 and XLR11
5F-PB-22 (Quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate)	7225	I	N	5-Flouro-PB-22; 5F-PB-22
5-Methoxy-3,4-methylenedioxyamphetamine	7401	I	N	MMDA
5-Methoxy-N,N-diisopropyltryptamine	7439	I	N	5-MeO-DIPT (Positional Isomer: 5-Methoxy-N,N-dipropyltryptamine (5-MeO-DPT))
5-Methoxy-N,N-dimethyltryptamine	7431	I	N	5-MeO-DMT (Positional Isomer: 4-Methoxy-N,N-dimethyltryptamine (4-MeO-DMT))
AB-CHMINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide	7031	I	N	AB-CHMINACA
AB-FUBINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide)	7012	I	N	AB-FUBINACA
AB-PINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide)	7023	I	N	AB-PINACA
Acetorphine	9319	I	Y	
Acetyl Fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide)	9821	I	Y	
Acetyl-alpha-methylfentanyl	9815	I	Y	
Acetyldihydrocodeine	9051	I	Y	Acetylcodeone
Acetylmethadol	9601	I	Y	Methadyl acetate
ADB-PINACA (N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide)	7035	I	N	ADB-PINACA
Allyprodine	9602	I	Y	
Alphacetylmethadol except levo-alphacetylmethadol	9603	I	Y	
Alpha-ethyltryptamine	7249	I	N	ET, Trip
Alphameprodine	9604	I	Y	
Alphamethadol	9605	I	Y	
Alpha-methylfentanyl	9814	I	Y	China White, fentanyl

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Alpha-methylthiofentanyl	9832	I	Y	China White, fentanyl
Alpha-methyltryptamine	7432	I	N	AMT (Positional Isomer: N-Methyltryptamine)
alpha-pyrrolidinobutiophenone (α-PBP)	7546	I	N	1-phenyl-2-(pyrrolidin-1-yl)butan-1-one)
alpha-pyrrolidinopentiophenone (α-PVP)	7545	I	N	α-pyrrolidinovalerophenone, 1-phenyl-2- (pyrrolidin-1-yl)pentan-1-one)(Positional isomers: 4-methyl-α-pyrrolidinobutiophenone (4-MePBP), 1-phenyl-2-(piperidin-1-yl)butan-1-one)
AM-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl) indole)	7201	I	N	AM-2201
AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl) indole)	7694	I	N	AM-694
Aminorex	1585	I	N	has been sold as methamphetamine
APINACA and AKB48 N-(1-Adamantyl)-1-pentyl-1H-indazole-3-carboxamide	7048	I	N	APINACA and AKB48
Benzethidine	9606	I	Y	
Benzylmorphine	9052	I	Y	
Betacetylmethadol	9607	I	Y	
Beta-hydroxy-3-methylfentanyl	9831	I	Y	China White, fentanyl
Beta-hydroxyfentanyl	9830	I	Y	China White, fentanyl
Betameprodine	9608	I	Y	
Betamethadol	9609	I	Y	
Betaprodine	9611	I	Y	
Bufotenine	7433	I	N	Mappine, N,N-dimethylserotonin
Butylone	7541	I	N	bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one) (Positional Isomers: ethylone (bk-MDEA; MDEC), dimethylone (bk-MDDMA; MDDMC))
Cathinone	1235	I	N	Constituent of "Khat" plant
Clonitazene	9612	I	Y	
Codeine methylbromide	9070	I	Y	
Codeine-N-oxide	9053	I	Y	
CP-47,497 (5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol)	7297	I	N	CP-47,497
CP-47,497 C8 Homologue (5-(1,1-Dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol)	7298	I	N	CP-47,497 C8 Homologue
Cyprenorphine	9054	I	Y	
Desomorphine	9055	I	Y	
Dextromoramide	9613	I	Y	Palfium, Jetricum, Narcolo
Diampromide	9615	I	Y	
Diethylthiambutene	9616	I	Y	
Diethyltryptamine	7434	I	N	DET, N,N-Diethyltryptamine (Positional Isomer: N-Methyl-N-isopropyltryptamine (MIPT))
Difenoxin	9168	I	Y	Lyspafen
Dihydromorphine	9145	I	Y	

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

Controlled Substances - by CSA Schedule

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Dimenoxadol	9617	I	Y	
Dimepheptanol	9618	I	Y	
Dimethylthiambutene	9619	I	Y	
Dimethyltryptamine	7435	I	N	DMT
Dioxaphetyl butyrate	9621	I	Y	
Dipipanone	9622	I	Y	Dipipan, phenylpiperone HCl, Diconal, Wellconal
Drotebanol	9335	I	Y	Metebanyl, oxymethebanol
Ethylmethylthiambutene	9623	I	Y	
Etonitazene	9624	I	Y	
Etorphine (except HCl)	9056	I	Y	
Etoxidine	9625	I	Y	
Fenethylamine	1503	I	N	Captagon, amfetamine, ethyltheophylline amphetamine
Furethidine	9626	I	Y	
Gamma Hydroxybutyric Acid	2010	I	N	GHB, gamma hydroxybutyrate, sodium oxybate
Heroin	9200	I	Y	Diacetylmorphine, diamorphine
Hydromorphanol	9301	I	Y	
Hydroxypethidine	9627	I	Y	
Ibogaine	7260	I	N	Constituent of "Tabernanthe iboga" plant
JWH-018 (also known as AM678) (1-Pentyl-3-(1-naphthoyl)indole)	7118	I	N	JWH-018 and AM-678
JWH-019 (1-Hexyl-3-(1-naphthoyl)indole)	7019	I	N	JWH-019
JWH-073 (1-Butyl-3-(1-naphthoyl)indole)	7173	I	N	JWH-073
JWH-081 (1-Pentyl-3-(1-(4-methoxynaphthoyl) indole)	7081	I	N	JWH-081
JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl) indole)	7122	I	N	JWH-122
JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-naphthoyl)indole)	7200	I	N	JWH-200
JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl) indole)	7203	I	N	JWH-203
JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl) indole)	6250	I	N	JWH-250
JWH-398 (1-Pentyl-3-(4-chloro-1-naphthoyl) indole)	7398	I	N	JWH-398
Ketobemidone	9628	I	Y	Cliradon
Levomoramide	9629	I	Y	
Levophenacymorphan	9631	I	Y	
Lysergic acid diethylamide	7315	I	N	LSD, lysergide
MAB-CHMINACA (N-(1-amino-3,3dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide)	7032	I	N	MAB-CHMINACA and ADB-CHMINACA
Marihuana	7360	I	N	Cannabis, marijuana
MDPV (3,4-Methylenedioxypropylvalerone)	7535	I	N	MDPV
Mecloqualone	2572	I	N	Nubarene

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

Controlled Substances - by CSA Schedule

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Mephedrone (4-Methyl-N-methylcathinone)	1248	I	N	(Positional Isomers: 3-Methyl-methcathinone, Buphedrone, Ethcathinone, N,N-Dimethyl-cathinone)
Mescaline	7381	I	N	Constituent of "Peyote" cacti
Methaqualone	2565	I	N	Quaalude, Parest, Somnafac, Opitamil, Mandrax
Methcathinone	1237	I	N	N-Methylcathinone, "cat"
Methyldesorphine	9302	I	Y	
Methyldihydromorphine	9304	I	Y	
Methylone (3,4-Methylenedioxy-N-methylcathinone)	7540	I	N	Methylone
Morpheridine	9632	I	Y	
Morphine methylbromide	9305	I	Y	
Morphine methylsulfonate	9306	I	Y	
Morphine-N-oxide	9307	I	Y	
Myrophine	9308	I	Y	
N,N-Dimethylamphetamine	1480	I	N	
Naphyrone	1258	I	N	naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one (Positional Isomer: $\alpha$ -naphyrone)
N-Benzylpiperazine	7493	I	N	BZP, 1-benzylpiperazine
N-Ethyl-1-phenylcyclohexylamine	7455	I	N	PCE
N-Ethyl-3-piperidyl benzilate	7482	I	N	JB 323
N-Ethylamphetamine	1475	I	N	NEA
N-Hydroxy-3,4-methylenedioxyamphetamine	7402	I	N	N-hydroxy MDA
Nicocodeine	9309	I	Y	
Nicomorphine	9312	I	Y	Vilan
N-Methyl-3-piperidyl benzilate	7484	I	N	JB 336
Noracymethadol	9633	I	Y	
Norlevorphanol	9634	I	Y	
Normethadone	9635	I	Y	Phenylidimazone
Normorphine	9313	I	Y	
Norpipanone	9636	I	Y	
Para-Fluorofentanyl	9812	I	Y	China White, fentanyl
Parahexyl	7374	I	N	Synhexyl,
PB-22 (Quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate)	7222	I	N	QUPIC; PB-22
Pentedrone ( $\alpha$ -methylaminovalerophenone)	1246	I	N	2-(methylamino)-1-phenylpentan-1-one)(Positional Isomers:3-methylethcathinone (3-MEC), 4-ethylmethcathinone (4-EMC), 4-methylbuphedrone (4-MeMABP;4-MeBP), 3,4-dimethylmethcathinone (3,4-DMMC),N-ethylbuphedrone (NEB),N-ethyl-N-methylcathinone(EMC))
Pentylone	7542	I	N	bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (Positional Isomer: dibutylone (bk-DMBDB))

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Peyote	7415	I	N	Cactus which contains mescaline
Phenadoxone	9637	I	Y	
Phenampramide	9638	I	Y	
Phenomorphane	9647	I	Y	
Phenoperidine	9641	I	Y	Operidine, Lealgin
Pholcodine	9314	I	Y	Copholco, Adaphol, Codisol, Lantuss, Pholcolin
Piritramide	9642	I	Y	Piridolan
Proheptazine	9643	I	Y	
Propiridine	9644	I	Y	
Propiram	9649	I	Y	Algeril
Psilocybin	7437	I	N	Constituent of "Magic mushrooms"
Psilocyn	7438	I	N	Psilocin, constituent of "Magic mushrooms"
Racemoramide	9645	I	Y	
SR-18 (Also known as RCS-8) (1-Cyclohexylethyl-3-(2-methoxyphenylacetyl) indole)	7008	I	N	SR-18 and RCS-8
SR-19 (Also known as RCS-4) (1-Pentyl-3-[(4-methoxy)-benzoyl] indole)	7104	I	N	SR-19 and RCS-4
Tetrahydrocannabinols	7370	I	N	THC, Delta-8 THC, Delta-9 THC, dronabinol and others
Thebacon	9315	I	Y	Acetylhydrocodone, Acedicon, Thebacetyl
Thiofentanyl	9835	I	Y	Chine white, fentanyl
THJ-2201 [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone	7024	I	N	THJ-2201
Tilidine	9750	I	Y	Tilidate, Valoron, Kitadol, Lak, Tilsa
Trimeperidine	9646	I	Y	Promedolum
UR-144 (1-Pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone	7144	I	N	UR-144
1-Phenylcyclohexylamine	7460	II	N	PCP precursor
1-Piperidinocyclohexanecarbonitrile	8603	II	N	PCC, PCP precursor
4-Anilino-N-phenethyl-4-piperidine (ANPP)	8333	II	N	ANPP
Alfentanil	9737	II	Y	Alfenta
Alphaprodine	9010	II	Y	Nisentil
Amobarbital	2125	II	N	Amytal, Tuinal
Amphetamine	1100	II	N	Dexedrine, Adderall, Obetrol
Anileridine	9020	II	Y	Leritine
Bezitramide	9800	II	Y	Burgodin
Carfentanil	9743	II	Y	Wildnil
Coca Leaves	9040	II	Y	
Cocaine	9041	II	Y	Methyl benzoylcegonine, Crack
Codeine	9050	II	Y	Morphine methyl ester, methyl morphine Cough, Pain

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Dextropropoxyphene, bulk (non-dosage forms)	9273	II	Y	Propoxyphene
Dihydrocodeine	9120	II	Y	Didrate, Parzone
Dihydroetorphine	9334	II	Y	DHE
Diphenoxylate	9170	II	Y	
Ecgonine	9180	II	Y	Cocaine precursor, in Coca leaves
Ethylmorphine	9190	II	Y	Dionin
Etorphine HCl	9059	II	Y	M 99
Fentanyl	9801	II	Y	Duragesic, Oralet, Actiq, Sublimaze, Innovar Pain
Glutethimide	2550	II	N	Doriden, Dorimide
Hydrocodone	9193	II	Y	dihydrocodeinone TUSSIONEX Cough, Pain
Hydromorphone	9150	II	Y	Dilaudid, dihydromorphinone Pain
Isomethadone	9226	II	Y	Isoamidone
Levo-alphaacetylmethadol	9648	II	Y	LAAM, long acting methadone, levomethadyl acetate
Levomethorphan	9210	II	Y	
Levorphanol	9220	II	Y	Levo-Dromoran
Lisdexamfetamine	1205	II	N	Vyvanse ADD/ADHD
Meperidine	9230	II	Y	Demerol, Mepergan, pethidine Pain
Meperidine intermediate-A	9232	II	Y	Meperidine precursor
Meperidine intermediate-B	9233	II	Y	Meperidine precursor, normeperidine
Meperidine intermediate-C	9234	II	Y	Meperidine precursor
Metazocine	9240	II	Y	
Methadone	9250	II	Y	Dolophine, Methadose, Amidone
Methadone intermediate	9254	II	Y	Methadone precursor
Methamphetamine	1105	II	N	Desoxyn, D-desoxyephedrine, ICE, Crank, Speed
Methylphenidate	1724	II	N	Concerta, Ritalin, Methylin ADD/ADHD
Metopon	9260	II	Y	
Moramide-intermediate	9802	II	Y	
Morphine	9300	II	Y	MS Contin, Roxanol, Oramorph, RMS, MSIR PAIN
Nabilone	7379	II	N	Cesamet
Opium extracts	9610	II	Y	
Opium fluid extract	9620	II	Y	
Opium poppy	9650	II	Y	Papaver somniferum
Opium tincture	9630	II	Y	Laudanum
Opium, granulated	9640	II	Y	Granulated opium
Opium, powdered	9639	II	Y	Powdered opium
Opium, raw	9600	II	Y	Raw opium, gum opium
Oripavine	9330	II	Y	

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Oxycodone	9143	II	Y	OxyContin, Percocet, Endocet, Roxicodone, Roxicet, <i>Pain</i>
Oxymorphone	9652	II	Y	Numorphan
Pentobarbital	2270	II	N	Nembutal
Phenazocine	9715	II	Y	Narphen, Prinadol
Phencyclidine	7471	II	N	PCP, Sernylan
Phenmetrazine	1631	II	N	Preludin
Phenylacetone	8501	II	N	P2P, phenyl-2-propanone, benzyl methyl ketone
Piminodine	9730	II	Y	
Poppy Straw	9650	II	Y	Opium poppy capsules, poppy heads
Poppy Straw Concentrate	9670	II	Y	Concentrate of Poppy Straw, CPS
Racemethorphan	9732	II	Y	
Racemorphan	9733	II	Y	Dromoran
Remifentanil	9739	II	Y	Ultiva
Secobarbital	2315	II	N	Seconal, Tuinal
Sufentanil	9740	II	Y	Sufenta
Tapentadol	9780	II	Y	
Thebaine	9333	II	Y	Precursor of many narcotics
13Beta-ethyl-17beta-hydroxygon-4-en-3-one	4000	III	N	
17Alpha-methyl-3alpha,17beta-dihydroxy-5alpha-androstane	4000	III	N	
17Alpha-methyl-3beta,17beta-dihydroxy-5alpha-androstane	4000	III	N	
17Alpha-methyl-3beta,17beta-dihydroxyandrost-4-ene	4000	III	N	
17Alpha-methyl-4-hydroxynandrolone (17alpha-methyl-4-hydroxy-17beta-hydroxyestr-4-en-3-one)	4000	III	N	
17Alpha-methyl-delta1-dihydrotestosterone (17beta-hydroxy-17alpha-methyl-5alpha-androst-1-en-3-one)	4000	III	N	17-Alpha-methyl-1-testosterone
19-Nor-4,9(10)-androstadienedione	4000	III	N	
19-Nor-4-androstenediol (3beta,17beta-dihydroxyestr-4-ene; 3alpha,17beta-dihydroxyestr-4-ene)	4000	III	N	
19-Nor-4-androstenedione (estr-4-en-3,17-dione)	4000	III	N	
19-Nor-5-androstenediol (3beta,17beta-dihydroxyestr-5-ene; 3alpha,17beta-dihydroxyestr-5-ene)	4000	III	N	
19-Nor-5-androstenedione (estr-5-en-3,17-dione)	4000	III	N	
1-Androstenediol (3beta,17beta-dihydroxy-5alpha-androst-1-ene; 3alpha,17beta-dihydroxy-5alpha-androst-1-ene)	4000	III	N	
1-Androstenedione (5alpha-androst-1-en-3,17-dione)	4000	III	N	
3Alpha,17beta-dihydroxy-5alpha-androstane	4000	III	N	
3Beta,17beta-dihydroxy-5alpha-androstane	4000	III	N	
4-Androstenediol (3beta,17beta-dihydroxy-androst-4-ene)	4000	III	N	4-AD

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4-Androstenedione (androst-4-en-3,17-dione)	4000	III	N	
4-Dihydrotestosterone (17beta-hydroxyandrost-3-one)	4000	III	N	Anabolex, Andractim, Pesomax, Stanolone
4-Hydroxy-19-nortestosterone (4,17beta-dihydroxyestr-4-en-3-one)	4000	III	N	
4-Hydroxytestosterone (4,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	
5-Androstenediol (3beta,17beta-dihydroxy-androst-5-ene)	4000	III	N	
5-Androstenedione (androst-5-en-3,17-dione)	4000	III	N	
Amobarbital & noncontrolled active ingred.	2126	III	N	
Amobarbital suppository dosage form	2126	III	N	
Anabolic steroids	4000	III	N	"Body Building" drugs
Androstenedione (5alpha-androst-3,17-dione)	4000	III	N	
Aprobarbital	2100	III	N	Alurate
Barbituric acid derivative	2100	III	N	Barbiturates not specifically listed
Benzphetamine	1228	III	N	Didrex, Inapetyl
Bolasterone (7alpha,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	
Boldenone (17beta-hydroxyandrost-1,4-diene-3-one)	4000	III	N	Equipoise, Parenabol, Vebonol, dehydrotestosterone
Boldione	4000	III	N	
Buprenorphine	9064	III	Y	Buprenex, Temgesic, Subutex, Suboxone
Butabarbital (secbutabarbital)	2100	III	N	Butisol, Butibel
Butalbital	2100	III	N	Fiorinal, Butalbital with aspirin <i>Migraines</i>
Butobarbital (butethal)	2100	III	N	Soneryl (UK)
Calusterone (7beta,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Methosarb
Chlorhexadol	2510	III	N	Mechloral, Mecoral, Medodorm, Chloralodol
Chlorphentermine	1645	III	N	Pre-Sate, Lucofen, Apsedon, Desopimon
Clortermine	1647	III	N	Voranil
Clostebol (4-chloro-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Alfa-Trofodermin, Clostene, 4-chlorotestosterone
Codeine & isoquinoline alkaloid 90 mg/du	9803	III	Y	Codeine with papaverine or noscapine
Codeine combination product 90 mg/du	9804	III	Y	Empirin, Fiorinal, Tylenol, ASA or APAP w/codeine <i>Cough Pain</i>
Dehydrochloromethyltestosterone (4-chloro-17beta-hydroxy-17alpha-methylandrost-1,4-dien-3-one)	4000	III	N	Oral-Turinabol
Delta1-dihydrotestosterone (17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	III	N	1-Testosterone
Desoxymethyltestosterone	4000	III	N	
Dihydrocodeine combination product 90 mg/du	9807	III	Y	Synalgos-DC, Compal
Dronabinol (synthetic) in sesame oil in soft gelatin capsule as approved by FDA	7369	III	N	Marinol, synthetic THC in sesame oil/soft gelatin as approved by FDA <i>Nausea, chemotherapy</i>

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Drostanolone (17beta-hydroxy-2alpha-methyl-5alpha-androstan-3-one)	4000	III	N	Drolban, Masterid, Permastril
Embutramide	2020	III	N	Tributane
Ethylestrenol (17alpha-ethyl-17beta-hydroxyestr-4-ene)	4000	III	N	Maxibolin, Orabolin, Durabolin-O, Duraboral
Ethylmorphine combination product 15 mg/du	9808	III	Y	
Fluoxymesterone (9-fluoro-17alpha-methyl-11beta,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	Anadroid-F, Halotestin, Ora-Testryl
Formebolone (2-formyl-17alpha-methyl-11alpha,17beta-dihydroxyandrost-1,4-dien-3-one)	4000	III	N	Esiclene, Hubernol
Furazabol (17alpha-methyl-17beta-hydroxyandrostano[2,3-c]-furazan)	4000	III	N	Frazalon, Miotolon, Qu Zhi Shu
Gamma Hydroxybutyric Acid preparations	2012	III	N	Xyrem
Ketamine	7285	III	N	Ketaset, Ketalar, Special K, K
Lysergic acid	7300	III	N	LSD precursor
Lysergic acid amide	7310	III	N	LSD precursor
Mestanolone (17alpha-methyl-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Assimil, Ermalone, Methybol, Tantarone
Mesterolone (1alpha-methyl-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Androviron, Proviron, Testiwop
Methandienone (17alpha-methyl-17beta-hydroxyandrost-1,4-diene-3-one)	4000	III	N	Dianabol, Metabolina, Nerobol, Perbolin
Methandriol (17alpha-methyl-3beta,17beta-dihydroxyandrost-5-ene)	4000	III	N	Sinesex, Stenediol, Troformone
Methasterone (2alpha,17alpha-dimethyl-5alpha-androstan-17beta-ol-3-one)	4000	III	N	Methasterone
Methenolone (1-methyl-17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	III	N	Primobolan, Primobolan Depot, Primobolan S
Methyldienolone (17alpha-methyl-17beta-hydroxyestr-4,9(10)-dien-3-one)	4000	III	N	
Methyltestosterone (17alpha-methyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Android, Oreton, Testred, Virilon <i>how Testosterone</i>
Methyltrienolone (17alpha-methyl-17beta-hydroxyestr-4,9,11-trien-3-one)	4000	III	N	Metribolone
Methyprylon	2575	III	N	Noludar
Mibolerone (7alpha,17alpha-dimethyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Cheque, Matenon
Morphine combination product/50 mg/(100 ml or 100 gm)	9810	III	Y	
Nalorphine	9400	III	Y	Nalline
Nandrolone (17beta-hydroxyestr-4-en-3-one)	4000	III	N	Deca-Durabolin, Durabolin, Durabolin-50
Norbolethone (13beta,17alpha-diethyl-17beta-hydroxygon-4-en-3-one)	4000	III	N	Genabol
Norclostebol (4-chloro-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Anabol-4-19, Lentabol
Norethandrolone (17alpha-ethyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Nilevar, Pronabol, Solevar
Normethandrolone (17alpha-methyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Lutenin, Matronal, Orgasteron

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Opium combination product 25 mg/du	9809	III	Y	Paregoric, other combination products
Oxandrolone (17alpha-methyl-17beta-hydroxy-2-oxa-5alpha-androstan-3-one)	4000	III	N	Anavar, Lonavar, Oxandrin, Provitara, Vasorome
Oxymesterone (17alpha-methyl-4,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	Anamidol, Balnimax, Oranabol, Oranabol 10
Oxymetholone (17alpha-methyl-2-hydroxymethylene-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Anadrol-50, Adroyd, Anapolon, Anasteron, Pardroyd
Pentobarbital & noncontrolled active ingred.	2271	III	N	FP-3
Pentobarbital suppository dosage form	2271	III	N	WANS
Perampanel	2261	III	N	Fycompa, [2-(2-oxo-1-phenyl-5-pyridin-2-yl-1,2-dihydropyridin-3-yl) benzonitrile ]
Phendimetrazine	1615	III	N	Plegine, Prelu-2, Bontril, Melfiat, Statobex
Prostanozol (17beta-hydroxy-5alpha-androstano[3,2-c]pyrazole)	4000	III	N	Prostanozol
Secobarbital & noncontrolled active ingred	2316	III	N	
Secobarbital suppository dosage form	2316	III	N	
Stanozolol (17alpha-methyl-17beta-hydroxy-5alpha-androst-2-eno[3,2-c]-pyrazole)	4000	III	N	Winstrol, Winstrol-V
Stenbolone (17beta-hydroxy-2-methyl-5alpha-androst-1-en-3-one)	4000	III	N	
Stimulant compounds previously excepted	1405	III	N	Mediatric
Sulfondiethylmethane	2600	III	N	
Sulfonethylmethane	2605	III	N	
Sulfonmethane	2610	III	N	
Talbutal	2100	III	N	Lotusate
Testolactone (13-hydroxy-3-oxo-13,17-secoandrost-1,4-dien-17-oic acid lactone)	4000	III	N	Teolit, Teslac
Testosterone (17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Android-T, Androlan, Depotest, Delatestryl ; <i>Androgel</i> <i>→ how testosterone</i>
Tetrahydrogestrinone (13beta,17alpha-diethyl-17beta-hydroxygon-4,9,11-trien-3-one)	4000	III	N	THG
Thiamylal	2100	III	N	Surital
Thiopental	2100	III	N	Pentothal
Tiletamine & Zolazepam Combination Product	7295	III	N	Telazol
Trenbolone (17beta-hydroxyestr-4,9,11-trien-3-one)	4000	III	N	Finaplix-S, Finajet, Parabolan
Vinbarbital	2100	III	N	Delvinal, vinbarbitone
Alfaxalone	2731	IV	N	Alfaxan, 5alpha-pregnan-3alpha-ol-11,20-dione
Alprazolam	2882	IV	N	Xanax <i>Anxiety, Travel, MRI's</i>
Barbital	2145	IV	N	Veronal, Plexonal, barbitone
Bromazepam	2748	IV	N	Lexotan, Lexatin, Lexotamil
Butorphanol	9720	IV	N	Stadol, Stadol NS, Torbugesic, Torbutrol <i>Migraines</i>
Camazepam	2749	IV	N	Albego, Limpidon, Paxor
Carisoprodol	8192	IV	N	Soma <i>Muscle Relaxant</i>

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Cathine	1230	IV	N	Constituent of "Khat" plant, (+)-norpseudoephedrine
Chloral betaine	2460	IV	N	Beta Chlor
Chloral hydrate	2465	IV	N	Noctec
Chlordiazepoxide	2744	IV	N	Librium, Libritabs, Limbitrol, SK-Lygen
Clobazam	2751	IV	N	Urbadan, Urbanyl
Clonazepam	2737	IV	N	Klonopin, Clonopin
Clorazepate	2768	IV	N	Tranxene
Clotiazepam	2752	IV	N	Trecalmo, Rize, Clozan, Veratran
Cloxazolam	2753	IV	N	Akton, Lubalix, Olcadil, Sepazon
Delorazepam	2754	IV	N	
Dexfenfluramine	1670	IV	N	Redux
Dextropropoxyphene dosage forms	9278	IV	Y	Darvon, propoxyphene, Darvocet, Propacet
Diazepam	2765	IV	N	Valium, Diastat
Dichloralphenazone	2467	IV	N	Midrin, dichloralantipyrine
Diethylpropion	1610	IV	N	Tenuate, Tepanil
Difenoxin 1 mg/25 ug AtSO4/du	9167	IV	Y	Motofen
Eluxadoline	9725	IV	N	VIBERZI
Estazolam	2756	IV	N	ProSom, Domnamid, Eurodin, Nuctalon
Ethchlorvynol	2540	IV	N	Placidyl
Ethinamate	2545	IV	N	Valmid, Valamin
Ethyl loflazepate	2758	IV	N	
Fencamfamin	1760	IV	N	Reactivan
Fenfluramine	1670	IV	N	Pondimin, Ponderal
Fenproporex	1575	IV	N	Gacilin, Solvolip
Fludiazepam	2759	IV	N	
Flunitrazepam	2763	IV	N	Rohypnol, Narcozep, Darkene, Roipnol
Flurazepam	2767	IV	N	Dalmane
Fospropofol	2138	IV	N	Lusedra
Halazepam	2762	IV	N	Paxipam
Haloxazolam	2771	IV	N	
Ketazolam	2772	IV	N	Anxon, Loftran, Solatran, Contamex
Loprazolam	2773	IV	N	
Lorazepam	2885	IV	N	Ativan
Lorcaserin	1625	IV	N	Belviq
Lormetazepam	2774	IV	N	Noctamid
Mazindol	1605	IV	N	Sanorex, Mazanor
Mebutamate	2800	IV	N	Capla

*alcohol withdrawal*

*Sleep, Anxiety*

*Removed from Market w/ loss*

*Pain*

*Severe Back Pain, Pre MRI*

*CRAMPS, Migraines*

*Sleep*

*Removed from Market w/ loss*

*Sleep*

*Sleep, Travel, Anxiety, MRI w/ loss*

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Medazepam	2836	IV	N	Nobrium
Mefenorex	1580	IV	N	Anorexic, Amexate, Doracil, Pondinil
Meprobamate	2820	IV	N	Miltown, Equanil, Micrainin, Equagesic, Meprospan
Methohexital	2264	IV	N	Brevital
Methylphenobarbital (mephobarbital)	2250	IV	N	Mebaral, mephobarbital
Midazolam	2884	IV	N	Versed
Modafinil	1680	IV	N	Provigil <i>Shift work, Narcolepsy</i>
Nimetazepam	2837	IV	N	Erimin
Nitrazepam	2834	IV	N	Mogadon
Nordiazepam	2838	IV	N	Nordazepam, Demadar, Madar
Oxazepam	2835	IV	N	Serax, Serenid-D <i>anxiety, alcohol withdrawal</i>
Oxazolam	2839	IV	N	Serenal, Convertal
Paraldehyde	2585	IV	N	Paral
Pemoline	1530	IV	N	Cylert
Pentazocine	9709	IV	N	Talwin, Talwin NX, Talacen, Talwin Compound
Petrichloral	2591	IV	N	Pentaerythritol chloral, Periclor
Phenobarbital	2285	IV	N	Luminal, Bellergal-S <i>Seizures</i>
Phentermine	1640	IV	N	Ionamin, Fastin, Adipex-P, Obe-Nix, Zantryl <i>w/loss</i>
Pinazepam	2883	IV	N	Domar
Pipradrol	1750	IV	N	Detaril, Stimolag Fortis
Prazepam	2764	IV	N	Centrax
Quazepam	2881	IV	N	Doral
Sibutramine	1675	IV	N	Meridia <i>w/loss</i>
SPA	1635	IV	N	1-dimethylamino-1,2-diphenylethane, Lefetamine
Suvorexant	2223	IV	N	MK-4305, [(7R)-4-(5-chloro-1,3-benzoxazol-2-yl)-7-methyl-1,4-diazepan-1-yl][5-methyl-2-(2H-1,2,3-triazol-2-yl)phenyl]methanone
Temazepam	2925	IV	N	Restoril <i>Sleep</i>
Tetrazepam	2886	IV	N	Myolastan, Musaril
Tramadol (2-[(dimethylamino)methyl]-1-(3-methoxyphenyl)cyclohexanol)	9752	IV	Y	Tramadol <i>Pain</i>
Triazolam	2887	IV	N	Halcion <i>Sleep</i>
Zaleplon	2781	IV	N	Sonata <i>Sleep</i>
Zolpidem	2783	IV	N	Ambien, Ivadal, Stilnoct, Stilnox <i>Sleep</i>
Zopiclone	2784	IV	N	Lunesta <i>Sleep</i>
Codeine preparations - 200 mg/(100 ml or 100 gm)		V	Y	Cosanyl, Robitussin A-C, Cheracol, Cerose, Pediacof
Difenoxin preparations - 0.5 mg/25 ug AtSO4/du		V	Y	Motofen
Dihydrocodeine preparations 100mg/(100 ml or 100 gm)		V	Y	Cophene-S, various others

*(also Belsomra)*

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Diphenoxylate preparations 2.5 mg/25 ug AtSO4		V	Y	Lomotil, Logen <i>Diarrhea</i>
Ethylmorphine preparations 100 mg/(100 ml or 100 gm)		V	Y	
Ezogabine	2779	V	N	Potiga
Lacosamide	2746	V	N	Vimpat
Opium preparations - 100 mg/(100 ml or 100 gm)		V	Y	Parepectolin, Kapectolin PG, Kaolin Pectin P.G. <i>Diarrhea</i>
Pregabalin	2782	V	N	Lyrica <i>Neuralgic Pain</i>
Pyrovalerone	1485	V	N	Centroton, Thymergix

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For the record, my name is Jocelyn Pemberton and I am the executive director for The Alaska Hospitalist Group, a large physician practice as well as a founding member of Alaska Innovative Medicine (AIM), a local physician driven, care coordination company. More importantly, I was born and raised in Alaska, I'm raising my three beautiful girls in Anchorage and I am watching my parents grow old in Alaska.

I agree with the other comments that we need to bend the cost curve and that the pure fee for service model ultimately needs to change. Financial incentives need to be aligned between patients, providers and payers, in this case, the State. As you know, this is much easier said than done.

The vast majority of our provider community are in private practice; Alaskan physicians and nurse practitioners running small businesses to provide medical care in their community. To make sweeping changes in the payment model is extremely risky and could be a hugely damaging to our industry, especially in pediatrics which often have 50% or greater percentage of Medicaid patients. However, there are models that would allow physicians that are willing to take risk and participate in shared savings to do so, thereby aligning the incentives.

The model that we have experience with is the Bundled Payment for Care Improvement, or BPCI, which is a demonstration project we are participating in with Medicare. Essentially, BPCI sets a cost, based on historical data, for the episode of care initiated from a hospitalization plus 90 days post discharge and aligns incentives to provide better care at a lower cost. For example, the total cost for a patient with a hip fracture might be \$20,000 on average. If we are able to provide services for less, by working to avoid readmissions for example, there are shared savings back to the providers who are working to reduce cost and improve outcomes. BPCI allows for utilization management by incentivizing models of care that prevent re-hospitalizations, over-utilization of the ER or duplicative testing, rather than merely slashing payments to providers or restricting access for patients.

We appreciate the work that the legislature has done and the recognition of the impact care coordination can bring to the Medicaid program. As physicians, we have recognized this as well and have created Alaska Innovative Medicine or AIM for short. AIM is a local, physician driven care coordination company, a result of a collaboration between primary care physicians and hospitalists. AIM has initially contracted with Premera Blue Cross to improve the care of their high risk members. AIM has a multi-disciplinary approach including case managers, social workers, a clinical nursing staff, dieticians etc.

Think of AIM as a mobile patient centered medical home deploying services as needed. AIM social workers collaborate with Primary Care Physicians as well as specialists to best support the health plan for the patient. Our clinical nursing staff, as well as our physicians are able to meet patients in their home to avoid over ER utilization, educate on medications and nutrition to promote health. With the local provider relationships and Alaskan experience, the AIM model has the ability to have huge impact to improve patient care and reduce cost in our state.

**TESTIMONY OF DAVE DONLEY  
REPRESENTING HOPE COMMUNITY RESOURCES  
REGARDING SB74 MEDICAID REFORM MARCH 29, 2016  
IN THE HOUSE FINANCE COMMITTEE 3.29.16**

**Hope Community Resources Inc., comments on SB74 Medicaid False Claims and Reporting Act**

Members of the House Finance committee:

Hope community resources supports the state's efforts toward Medicaid reform and appreciates the work that has gone into SB74. We were disappointed to learn last week that the language contained in the false claims and reporting act has been submitted for federal approval months ago, without the opportunity for public comments and input.

We remain concerned that the current language does not adequately protect honest providers against liability for the bad acts of rouge employees and provides insufficient protections for self-reporting and self-correction of problems. The vast majority of Medicaid providers seek to provide quality services and are the first line of defense against false claims and fraud against Medicaid. Many providers are nationally accredited and have implemented policies designed to prevent false claims and maintain integrity of the service delivery system.

The senate, instead of addressing some of our specific suggestions, chose to place a three year sunset on portions of the Medicaid fraud act section. We are grateful for that sunset provision but continue to believe it would be much better to address the specific concerns prior to passing new law.

We believe we and other providers have asked for very reasonable safeguards for honest law abiding providers. We regret if our suggestions cannot now be considered due to the pending federal approval of the existing language.

It is unclear to me what differences might be allowed in the federal investigator general review process. We have reviewed the many pages of guidelines and find them unclear regarding how much flexibility in some of the federally mandated language is allowed.

This raises the question of if it is worth it for a 5% or maybe sometimes 10% increase in fraud recovery amounts for the state to not attempt to address reasonable concerns raised by the public?

We suggest it be better public policy to first attempt to work out concerns with Alaskan stakeholders, draft language that better fits Alaska, and then submit it to the feds to see if they will approve it and if not then negotiate changes with the federal authorities and bring that language back to the legislature for approval?

## **SB74 REQUESTED AMENDMENTS**

### **1. Self-reporting protections for providers within Medicaid Fraud Act.**

#### **Sec 3. AS 09.58.010 (b) (p7) to read:**

A beneficiary of an intentional or inadvertent submission of a false or fraudulent claim under the medical assistance program who later discovers the claim is false or fraudulent shall disclose the false or fraudulent claim to the state nor later than 60 days after discovering the false claim. **The department of health and social services may not assess interest or penalties on an overpayment self- identified and repaid by a medical assistance provider under this section.**

There was testimony last week by state officials that similar language at page 23, Section 27 would apply to the Fraud Act sections but how that would work is unclear since the Fraud Act seems to stand alone.

### **2. More precise definition of “agent” as used in Sec. 09.58.010(e).**

#### **Page 14, Sec. 10, Sec. 09.58.100 Definitions**

Add the following definition of “agent”

**“agent with apparent authority” does not include someone acting in violation of the policies or instruction of the principal provider without that provider’s knowledge.**

### **3. Protections from liability from actions of rogue employees.**

#### **Page 8, Sec. 10, Sec. 09.58.010(e) to read:**

#### **Sec. 09.58.010 False claims for medical assistance; civil penalty.**

(e) A corporation, partnership, or other individual is liable under this chapter for acts of its agents if the agent acted with apparent authority, regardless of whether the agent acted, in whole or in part, to benefit the principal and regardless of whether the principal adopted or ratified the agent’s claims, representations, statement, or other action or conduct, **unless the evidence shows that the agent or apparent agent acted with intent to deceive the principal.**

Contact: Dave Donley 907-561-8234 / dd1@gci.net



THE STATE  
of **ALASKA**

GOVERNOR BILL WALKER

Department of Commerce, Community,  
and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND  
PROFESSIONAL LICENSING

P.O. Box 110806  
Juneau, Alaska 99811-0806  
Main: 907.465.2550  
Fax: 907.465.2974

March 30, 2016

The Honorable Representative Steve Thompson and Representative Mark Neuman  
Co-Chairs, House Finance Committee  
State Capitol Room 519  
Juneau, AK 99801

Dear Representative Thompson and Representative Neuman,

During the House Finance Committee hearings on March 29, I was asked to follow up on questions concerning SB74 - Medicaid Reform/PFD/HSAS/ER Use/Studies:

***Are there any conditions or obligations by the State in return for the federal money received for the Prescription Drug Monitoring Program?***

There are no conditions required by the grant in order to receive annual funding for the PDMP database. This grant was awarded to the Department of Health and Social Services and the PDMP funding distributed to the Department of Commerce, Community, and Economic Development through a reimbursable services agreement.

***Does the Federal Government have access to the Prescription Drug Monitoring Program?***

There is no direct access by the Federal Government, except that Veteran Administration (VA) and Indian Health Service prescribers and dispensers may access data related to their patient.

The only other access would be by law enforcement, per AS 17:30.200(d)(5):

*AS 17.30.200 (d)(5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database under a search warrant, subpoena, or order issued by a court establishing probable cause for the access and use of the information.*

***How were the legal costs determined in the DCCED Fiscal Note?***

The legal cost is based on the average, over a two-year period (FY2014-FY2015), of the expenses for expert witness, Department of Law legal services, and services rendered by the Office of Administrative Hearings for the Alaska State Medical Board, Board of Psychologist and Psychological Associate Examiners, Board of Marital and Family Therapy, Board of Social Work Examiners, and Board of Professional Counselors combined. This section of the fiscal note pertains to the bill's expansion of telehealth and telemedicine, not the Prescription Drug Monitoring Program.

***What if the federal funding for the program terminates, how many licensees will be charged to cover the Prescription Drug Monitoring Program?***

The current grant is in year 1 of 5. Additional grant funding is being sought to defray additional costs of program compliance. Under current law, all expenses of the PDMP and its program/support/investigative components must be covered by the Board of Pharmacy and its

licensees. Should this bill pass, the costs of the program would be spread among all required registrants if grant funds cease to exist. The actual number of registrants under the proposed legislation is unknown since delegation would be optional and each licensee could delegate to several personnel. Each of those personnel would be required to register. So, authorized dispensers/prescribers under the bill, using current licensing numbers, is approximately 9000; however, delegation would increase that number to an unknown amount. The number of new licensees in each of the professions would increase that number annually:

	New in FY15	Total in FY15
Pharmacists	100	1156
Dentists	42	915
Physicians	250	4119
Physicians Assistants	85	808
Adv. Nurse Practitioners	105	1059
Optometrists	19	202
Veterinarians	70	519
Estimated Totals	671	8778

We hope this helps to answer some of the questions posed in committee. If you or any members of the committee have further questions or require additional information about anything provided here, please contact DCCED Special Assistant Micaela Fowler at 465-2503.

Sincerely,



Janey Hovenden  
Director

# SB 74

## FISCAL NOTES THAT REPORTED OUT OF THE SENATE FINANCE COMMITTEE

(See Following Pages)

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	31
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-AKPH-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Alaska Pioneer Homes  
 Allocation: Pioneer Homes  
 OMB Component Number: 2671

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below.

(Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>	<b>FY 2020</b>	<b>FY 2021</b>	<b>FY 2022</b>
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Fund Source (Operating Only)**

1004 Gen Fund	(1,066.7)		(1,066.7)	(1,066.7)	(1,066.7)	(1,066.7)	(1,066.7)
1007 I/A Rcpts	1,066.7		1,066.7	1,066.7	1,066.7	1,066.7	1,066.7
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
 If yes, by what date are the regulations to be adopted, amended or repealed? n/a

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

Prepared By: Vickie Wilson, Director  
 Division: Alaska Pioneer Homes  
 Approved By: Sana Efir, Assistant Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)458-2228  
 Date: 03/05/2016 07:00 PM  
 Date: 03/08/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

Included within the House Bill 30, State Agency Performance Audits (Chapter 19 SLA 2013), was a recommendation that the Department of Health and Social Services, Division of Alaska Pioneer Homes require that applicants for the payment assistance program first apply for Medicaid. **Section 35, page 35** of Senate Bill 74 (SCSB74(FIN), version U), would adopt this recommendation into law. The Division of Alaska Pioneer Homes estimates that 24 Level-3 residents will be eligible for the Alaskans Living Independently Waiver.

Once eligible, the division can bill Medicaid for the services being provided to the residents. This change would reduce the general fund required for the 24 residents by (\$1,066.7). However, in order to collect the revenue from Medicaid the division would need an additional \$1,066.7 in inter-agency receipts, as this is how the division is allocated revenue authority for Medicaid receipts.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	32
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-BHA-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Behavioral Health  
 Allocation: Behavioral Health Administration  
 OMB Component Number: 2665

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>					
Personal Services				(226.7)	(453.4)	(453.4)	(453.4)
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(226.7)</b>	<b>(453.4)</b>	<b>(453.4)</b>	<b>(453.4)</b>

### Fund Source (Operating Only)

1002 Fed Rcpts				(113.4)	(226.7)	(226.7)	(226.7)
1003 G/F Match				(113.3)	(226.7)	(226.7)	(226.7)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(226.7)</b>	<b>(453.4)</b>	<b>(453.4)</b>	<b>(453.4)</b>

### Positions

Full-time				(2.0)	(4.0)	(4.0)	(4.0)
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
 If yes, by what date are the regulations to be adopted, amended or repealed? n/a

### Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the CS, version U.

Prepared By: Randall P. Burns, Acting Director	Phone: (907)269-5948
Division: Behavioral Health	Date: 03/05/2016 06:00 PM
Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services	Date: 03/08/16
Agency: Health and Social Services	

**REPORTED OUT OF**  
**SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

**Section 28** of **CSSB74(FIN)** adds a new section, AS 47.05.270, entitled "Medical assistance reform program." New subsection AS 47.05.270(b) instructs the Department of Health and Social Services (DHSS), in coordination with the Alaska Mental Health Trust Authority, to "manage a comprehensive and integrated behavioral health program," including a plan for providing a continuum of community-based services from a wide array of providers and disciplines that addresses housing, employment, and criminal justice, and reduces barriers that fragment services and reduce effectiveness and efficiency. It is expected that Alaskans served by the criminal justice system will benefit from the reformed system of behavioral health care, and savings will be realized in the Department of Corrections, Public Safety and the Court system as well as within the Office of Children's Services.

**Section 30** adds new subsections AS 47.07.036(d)(4) and (5) that authorize the Department to develop demonstration projects for innovative service delivery and payment models, and provide incentives for telehealth. New subsection AS 47.07.036(e) requires the Department to seek 1115 demonstration waivers from the Centers for Medicare and Medicaid Services (CMS), and subsection (f) requires that one of these 1115 waivers focus on behavioral health system improvements for Medicaid recipients. These system improvements must be consistent with the improvements expected under Section 28, p. 26 of the bill (47.05.270(b)) that are intended to improve access to quality care while managing costs.

**OPERATING BUDGET SAVINGS:** In both FY2019 and FY2020, the Division of Behavioral Health will reduced its personal services line by one Mental Health Clinician III (\$119.8) and one Health Program Manager II (\$106.9), for a total of four positions between SFY2019 and SFY2020.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	33
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-MAA-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Health Care Services  
 Allocation: Medical Assistance Administration  
 OMB Component Number: 242

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	218.4		218.4	218.4	218.4	218.4	218.4	218.4
Travel	1.0							
Services	95.3		93.8	93.8	93.8	93.8	93.8	93.8
Commodities	19.2		4.0	4.0	4.0	4.0	4.0	4.0
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>333.9</b>	<b>0.0</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	167.0		158.1	158.1	158.1	158.1	158.1	158.1
1003 G/F Match	166.9		158.1	158.1	158.1	158.1	158.1	158.1
<b>Total</b>	<b>333.9</b>	<b>0.0</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>	<b>316.2</b>

**Positions**

Full-time	2.0		2.0	2.0	2.0	2.0	2.0	2.0
Part-time								
Temporary								

<b>Change in Revenues</b>								
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

**Why this fiscal note differs from previous version:**

Provided more accurate language in narrative regarding demonstration projects. Updated to reflect the provisions of the current CSSB074(FIN), version U.

Prepared By: Margaret Brodie, Director  
 Division: Health Care Services  
 Approved By: Sana Efir, Assistant Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)334-2520  
 Date: 03/05/2016 12:00 AM  
 Date: 03/08/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

**Sections 8 through 12 and 26-28** establish a series of new provisions intended to strengthen fraud and abuse prevention and remediation, and include the addition of a new Alaska Medicaid False Claim and Reporting Act. These provisions would authorize the department to assess interest and penalties on overpayments, impose civil fines, and seize property of medical assistance providers who have or are committing medical assistance fraud.

Promulgation of associated regulations will take approximately six months, with implementation effective January 1, 2017. There will be a significant increase in appeals from these new policies. Although the Department anticipates that this additional workload can be accomplished without any additional positions, it will require additional training and minimal travel costs associated with this training. The estimated training cost for tuition is \$1.5 and \$1.0 for estimated travel costs.

Due to the increase in appeals with the Office of Administrative Hearings for fraud and abuse handled under these sections, the reimbursable services agreement with that office is increased by \$75.0 per year to accommodate the increased workload.

**Section 29, pp. 28-29**, direct the department to implement the Primary Care Case Management system or managed care organization (MCO) contract authorized under AS 47.07.030(d). This system would require certain Medicaid recipients to obtain approval from a case manager or MCO before receiving certain services in order to increase the use of primary and preventive care, and decrease the use of specialty care and hospital services.

Additional staff will be required to develop this program, including establishing and overseeing the contract with the Administrative Services Organization, and data development and analysis. Two positions will be established to support this and all other health delivery and payment reform initiatives in this bill (Section 30, subsection (d)(3), Health Homes; Section 30, subsection (d)(5) telemedicine; Section 31 (47.07.038) hospital emergency use reduction).

Personal Services:

One permanent full-time Medical Assistance Administrator IV for program development and management; Range 21, Anchorage; \$112.4 annually

One permanent full-time Medical Assistance Administrator III for data systems and analysis; Range 20 Anchorage; \$106.0 annually

Services: Office space, phones, reimbursable service agreements (RSAs) for position support costs: \$18.8 annually

Commodities: Office supplies: \$4.0 annually

One-Time Commodities Cost: Computer, software, and office equipment: \$15.2

**Section 30 (d)(3)** directs the department to implement the Health Homes option under section 1945 of the Social Security Act. Health Homes provide integrated and coordinated care for people with chronic health conditions. The department would need approximately two years for planning and development prior to implementation in order to determine eligibility criteria for recipients and for providers, design the new payment methodology and required reporting systems, develop and receive approval on the State Plan Amendment and associated regulations, and make required modifications to the Medicaid Management Information System.

The planning phase for this initiative would begin in FY2018, with implementation in FY2020. The positions established to develop the Primary Care Case Management system (Section 29 of this bill) will staff this initiative.

**Section 31, pp.30-31 (47.07.038)** directs the department to establish, in collaboration with the Alaska State Hospital and Nursing Home Association, a hospital-based project designed to reduce the use of hospital emergency

**Analysis Continued**

departments by Medicaid enrollees.

The department proposes the existing Health Information Exchange (HIE) be utilized as the foundational technology for electronic exchange of patient information among hospital emergency departments. This technology is already in place, but education and outreach to emergency department staff to help them learn how to use the HIE is required.

Program staff support would be required for negotiation and contracting with hospitals for the shared-savings payment reform associated with this initiative, and also for data systems and analysis. The positions established to develop the Primary Care Case Management system (Section 29 of this bill) will staff this initiative.

**Section 31 (47.07.039)** directs the department to contract with one or more third parties to implement one or more coordinated care demonstration projects for Medicaid recipients, with proposals requested on or before 12/31/2016. Demonstration projects must include three or more of the following: comprehensive primary-care-based management for medical and behavioral health service; care coordination including assignment of recipients to local primary care providers, where possible; health promotion; comprehensive transitional care and post-discharge follow-up care; referrals to community and social support services; sustainability and the ability to implement in other areas of the state; integration and coordination of benefits and services; and local accountability for health and resource allocation.

The demonstration projects will be implemented in three regions of the state. Planning and development would begin in FY2017, with implementation starting in FY2019. An estimated 30,000 Medicaid recipients would be enrolled to receive services through entities yet to be determined. The entities would be reimbursed on a fee-for-service basis plus shared-savings, with the entities receiving any savings accrued to the state Medicaid program, for the first two years. The entities would begin accepting financial risk in the third year, with a shared savings/shared losses payment plan implemented in FY2021.

Program staff support would be required for negotiation and contracting with the entities, and also for data systems and analysis. The positions established to develop the Primary Care Case Management system (Section 29 of this bill) will staff this initiative.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	34
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-RR-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Health Care Services  
 Allocation: Rate Review  
 OMB Component Number: 2696

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services	500.0		200.0	200.0	200.0	200.0	200.0	200.0
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>500.0</b>	<b>0.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	250.0		100.0	100.0	100.0	100.0	100.0
1003 G/F Match	250.0		100.0	100.0	100.0	100.0	100.0
<b>Total</b>	<b>500.0</b>	<b>0.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>	<b>200.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

**Why this fiscal note differs from previous version:**

Updated to reflect the provisions of the current CSSB074(FIN), version U.

Prepared By: Margaret Brodie, Director  
 Division: Health Care Services  
 Approved By: Sana Efird, Assistant Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)334-2520  
 Date: 03/04/2016 05:00 PM  
 Date: 03/08/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

**Section 28 (47.05.270(a)(8))** requires the Department to adopt regulations to design and implement a program for reforming the state medical assistance program under AS 47.07. The reform program must include redesigning the payment process by implementing fee agreements that include certain premium payments, penalties, bundled payments, and global payments. This work will specifically be accomplished through the demonstration projects required under Section 30 of the bill because the projects will focus on innovative payment models. Therefore, fiscal impact for this section is fully accounted for in the analysis of Section 30 of the bill (see below).

**Section 30 (47.07.036(e))** requires the Department to apply for a §1115 demonstration waiver to establish one or more demonstration projects focused on innovative payment models. The projects may include managed care organizations, community care organizations, patient-centered medical homes, or innovative payment models.

Redesigning payment processes and/or service delivery models would require changes in regulation, and possibly State Plan Amendments (in addition to the demonstration waiver). Changes in regulation would vary for each provider type and would require stakeholder input before implementation.

Demonstration projects that focus on innovative payment models, including a managed care system with care coordination and global payments, will involve complex data analysis and calculations that require actuarial expertise. Once an innovative payment model is established, administration of the system would still require actuarial expertise that is available by contract.

The initial and ongoing costs associated with hiring a contractor to perform this work are not fully known at this time. Based on consultation with other states and experts concerning the cost of actuarial services for Medicaid managed care systems, the Department estimates a one-time \$500.0 contract for a firm to analyze and implement one or more innovative payment models, and an annual \$100.0 contract for actuarial work and assistance with administration.

While the Department will contract for actuarial services and support, the Office of Rate Review will be responsible for the rate calculations and financial analysis. The Department anticipates that this work can be accomplished without adding any positions.

**Section 31 p. 33 (47.07.039(c))** requires that for any contract with a managed care organization, primary care case manager, accountable care organization, prepaid ambulatory health plan, or provider-led entity to implement a demonstration project, the fee structure may include global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures. Since this pertains to implementing a demonstration project and concerns innovative payment models, the fiscal impact for this section is fully accounted for in the analysis of Section 30 of the bill (see above).

**Section 31, p. 33 (47.07.039(e))** requires the Department 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. Starting in 2018, on or before December 31 of each year, the actuary must submit a final report to the department regarding any demonstration project that has been in operation for at least one year. Since this will likely result in actuarial review of multiple projects or project components each year in the immediate future, this work would be incorporated in the actuary contract described in the analysis of Section 30 of the bill (see above). To account for this increased workload, the Department estimates that the annual contract for actuarial work and assistance with administration would be increased by an additional \$100.0.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	35
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-FI-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Public Assistance  
 Allocation: Fraud Investigation  
 OMB Component Number: 237

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>	<b>FY 2020</b>	<b>FY 2021</b>	<b>FY 2022</b>
Personal Services			(46.0)	(46.0)	(46.0)	(46.0)	(46.0)
Travel							
Services	680.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>680.0</b>	<b>0.0</b>	<b>(46.0)</b>	<b>(46.0)</b>	<b>(46.0)</b>	<b>(46.0)</b>	<b>(46.0)</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	61.2		(23.0)	(23.0)	(23.0)	(23.0)	(23.0)
1004 Gen Fund	618.8		(23.0)	(23.0)	(23.0)	(23.0)	(23.0)
<b>Total</b>	<b>680.0</b>	<b>0.0</b>	<b>(46.0)</b>	<b>(46.0)</b>	<b>(46.0)</b>	<b>(46.0)</b>	<b>(46.0)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
 If yes, by what date are the regulations to be adopted, amended or repealed? n/a

**Why this fiscal note differs from previous version:**

Initial version; replacing a fiscal note for Public Assistance Administration.
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Prepared By: Sean O'Brien, Director  
 Division: Public Assistance  
 Approved By: Sana Efrid, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)465-5847  
 Date: 03/05/2016 10:00 PM  
 Date: 03/08/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

Section 24 of the proposed legislation directs the department to establish an enhanced computerized income, asset, and identity verification system in order to deter fraud and eliminate duplication of public assistance benefits. The department is directed to procure the system through a competitive contract with a third party vendor. The annual savings to the state resulting from the system must exceed the cost of the system.

## Assumptions:

The system will be web-enabled and interface electronically with the department's eligibility and enrollment system. Following a competitive process, the selected system will be implemented January 1, 2017, to allow the interface to begin along with full implementation of the division's new eligibility and enrollment system, ARIES.

The contractual system costs will be based on number of inquiries (encounters) submitted to the system. The estimated cost per encounter is 60 cents. The anticipated savings for cost avoidance will be used to offset the costs of the system starting in FY2018.

The Division of Public Assistance Fraud Unit may see a net savings of up to \$46.0 in personal services by FY2018 as a result of the overall decreased volume of cases the division will need to investigate as a result of this new system being able to screen out individuals who might have otherwise been found eligible.

The department received federal financial participation to fund the existing 12 interfaces (two state and ten federal) that provide an array of information to verify residency, citizenship, incarceration, felons, date of death, child support, intentional program violations in another state, identity and income. We anticipate very little federal financial participation for this new system because it duplicates many of these functions.

## One-time costs:

- ARIES related changes (interface design, security setup to allow single sign on, potential page display within ARIES): \$250,000.
- State implementation costs (process define, documentation updates, user acceptance testing, training, heightened support during implementation, potential IV&V support) \$400,000

**Section 31** of the proposed legislation directs the department to refer Medicaid recipients to community resources, Department of Labor and the University for education and career opportunities.

## Assumptions:

Notice will be sent from ARIES to refer adults approved for Medicaid to Department of Labor, universities or community resources.

The Division will program ARIES to send the new notice to adult Medicaid recipients who are not elderly or disabled.

## One-time cost:

- \$30.0, 75% of which will be federal funds and 25 percent will be state general funds.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	36
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-SDSA-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Senior and Disabilities Services  
 Allocation: Senior and Disabilities Services Administration  
 OMB Component Number: 2663

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>							
Personal Services	97.3		318.3	318.3	318.3	318.3	318.3
Travel	2.3		6.9	6.9	6.9	6.9	6.9
Services	186.8		408.6	325.9	10.5	10.5	10.5
Commodities	2.5		7.5	7.5	7.5	7.5	7.5
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>288.9</b>	<b>0.0</b>	<b>741.3</b>	<b>658.6</b>	<b>343.2</b>	<b>343.2</b>	<b>343.2</b>

### Fund Source (Operating Only)

1002 Fed Rcpts	217.8		444.0	402.6	171.6	171.6	171.6
1003 G/F Match	71.1		297.3	256.0	171.6	171.6	171.6
<b>Total</b>	<b>288.9</b>	<b>0.0</b>	<b>741.3</b>	<b>658.6</b>	<b>343.2</b>	<b>343.2</b>	<b>343.2</b>

### Positions

Full-time	1.0		3.0	3.0	3.0	3.0	3.0
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

### Why this fiscal note differs from previous version:

Updates personal services costs, allocates costs for assessments in FY2018 and FY2019 and corrects fund source for CS SB 74, version U.

Prepared By: Duane Mayes, Director  
 Division: Senior and Disabilities Services  
 Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)269-2083  
 Date: 03/05/2016 08:00 AM  
 Date: 03/08/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

**CSSB74(FIN)** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 28, p.25 lines 27-29** charge the Department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 30, p. 29, lines 10-13, subsections (d) (1) and (2)** of the bill more specifically directs the State to apply to the Centers for Medicare and Medicaid Services (CMS) to develop two new Medicaid funding authorities, the 1915(i) and 1915(k) State Plan options. Under these new authorities the state will realize savings in the provision of home and community-based services (HCBS).

Services under these new funding authorities will reduce general fund expenditures by replacing 100% general fund services with 50% fed / 50% GF match (1915(i) option) or capturing a higher federal match rate (1915(k)).

In FY2018 and FY2019, the department anticipates new costs associated with initial eligibility assessments of individuals previously served through the general fund grant programs or services. The estimated number of new assessments = 1,539. Cost per assessment = \$225.41 (not including travel). Assessments for 953 recipients transitioning from Community Developmental Disabilities Grant total \$214.8 in FY2018, at 50% fed / 50% GF match. Assessments for 586 recipients transitioning from Senior Community Based Grants and General Relief /Temporary Assistance total \$132.1 in FY2019, at 50% fed / 50% GF match. Total estimated cost (FY2018 and FY2019) to manage the 1,539 initial eligibility assessments = \$346.9.

In FY2017, FY2018 and FY2019 the Department anticipates additional expenditures related to the "Automated Services Plan" management information system. State staff, providers, and consumers will have access to the system and a public web resource center. The Department will plan and configure substantial, necessary software changes to this system for new assessments, additional programmatic elements, and interfaces with other department data management systems. Additional user accounts and licenses, and training and support for all users, will need to be developed and supported. The estimated costs for case management system development = \$ 550.0, eligible for enhanced federal funding at a 90 percent federal match, and spread in equal thirds over FY2017-2019.

Both the increased assessments at \$346.9, and case management system development at \$550.0, will be services line item expenditures. These costs will be realized in the development years, while the savings will continue and grow as overall expenditures grow.

To plan, develop, and manage the new program, beginning in FY2017 Senior and Disabilities Services will require three additional full-time staff: one staff person beginning in August 2016 (FY2017), and two more staff beginning in FY2018. These will be Health Program Manager II positions, located in Anchorage, in the GG unit, each = \$106.1; Travel = \$2.3; Services = \$3.5; Commodities = \$2.5. FY2017 personal services costs are prorated to reflect the August 1, 2016 start date.

Regulation changes are required to implement the new options and would involve extensive public comment. The estimated effective date of this regulation change is July 2017.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	37
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-GRTAL-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Senior and Disabilities Services  
 Allocation: General Relief/Temporary Assisted Living  
 OMB Component Number: 2875

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>

## Fund Source (Operating Only)

1004 Gen Fund				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>	<b>(4,689.9)</b>

## Positions

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

## ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

## Why this fiscal note differs from previous version:

Corrects the year of first anticipated UGF savings under 1915(i) option for CS SB 74 version U.

Prepared By: Duane Mayes, Director  
 Division: Senior and Disabilities Services  
 Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)269-2083  
 Date: 02/26/2016 03:00 PM  
 Date: 03/08/16

REPORTED OUT OF  
SFC 03/08/2016

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

Analysis

In part, **CSSB74(FIN)** authorizes the DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 28, p.25 lines 27-29** require the department to "reduce the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community based waiver."

**Section 19, lines 10-13, subsection (d) (1)** of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the Department the opportunity to shift eligible recipients from 100% general funded grant programs to the 50% federal/50% general fund funded 1915(i) Medicaid option.

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs. The Department assumes that all general relief recipients will be assessed for eligibility under the 1915(i) or behavioral health 1115 demonstration project. Of those assessed, the Department anticipates 349 being eligible for the 1915(i) option.

Current funding for GR program: \$7,323.9

Total number served: 545

Average cost per individual: \$13,438.35

Estimated eligible for 1915(i): 349

General fund services to be refinanced through the 1915(i) Medicaid option = \$ 4,689.9

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for temporary assisted living services to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	38
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-SCBG-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Senior and Disabilities Services  
 Allocation: Senior Community Based Grants  
 OMB Component Number: 2787

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					(735.2)	(735.2)	(735.2)	(735.2)
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>

**Fund Source (Operating Only)**

1004 Gen Fund				(735.2)	(735.2)	(735.2)	(735.2)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>	<b>(735.2)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

**Why this fiscal note differs from previous version:**

Corrects the year of first anticipated UGF savings under 1915(i) option for CS SB 74, version U.
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Prepared By: Duane Mayes, Director  
 Division: Senior and Disabilities Services  
 Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)269-2083  
 Date: 02/26/2016 03:00 PM  
 Date: 03/08/16

**REPORTED OUT OF**  
**SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

In part, **CSSB74(FIN)** authorizes the DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 28, p. 25 lines 27-29** charge the Department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 30, p. 29, lines 11-13** direct the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the Department the opportunity to shift eligible recipients from 100% general funded grant programs to the 50% federal/50% general fund funded 1915(i) Medicaid option.

The Department will use this option to refinance the Senior Community Based Grant component's Adult Day and Senior In-Home Services for those who are receiving the service and are also Medicaid eligible.

Adult Day Grant: Total general fund expenditures = \$1,757.0, serving 423 recipients. Of those, the Division of Senior and Disabilities Services (SDS) anticipates serving 114 under the 1915(i) option with an average cost per individual of \$4,153.69. Estimated general fund Adult Day grant services to be refinanced with the 1915(i) Medicaid option = \$473.5.

Senior In-Home Grant: Total general fund expenditures = \$2,917.3, serving 1,371 individuals. Of those, SDS anticipates serving 123 under the 1915(i) option with an average cost per individual of \$2,127.84. Estimated general Senior In-Home grant services to be refinanced with the 1915(i) Medicaid option = \$261.7.

The combined estimated general fund to be refinanced through the use of the 1915(i) option = \$735.2.

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for senior community based services to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	39
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-CDDG-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Senior and Disabilities Services  
 Allocation: Community Developmental Disabilities Grants  
 OMB Component Number: 309

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits			(5,817.9)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>(5,817.9)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>

**Fund Source (Operating Only)**

	FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
1037 GF/MH			(5,817.9)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>(5,817.9)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>

**Positions**

	FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Full-time							
Part-time							
Temporary							

**Change in Revenues**

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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/18

**Why this fiscal note differs from previous version:**

Corrects the year of first anticipated UGF savings under 1915(i) option for CS SB 74, version U.

Prepared By: Duane Mayes, Director  
 Division: Senior and Disabilities Services  
 Approved By: Sana Efir, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)269-2083  
 Date: 03/05/2016 12:00 AM  
 Date: 03/08/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

In part, **CSSB74 (FIN)** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 28, p.25 lines 27-29** charge the department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 30 (d) (1)** of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the Department the opportunity to shift eligible recipients from 100% general funded grant programs to the 50% federal/50% general fund funded 1915(i) Medicaid option.

Individuals receiving home and community-based services through the Community Developmental Disabilities Grant (CDDG) program must meet the definition of a person with a developmental disability presented in AS 47.80.900. The CDDG program provides home and community-based services to support individuals' desire to live as independently as they are able.

The Department will use the 1915(i) funding option to refinance services provided through the Community Developmental Disabilities Grant program. 969 individuals accessed CDDG services in FY2015 with an average cost per recipient of \$12,008.04 per individual per year, for a total budget of \$11,635.8 general funds. All recipients could be transitioned from the CDDG program to the 1915(i) Medicaid option.

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for community developmental disabilities services to be implemented by January 1, 2018. Savings have been prorated for FY2018.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	40
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-CO-3-8-16  
Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
DATABAS  
Sponsor: KELLY  
Requester: Senate Finance Committee

Department: Department of Health and Social Services  
Appropriation: Departmental Support Services  
Allocation: Commissioner's Office  
OMB Component Number: 317

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below.

(Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	496.4		496.4	496.4	496.4	496.4	496.4	496.4
Travel	9.6		9.6	9.6	9.6	9.6	9.6	9.6
Services	772.6		37.6	37.6	37.6	37.6	37.6	37.6
Commodities	38.4							
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>1,317.0</b>	<b>0.0</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>

## Fund Source (Operating Only)

1002 Fed Rcpts	291.0		271.8	271.8	271.8	271.8	271.8	271.8
1003 G/F Match	291.0		271.8	271.8	271.8	271.8	271.8	271.8
1004 Gen Fund	735.0							
<b>Total</b>	<b>1,317.0</b>	<b>0.0</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>	<b>543.6</b>

## Positions

Full-time	4.0		4.0	4.0	4.0	4.0	4.0	4.0
Part-time								
Temporary								

Change in Revenues								

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 (separate supplemental appropriation required)  
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

## ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? no  
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

## Why this fiscal note differs from previous version:

Corrected typo in feasibility study cost in analysis.

Prepared By: Melissa Ordner, Budget Manager  
Division: Departmental Support Services  
Approved By: Sana Efir, Asst. Commissioner, Finance and Management Services  
Agency: Health and Social Services

Phone: (907)465-1629  
Date: 03/05/2016 09:00 PM  
Date: 03/08/16

REPORTED OUT OF  
SFC 03/08/2016

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

Analysis

**Section 40** of this bill directs the Department to conduct a study analyzing the feasibility of privatizing services delivered at some of the Department's 24/7 residential facilities - Alaska Pioneer Homes and select facilities in the Division of Juvenile Justice (DJJ). In addition, the Department is directed to, in conjunction with the Alaska Mental Health Trust Authority, conduct a study analyzing the feasibility of privatizing services delivered at the Alaska Psychiatric Institute. A summary of the findings is due to the legislature by the 10th day of the first regular session of the thirtieth legislature.

The Division of Alaska Pioneer Homes (AKPH) has a central office, a pharmacy, and six 24-hour facilities which provide assisted living care and memory care to residents. In total, the central office, pharmacy, and six facilities account for 600 permanent positions and 501 licensed assisted living home beds.

The Division of Juvenile Justice operates eight 24-hour Alaska youth facilities that account for 342 permanent positions and 258 beds.

The Alaska Psychiatric Institute is a 24-hour, 80 bed, nationally accredited inpatient psychiatric hospital employing about 250 permanent staff and organizationally housed within the Division of Behavioral Health (DBH).

The Department will contract out for this study, which will assess the most common types of privatization and rank them by applicability for DHSS residential services.

The contractor will need to provide:

- (1) a final written feasibility analysis report
- (2) a comprehensive assessment of the ranked privatization options
- (3) an analysis of the impact to DHSS DJJ, AKPH and API services and clientele thereof that privatization will cause
- (4) employer costs resulting from any labor relations and/or union contract stipulations regarding privatizing state employee duties
- (5) recommendations for cost saving measures that would help the Department if privatization is not feasible

The contractor must consider:

- the complex nature of the population served by each facility
- the variety of Alaskan communities
- stakeholders' needs

The contractor must bring to bear considerable expertise in the services and systems, legal authorities, frameworks and funding mechanisms specific to the two Divisions. Additionally, the contractor must have knowledge of the process and outcomes of privatization of similar services in other states, and specific application to services provided in Alaska.

To arrive at the estimated contract cost of \$735.0, the Department assumed that the options outlined by the National League of Cities guidance regarding privatizing municipal services are followed (see <http://www.nlc.org/Documents/Find%20City%20Solutions/Research%20Innovation/Economic%20Development/privitizing-municipal-services-gid-10.pdf>) and contractors would charge similar rates to those previously paid by DHSS. In addition, a well-planned feasibility study would require on-site visits.

Included in this note is the creation of the Tribal Federal Liaison Section that will aggressively move forward on the new Centers for Medicare and Medicaid Services (CMS) policy to obtain maximum savings in as quick a timeline as possible. This section would have statewide multi-division and departmental responsibility for effectively implementing tasks to obtain maximum refinancing and savings associated with the CMS policy clarification on tribal claiming. It would include federal tribal liaison work with CMS, covering all aspects of the Alaska Medicaid program.

**Analysis Continued**

This section will be responsible for achieving the enhanced savings in tribal claiming shown in the Health Care Medicaid Services component. **These positions have also been proposed in the House and Senate Finance subcommittee recommendations for the DHSS operating budget.**

Enhanced federal funding for the Medicaid program is contingent upon development and implementation of referrals, care plans and claiming for services to Alaska Native and American Indians (AN/AI). This will require maintaining and amending the Medicaid State Plan in accordance with federal requirements and regulations. As such, this section will provide department-wide oversight and expert policy analysis to meet the new CMS policy requirements.

This new section will be made up of four new positions: One Division Operations Manager, two Medical Assistance Administrator IVs, and one Medical Assistance Administrator I. Costs are as follows.

Personal Services: One permanent full-time Division Operations Manager; Range 24, Juneau; \$ 152.9 annual cost

Two permanent full-time Medical Assistance Administrator IV; Range 21, Juneau; \$ 249.8 annual cost

One permanent full-time Medical Assistance Administrator I; Range 16, Juneau; \$ 93.6 annual cost

Travel: 9.6 annually (only the Manager and one Administrator IV will travel)

Services: Office space, phones, reimbursable service agreements (RSA) for position support costs: \$37.6 annually

Commodities: Office supplies: \$8.0 annually

One-Time Commodities Cost: Computer, software, and office equipment: \$30.4 (FY2017)

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	41
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-BHMS-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Medicaid Services  
 Allocation: Behavioral Health Medicaid Services  
 OMB Component Number: 2660

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>	<b>FY 2017</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>	<b>FY 2020</b>	<b>FY 2021</b>	<b>FY 2022</b>
Personal Services							
Travel							
Services	250.0		3,750.0	5,300.0	5,500.0	5,800.0	5,800.0
Commodities							
Capital Outlay							
Grants & Benefits			1,100.0	4,600.0	8,700.0	13,200.0	13,200.0
Miscellaneous							
<b>Total Operating</b>	<b>250.0</b>	<b>0.0</b>	<b>4,850.0</b>	<b>9,900.0</b>	<b>14,200.0</b>	<b>19,000.0</b>	<b>19,000.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	125.0	2,750.0	6,187.0	10,132.0	13,804.0	17,794.0	17,794.0
1037 GF/MH	125.0	(2,750.0)	(1,337.0)	(232.0)	396.0	1,206.0	1,206.0
<b>Total</b>	<b>250.0</b>	<b>0.0</b>	<b>4,850.0</b>	<b>9,900.0</b>	<b>14,200.0</b>	<b>19,000.0</b>	<b>19,000.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 1,000.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

**Why this fiscal note differs from previous version:**

This fiscal note has been updated to reflect the provisions of CSSB74(FIN) version U.

Prepared By:	Randall P. Burns, Acting Director	Phone:	(907)269-5948
Division:	Behavioral Health	Date:	03/05/2015 06:00 PM
Approved By:	Sana Efird, Asst. Commissioner, Finance and Management Services	Date:	03/08/16
Agency:	Health and Social Services		

**REPORTED OUT OF**  
**SFC 03/08/2016**

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

Analysis

**Section 28 of CSSB74(FIN)** adds a new section, AS 47.05.270, entitled "Medical assistance reform program." New subsection AS 47.05.270(b) instructs the Department of Health and Social Services (DHSS), in coordination with the Alaska Mental Health Trust Authority, to "manage a comprehensive and integrated behavioral health program," including a plan for providing a continuum of community-based services from a wide array of providers and disciplines that addresses housing, employment, and criminal justice, and reduces barriers that fragment services and reduce effectiveness and efficiency. It is expected that Alaskans served by the criminal justice system will benefit from the reformed system of behavioral health care, and savings will be realized in the Department of Corrections, Public Safety and the Court system as well as within the Office of Children's Services.

**Section 30** adds new subsections AS 47.07.036(d)(4) and (5) that authorize the Department to develop demonstration projects for innovative service delivery and payment models, and provide incentives for telehealth. New subsection AS 47.07.036(e) requires the Department to seek 1115 demonstration waivers from the Centers for Medicare and Medicaid Services (CMS), and subsection (f) requires that one of these 1115 waivers focus on behavioral health system improvements for Medicaid recipients. These system improvements must be consistent with the improvements expected under Section 28, p. 26 of the bill (47.05.270(b)) that are intended to improve access to quality care while managing costs.

Following CMS approval of the 1115 behavioral health Medicaid demonstration waiver, DHSS will apply to amend that waiver to expand access to substance use disorder services. The amendment will seek an Institution for Mental Diseases (IMD) exclusion for those services currently not reimbursed by Medicaid that are provided in an inpatient or residential substance use disorder setting having more than 16 beds. Starting in FY2018, the division will contract with an Administrative Services Organization (ASO) to develop and manage a network of providers; establish utilization management; provide quality and outcomes reporting; provide fraud, waste, and abuse auditing; and demonstrate benchmarks on healthcare outcomes and quality.

This fiscal note includes \$250.0 in both SFY2017 and SFY2018 for consulting contracts to assist the Department in the design and implementation of a managed behavioral health system of care, and to assist with development of the 1115 demonstration waiver application.

The design and implementation of a managed system of behavioral health care will require necessary changes to the Medicaid Management Information System (MMIS).

Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal\10% GF match)

The table below summarizes the Behavioral Health Medicaid Services operating costs of this legislation. Costs are subject to a blended FMAP rate of between 50% and 100%, depending on the populations served.

Behavioral Health Medicaid Services						
Summary of Operating Expenditures						
	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Grants: Change in Medical Costs due to Medicaid Redesign Initiatives		\$ 1,100.0	\$ 4,600.0	\$ 8,700.0	\$ 13,200.0	\$ 13,200.0
Services: Administrative Service Organization Contract		\$ 3,500.0	\$ 5,300.0	\$ 5,500.0	\$ 5,800.0	\$ 5,800.0
Services: 1115 Consulting Contract	\$ 250.0	\$ 250.0				
<b>Total Expenditures</b>	<b>\$ 250.0</b>	<b>\$ 4,850.0</b>	<b>\$ 9,900.0</b>	<b>\$ 14,200.0</b>	<b>\$ 19,000.0</b>	<b>\$ 19,000.0</b>

**Analysis Continued**

**Section 38** directs the Department to collaborate with Alaska tribal health organizations to implement federal policy on tribal Medicaid reimbursement. The Department, anticipating benefits from the recently published CMS national policy allowing states to broaden the range of services eligible for 100% Federal Medical Assistance, has projected impacts in the initial years of policy implementation. This fiscal note addresses a percentage of the total expenditures for Alaska Native/American Indian (AN/AI) recipients served at the largest in-state, *non-tribal* RPTC's facilities, then working into the out-of-state medium and smaller sized facilities as the contracting process is refined and the policy fully understood.

Percentage of total payments to non-tribal Residential Psychiatric Treatment Centers (RPTC) FY2015

Based on SFY2015 data, which indicated that there were a total of 193 unduplicated AN/AI recipients receiving RPTC services at non-tribal sites, DHSS projected the maximum State benefit that could be realized from the new tribal policy between now and SFY2021; that total is \$6,050.0 (estimated \$12,100.0 in expenditures by 2021, at the previous FMAP rate of 50%). Under the new policy, the chart below shows in-state provider savings beginning in SFY2017 (\$2,750.0). From FY2018 forward, out-of-state providers are added for an additional savings of \$825.0 in each subsequent year.

RPTC svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 2,750.0	\$ 3,575.0	\$ 4,400.0	\$ 5,225.0	\$ 6,050.0	\$ 6,050.0
GF/MH	\$ (2,750.0)	\$ (3,575.0)	\$ (4,400.0)	\$ (5,225.0)	\$ (6,050.0)	\$ (6,050.0)

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	42
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-SDMS-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Medicaid Services  
 Allocation: Senior and Disabilities Medicaid Services  
 OMB Component Number: 2662

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits			5,817.9	17,061.0	17,061.0	17,061.0	17,061.0	17,061.0
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>5,817.9</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>

### Fund Source (Operating Only)

1002 Fed Rcpts		2,900.0	10,616.1	34,237.7	43,737.7	48,687.7	53,637.7
1003 G/F Match		(2,900.0)	(4,798.2)	(17,176.7)	(26,676.7)	(31,626.7)	(36,576.7)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>5,817.9</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>	<b>17,061.0</b>

### Positions

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 1,200.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

### ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

### Why this fiscal note differs from previous version:

For version U: Corrects the year of first anticipated UGF savings under 1915(i) and (k) option, aligning with related fiscal notes for the three Senior and Disabilities Services (SDS) grants program components, General Relief/Temporary Assisted Living, Senior Community-Based Grants, and Community Developmental Disabilities Grants. Also added Federal Tribal Federal Medical Assistance Percentages (FMAP) policy and one time capital cost for changes to MMIS system.

Prepared By: Duane Mayes, Director  
 Division: Senior and Disabilities Services  
 Approved By: Sana Efrid, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)269-2083  
 Date: 03/05/2016 10:00 AM  
 Date: 03/08/16

**REPORTED OUT OF**  
**SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

In part, **CSSB74(FIN)** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

**Section 28, p.25, lines 27-29** charge the Department with "reducing the cost of... senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver."

**Section 30 (d) (1)** directs the Department to apply for the **1915(i)** option under Medicaid. The 1915(i) option includes a federal match of 50%, reducing to 50% what is currently a 100% general fund contribution for certain services.

The Department will use this option to refinance portions of the following 100% GF-funded grant programs: General Relief/Temporary Assistance (GR), certain Senior Community Based Grant components (SCBG), and Community Developmental Disabilities Grant (CDDG).

1915(i) Refinancing (\$8,530.5 estimated net general fund savings across Senior and Disabilities Services (SDS) grant programs and SD Medicaid):

General Relief/Temporary Assistance Grants: Services for 349 of 545 current recipients at an average cost of \$13,438.35 = \$4,689.9, or \$2,345.0 in net GF savings.

Adult Day Grants: Services for 114 of 423 recipients at an average cost of \$4,153.69 = \$473.5, or \$236.8 in net GF savings.

Senior In-Home Grants: Services for 123 of 1,371 recipients at an average cost of \$2,127.84 = \$267.1, or \$130.8 in net GF savings.

Community Developmental Disabilities Grants: Services for all recipients, total grant budget of \$11,635.8, or \$5,817.9 in net GF savings.

Changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option for CDDG recipients to be implemented effective 01/01/2018 (FY2018) and for General Relief/Temporary Assistance and Senior Community Based Grant recipients to be implemented effective 07/01/2018 (FY2019).

**Section 30 (d) (2)** of the bill directs the Department to apply for the **1915(k)** option under Medicaid. The "Community First Choice Option" (CFC), also known as 1915(k), will be used for people who meet an institutional level of care (LOC). The 1915(k) option authorities will replace all current 1915(c) waivers for all 1915(k) services, as all 1915(c) recipients do meet the level of care. The 1915(k) option offers a 56% federal match, an increase of 6%, thus lowering the general fund match to 44%.

The service of Personal Care Assistance (PCA), for persons on the 1915(c) waivers, would transition to the 1915(k) state plan option authority.

Number of recipients on the 1915(c) waiver also receiving PCA Services = 1,603

General fund Spend (current) at FMAP (50%) = \$20,893.4

General fund Spend for PCA under proposed 1915(k) option at FMAP (56%) = \$18,386.2

The program transition results in annual general fund savings of \$2,507.2

Implementation of the new funding option will require substantial changes to the current Home and Community Based Services (HCBS) operational infrastructure. The estimated effective date for this refinancing proposal from (c) to (k) is 7/1/2017 (FY2018).

Design and implementation of 1915(i) and 1915(k) options will require resources to support necessary changes to

Analysis Continued

Enterprise, or the Medicaid Management Information System (MMIS). **Capital Budget: One-time MMIS system changes: \$1,200.0**

Under **Section 38** of the bill, the Department of Health and Social Services shall collaborate with Alaska tribal health organizations and the United States Department of Health and Human Services to fully implement changes in federal policy that authorize 100 percent federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid.

Based on this information from Centers for Medicare and Medicaid Services (CMS), the Department has examined the number of Alaska Native/American Indian (AN/AI) Medicaid beneficiaries who received services in FY2015 at non-tribal facilities in order to estimate the additional federal Medicaid funds Alaska could claim under the new rule.

For the Division of Seniors and Disabilities Services (SDS), tribal members who receive services at nontribal nursing facilities are impacted by these changes. This fiscal note addresses a percentage (spanning across FY2017 to FY2022) of the total expenditures for AN/AI recipients, starting with larger communities and then phasing in the rest of the state. The SDS will implement these provisions for home and community and based services in FY2019 to accommodate the implementation of the CMS-mandated Conflict Case Management in FY2017 and FY2018.

Total Nursing Facility for 2015

Includes 139 unduplicated AI/AN recipients at 14 non-tribal sites in SFY2015 (excluding existing tribal facilities). 50 percent of the 12 month total of \$25,650.0 = **\$12,800.0 to be realized incrementally over the six year, FY2017 - FY2022 period.**

- In 2017, \$2,900.0
- In 2018, \$5,200.0
- In 2019, \$8,300.0
- In 2020, \$9,800.0
- In 2021, \$11,300.0
- In 2022, \$12,800.0

Total Home and Community Based (HCB) for 2015

Total of 1,486 unduplicated AI/AN recipients at non-tribal HCB agencies in SFY2015 (excluding existing tribal facilities). 50 percent of the 12 month total of \$59,600,000 = **\$29,800.0 to be realized incrementally over the four year, FY2019 - FY2022 period.**

- In 2019, \$14,900.0
- In 2020, \$22,900.0
- In 2021, \$26,350.0
- In 2022, \$29,800.0

nursing facilities	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 2,900.0	\$ 5,200.0	\$ 8,300.0	\$ 9,800.0	\$ 11,300.0	\$ 12,800.0
GF match	\$ (2,900.0)	\$ (5,200.0)	\$ (8,300.0)	\$ (9,800.0)	\$ (11,300.0)	\$ (12,800.0)
HCB svcs						
fed			\$ 14,900.0	\$ 22,900.0	\$ 26,350.0	\$ 29,800.0
GF match			\$ (14,900.0)	\$ (22,900.0)	\$ (26,350.0)	\$ (29,800.0)
SDMS Total						
fed	\$ 2,900.0	\$ 5,200.0	\$ 23,200.0	\$ 32,700.0	\$ 37,650.0	\$ 42,600.0
GF match	\$ (2,900.0)	\$ (5,200.0)	\$ (23,200.0)	\$ (32,700.0)	\$ (37,650.0)	\$ (42,600.0)

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	44
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-HCMS-3-8-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Rules

Department: Department of Health and Social Services  
 Appropriation: Medicaid Services  
 Allocation: Health Care Medicaid Services  
 OMB Component Number: 2077

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services	1,887.5		536.5	436.5	436.5	436.5	436.5	436.5
Commodities								
Capital Outlay								
Grants & Benefits	(1,550.3)		(4,304.9)	(16,795.7)	(22,487.1)	(28,644.1)	(32,548.4)	(32,548.4)
Miscellaneous								
<b>Total Operating</b>	<b>337.2</b>	<b>0.0</b>	<b>(3,768.4)</b>	<b>(16,359.2)</b>	<b>(22,050.6)</b>	<b>(28,207.6)</b>	<b>(32,111.9)</b>	<b>(32,111.9)</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	20,407.1	6,700.0	31,427.1	28,710.4	29,464.7	29,986.2	28,034.1
1003 G/F Match	(20,204.8)	(6,700.0)	(35,372.9)	(45,289.4)	(51,735.1)	(58,413.6)	(60,365.8)
1108 Stat Desig	134.9		177.4	219.8	219.8	219.8	219.8
<b>Total</b>	<b>337.2</b>	<b>0.0</b>	<b>(3,768.4)</b>	<b>(16,359.2)</b>	<b>(22,050.6)</b>	<b>(28,207.6)</b>	<b>(32,111.9)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 6,900.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
 If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

**Why this fiscal note differs from previous version:**

Corrected calculations for coordinated care demonstration project under Section 31 (47.07.039)(c).
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Prepared By: Margaret Brodie, Director  
 Division: Health Care Services  
 Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services  
 Agency: Health and Social Services

Phone: (907)334-2520  
 Date: 03/06/2016 06:30 PM  
 Date: 03/08/16

**REPORTED OUT OF**  
**SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

**Section 10 (Chapter 58) (Sec. 09.58.010)** establishes the Alaska Medicaid False Claim and Reporting Act (AMFCA) and includes several subsections related to liability for certain acts and omissions, civil actions, rights of participants in such actions, seizures of property related to Medicaid fraud cases, awards allowed, actions that are not allowed, limits on state liability, and protections for whistleblowers. The Department recovered \$250.0 per year for the last two fiscal years for whistleblower recoveries. Under the new law these recoveries are estimated to triple to \$750.0 *each fiscal year*. Whistleblowers will receive approximately 25% of the ultimate recovery, leaving 75% for the State, or \$562.5. Compared to current annual recoveries, this represents an increase of \$312.5 annually. A conservative estimate of \$100.0 of recoverable overpayments subject to the treble damages provision equates to an additional \$300.0 in recoveries annually. Receipt of these recoveries will be categorized as *abatements of expenditures*.

<b>AMFCA recoveries FY 2017</b>	<b>\$306,250</b>
<b>AMFCA annual recoveries FY 2018-FY2019</b>	<b>\$612,500</b>
<b>AMFCA annual recoveries FY 2020-FY2022</b>	<b>\$512,500</b>

**Section 25 (a)** decreases the number of required audits of Medicaid providers, conducted by an independent contractor, from at least 75 annually to at least 50 annually. Audits are conducted on a representative sample of all Medicaid providers in order to identify both overpayments and violations of criminal statutes. The department is directed to attempt to minimize concurrent state or federal audits of specific providers. This section of the bill will have no fiscal impact on the department. Any change in the cost of audits is estimated to be offset by a change in recoveries.

**Section 26 (b)** allows the Department to assess interest on recoveries for audits performed under AS 47.05.200 as well as other audits and reviews conducted by the state and federal government. There is no additional cost to the department to implement interest penalties on identified overpayments, but recoveries will increase. The Department estimates it will take three years to reach the current volume of outstanding appeals subject to interest penalties. Interest penalty recoveries are calculated by taking the current amount of outstanding appeals and applying an estimated recovery percentage. The result is multiplied by the statutory rate for post-judgment interest of 3.75% and phased in over a period of three years, as shown below. (50% fed/50% GF match)

<b>Amount of Interest Penalty Recoveries FY2017</b>	<b>\$ 84,910</b>
<b>Amount of Interest Penalty Recoveries FY2018</b>	<b>\$127,365</b>
<b>Amount for FY2019-FY2022</b>	<b>\$169,821</b>

**Section 27** requires enrolled Medicaid providers to conduct one biennial review, identify overpayment and report findings to the department within ten business days, and create a repayment agreement with the state. The DHSS currently receives an average of approximately \$500,000 in self disclosures annually. Although it is currently required by federal law, the DHSS estimates an increase in self-reporting of approximately 100% would result by requiring biennial audits. Based on the Department's prior experience with self-disclosure recoveries, the State can expect to receive an estimated \$500,000 in additional recoveries for the first 2 years, then decreasing \$25,000 annually to FY2022.

Regulations required to implement the provisions of the bill. Receipt of repayments will be categorized as abatements.

<b>Amount of Self-Identified Recoveries FY2017</b>	<b>\$ 500,000</b>
<b>Amount of Self-Identified Recoveries FY2018</b>	<b>\$ 500,000</b>
<b>Amount of Self-Identified Recoveries FY2019</b>	<b>\$ 475,000</b>
<b>FY 2020</b>	<b>\$ 450,000</b>
<b>FY 2021</b>	<b>\$ 425,000</b>
<b>FY 2022</b>	<b>\$ 400,000</b>

Analysis Continued

**Section 28** grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers. Fines are to be assessed within a range of from \$100 to \$25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section. Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. The estimated amount of the recoveries would be \$50.0 per year. (50% fed/50% GF match). These recoveries are categorized as revenue receipts. This Section 11 also addresses overpayments and restitution from providers who are subject to Civil Forfeiture laws. During the past two years, overpayments and restitution amounts of \$5,650.0 were due from providers who may be subject to Civil Forfeiture laws. Annualized, this amounts to \$2,825.0. The DHSS estimates that 10% of this amount is recoverable through civil forfeiture or \$282.5 annually. Regulations will be required to implement these provisions of the bill. Receipt of these overpayments will be categorized as *abatements of expenditures*.

Annual recoveries from fines	\$ 50,000
<u>Annual Recovery from Civil forfeiture</u>	<u>\$ 282,500</u>
<b>Annual recoveries for FY2017-FY2022</b>	<b>\$ 332,500</b>

**Section 28 47.05.270 Medical assistance reform program (a) (2)** of this bill requires the department to provide an electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program. It is the intent of the department to fully implement this section of the bill through the My Alaska Portal . It estimates that it will cost \$707,500 (90% federal/10% GF) to fully implement the electronic distribution of an explanation of medical assistance benefits in FY2017. After the initial set-up, estimated on-going costs are the concurrent user license, \$76,500, and the yearly maintenance fee, \$17,000, for a total of \$93,500 (50% federal/50% GF) annual costs.

**Section 28 47.05.270(a)(9)** directs the department to provide for stakeholder involvement in setting annual targets for quality and cost effectiveness. Existing department employees will staff this effort, and meetings of the workgroup will occur telephonically with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 annually for consultant contract**

**Section 29** directs the department to implement the Primary Care Case Management system authorized under AS 47.07.030(d). This is a foundational component to other initiatives and projected savings. This system would assign Medicaid enrollees to a case manager in order to increase use of primary and preventive care, and decrease the use of specialty care and hospital services. The department proposes expansion of an existing case management contract, at \$500.0 across FY2017-2018 (50% federal\50% GF match). The contractor will case manage at \$3.85 per member per month to approximately 30,000 recipients. This approach would reduce implementation timelines.

This initiative will require planning and development in SFY2017 with implementation in the 2<sup>nd</sup> quarter SFY2018 (on Oct 1, 2017). Activities will include determining regions/communities for which PCCM is practicable and determining populations/beneficiary groups to include in PCCM. It also includes drafting a SPA, regulations, revising beneficiary and provider manuals, provider education, evaluation and reporting plan, to compare before and after costs and patient outcomes, MMIS system changes to add per member per month payments.

Funding is also required to implement associated changes to MMIS, including one-time capital funds for systems changes, and additional contractual costs for on-going operations.

**Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)**

**Analysis Continued**

Once primary care case management is fully implemented, the department projects an increase in expenditures for physician services, but a decrease in outpatient, inpatient, and pharmacy services to produce a net savings of:

FY2017	(\$596,389)
FY2018	(\$1,787,333)
FY2019	(\$4,375,526)
FY2020	(\$6,963,720)
FY2021	(\$9,517,530)
FY2022	(\$9,517,530)

**Section 30 (d)(3)** directs the department to implement the Health Homes option under section 1945 of the Social Security Act. Health Homes provide integrated and coordinated care for people with chronic health conditions. The federal government would provide a 90% enhanced Federal Medical Assistance Percentage (FMAP) reimbursement for the new Health Home services for the first eight quarters following their approval of the state's Medicaid State Plan Amendment.

The department would need approximately two years (SFY2017-2018) for planning and development prior to implementation in SFY2019, in order to determine eligibility criteria for recipients and providers, design the new payment methodology and required reporting systems, develop and receive approval on the State Plan Amendment and process associated regulations, and make required IT modifications to the Medicaid payment system.

Additional resources would also be required to support systems changes required in MMIS. A portion of these would be a one-time capital budget request, but the MMIS contract would also need to be increased on an on-going basis to support the new workload associated with payment reform.

**Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)**

The above planning and development work would move the department to an enhanced reimbursement/provider payment model and would follow 2 years after the Primary Care Improvement Initiative. This would lead to potentially paying enrolled Health Home providers per month for enrolled recipients (on top of regular fee-for-service reimbursement). Projected Savings would be assumed through utilization reduction factors specific to Health Homes and based on the above with a reduction in 0.25% of inpatient costs at \$5,230,000 (based on the FY 2016 budget line items) for the projected population of 10,000 recipients and offset by the projected 10,000 recipients X \$15.00 per member per month = \$150,000 X 12 months = \$1,800,000 for a **total projected future savings of \$3,430,000**

**Section 30 (d)(5)** directs the department to provide incentives for telehealth, including increasing the capability for and reimbursement of telehealth for recipients. The department's first step in implementing this new provision will be to convene a workgroup, including stakeholders from the health care community, for one year to identify legal, technical and financial barriers to increasing use of telehealth in Alaska.

Existing department employees will staff this effort, and meetings of the workgroup will occur telephonically with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 one-time cost in FY2017 for consultant contract.**

## Analysis Continued

FY2017 will be used to implement the final recommendations of the workgroup. Once those recommendations are fully implemented, the department expects the following savings:

FY2018	(\$1,300,000)
FY2019	(\$2,600,000)
FY2020	(\$5,800,000)
FY2021	(\$9,400,000)
FY2022	(\$13,300,000)

**Section 31 (47.07.038)** authorizes the department to support private initiatives designed to reduce non-urgent use of hospital emergency departments by Medicaid enrollees. The department's supporting role would include data sharing, support for the Prescription Drug Monitoring Program database, support for electronic health record sharing between participating hospitals' emergency departments, and development of a shared savings payment model reflected below.

The planning phase for this initiative would begin during FY2017, and the required data, reporting and information system infrastructure would be built in FY2018. The department would implement the shared-savings payment model in FY2019.

Resources would also be required to support Health Information Exchange interface and other changes related to payment reform for MMIS. A portion of these would be a one-time capital budget request.

**Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)**

The Prescription Drug Monitoring Program (PDMP) is an integral part of this initiative, as it is required to help prevent the misuse and abuse of opioids prescribed or administered through emergency departments. Access to the PDMP database by physicians and pharmacists could be improved if the current stand-alone system was integrated into the Health Information Exchange (HIE). The following costs are one-time in addition to \$20.0 annual operating costs:

**FY2017 PDMP system and interface to the HIE is \$285.0 (90% federal/10% GF), and FY2017 costs to connect pharmacies is \$480.0 (90% federal/10% GF)**

The projected DHSS savings from this would be calculated from reduced utilization in 2% of hospital outpatient services. **Total savings are estimated at \$3,200,000, including \$960,000 of shared savings paid to providers, for a savings to the department of \$2,240,000, with an increase of 0.5% to the savings in each subsequent year.**

**Section 31 (47.07.039)(C)** authorizes the department to contract with one or more entities to demonstrate the use of local, provider-led coordinated care entities that agree to monitor care across multiple care settings and that will be accountable to the department for the overall cost and quality of care. This demonstration project will be implemented in three regions of the state. Planning and development would begin in FY2017, with implementation starting in FY2019. An estimated 30,000 Medicaid recipients would be enrolled to receive services through this demonstration project. For purposes of estimation, the Department assumes the entities would be reimbursed on a fee-for-service basis plus shared-savings, with the entities receiving a portion of any savings accrued to the state Medicaid program, for the first two years. The department's best estimate at this time is approximately \$1,500,000 in GF savings. The state's fiscal agent will require an additional 3 staff members for the additional work in provider enrollment, claims processing, and telephone inquiries as a result of the change - **increase contract by \$318.0 (50% federal/50% GF)**. These individuals will provide support across the primary care case management project, health homes, and the hospital emergency room project as well.

**Analysis Continued**

The estimated capital budget start up cost for FY2017 is **\$3,125,000** for technical development and consulting services, reimbursed at 90% federal, 10% GF. On-going annual maintenance costs is expected to be approximately \$318,000 to the fiscal agent for Medicaid reform activities. These costs are placed in the operating budget and are reimbursed at 50% federal, 50% GF.

Program staff support would be required for negotiation and contracting with such entities, and also for data systems and analysis. The positions established to develop (Sec. 30(d)(3) Health Homes; Sec 29 Primary Care Case Management system) will staff this initiative as well.

**Section 38** directs the Department to implement federal policy on tribal Medicaid reimbursement to collaborate with Alaska tribal health organizations. The Department will utilize the Centers for Medicare and Medicaid (CMS) recent proposed clarification of national policy to allow states to broaden the range of services eligible for 100% Federal Medical Assistance. However, the Department is cautious in projecting the impacts in the initial years of implementation.

Total Transportation to US TRAVEL for 2015 Payments

Total Monthly average reimbursement for AI/AN transportation claims = \$3,000,000

Monthly average X 12 months = \$3,000,000 x 12 = \$36,000,000 total costs. The refinancing from 50% federal/50% GF match to 100% federal results in **\$18,000,000 in GF match savings**, with a reciprocal increase to federal costs. This fund source change is to be equally spread at 20% per year for five years, or **\$3,600,000 in annual, cumulatively building GF match savings across each subsequent year from FY2017-2021**. The multi-year spread is because the cost shift to 100% federal is assumed to take several years. Full savings achieved in FY2021, year five of the effort.

Total Ground and Air Ambulance for 2015

Total quarterly average reimbursement for AI/AN claims = \$3,100,000

Total quarterly at \$3,100,000 X 4 quarters = \$12,400,000 total costs. Results in **\$6,200,000 GF match savings** and a reciprocal increase in federal costs. Assume a two-year spread to shift costs to 100% federal. **\$3,100,000 in annual, cumulatively building GF match savings across the two-year span, FY2017-2018**. Full savings achieved in FY2018, year two.

To aggressively pursue the new Centers for Medicare and Medicaid Services (CMS) policy and realize an additional \$20 million in savings in FY2017, the Department is requesting a Tribal Federal Liaison section, staffed with 4 positions in the Commissioner's Office. This section will focus on achieving these additional savings as referrals and care plans are approved by CMS. **This additional \$20 million in savings for FY2017 has also been proposed in the House and Senate Finance subcommittee recommendations for the DHSS operating budget.**

US Travel	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 3,600.0	\$ 7,200.0	\$ 10,800.0	\$ 14,400.0	\$ 18,000.0	\$ 18,000.0
GF match	\$ (3,600.0)	\$ (7,200.0)	\$ (10,800.0)	\$ (14,400.0)	\$ (18,000.0)	\$ (18,000.0)
ambulance	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 3,100.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0
GF match	\$ (3,100.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)
Addn'l Savings	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0
GF match	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)
<b>Total</b>	<b>FY2017</b>	<b>FY2018</b>	<b>FY2019</b>	<b>FY2020</b>	<b>FY2021</b>	<b>FY2022</b>
fed	\$ 26,700.0	\$ 33,400.0	\$ 37,000.0	\$ 40,600.0	\$ 44,200.0	\$ 44,200.0
GF match	\$ (26,700.0)	\$ (33,400.0)	\$ (37,000.0)	\$ (40,600.0)	\$ (44,200.0)	\$ (44,200.0)

**Analysis Continued**

**Section 39** directs the department to develop a health information infrastructure plan to support transformation of the healthcare system in the state by providing data health care providers require for care coordination and quality improvement, and the information support required by the department and providers to enable development and implementation of other provisions of this act.

The department's existing Health Information Technology program will staff this effort, and meetings of the workgroup will occur telephonically at minimal cost with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 one-time cost in FY 17 for consultant contract.**

**Capital Costs:**

Health Information Infrastructure Plan development to improve health care outcomes through:

**OUTCOMES:**

- Outcome I - Provide Personal Health View
- Outcome II - Provide Population Data Analytical view
- Outcome III - Provide Health Care Provider View

**ASSUMPTIONS:**

Assumption I - The Plan will include the use of the existing Health Information Exchange (HIE)

Assumption II - The Plan will provide a communication infrastructure plan that will utilize new and existing systems that include Electronic Medical Record Systems, Electronic Health Record Systems, Personal Health Record Systems, Registries and Data interchange capabilities.

Assumption III - The plan will provide:

- "As-Is" view of the existing systems.
- Gap analysis of what is missing.
- "To-Be/Desired" view of the future state.
- Design roadmap with milestone investment targets to incrementally achieve "To-Be" state.
- Implementation plan to achieve To-Be state.

**PHASES:**

- Phase I - Requirements Gathering/Define As-Is environment.
- Phase II - Development To-Be/Desired state roadmap with Gap analysis of what is missing.
- Phase III - Design/Engineering Implementation Plan with phases and achievement goals to implement the Health Information Infrastructure Plan.

The estimated capital budget cost to implement these changes is **\$775.0**, 90% federal, 10% GF.

# Fiscal Note

State of Alaska  
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	43
(S) Publish Date:	3/9/2016

Identifier: SB074CS(STA)-LAW-CRIM-03-07-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Finance

Department: Department of Law  
 Appropriation: Criminal Division  
 Allocation: Criminal Appeals/Special Litigation  
 OMB Component Number: 2203

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
<b>OPERATING EXPENDITURES</b>								
Personal Services	316.6		316.6	316.6	316.6	316.6	316.6	316.6
Travel	1.5		1.5	1.5	1.5	1.5	1.5	1.5
Services	39.8		39.8	39.8	39.8	39.8	39.8	39.8
Commodities	6.1		6.1	6.1	6.1	6.1	6.1	6.1
Capital Outlay	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>365.0</b>	<b>0.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	273.7		273.7	273.7	273.7	273.7	273.7
1003 G/F Match	45.5						
1108 Stat Desig	45.8		91.3	91.3	91.3	91.3	91.3
<b>Total</b>	<b>365.0</b>	<b>0.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>

**Positions**

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

<b>Change in Revenues</b>	500.0		500.0	500.0	500.0	500.0	500.0
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2017) cost:** 0.0 *(separate capital appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
 If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

This version contains a technical adjustment to the fund sources for the state's 25% match requirement from the initial version.

Prepared By: Valerie Rose, Budget Analyst IV  
 Division: Administrative Services Division  
 Approved By: Craig W. Richards, Attorney General  
 Agency: Department of Law

Phone: (907)465-3674  
 Date: 03/07/2016 08:47 AM  
 Date: 02/26/16

**REPORTED OUT OF  
SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

In addition to other provisions amending AS 47.05, the committee substitute for SB 74 (STA) would add a provision to Title 9, code of civil procedure, to establish an "Alaska Medical Assistance False Claim and Reporting Act." Under AS 09.58.010, sec. 4 of the bill, a medical assistance provider or medical assistance recipient may not knowingly submit, authorize, or cause to be submitted, a false or fraudulent claim under the medical assistance program. A beneficiary of a false or fraudulent claim, whether intentional or inadvertent, would be required to disclose the false or fraudulent claim to the state not later than 60 days after discovering the false claim.

Under proposed AS 09.58.010, a medical assistance provider or recipient who engages in the prohibited acts would be liable to the state in a civil action for a penalty of not less than \$5,500 and not more than \$11,000, three times the amount of damages sustained by the state and costs and attorney fees. Damages could be reduced if the person liable furnishes the attorney general or the Department of Health and Social Services all information known to the person about the violation not later than 30 days after the information was obtained and the person cooperates with the attorney general, and no action is pending with respect to the violation.

Under proposed AS 09.58.015 and 09.58.020, an action for damages due to a false or fraudulent claim for medical assistance may be brought by the attorney general, or by a private plaintiff. If a private person files a complaint, the complaint is under seal for at least 60 days to allow the attorney general time to investigate the action and decide whether to recommend dismissal due to lack of substantial evidence that a violation occurred, intervene and pursue the case on behalf of the state, or allow the private person to proceed with the action on behalf of the state. The attorney general may request an extension of time to conduct the investigation.

If the attorney general elects not to proceed with the action, and does not move to dismiss it, the person who brought the action has the right to proceed and conduct the action. The attorney general may request to be served with all documents related to an action pursued by a private plaintiff. To protect pending state investigations, under proposed AS 9.58.030(d), the attorney general may request a court to stay discovery for not more than 90 days.

For an action brought by a private plaintiff, if the claim is successful, a private plaintiff would be entitled to a percentage of damages. If the attorney general pursues the action, damages to the private plaintiff would be at least 15 percent but not more than 25 percent of the proceeds. If the attorney general does not proceed with the action, the available damages amount shall be at least 25 percent but not more than 30 percent of the proceeds.

Certain actions would be barred: actions based on evidence known to the state, actions based on allegation or transactions subject to an action in which the state is a party, actions based on public disclosure, and actions against the state or current or former state employees. The bill would also establish as part of AS 47.05, a provision authorizing seizure and forfeiture of property of a medical assistance provider if the attorney general finds probable cause that the provider has or is committing medical assistance fraud; seizure is subject to court review.

Both the proposed Medical Assistance False Claim and Reporting Act and provision on seizure and forfeiture of real property require involvement of the Department of Law. The Department of Law would require attorneys, investigators, and support staff in order to review the complaints and make recommendations as to which action to take under the Medical Assistance False Claim and Reporting Act. The department anticipates that the work could be done by attorneys in the Medicaid Fraud Control Unit (MFCU) of the Office of Special Prosecutions and Appeals. The bill would allow for recovery of attorney fees incurred in prosecuting civil action for Medicaid fraud, but under federal law fifty percent of attorney fees recovered must be paid to the federal government to reimburse the federal government its proportionate share of funding the Medicaid program.

**Analysis Continued**

The State of Alaska recovered approximately \$1.9 million in civil settlements in 2012 through the MFCU in the form of global class action cases as a result of the State's membership in the National Association of Medicaid Fraud Units. A portion of recovered monies could be used to pay MFCU attorney fees. While conservative estimates may not provide for full funding of the MFCU through attorney fee recoveries, it is likely that a significant portion will be recovered to pay for the twenty-five percent of matching state funds that are required. This fact combined with a positive fiscal note from the Department of Health and Social Services regarding this legislation (for savings in the amount of \$800,000 for the first year and approximately \$900,000 each year thereafter), along with the deterrent effect of the proposed legislation should result in significant savings for the State of Alaska.

# Fiscal Note

State of Alaska  
2016 Legislative Session

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Identifier: SB074CS(STA)-LAW-CRIM-03-07-16  
 Title: MEDICAID REFORM;TELEMEDICINE;DRUG  
 DATABAS  
 Sponsor: KELLY  
 Requester: Senate Finance

Department: Department of Law  
 Appropriation: Criminal Division  
 Allocation: Criminal Appeals/Special Litigation  
 OMB Component Number: 2203

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below.

(Thousands of Dollars)

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			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
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## Fund Source (Operating Only)

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<b>Total</b>	<b>365.0</b>	<b>0.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>	<b>365.0</b>

## Positions

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

<b>Change in Revenues</b>	<b>500.0</b>		<b>500.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>
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**Estimated SUPPLEMENTAL (FY2016) cost:** 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Estimated CAPITAL (FY2017) cost:** 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

## ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No  
 If yes, by what date are the regulations to be adopted, amended or repealed?

## Why this fiscal note differs from previous version:

This version contains a technical adjustment to the fund sources for the state's 25% match requirement from the initial version.

Prepared By: Valerie Rose, Budget Analyst IV  
 Division: Administrative Services Division  
 Approved By: Craig W. Richards, Attorney General  
 Agency: Department of Law

Phone: (907)465-3674  
 Date: 03/07/2016 08:47 AM  
 Date: 02/26/16

**REPORTED OUT OF  
 SFC 03/08/2016**

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2016 LEGISLATIVE SESSION

## Analysis

In addition to other provisions amending AS 47.05, the committee substitute for SB 74 (STA) would add a provision to Title 9, code of civil procedure, to establish an "Alaska Medical Assistance False Claim and Reporting Act." Under AS 09.58.010, sec. 4 of the bill, a medical assistance provider or medical assistance recipient may not knowingly submit, authorize, or cause to be submitted, a false or fraudulent claim under the medical assistance program. A beneficiary of a false or fraudulent claim, whether intentional or inadvertent, would be required to disclose the false or fraudulent claim to the state not later than 60 days after discovering the false claim.

Under proposed AS 09.58.010, a medical assistance provider or recipient who engages in the prohibited acts would be liable to the state in a civil action for a penalty of not less than \$5,500 and not more than \$11,000, three times the amount of damages sustained by the state and costs and attorney fees. Damages could be reduced if the person liable furnishes the attorney general or the Department of Health and Social Services all information known to the person about the violation not later than 30 days after the information was obtained and the person cooperates with the attorney general, and no action is pending with respect to the violation.

Under proposed AS 09.58.015 and 09.58.020, an action for damages due to a false or fraudulent claim for medical assistance may be brought by the attorney general, or by a private plaintiff. If a private person files a complaint, the complaint is under seal for at least 60 days to allow the attorney general time to investigate the action and decide whether to recommend dismissal due to lack of substantial evidence that a violation occurred, intervene and pursue the case on behalf of the state, or allow the private person to proceed with the action on behalf of the state. The attorney general may request an extension of time to conduct the investigation.

If the attorney general elects not to proceed with the action, and does not move to dismiss it, the person who brought the action has the right to proceed and conduct the action. The attorney general may request to be served with all documents related to an action pursued by a private plaintiff. To protect pending state investigations, under proposed AS 9.58.030(d), the attorney general may request a court to stay discovery for not more than 90 days.

For an action brought by a private plaintiff, if the claim is successful, a private plaintiff would be entitled to a percentage of damages. If the attorney general pursues the action, damages to the private plaintiff would be at least 15 percent but not more than 25 percent of the proceeds. If the attorney general does not proceed with the action, the available damages amount shall be at least 25 percent but not more than 30 percent of the proceeds.

Certain actions would be barred: actions based on evidence known to the state, actions based on allegation or transactions subject to an action in which the state is a party, actions based on public disclosure, and actions against the state or current or former state employees. The bill would also establish as part of AS 47.05, a provision authorizing seizure and forfeiture of property of a medical assistance provider if the attorney general finds probable cause that the provider has or is committing medical assistance fraud; seizure is subject to court review.

Both the proposed Medical Assistance False Claim and Reporting Act and provision on seizure and forfeiture of real property require involvement of the Department of Law. The Department of Law would require attorneys, investigators, and support staff in order to review the complaints and make recommendations as to which action to take under the Medical Assistance False Claim and Reporting Act. The department anticipates that the work could be done by attorneys in the Medicaid Fraud Control Unit (MFCU) of the Office of Special Prosecutions and Appeals. The bill would allow for recovery of attorney fees incurred in prosecuting civil action for Medicaid fraud, but under federal law fifty percent of attorney fees recovered must be paid to the federal government to reimburse the federal government its proportionate share of funding the Medicaid program.

**Analysis Continued**

The State of Alaska recovered approximately \$1.9 million in civil settlements in 2012 through the MFCU in the form of global class action cases as a result of the State's membership in the National Association of Medicaid Fraud Units. A portion of recovered monies could be used to pay MFCU attorney fees. While conservative estimates may not provide for full funding of the MFCU through attorney fee recoveries, it is likely that a significant portion will be recovered to pay for the twenty-five percent of matching state funds that are required. This fact combined with a positive fiscal note from the Department of Health and Social Services regarding this legislation (for savings in the amount of \$800,000 for the first year and approximately \$900,000 each year thereafter), along with the deterrent effect of the proposed legislation should result in significant savings for the State of Alaska.

<b>Date/Time</b>	<b>Topic</b>	<b>Presenter</b>	<b>Organization</b>
<b>Monday, Mar 21</b>	Introduction	Heather Shaduck	Sponsor's Office
		Stacie Kraley	Dept. of Law
<b>Tuesday, Mar 22</b>	Fraud, False Claims, Penalties	Andrew Peterson	Medicaid Fraud Control Unit
		Doug Jones	Health Care Services
		Stacie Kraley	Dept. of Law
<b>Wednesday, Mar 23</b>	Super-utilizers, Emergency Room Management	Lynne Keilman-Cruz	DHSS (SDS)
		Anne Zink, M.D.	MatSu ER doc; President, American College of Emergency Physicians Alaska Chapter
		Becky Hultberg	Alaska State Hospital & Nursing Home Assoc.
		Carl Heine, MD	Juneau ER Doc; Past President, American College of Emergency Physicians Alaska Chapter
<b>Thursday, Mar 24</b>	Managed Care, Accountable Care and Organizations	Margaret Brodie	DHSS (Update re current Super Utilizers Program)
		LeAnn Behrens	President, Medical Health Plan, Texas, Amerigroup
		Sabrina Gibson	Chief Medical Actuary, WellCare Health Plans, Inc.
		Jocelyn Pemberton, MBA, CMPE	E.D. Alaska Hospitalist Group, LLC
		Nancy Merriman	Alaska Primary Care Associates
<b>Monday, Mar 28</b>	Behavioral Health	Rich Davis	Central Peninsula Hospital
		Thea Agnew	Agnew Beck
		Bemben	
		Charlie Curie	CEO, The Curie Group (AMHTA expert)
		Jeff Jessee	AMHT
		Karen Forrest	DHSS

**Monday, Mar 28**

Federal Overview,  
Waivers, and Options

Randall Burns

DHSS

Thea Agnew  
Bemben

Agnew::Beck

Kate Burkhardt

ED, Advisory Board on Alcoholism  
& Drug Abuse

Tom Chard

ED, Alaska Behavioral Health  
Associates

Jerry Moses

Contact Alaska Native Tribal  
Health Consortium

Shane Spotts

Health Management Associates  
(contractor for 1915 i/k)

Valerie Davidson

DHSS

Jon Sherwood

DHSS

Duane Mayes

DHSS - 1915 i/k

**Tuesday, Mar 29**

Fiscal Notes  
Public Testimony

Jon Sherwood

5:00 PM- 7:00 PM

**Wednesday, Mar  
30**

Telemedicine

Stewart Ferguson

Chief Technology Officer, ANTHC

Rebecca Madison

Board Member of Northwest  
Telehealth/ Alaska eHealth  
Network

Henry DePhillips

Medical Director, Teledoc

Wallace Adamson

Strategic Partnership

Prescription Drug  
Database

Jay Butler

Chief Medical Officer

Dr. Erin Narus

State Medical Pharmacist

Janey Hovington

Boards & Commission

Carl Heine, MD

Juneau ER Doc; Past President,  
American College of Emergency  
Physicians Alaska Chapter

Brian Howes

Senior Investigator, AK CCED Div  
of Corp Business

GRAND TOTAL	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	\$35,783.8	\$49,550.0	\$74,207.6	\$87,460.9	\$96,922.4	\$99,920.3
GF match	(\$29,144.0)	(\$39,452.9)	(\$61,902.5)	(\$77,934.3)	(\$89,562.8)	(\$96,465.0)
GF	\$287.1	(\$1,089.7)	(\$6,514.8)	(\$6,514.8)	(\$6,514.8)	(\$6,514.8)
GF/MH	(\$2,750.0)	(\$9,029.9)	(\$14,517.8)	(\$11,239.8)	(\$10,429.8)	(\$10,429.8)
I/A	\$1,066.7	\$1,066.7	\$1,066.7	\$1,066.7	\$1,066.7	\$1,066.7
MHTAAR	\$2,157.8	\$2,352.8	\$3,090.3	\$0.0	\$0.0	\$0.0
SD/PR	\$134.9	\$177.4	\$219.8	\$219.8	\$219.8	\$219.8
<b>TOTAL</b>	<b>\$7,536.3</b>	<b>\$3,574.4</b>	<b>(\$4,350.7)</b>	<b>(\$6,941.5)</b>	<b>(\$8,298.5)</b>	<b>(\$12,202.8)</b>
<b>UGF subtotal</b>	<b>(\$31,606.9)</b>	<b>(\$49,572.5)</b>	<b>(\$82,935.1)</b>	<b>(\$95,688.9)</b>	<b>(\$106,507.4)</b>	<b>(\$113,409.6)</b>

**POSITIONS**

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
BHA			(2)	(4)	(4)	(4)
MAA	6	6	6	2	2	2
SDSA	5	7	7	3	3	3
CO	4	4	4	4	4	4
	<b>15</b>	<b>17</b>	<b>15</b>	<b>5</b>	<b>5</b>	<b>5</b>

**CAPITAL BUDGET COSTS**

amount	fed	GF match	description
\$ 1,200.0	\$ 1,080.0	\$ 120.0	MMIS system changes, 1915(i) & (k)
\$ 1,000.0	\$ 900.0	\$ 100.0	MMIS system changes, behavioral health system reform
\$ 1,348.0	\$ 1,213.2	\$ 134.8	connect providers and AKAIMS to the health information exchange
\$ 1,000.0	\$ 900.0	\$ 100.0	MMIS system changes, primary care case management
\$ 1,000.0	\$ 900.0	\$ 100.0	MMIS system changes, health homes
\$ 1,000.0	\$ 900.0	\$ 100.0	MMIS system changes, reduction of non-urgent use of hospital ER
\$ 3,125.0	\$ 2,812.5	\$ 312.5	tech development/consulting, provider-led coordinated care
\$ 775.0	\$ 697.5	\$ 77.5	development of health information infrastructure plan

\$10,448.0 \$ 9,403.2 \$ 1,044.8

## DHSS Fiscal Impacts for CSSB074(FIN)am, version UA

<b>SAVINGS MEASURES (UGF)</b>						
	<i>FY2017</i>	<i>FY2018</i>	<i>FY2019</i>	<i>FY2020</i>	<i>FY2021</i>	<i>FY2022</i>
Federal Tribal Policy	(\$32,060.5)	(\$41,900.5)	(\$64,325.5)	(\$78,250.5)	(\$87,625.5)	(\$92,575.5)
1915(i) and (k)	\$71.1	(\$5,118.8)	(\$10,781.6)	(\$10,866.0)	(\$10,866.0)	(\$10,866.0)
Primary Care Case Mgmt	(\$93.5)	(\$800.9)	(\$2,145.1)	(\$3,411.9)	(\$4,688.8)	(\$4,688.8)
Telemed	\$0.0	(\$650.0)	(\$1,300.0)	(\$2,900.0)	(\$4,700.0)	(\$6,650.0)
Health Homes	\$4.8	\$42.6	(\$1,672.4)	(\$1,653.6)	(\$1,662.1)	(\$1,671.1)
Conversion from AKPH	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)
Hospital ER Use Project	\$4.8	\$42.6	(\$1,077.4)	(\$1,055.7)	(\$1,061.3)	(\$1,067.0)
Fraud and Abuse	(\$543.1)	(\$697.6)	(\$684.9)	(\$622.4)	(\$609.9)	(\$597.4)
Coordinated Care project	\$4.8	\$42.6	(\$1,457.4)	(\$1,430.1)	(\$1,430.1)	(\$1,430.1)
Electronic Verification System, Savings	\$611.3	(\$23.0)	(\$23.0)	(\$23.0)	(\$23.0)	(\$23.0)
	<b>(\$33,067.1)</b>	<b>(\$50,129.7)</b>	<b>(\$84,534.0)</b>	<b>(\$101,279.9)</b>	<b>(\$113,733.4)</b>	<b>(\$120,635.6)</b>

Alaska Mental Health Trust Authority Medicaid Reform Implementation Support

3/29/16  
1:30 pm meeting

	Project/Program	FY16	FY17	FY18	FY19	TOTAL	
<b>1</b>	<b>DBH CAPACITY ASSESSMENT / DEVELOPMENT</b>	<b>MHTAAR / Authority Funds Requested:</b>					<b>\$ 112.5</b>
			75.0	37.5	-		
						<b>\$ -</b>	
						<b>\$ 112.5</b>	
			75.0	37.5	-	<b>\$ 112.5</b>	
						<b>\$ 112.5</b>	
	Training for staff based on SFY 16 assessment of KSA (Knowledge, Skills, & Abilities) of current staff vs. competencies needed to manage redesigned system of care	-	150.0	75.0	-	225.0	
<b>2</b>	<b>PROVIDER CAPACITY ASSESSMENT/DEVELOPMENT</b>	<b>MHTAAR / Authority Funds Requested:</b>					<b>\$ 162.5</b>
		25.0	100.0	37.5	-		
						<b>\$ -</b>	
						<b>\$ 162.5</b>	
		25.0	100.0	37.5	-	<b>\$ 162.5</b>	
						<b>\$ 162.5</b>	
	Finalize provider readiness assessments and produce report under direction of CCG <i>Charlie Corie Group</i>	50.0	50.0	-	-	100.0	
	TA for providers based on SFY 16 readiness assessment	-	150.0	75.0	-	225.0	
<b>3</b>	<b>1115 BEHAVIORAL HEALTH WAIVER</b>	<b>MHTAAR / Authority Funds Requested:</b>					<b>\$ 475.0</b>
			350.0	125.0	-		
						<b>\$ 475.0</b>	
						<b>\$ -</b>	
			350.0	125.0	-	<b>\$ 475.0</b>	
						<b>\$ 475.0</b>	
	New to Fiscal Notes		450.0	-	-	450.0	
	Amend existing fiscal note		250.0	250.0	-	500.0	
	Development of 1115 waiver application: actuarial analysis (\$250k) Public Input (\$100k)						
	1115 Development consulting contract						
<b>4</b>	<b>ADMINISTRATIVE SERVICES ORGANIZATION (ASO)</b>	<b>MHTAAR / Authority Funds Requested:</b>					<b>\$ 4,500.0</b>
			100.0	1,750.0	2,650.0		
						<b>\$ 4,400.0</b>	
						<b>\$ 100.0</b>	
				1,750.0	2,650.0	<b>\$ 4,400.0</b>	
						<b>\$ 4,400.0</b>	
	Travel costs for 3 DHSS, 1 AMHTA staff, and 1 redesign consultant to visit two states with existing BH ASOs (VA, MD, or CT)	-	100.0	-	-	100.0	
	ASO cost	-	-	3,500.0	5,300.0	8,800.0	

Alaska Mental Health Trust Authority Medicaid Reform Implementation Support





	Project/Program	FY16	FY17	FY18	FY19	TOTAL	
<b>5</b>	<b>PRIMARY CARE INTEGRATION</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	200.0	100.0	-	\$ 300.0	
		<b>MHTAAR:</b>					
		-	-	-	-	\$ -	
		<b>Authority Funds:</b>					
		-	200.0	100.0	-	\$ 300.0	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	200.0	100.0	-	\$ 300.0	
	Support SBIRT pilots in 2 Hospital Emergency Rooms	-	200.0	200.0	-	400.0	
	Implement standardized screening & assessment instruments in 3 existing combined FQHC & BH plus both CCBHCs	-	200.0	-	-	200.0	
<b>6</b>	<b>CCBHC PLANNING GRANT</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	75.0	37.5	-	\$ 112.5	
		<b>MHTAAR:</b>					
		-	75.0	37.5	-	\$ 112.5	
		<b>Authority Funds:</b>					
		-	-	-	-	\$ -	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	75.0	37.5	-	\$ 112.5	
	New to Fiscal Notes		150.0	75.0	-	225.0	
	Prospective payment pilot with SA or SAMH provider	-	150.0	75.0	-	225.0	
<b>7</b>	<b>DATA</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	104.8	30.0	-	\$ 134.8	
		<b>MHTAAR:</b>					
		-	104.8	30.0	-	\$ 134.8	
		<b>Authority Funds:</b>					
		-	-	-	-	\$ -	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	943.2	270.0	-	\$ 1,213.2	
	New to Fiscal Notes		300.0	300.0	-	600.0	
	Cost of connectivity to HIE (\$12k per provider; 25 providers each year)	-	300.0	300.0	-	600.0	
	New to Fiscal Notes		48.0	-	-	48.0	
	DHSS to connect HIE to AKAIMS (4 interfaces)	-	48.0	-	-	48.0	
	New to Fiscal Notes		700.0	-	-	700.0	
	Enhance AKAIMS to full capacity—FEi to build bi-directional connection from AKAIMS to HIE	-	700.0	-	-	700.0	
<b>8</b>	<b>WORKGROUPS</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	32.5	2.5	2.5	\$ 37.5	
		<b>MHTAAR:</b>					
		-	7.5	2.5	2.5	\$ 12.5	
		<b>Authority Funds:</b>					
		-	25.0	-	-	\$ 25.0	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	32.5	2.5	2.5	\$ 37.5	
	Amend existing fiscal note		5.0	5.0	5.0	15.0	
	Quality & Cost Effectiveness Workgroup (ongoing)	-	5.0	5.0	5.0	15.0	
	Amend existing fiscal note		5.0	-	-	5.0	
	Telehealth Workgroup (one-time)	-	5.0	-	-	5.0	
	Amend existing fiscal note		5.0	-	-	5.0	
	Health Information Infrastructure (one-time)	-	5.0	-	-	5.0	
	Stakeholder Engagement	-	50.0	-	-	50.0	

Alaska Mental Health Trust Authority Medicaid Reform Implementation Support

3/29/16  
1:30 pm meeting

	Project/Program	FY16	FY17	FY18	FY19	TOTAL	
<b>9</b>	<b>1915 i/k OPTIONS</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	2,073.8	213.8	213.8	\$ 2,501.4	
		<b>MHTAAR:</b>					
		-	1,478.8	213.8	213.8	\$ 1,906.4	
		<b>Authority Funds:</b>					
		-	595.0	-	-	\$ 595.0	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	1,523.8	213.8	213.8	\$ 1,951.4	
	New to Fiscal Notes	Assessment tool: Integrated tool that can be used across all waiver and state plan services	-	2,575.0	-	-	2,575.0
	New to Fiscal Notes	Four Long Term / Non Perm FTEs	-	427.6	427.6	427.6	1,282.8
		Expand Aging & Disability Resources Centers (ADRC) First Pilot to four additional sights	-	400.0	-	-	400.0
		National best practice site visits for ADRD/IDD service delivery	-	150.0	-	-	150.0
		Outreach for consumer and provider engagement/education for system change including reform efforts	-	45.0	-	-	45.0
<b>10</b>	<b>HEALTH CARE SERVICES STAFFING NEEDS</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	308.3	308.3	308.3	\$ 924.9	
		<b>MHTAAR:</b>					
		-	308.30	308.30	308.30	\$ 924.9	
		<b>Authority Funds:</b>					
		-	-	-	-	\$ -	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	308.3	308.3	308.3	\$ 924.9	
	New to Fiscal Notes	Two new staff positions dedicated to Primary Care Case Mgmt; Coordinated Care Demo Project; Health Homes; ER Initiative	-	218.4	218.4	218.4	655.2
	New to Fiscal Notes	Four Long Term / Non Perm FTEs	-	398.2	398.2	398.2	1,194.6
<b>11</b>	<b>OTHER</b>	<b>MHTAAR / Authority Funds Requested:</b>					
		-	360.0	40.0	-	\$ 400.0	
		<b>MHTAAR:</b>					
		-	60.00	40.00	-	\$ 100.0	
		<b>Authority Funds:</b>					
		-	300.0	-	-	\$ 300.0	
		<b>FEDERAL FUNDS LEVERAGED:</b>					
		-	-	-	-	\$ -	
		ABLE Act - start up and implementation (DOR Treasury Division) for HB188 / SB104 fiscal note	-	60.0	40.0	-	100.0
		TA contract for providers on revenue cycle & Medicaid billing systems	-	300.0	-	-	300.0
<b>TOTAL MHTAAR / Authority Funds Requested:</b>		<b>25.0</b>	<b>3,779.4</b>	<b>2,682.1</b>	<b>3,174.6</b>	<b>9,661.1</b>	
<b>Total MHTAAR:</b>		<b>-</b>	<b>2,384.4</b>	<b>2,507.1</b>	<b>3,174.6</b>	<b>8,066.1</b>	
<b>Total Authority Funds:</b>		<b>25.0</b>	<b>1,395.0</b>	<b>175.0</b>	<b>-</b>	<b>1,595.0</b>	
<b>Total Federal Funds Leveraged:</b>		<b>25.0</b>	<b>3,607.8</b>	<b>2,882.1</b>	<b>3,174.6</b>	<b>9,689.5</b>	

# Alaska Medicaid Redesign: Approaches to Coordinated Care and Value-based Purchasing

MODELS OF CARE	Current State	Primary Care Case Management	Patient Centered Medical Homes	Health Homes	Pre-paid Inpatient or Ambulatory Health Plans	Accountable Care Organizations	Full-risk Managed Care
FEATURES	<ul style="list-style-type: none"> <li>No performance- or value-based payment or quality metrics</li> </ul>	<ul style="list-style-type: none"> <li>Primary care provider coordinates and monitors patient care</li> </ul>	<ul style="list-style-type: none"> <li>Provider teams deliver whole person, integrated care</li> </ul>	<ul style="list-style-type: none"> <li>Serves patients with complex needs: behavioral health and chronic conditions</li> <li>Provider teams deliver whole person, integrated care and coordinate community supports</li> </ul>	<ul style="list-style-type: none"> <li>Risk-based contracts to provide a set of services to enrollees</li> </ul>	<ul style="list-style-type: none"> <li>Providers share accountability for care, health outcomes and costs for defined group of enrollees</li> </ul>	<ul style="list-style-type: none"> <li>State contracts with health plans for the delivery of services to Medicaid beneficiaries</li> </ul>
PAYMENT MECHANISMS	<p>LOW <span style="display: inline-block; width: 100%; border-bottom: 1px solid black;"></span> Level of financial risk assumed by providers + quality monitoring and reporting <span style="display: inline-block; width: 10%;"></span> HIGH</p>						
Fee For Service	✓	✓	✓	✓			
Care Coordination (Per Member Per Month Fees)		✓	✓	✓			
Shared Savings					✓	✓	✓
Shared Losses					✓	✓	✓
Bundled Payments (Specific Episodes)					✓	✓	✓
Partial or Global Capitated Payments					✓	✓	✓
ADDITIONAL PROGRAM FEATURES + OPTIONS	<ul style="list-style-type: none"> <li>Private Coverage Option</li> <li>Enrollee Contributions + Premiums</li> <li>Waivers of Required Benefits</li> <li>Wellness + Healthy Behavior Incentives</li> </ul>						
GOALS FOR ALASKA MEDICAID REDESIGN	<p>  IMPROVE HEALTH                OPTIMIZE ACCESS                INCREASE VALUE                CONTAIN COSTS         </p>						

June 2015 | Fact Sheet

## Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts

Historically, most state Medicaid programs delivered and paid for services for Medicaid beneficiaries on a fee-for-service (FFS) basis, directly paying participating physicians, clinics, hospitals, and other providers a fee for each service they furnish. The FFS payment model, by definition, rewards volume, irrespective of patient health outcomes or quality of care. Also, care provided in a FFS system can often be fragmented because there is no coordinating entity, and both redundancies and gaps in patient care can result. In addition, beneficiaries are on their own in FFS systems to identify providers who participate in Medicaid and are taking new patients.

Increasingly, state Medicaid programs have been expanding their use of managed care as well as other service delivery and payment systems, as an alternative to traditional FFS. States may have different purposes in doing so, including to improve beneficiary access to care, improve the quality of care, increase Medicaid budget predictability, and reduce Medicaid spending. On May 26, 2015, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that seeks to modernize Medicaid managed care regulations. State innovation in Medicaid service delivery and payment systems has been further catalyzed by new demonstration and pilot programs and state plan authorities provided by the ACA. Underpinning many of these new opportunities for innovation are important principles, including patient-centered care, cost and quality accountability, and population health management.

There is wide state variation in Medicaid health care delivery and payment systems, as states design and combine service delivery models and payment approaches in a multitude of ways (see [Mapping Medicaid Delivery System and Payment Reform](#) to learn more about activity across states). To help those interested in understanding the diversity of Medicaid reform initiatives underway or in development in states across the country, this guide defines key terms organized under two major headings: Delivery System Models and Payment Models. Under these headings, established/long-standing terms are defined first followed by newer, more emerging terms and concepts.

### **Delivery System Models**

#### **Medicaid Managed Care**

- Primary Care Case Management (PCCM)
- Risk-Based Managed Care/Managed Care Organization (RBMC/MCO)
- Prepaid Health Plan (PHP)
- Managed Long-Term Services and Supports (MLTSS)

#### **Other Delivery System Models**

- Patient-Centered Medical Home (PCMH)
- Health Home (HH)
- Accountable Care Organization (ACO)

## Payment Models

- Fee-for-Service (FFS)
- Capitation
- Care Management Fee
- Pay-for-Performance (P4P)
- Shared Savings Arrangements (Gain-Sharing)
- Shared Risk Arrangements (Risk-Sharing)
- Episode of Care (EOC) Payment
- Global Bundling
- Delivery System Reform Incentive Payment (DSRIP)

## Delivery System

### MEDICAID MANAGED CARE

**Primary Care Case Management (PCCM):** PCCM is a model of Medicaid managed care that is outlined in the Medicaid statute. In PCCM programs, state Medicaid agencies contract with primary care providers to provide, locate, coordinate, and monitor primary care services for Medicaid beneficiaries who select them or are assigned to them by the state.<sup>1 2</sup> In effect, the primary care provider – usually a physician or a physician practice, but sometimes a nurse practitioner, physician assistant, or other provider – serves as a beneficiary’s “medical home” for primary and preventive care. Under their contracts with primary care providers, states pay them a small monthly case management fee in addition to regular FFS payments; unlike in risk-based managed care (see definition below), providers do not assume any financial risk under this model. States set requirements for the participating primary care providers, such as minimum hours of operation at each location, specific credentials or training, and responsibility for referrals to specialists. State staff carry out, or contract out, administrative functions related to PCCM (e.g., network development and credentialing). “Enhanced” PCCM refers to PCCM programs that include additional services and responsibilities to strengthen care coordination.

**Risk-Based Managed Care/Managed Care Organization (RBMC/MCO):** MCOs are health plans that contract with states to provide comprehensive Medicaid benefits to enrolled Medicaid beneficiaries for a pre-set per-member-per-month (PMPM) premium, or capitation payment.<sup>3</sup> This arrangement is known as risk-based managed care because MCOs are at financial risk for the Medicaid services specified in their contracts. States develop and oversee their own Medicaid managed care programs, subject to federal requirements. MCOs must meet federal and state-specific requirements that address matters such as: protocols for enrollment, disenrollment, and member support; ensuring an adequate provider network and access to care; grievances and appeals, and collection and reporting of data. Although MCOs are at financial risk for comprehensive Medicaid benefits, many states “carve out” certain services from their MCO contracts, such as prescription drugs or behavioral health services. These carved-out benefits may be provided and financed under a separate contract with a prepaid health plan (see definition below) or on a FFS basis. Alternatively, some MCOs may subcontract with prepaid health plans to provide such benefits.

**Prepaid Health Plan (PHP):** As distinct from an MCO, a PHP is a *non*-comprehensive health plan that provides only certain services, such as dental services or non-emergency medical transportation.<sup>4</sup> Most PHPs are paid on a risk, or capitated, basis. There are several types of PHPs:

- **Prepaid Ambulatory Health Plan (PAHP):** A PAHP is a non-comprehensive prepaid health plan that provides only certain outpatient services, such as dental services or outpatient behavioral health care, and does not cover any inpatient services.<sup>5</sup>
- **Prepaid Inpatient Health Plan (PIHP):** A PIHP is a non-comprehensive prepaid health plan that provides only inpatient hospital or institutional services, such as inpatient behavioral health care, and does not have a comprehensive risk contract.<sup>6</sup>

**Managed Long-Term Services and Supports (MLTSS):** MLTSS refers to risk-based arrangements for the delivery of Medicaid long-term services and supports, which often include institutional and home and community-based services (e.g., adult day care), enabling Medicaid beneficiaries to live independently in their homes and communities rather than receive care in an institution.<sup>7</sup> Some MLTSS programs provide only long-term services and supports (e.g., operate as PHPs), but, in other arrangements, MLTSS are provided through comprehensive MCOs.

## OTHER DELIVERY SYSTEM MODELS

**Patient-Centered Medical Home (PCMH):** In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released key principles that define a PCMH: (1) the personal physician leads a team that is collectively responsible for the patient's ongoing care; (2) the physician is responsible for the whole person in all stages of life; (3) care is coordinated and/or integrated; (4) quality and safety are hallmarks of a medical home; (5) enhanced access to care is available through all systems; and (6) payment appropriately recognizes the added value to the patient.<sup>8</sup> The National Committee for Quality Assurance (NCQA) is one of a small number of organizations that has issued specific standards that the PCMHs must meet to receive its accreditation.<sup>9</sup> Providers or provider organizations that perform PCMH functions are often paid (by state Medicaid agencies directly or through MCO contracts) a PMPM fee in addition to regular FFS payments for their Medicaid patients. Providers or provider organizations seeking PCMH recognition may also be supported through upfront grants (to cover PCMH infrastructure costs) and/or through performance-based payments (i.e., P4P).<sup>10</sup>

**Health Home (HH):** Section 2703 of the Affordable Care Act (ACA) established the Medicaid health home (HH) program. The Medicaid HH model builds on the patient-centered medical home concept.<sup>11</sup> Targeted to individuals with multiple chronic conditions, including serious mental illness, HHs are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, long-term services and supports, and social service supports. HHs establish care plans for Medicaid beneficiaries, and coordinate and integrate clinical and non-clinical services.<sup>12</sup> Medicaid HHs must provide the following services: comprehensive care management, care coordination and health promotion, transitional care, referrals to community and social services, patient and family support, and use of health information technology. States receive a 90% federal match rate for HH services (not to exceed eight quarters) and have considerable flexibility to design their own methods for paying

HHs. HH providers are required to report quality measures established by CMS.<sup>13</sup> States may implement multiple HH programs that target different populations.

**Accountable Care Organization (ACO):** There is currently no uniform federal definition of an ACO and the concept continues to evolve.<sup>14</sup> Generally, an ACO is a group of health care providers or, in some cases, a regional entity that contracts with providers and/or health plans, that agrees to share responsibility for the health care delivery and outcomes for a defined population. The organizational structure of ACOs varies, but, in concept, ACOs generally include primary and specialty care providers and at least one hospital. Providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency, and the ACO as an entity is accountable for that care, specifically for the quality and total cost of care. An ACO that meets quality performance standards that have been set by the payer and achieves savings relative to a benchmark can share in the savings. Some states that are pursuing ACOs for Medicaid beneficiaries are building on existing care delivery programs (e.g., PCCM, medical homes, MCOs) that already involve some degree of coordination among providers and may have developed key infrastructure necessary to facilitate coordination among ACO providers (e.g., electronic medical records). States use different terminology in referring to their Medicaid ACO initiatives, such as Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado.

## Payment Models

**Fee-for-Service (FFS):** In a FFS system, the state Medicaid agency establishes the fee levels for covered services and pays participating providers directly for each service they deliver to Medicaid beneficiaries. Providers do not bear any financial risk. Beneficiaries seeking care in the traditional FFS environment must identify providers who participate in Medicaid and accept new patients. Except in the context of PCCM programs, there is generally no organized provider network in the FFS environment.

**Capitation:** Capitation payment refers to the fixed per-member-per-month (PMPM) amount that a state Medicaid agency pays a managed care organization (MCO) to provide or arrange for covered Medicaid services delivered to enrolled beneficiaries. Capitation rates are pre-set, so MCOs are at financial risk for the services they actually provide. States adjust capitation rates for Medicaid enrollees based on their demographic characteristics, such as age and gender, and often based on other factors as well. Medicaid MCOs may pay the providers in their network on a capitation basis, a FFS basis, or on other terms.

**Care Management Fee:** FFS providers or provider organizations operating as patient-centered medical homes and/or health homes are often paid a supplemental per-member per-month care management fee for Medicaid patients assigned to them. These care management fees may be adjusted based on patient demographics and/or health status, or on characteristics of the provider entity, such as its score by an accrediting body.<sup>15</sup>

**Pay-for-Performance (P4P):** P4P is a health care payment model that rewards providers or managed care organizations (MCOs) financially for achieving or exceeding specified quality benchmarks or other goals.<sup>16</sup> P4P payments may be made based on performance on structure, process, and/or outcome measures, with providers evaluated against benchmarks or by comparison with other providers. Some state Medicaid programs contracting with MCOs incorporate a P4P component into their payment methods. For example, they may

withhold a portion of the capitation payment, which the MCO can earn back by demonstrating high performance, or make performance-based bonus payments in addition to the regular capitation payments.

**Shared Savings Arrangements (Gain-Sharing):** Under shared savings arrangements, sometimes referred to as gain-sharing, provider organizations or ACOs have an opportunity to share in any net savings that accrue to a payer for a defined panel of patients over a specified time period (usually 12 months). Actual costs for the patient panel are compared to a pre-established benchmark that is determined using historical utilization and/or cost data for the patient panel or a similar population. To be eligible for savings, provider organizations/ACOs must meet performance/quality requirements while also reducing costs.<sup>17 18</sup> In shared savings-only models, provider organizations/ACOs do not face downside risk. That is, they face no financial penalty if actual costs exceed the benchmark. Most typically, the shared savings model is used by ACOs and some PCMHs.

**Shared Risk Arrangements (Risk-Sharing):** Entities that enter into shared savings arrangements with payers may also agree to share in losses. Risk-sharing is often added to shared savings arrangements after some experience has been accumulated. Under a shared risk arrangement, if actual costs for the defined patient population exceed the benchmark, the provider group/entity is accountable for a portion of the excess costs and must return funds to the payer.

**Episode of Care (EOC) Payment:** Episode of care payments are single, pre-established amounts paid to providers for the set of services involved in treating a patient's health event, such as a knee replacement, or a particular health condition, such as Attention Deficit Hyperactivity Disorder (ADHD), over a specified period of time. Episodes have a defined beginning and end and usually involve payment for multiple services and providers.<sup>19 20</sup> Payment amounts are set based on established clinical protocols and guidelines and are typically adjusted to account for the severity of the patient's condition. Episode of care payments can be prospective or retrospective. Under the prospective model, a single payment is made for a defined "episode of care." Under the retrospective model, providers and hospitals involved in the episode receive payment as they normally would according to the payer fee schedule, but actual expenditures are later reconciled against the pre-set price for the episode, which may trigger gain- or risk-sharing. As distinct from global bundling (see definition below), episode-based payment is a tool for managing costs incurred over a shorter time period, such as 30 or 90 days, usually beginning with initial treatment of the health event or condition. Other terms sometimes used to describe the concept of episode of care payments include bundled payment, episode-based payment, and episodic bundling.

**Global Bundling:** Global bundling involves a single, pre-set payment for a wide range of services delivered to an individual over a defined period of time, usually one year. Global payment amounts are risk-adjusted based on the patient's health and other characteristics that may affect the services needed, such as age or gender. In addition, global payment models incorporate outcome or quality measures to safeguard against under-service and reward high performance.<sup>21</sup> Other terms sometimes used to refer to the concept of global bundling include risk-adjusted global fees, comprehensive care payment, global payments, and global budgets.

**Delivery System Reform Incentive Payment (DSRIP):** DSRIP initiatives, which are part of broader Section 1115 demonstration waiver programs, provide states with significant funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. DSRIP waivers are not grant programs – they are performance-based incentive programs. The concept is that states undertake initiatives expected to save Medicaid funds and then use the available savings for new investments in delivery system reform. To obtain DSRIP funds, eligible entities, including hospitals and other providers and/or provider coalitions, must meet certain milestones or performance metrics. While the exact structure and requirements of DSRIP initiatives vary, there is often a focus on meeting process-oriented metrics in the early years of the waiver, such as metrics related to infrastructure development or system redesign, and a focus on more outcome-oriented metrics in later years.<sup>22</sup> For example, infrastructure related metrics might pertain to implementation of chronic care management registries or enhanced interpretation services. System redesign metrics might relate to expansion of medical homes or physical and behavioral health care integration. Outcome measures might address clinical care improvements or population health.

# Appendix

The table below provides links to relevant federal legislation, regulations, and other guidance where available for Medicaid delivery system and payment models. Some terms originate from authorizing legislation, regulations, or other CMS guidance while other terms, which may be used by other federal programs or in the private sector, may not be specifically defined by the Medicaid program.

Medicaid Delivery System and Payment Model Legislation, Regulations, and Other Guidance	
<b>Primary Care Case Management (PCCM)</b>	<p>Primary Care Case Management, <a href="#">Social Security Act §1905(t)</a>.</p> <p><a href="#">42 C.F.R. Part 438</a>. CMS regulations on Medicaid managed care.</p> <p><a href="#">42 CFR Parts 431, 433, 438, 440, 457 and 495</a>. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p> <p><a href="#">CMS Medicaid Director Letter regarding primary care case management services and section 1905(t) of the Social Security Act</a>. January 1998.</p>
<b>Risk-Based Managed Care(RBMC)/ Managed Care Organization (MCO)</b>	<p>State Option to Use Managed Care, <a href="#">Social Security Act, §1932</a>.</p> <p>Medicaid Managed Care Organization, <a href="#">Social Security Act, §1903(m)</a>.</p> <p><a href="#">42 C.F.R. Part 438</a>. CMS regulations on Medicaid managed care.</p> <p><a href="#">42 CFR Parts 438, 440, 456, and 457</a>. Notice of Proposed Rulemaking (NPRM). Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans.</p> <p><a href="#">42 CFR Parts 431, 433, 438, 440, 457 and 495</a>. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
<b>Prepaid Health Plans (PHP)</b>	<p><a href="#">42 C.F.R. Part 438</a>. CMS regulations on Medicaid managed care.</p> <p><a href="#">42 CFR Parts 431, 433, 438, 440, 457 and 495</a>. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
<b>Prepaid Ambulatory Health Plan (PAHP)</b>	<p><a href="#">42 C.F.R. § 438.2</a>. CMS regulation regarding prepaid ambulatory health plans.</p> <p><a href="#">42 CFR Parts 431, 433, 438, 440, 457 and 495</a>. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
<b>Prepaid Inpatient Health Plan (PIHP)</b>	<p><a href="#">42 C.F.R. § 438.2</a>. CMS regulation regarding prepaid inpatient health plans.</p> <p><a href="#">42 CFR Parts 431, 433, 438, 440, 457 and 495</a>. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>

**Managed Long-Term Services and Supports (MLTSS)**

[42 CFR Parts 431, 433, 438, 440, 457 and 495](#). Notice of Proposed Rulemaking (NPRM). Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.

[CMCS Informational Bulletin: Long Term Services and Supports Delivered Through Medicaid Managed Care Programs](#). May 21, 2013.

[CMCS Informational Bulletin: Long Term Services and Supports Delivered Through Medicaid Managed Care Programs – Continued Technical Assistance](#). October 22, 2013.

**Patient-Centered Medical Home (PCMH)**

American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. [Joint principles of a patient-centered medical home](#). Released March 2007.

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1](#). July 10, 2012.

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2](#). July 10, 2012.

**Health Home (HH)**

State Option to Provide Coordinated Care through Health Homes for Individuals with Chronic Conditions, [Social Security Act §1945](#).

[CMS State Medicaid Director Letter regarding implementation of the ACA provision on health homes for enrollees with chronic conditions](#). November 16, 2010.

[Health Homes \(Section 2703\) Frequently Asked Questions](#). May 2012.

[CMS State Medicaid Director Letter regarding Health Home Core Quality Measures](#). January 15, 2013.

**Accountable Care Organization (ACO)**

Pediatric Accountable Care Organization demonstration Project, [ACA §2706](#). This demonstration is not currently funded.

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1](#). July 10, 2012.

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2](#). July 10, 2012.

Currently, there is no uniform Medicaid ACO definition. While outside the Medicaid context per se, a useful definition of an ACO can be found within the Medicare Shared Savings Program, [ACA § 3022](#).

[42 C.F.R. Part 425](#). CMS regulation regarding the Medicare Shared Savings Program and Accountable Care Organizations.

**Shared Savings Arrangements (Gain-Sharing)**

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1](#). July 10, 2012.

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2](#). July 10, 2012.

[CMS State Medicaid Director Letter regarding Shared Savings Methodologies](#). August 30, 2013.

**Shared Risk Arrangements (Risk-Sharing)**

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1](#). July 10, 2012.

[CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2](#). July 10, 2012.

[CMS State Medicaid Director Letter regarding Shared Savings Methodologies](#). August 30, 2013.

**Episode of Care (EOC) Payment**

Demonstration Project to Evaluate Integrated Care around a Hospitalization, [ACA § 2704](#). This demonstration is not currently funded.

**Global Bundling**

Medicaid Global Payment System Demonstration Project, [ACA § 2705](#). This demonstration is not currently funded.

# Endnotes

- <sup>1</sup> *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Family Foundation, 2012. Available at: <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/>.
- <sup>2</sup> *Medicaid Managed Care Enrollment Report*. Centers for Medicare and Medicaid Services (CMS). 2012. Available at: <http://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicare-managed-care-enrollment-report.pdf>.
- <sup>3</sup> *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Family Foundation, 2012. Available at: <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/>.
- <sup>4</sup> Rosenbaum S and Sonosky C. 2002. *Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers*. The George Washington University, Center for Health Services Research and Policy. Available at: <http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/PAHP.pdf>.
- <sup>5</sup> Rosenbaum S and Sonosky C. 2002. *Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers*. The George Washington University, Center for Health Services Research and Policy. Available at: <http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/PAHP.pdf>.
- <sup>6</sup> Rosenbaum S and Sonosky C. 2002. *Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers*. The George Washington University, Center for Health Services Research and Policy. Available at: <http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/PAHP.pdf>.
- <sup>7</sup> *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Family Foundation, 2012. Available at: <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/>.
- <sup>8</sup> Defining the Medical Home. Patient-Centered Primary Care Collaborative. Available at: <https://www.pcpcc.org/about/medical-home>
- <sup>9</sup> *NCQA Patient-Centered Medical Home*. National Committee for Quality Assurance (NCQA). Available at: <http://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf>.
- <sup>10</sup> Takach M. 2012. "About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations." *Health Affairs* 31(11): 2432-2440. Available at: <http://content.healthaffairs.org/content/31/11/2432.full.pdf+html>.
- <sup>11</sup> CMS State Medicaid Director Letter regarding implementation of the ACA provision on health homes for enrollees with chronic conditions. November 16, 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SM10024.pdf>.
- <sup>12</sup> *Medicaid Health Homes: An Overview*. Centers for Medicare and Medicaid Services (CMS). 2015. Available at: <http://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/medicaid-health-homes-overview.pdf>.
- <sup>13</sup> Health Homes (Section 2703) Frequently Asked Questions. Centers for Medicare and Medicaid Services (CMS). 2012. Available at: [http://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12\\_2.pdf](http://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf).
- <sup>14</sup> There is no uniform Medicaid definition of an ACO nor a uniform definition across payers. Medicare, as part of their Pioneer ACO program, defines an ACO as follows: "Under the program regulations, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare Fee-For-Service patients they serve. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers receive different, disconnected payments. The ACO will be a patient-centered organization where the patient and providers are true partners in care decisions. The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services: ACO professionals (i.e., practitioners meeting the statutory definition) in group practice arrangements, networks of individual practices of ACO professionals, partnerships or joint ventures arrangements between hospitals and ACO professionals, hospitals employing ACO professionals, or other Medicare providers and suppliers as determined by the Secretary." "An ACO professional is defined as a physician, as well as a physician assistant, nurse practitioner or clinical nurse specialist." See: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO\\_Providers\\_Factsheet\\_ICN907406.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf).
- <sup>15</sup> Takach M. 2012. "About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations." *Health Affairs* 31(11): 2432-2440. Available at: <http://content.healthaffairs.org/content/31/11/2432.full.pdf+html>.
- <sup>16</sup> Kuhmerker K and Hartman T. 2007. *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*. The Commonwealth Fund. Available at: <http://www.commonwealthfund.org/publications/fund-reports/2007/apr/pay-for-performance-in-state-medicare-programs--a-survey-of-state-medicare-directors-and-programs>.

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- <sup>17</sup> Bailit M and Hughes C. 2011. *Key Design Elements of Shared Savings Payment Arrangements*. The Commonwealth Fund Available at: [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/aug/1539\\_bailit\\_key\\_design\\_elements\\_sharesavings\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/aug/1539_bailit_key_design_elements_sharesavings_ib_v2.pdf).
- <sup>18</sup> Berenson R, Brantes F, and Burton R. 2012. *Payment Reform: Bundled Episodes vs. Global Payments*. Urban Institute. Available at: [http://www.urban.org/research/publication/payment-reform-bundled-episodes-vs-global-payments/view/full\\_report](http://www.urban.org/research/publication/payment-reform-bundled-episodes-vs-global-payments/view/full_report).
- <sup>19</sup> Volk G and Pettersson J. 2011. *Global and Episodic Bundling: An Overview and Considerations for Medicaid*. Academy Health and the Robert Wood Johnson Foundation. Available at: <http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf70118>.
- <sup>20</sup> Berenson R, Brantes F, and Burton R. 2012. *Payment Reform: Bundled Episodes vs. Global Payments*. Urban Institute. Available at: [http://www.urban.org/research/publication/payment-reform-bundled-episodes-vs-global-payments/view/full\\_report](http://www.urban.org/research/publication/payment-reform-bundled-episodes-vs-global-payments/view/full_report).
- <sup>21</sup> Volk G and Pettersson J. 2011. *Global and Episodic Bundling: An Overview and Considerations for Medicaid*. Academy Health and the Robert Wood Johnson Foundation. Available at: <http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf70118>.
- <sup>22</sup> Gates A, Rudowitz R, and Guyer J. 2014. *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*. Available at: <http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.



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## INTRODUCTION

There is growing national recognition that the current systems used to pay physicians, hospitals, and other healthcare providers fail to encourage the highest-quality, most affordable approaches to care delivery. However, there has been little consensus as to how payment reforms should be structured to solve the problems in current payment systems without creating new and potentially worse problems in their place.

One of the barriers to reaching consensus on significant payment reforms has been the complex and confusing array of terminology that has been used to describe different payment systems. It is difficult for stakeholders to determine whether to support a proposal if they do not understand the words and abbreviations used to describe it, and it is difficult to reach agreement when the same words are used by different people to mean different things or when words are perceived by some stakeholders to mean something different than what was actually intended.

The Payment Reform Glossary is designed to facilitate a better understanding of payment reform concepts and to create a foundation for a common language for developing and discussing payment reform concepts so they can be supported and implemented by all stakeholders — patients, providers, employers, health plans, and government agencies.

- In addition to providing definitions, the Glossary attempts to explain many of the most important words and phrases in enough detail that patients, providers, purchasers, and policy-makers can understand the advantages and disadvantages of different payment models and the rationale for including various components of payment models that might otherwise seem to make them unnecessarily complex.
- Because there is not just one “fee-for-service payment system” but more than a dozen different systems for different types of providers, each with their own unique structures and their own unique strengths and weaknesses, The Payment Reform Glossary provides a basic description of the major payment systems used today to pay physicians, hospitals, and other providers.

- The Payment Reform Glossary also provides descriptions of many of the most significant payment reform models that have been proposed or implemented by public and private payers.
- A unique feature of The Payment Reform Glossary is that explicit comparisons and contrasts among key concepts are provided in highlighted sections of the Glossary.

The intense focus on payment reform across the country means that concepts will be evolving rapidly and new programs will be proposed and implemented almost continuously. New editions of The Payment Reform Glossary will be issued regularly to ensure that the content is as current as possible.

**Additions, corrections, and suggestions for improvements to the content of The Payment Reform Glossary are welcome. Comments can be submitted to [Glossary@CHQPR.org](mailto:Glossary@CHQPR.org).**

More information is available on many of the payment reform concepts described in The Payment Reform Glossary in the following additional reports:

- *The Building Blocks of Successful Payment Reform: Designing Payment Systems That Support Higher-Value Health Care*
- *Making the Business Case for Payment and Delivery Reform*
- *Measuring and Assigning Accountability for Healthcare Spending: Fair and Effective Ways to Analyze the Drivers of Healthcare Costs and Transition to Value-Based Payment*
- *Ten Barriers to Healthcare Payment Reform and How to Overcome Them*
- *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*

All of these reports can be downloaded free of charge at [www.PaymentReform.org](http://www.PaymentReform.org).

# A

**Accountable Care Organization (ACO).** An Accountable Care Organization is a group of providers who have organized themselves in a way that enables them to take accountability for the overall quality of care and the total cost to payers of all or most of the healthcare services needed by a group of patients over a period of time. In the Affordable Care Act, Congress authorized the use of different methods of paying for services to Medicare beneficiaries if the providers are part of an Accountable Care Organization that meets specific eligibility criteria established in the statute and in regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). However, the term Accountable Care Organization is also used to describe provider organizations that may not meet all of the standards established in the Medicare Shared Savings program but are measuring and managing the cost and quality of services for their patients.

An Accountable Care Organization is not a *payment model*, it is an *organizational structure designed to deliver care* in a different way. Although CMS is paying providers that meet its ACO standards using a shared savings payment model, the Affordable Care Act authorized the use of other payment models for ACOs in the Medicare program, including partial capitation. A number of providers who have defined themselves as an Accountable Care Organization are participating in payment contracts with commercial health insurance plans, Medicaid programs, etc. that use payment models different from the payment model used in the Medicare Shared Savings Program. Moreover, providers do not need to form an ACO in order to participate in a shared savings payment model, since many payers, including CMS, are using shared savings payment models to pay individual physician practices and hospitals that are not part of an Accountable Care Organization.

While CMS has defined an Accountable Care Organization as a group of providers that includes primary care physicians and that takes accountability for the costs of all services associated with the patients attributed to those primary care physicians, the term Accountable Care Organization is also used to describe a group of specialists who take accountability for all of the costs related to a particular health condition, such as cancer.

**Next Generation ACO.** The Next Generation ACO Program is a demonstration program announced by

the Center for Medicare and Medicaid Innovation in 2015. It offers multiple payment options, including a capitation payment model, and it requires providers to accept virtually full performance risk and some insurance risk for the population of Medicare beneficiaries assigned to the ACO.

**Pioneer ACO.** A Pioneer ACO is a provider organization participating in a special demonstration program with the Center for Medicare and Medicaid Innovation using a shared savings payment model with different rules than those that apply to provider organizations participating as ACOs in the Medicare Shared Savings Program.

**Track 1 ACO.** In the Medicare Shared Savings Program, a "Track 1 ACO" is an Accountable Care Organization that is eligible for a shared savings payment if savings are achieved, but the ACO is not liable to make payments to CMS if spending increases (i.e., Track 1 is an "upside only" shared savings model).

**Track 2 ACO.** In the Medicare Shared Savings Program, a "Track 2 ACO" is an Accountable Care Organization that is eligible for a shared savings payment if savings are achieved, but the ACO is also liable to make payments to CMS if spending increases (i.e., Track 2 is a "shared risk" payment model).

**Track 3 ACO.** In the Medicare Shared Savings Program, a "Track 3 ACO" is an Accountable Care Organization that is eligible for a shared savings payment if savings are achieved and is liable to make payments to CMS if spending increases, but the ACO receives a greater share of savings and is liable for larger payments to CMS than a Track 2 ACO.

**ACO vs. HMO vs. PPO.** There are a number of important similarities and differences between ACOs, HMOs (Health Maintenance Organizations), and PPOs (Preferred Provider Organizations):

- An ACO is generally based on a self-defined network of providers, whereas in most HMOs and PPOs, the network is defined by a health plan.
- In the Medicare Shared Savings Program and most commercial ACOs that are part of PPO health plans, an ACO cannot limit a patient's ability to use providers that are not part of the ACO, whereas the primary care providers in an HMO typically have the ability to limit which services a patient can receive and from which providers they can receive approved services. In the Medicare Shared Savings Program, a Medicare beneficiary remains able to use any Medicare provider, and in most commercial ACO programs, a commercially-insured patient can continue to use any provider in the network of providers that is under contract to the payer.
- In an ACO that is paid through shared saving programs, there is no change to the underlying fee-for-service payment structure for the providers in the ACO. In contrast, in many HMOs, a provider group receives a capitation payment that it can use to pay its physicians and other providers in different ways.

**Accountable Payment Model.** An Accountable Payment Model is a generic term describing a payment model in which an accountable provider takes responsibility for achieving specific performance levels on quality and cost measures and receives a payment designed to support the services and activities needed to achieve those performance levels. See **Payment Model** and **Accountable Provider**.

**Accountable Provider.** In any payment model, there needs to be an accountable provider who accepts responsibility for ensuring that a payment is used to produce the results that are expected, whether that be the delivery of one or more specific services to the patient or achieving specific outcomes for the patient. In a traditional fee-for-service payment model, it is straightforward to identify the accountable provider because it is the individual or provider organization that bills for payment for a particular service. However, in shared savings payment models, multi-provider bundled payment models, and global payment models, where a patient receives services from multiple providers, a method is generally needed for determining which provider is the accountable provider. This can be done either by having the provider agree to accept accountability before the relevant services are to be delivered, or by using a retrospective attribution methodology to designate the accountable provider.

**ACE Demonstration.** See **Acute Care Episode Demonstration**.

**Achievement.** In a payment model where the amount of payment is based on performance on one or more measures of quality or spending, “achievement” is used to refer to the provider’s level of performance compared to a benchmark that is established in some way. In contrast, “improvement” is a measure of how the provider’s own level of performance has changed over time. Since a provider may have improved its performance but failed to meet an achievement threshold, many pay-for-performance systems are based on both achievement and improvement.

**Achievement Threshold.** In a pay-for-performance system, an achievement threshold is a level of achievement that must be reached in order to qualify for a payment or an adjustment in payment.

**ACG.** See **Adjusted Clinical Groups**.

**ACO.** See **Accountable Care Organization**.

**Actuarially Equivalent.** Two health insurance plans or bundled payments are said to be actuarially equivalent if it is estimated that the total spending on the services that the insured members receive under the two plans or payments will be the same.

**Acute Care Episode Demonstration.** The Acute Care Episode (ACE) Demonstration was a Medicare demonstration project in which several hospitals and their affiliated physicians received bundled payments for

cardiovascular and orthopedic procedures.

**Adjudication.** Adjudication is the process through which a payer determines that a claim from a provider for delivery of healthcare services should be paid and the allowed amount for the claim. See also **Allowed Amount**.

**Adjusted Clinical Groups (ACGs).** Adjusted Clinical Groups (ACG) is a risk adjustment system developed by Johns Hopkins University that uses information on the duration, severity, diagnostic certainty, and origin of a patient’s diagnoses to categorize each of the patient’s health problems into one of 32 diagnosis clusters. Then, based on the patient’s age, sex, and the diagnosis clusters applicable to them, the patient is assigned to one of 93 different ACG categories.

**Administrative Services Only (ASO).** In an Administrative Services Only contract, an insurance company or Third-Party Administrator (TPA) agrees to receive and pay claims on behalf of a self-funded employer or other self-insured purchaser, but the ASO entity does not take any direct risk related to the cost of those claims.

**Alignment.** In the context of payment models, the word “alignment” is being used in three different ways:

- **Alignment of a payer’s payment models for multiple providers.** In this context, “alignment” means that a payer pays two different providers in ways that encourage them to work together toward the same outcomes. For example, hospital and physician payment models are said to be “aligned” if they reward both the hospital and the physician for improvements in the same quality measure.
- **Alignment of the payment models used for a single provider by multiple payers.** In this context, “alignment” means that two different payers are using payment models that are structured in similar ways. For example, two different pay-for-performance systems are said to be aligned if they use the same quality measures to adjust payments.
- **Alignment of patients to a particular provider.** In some of its demonstration programs, CMS has described the process of having beneficiaries attributed to a provider as “aligning” the beneficiaries, i.e., in this context, “alignment” is a synonym for “attribution.”

**Allowed Amount.** The allowed amount is the total payment that a provider is eligible to receive for a particular service delivered to a patient insured by a payer. The provider is generally responsible for collecting the patient’s cost-sharing, so the payer pays the provider the allowed amount less the required patient cost-sharing.

**All Payer Claims Database (APCD).** An All Payer Claims Database is a database containing information from the claims received or paid by all or most of the third-party payers who pay for claims for services rendered to patients living in a geographic area, such as a state or metropolitan area. A number of state governments have established All Payer Claims Databases and re-

quire health insurance plans to submit information from the claims they pay for residents of the state.

**Alternative Payment Entity.** The Medicare Access and Chip Reauthorization Act (MACRA) defines an Alternative Payment Entity as an organization that (1) participates in an Alternative Payment Model that meets the requirements of the law and also (2) either (a) bears “financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount,” or (b) is a medical home expanded under the powers of the Center for Medicare and Medicaid Innovation. An Alternative Payment Entity could be an existing provider organization that accepts payment under fee for service or other standard payment models, but it could also be an organization that is specifically created to accept payments under an Alternative Payment Model and then allocates those payments to individual providers.

**Alternative Payment Model (APM).** The term “alternative payment model” has generally been used to describe a method of paying for services in which providers can voluntarily choose to participate that is different from the standard payment method used to pay those providers. (See the definition of **Payment Model** for a description of the elements of a payment model that can be used to define how an alternative payment model differs from existing payment models.)

In the Medicare Access and Chip Reauthorization Act (MACRA), Congress authorized higher fee-for-service payments to physicians who receive a specific proportion of their revenues, or who are paid for a specific proportion of their patients, through an Alternative Payment Model that meets criteria established in the law and in regulations to be promulgated by CMS.

MACRA establishes two slightly different sets of criteria for defining an Alternative Payment Model, one for payments in the traditional Medicare program and one for payments from other payers.

For Medicare payments, an Alternative Payment Model must be either:

- One of the innovative payment models described in Section 1115A of the Social Security Act establishing the Center for Medicare and Medicaid Innovation (see **Center for Medicare and Medicaid Innovation** for a description of the models in Section 1115A);
- The Medicare Shared Savings Program;
- A demonstration under the Health Care Quality Demonstration Program; or
- A demonstration program required under federal law.

In addition, the Alternative Payment Model must:

- require participants to use certified EHR technology;
- base payments on quality measures comparable to those used in the Merit-Based Incentive Payment System (MIPS); and
- make payments through an Alternative Payment Entity that either (1) bears financial risk for monetary losses under the Alternative Payment Model

that are in excess of a nominal amount, or (2) is a medical home tested and expanded by the Center for Medicare and Medicaid Innovation.

For payments from other payers, the Alternative Payment Model must:

- use quality measures comparable to those used by Medicare in the Merit-Based Incentive Payment System (MIPS);
- use certified EHR technology;
- make payments through an entity that “bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures” or, for Medicaid beneficiaries, is a medical home similar to medical homes tested and found to be effective by the Center for Medicare and Medicaid Innovation.

**Ambulatory Patient Groups (APGs).** Ambulatory Patient Groups (APGs) is a system of classifying patients into categories based on their expected relative use of outpatient hospital services and other ambulatory care services that was developed and is maintained by 3M Information Systems. It was originally designed for use as part of the Medicare Outpatient Prospective Payment System, but it was not implemented as part of the OPPTS (Ambulatory Payment Classifications were used instead). APGs are similar to DRGs but are designed to risk adjust payments for services delivered in outpatient settings rather than inpatient settings.

**Ambulatory Payment Classifications (APCs).** Ambulatory Payment Classifications (APCs) are used in the Medicare Outpatient Prospective Payment System (OPPTS) to define the amounts Medicare will pay for services delivered in outpatient hospital departments. They provide a mechanism for partial bundling of individual hospital outpatient services. APCs are not a risk-adjustment system, since they do not provide a way of differentiating spending or performance levels based on patient characteristics independent of the services actually delivered. See **Outpatient Prospective Payment System** for more information.

**Alternative Quality Contract (AQC).** The Alternative Quality Contract (AQC) is a risk-adjusted global budget payment model used by Blue Cross Blue Shield of Massachusetts.

**Ancillary Services.** The term ancillary services is generally used to describe three different types of services:

- laboratory tests and imaging that support accurate diagnosis of patients, but do not have a direct therapeutic value in addressing a patient’s health condition.
- services such as physical therapy, nutrition counseling, dispensing of medications, etc. that have therapeutic value but are not delivered by a physician.
- services such as home care aides, assisted living facilities, hospice services, etc. that assist patients in managing activities of daily living or improve

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their quality of life but do not have direct therapeutic value in treating a health condition. (Some of these services are sometimes referred to as “custodial” services.)

The federal Stark Law prohibits physicians from referring patients for services, including ancillary services, delivered by providers in which the physician has a financial interest. An exception is ancillary services delivered in the physician's office that meet the criteria for the In-Office Ancillary Services Exemption.

**Anti-Kickback.** The federal Anti-Kickback statute makes it a felony for any person to knowingly and willingly offer, solicit, or receive any remuneration for either referring a patient for an item or service, or for arranging or recommending an item or service, paid in whole or in part under a federal health care program. Many states have also enacted anti-kickback statutes or regulations. The federal Anti-Kickback statute and state anti-kickback laws can make it illegal to create payment models in which physicians are rewarded for following specific guidelines regarding the use of particular drugs or devices that have lower costs and higher quality.

The Office of Inspector General at the U.S. Department of Health and Human Services (OIG), which is responsible for interpreting the federal Anti-Kickback law and is one of the agencies responsible for enforcing it, can issue advisory opinions upon request concerning the applicability of the federal Anti-Kickback statute to specific arrangements. The OIG has created some “safe harbors” that protect certain types of arrangements from liability under the federal Anti-Kickback statute.

**Antitrust.** Federal and state antitrust laws are designed to prohibit payers and providers from jointly acting in anti-competitive ways, such as payers colluding to reduce provider payments or providers colluding to raise prices. Antitrust laws can also create barriers to the kinds of cooperation or coordination among payers and providers that have the potential to improve quality of care or reduce the cost of care. For example, efforts to reach agreement among multiple health insurance plans to use a new approach to payment (i.e., alignment of payment models) can raise concerns about antitrust violations, even if there is no discussion or agreement on the actual payment levels. Multiple independent providers who want to work together as an Accountable Care Organization or Clinically Integrated Network may fear antitrust action if they attempt to negotiate a joint contract with payers, even if their goal is to create a more efficient and effective method of delivering care.

The Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) have issued joint statements indicating that they are not likely to challenge joint conduct of physicians in a physician network joint venture or participants in a multi-provider network if those physicians or participants share substantial financial risk, e.g., through a global payment arrangement such as capitation, or if they are clinically integrated.

States can protect healthcare payers and providers

from antitrust liability under the “state action” doctrine of antitrust law if the state (1) has a clearly articulated state policy supporting the need for common approaches, and (2) engages in active supervision of the activities that might otherwise cause antitrust concerns.

**APCD.** See **All Payer Claims Database.**

**APM.** See **Alternative Payment Model.**

**Appropriate Use Criteria (AUC).** Appropriate use criteria are guidelines established by a medical society or other organization to help physicians or other providers to select the services that are appropriate for a particular patient. In general, the term “appropriate” is used to mean that the benefits to the patient are much greater than the risks, but the tradeoff between benefits and risks is inherently a subjective decision. Some payment models require providers to follow appropriate use criteria in order to be paid, or pay higher amounts if the criteria are followed. See also **Clinical Pathway.**

**APC.** See **Ambulatory Payment Classification.**

**APG.** See **Ambulatory Patient Group.**

**APR-DRG (All Patient-Refined Diagnosis Related Group).** APR-DRGs are a version of DRGs developed and maintained by 3M Information Systems. They are applicable to a broader range of patients than the version of DRGs (called MS-DRGs) used in the Medicare Inpatient Prospective Payment System.

**ASP.** See **Average Sales Price.**

**Assignment (for Physicians).** A physician “accepts assignment” in the Medicare program by agreeing to accept the Medicare Physician Fee Schedule payment (80% from Medicare and 20% cost-sharing from the patient) as payment in full for a service to a Medicare beneficiary. A physician who accepts assignment for all services is described as a “participating physician.” For more information, see **Participating Physician.**

**Assignment (for Patients).** In many HMO health plans, a patient is assigned to a primary care physician if the patient does not choose a physician or other provider as their designated primary care provider. In some shared savings and other payment models, the word “assignment” is used as a synonym for attribution.

**Attachment Point.** An attachment point is a dollar amount established in a stop-loss policy purchased by a provider or health insurance plan from a reinsurer, such that when the total amount of costs or claims payments incurred by the provider or health plan reaches the attachment point, the reinsurer pays all or part of the amount of costs or claims above the attachment point. For more information, see **Stop-Loss.**

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**Attestation (by Provider).** A statement by a healthcare provider that a task has been performed, a goal has been achieved, or a criterion has been met. For example, in pay for performance programs, if it is difficult for a payer to independently measure whether a provider is carrying out a particular activity, the provider may be asked to attest that the activity is being performed.

**Attestation (by Patient).** In order for a payer to know which provider will be accountable for quality or costs under a payment model, a patient may be asked to attest that the provider is managing the patient's care under the payment model. For alternative methods of identifying accountable providers, see **Assignment and Attribution**.

**Attribution.** Attribution is a process for determining which healthcare provider or providers should be held responsible for one or more specific aspects of the cost or quality of a patient's care in the absence of an explicit signal from the patient or a particular provider that the provider will be responsible. For example, when one of a health plan's members is admitted to the hospital, the health plan may "attribute" responsibility for that admission to a primary care physician that the member had seen during the prior year, even if the physician did not order the admission, did not provide any services during the admission, was not aware that the admission occurred, and did not explicitly accept responsibility for providing services to the patient that could have avoided the admission.

NOTE: CMS has used the word "assignment" to describe its attribution process in the Medicare Shared Savings Program; however, this is confusing because "assignment" is commonly associated with a prospective process in which the patient is notified of their assignment. CMS has also used the term "alignment" to describe the Medicare beneficiaries who have been attributed to an ACO or other provider.

Attribution is not needed for issues related directly to a specific service that a specific provider delivered to a patient, because it is obvious which provider delivered that service. Attribution is also not needed if a provider has been assigned in advance the responsibility for that aspect of cost or quality for that patient. For example, if a health insurance plan requires a patient to designate a primary care physician, then the designated PCP can be held responsible for various aspects of the cost and quality of the patient's care, and there is no need for an attribution methodology. (See also **Assignment and Attestation**.) The need for attribution arises when (a) there is a desire to hold a provider responsible for (i) services delivered by other providers, (ii) for a patient's failure to obtain needed services, or (iii) for potentially preventable problems or complications that a patient experienced, and (b) there are multiple providers who could potentially be held responsible and none have been assigned responsibility in advance. An attribution methodology identifies which, if any, providers could potentially be assigned responsibility and then chooses one or more of the providers based on an algorithm or set of rules.

An attribution methodology can be designed to choose only a single provider or it can allow more than one provider to be assigned responsibility for the same event or outcome. If more than one provider is assigned responsibility, the methodology may or may not define an allocation of responsibility among the providers (i.e., two providers could both be assigned 100% responsibility for the same event or outcome, or that responsibility could be allocated between them in some proportion).

An attribution methodology generally involves a number of inherently arbitrary decisions about the variables and calculations used in the methodology, such as the providers who are eligible for attribution, the measure used for attribution, the threshold the measure must reach in order for a patient to be attributed based on the measure, the look-back period, what tie-breakers will be used, and how often attribution is done. Studies have shown that the results of the attribution process can differ dramatically depending on the methodology used. Moreover, most attribution methodologies cannot attribute some patients, events, or outcomes to any provider, in which case those patients, events, or outcomes are "unattributed" and no provider is held accountable for them.

Attribution is inherently a retrospective process – the attribution methodology looks backward in time to determine which providers were involved with a patient's care and could potentially have influenced the aspect of cost or quality in question and then the methodology chooses one or more of those providers to hold accountable for a performance measure. Despite the confusing name, even what is referred to as "prospective attribution" is still inherently a retrospective process.

**Prospective Attribution.** Under common retrospective attribution methodologies, a provider does not know which patients the provider is being held accountable for until after the care has already been delivered. A partial solution to this is what is called "prospective attribution." It is still a retrospective calculation, i.e., it is based on where a patient received services during a time period prior to when the attribution is determined, rather than where the patient intends to obtain services in the future, but it is prospective in the sense that the attribution is made prior to the beginning of the time period in which a provider's performance is being measured. However, a patient who had been receiving services from one provider during the period of time on which the attribution calculation is based may decide to use a different provider after the attribution calculation is completed; this means that some patients who are attributed to a provider under prospective attribution will be receiving their care from some other provider during the performance period, and patients who began receiving care from a provider during the performance period will not have been attributed to that provider.

**Two-Step Attribution.** A two-step attribution methodology first attempts to attribute individuals to a provider using one formula, and if no provider meets

the criteria for attribution, a second formula is used. For example, in the Medicare Shared Savings Program, the first step is to try to attribute a beneficiary to a primary care physician, but if the beneficiary has not received any primary care services from a primary care physician, the attribution methodology then looks for specialists who have delivered primary care services to the patient.

**AUC.** See **Appropriate Use Criteria**.

**Average Sales Price.** In the buy and bill system used by Medicare and many commercial payers to pay physicians and hospitals for drugs administered to patients in physician offices or infusion centers, the payment to the provider for the drug is based on the “Average Sales Price” (ASP) of the drug. Each drug manufacturer reports the average amount it was paid for each of its drugs on a quarterly basis to enable CMS to calculate the ASP. The amount paid to providers for use of a drug is based on the ASP for the drug two quarters earlier plus a small additional percentage of the ASP (e.g., the total payment to the provider for the drug is 106% of ASP). As a result, the payment from Medicare to a provider for administering a drug can be higher or lower than the amount the provider paid to acquire that drug from the manufacturer or a wholesaler, and the difference will vary from drug to drug, from quarter to quarter, and from provider to provider.

# B

**Balance Billing.** Balance billing is a form of cost-sharing. If the combination of the payment from a payer for a service and the patient’s cost-sharing amount required by the payer is less than the amount the provider charges for a service, balance billing is a process whereby the provider requires the patient (or some other payer) to pay for all or part of the remainder of the provider’s charge. Many payment contracts prohibit balance billing and require a provider to accept the payer’s payment and the patient’s cost-sharing amount as payment in full for a service.

Balance billing is an alternative to co-payments, co-insurance, and deductibles for having patients share the cost of healthcare services; under balance billing, the patient pays the “last dollar” of costs (i.e., the difference between the amounts two providers charge) rather than the “first dollar” of costs; this gives the patient a stronger incentive to choose lower-priced providers and services than under other forms

of cost-sharing. Balance billing is also an integral part of a reference price benefit structure, where the payer agrees to pay up to the reference price for a particular service and then the patient pays the remainder of the provider’s charge. However, balance billing could result in very high prices if there is only one provider available to deliver a service a patient needs unless there is way to limit the amount the provider can charge.

**Baseline.** A baseline is a provider’s performance level on a spending or quality measure during a period of time (a baseline period) prior to a performance period. A provider’s payment may be based in part on a comparison of its performance during the performance period relative to the baseline.

**Baseline Period.** A baseline period is a period of time in which a provider’s baseline performance is measured.

**BPCI.** See **Bundled Payments for Care Improvement**.

**Benchmark.** A benchmark is a particular level on a measure of spending or quality that a provider must achieve in order to qualify for a payment or a payment adjustment. In addition, the payment adjustment may be proportional to the amount of difference between the provider’s performance level and the benchmark level. For example, in many shared savings payment models, the spending for a provider’s patients must be below a benchmark spending level and multiple quality measures must be above benchmark quality levels in order for the provider to qualify for a shared savings payment, and then the amount of the shared savings payment is proportional to the amount of savings (as determined by the difference between the provider’s spending and the benchmark level for spending ) and the level of quality (as determined by the difference between the provider’s quality scores and the benchmark levels for quality).

A benchmark can be determined in many ways. Most approaches fall into one of the following two categories:

- *Trending the provider’s baseline performance forward to the performance period.* In this approach, the provider’s performance is calculated during a baseline period that precedes the performance period. Then a method is used to adjust that performance level in some way to serve as a benchmark during the performance period. For example, the provider’s spending level during the year preceding the performance year might be trended forward using a measure of inflation (such as the Medicare Economic Index) to estimate what spending would be in the performance year with no change in service delivery. This trended spending level serves as the benchmark, and if the actual spending is below that level, the provider is determined to have achieved savings.
- *Calculating the distribution of performance for other providers during the performance period.* In this approach, the same measure is computed for all other providers during the same period as the pro-

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vider's performance is being measured, and then a particular point on the distribution is chosen as the benchmark. For example, the benchmark might be set at the median or 75<sup>th</sup> percentile of the performance of other providers on the spending or quality measure. See **Tournament Pay for Performance** for additional information.

**Benefit Design.** In a health insurance plan, the benefit design is a set of rules that describe which types of healthcare services will be covered by the plan, the providers from which a member of the plan can receive a covered service, the cost-sharing amounts that a member of the plan will be responsible to pay when receiving a service, and any other requirements or restrictions on how or when the plan member can receive covered healthcare services. See also **Value-Based Insurance Design**.

**Billing Code.** A billing code is a numeric code identifying a service, procedure, bundle of services, episode of care, patient condition, or type of patient for which a provider is requesting payment under a fee-for-service, bundled payment, episode-of-care payment, or condition-based payment model. Although traditional billing codes have been associated with delivery of a specific service (e.g., knee replacement surgery), billing codes can also be used to request payment for a procedural bundle or episode of care (e.g., all services associated with knee replacement surgery, including post-acute care and treatment of complications) or to request payment for care of a particular condition (e.g., treatment of knee osteoarthritis, regardless of the specific treatment used).

**Budget-Neutral.** A change in a payment system is said to be "budget neutral" if (1) the additional spending on one set of services that is estimated to result from increases in payments or the volume of services is less than or equal to (2) the reduction in spending that is estimated to result from lower payments for other services or lower volumes of other services.

**Bundled Payment.** A payment is described as "bundled" when it covers multiple healthcare services, particularly if those services had previously been paid for separately. Bundling is a very generic term and it can apply to many different combinations of services, so the mere fact that a payment is "bundled" does not communicate very much. For example, a bundled payment can involve just one provider or many providers and it can involve two services or dozens of services. (Many current fee for service payments are already "bundled;" see **Bundled Payment vs. Fee-for-Service**). At one extreme, bundling two services that a patient always receives in the same combination from the same provider may accomplish little more than to simplify billing and payment slightly (since the provider bills for one combined service rather than two and the patient has one cost-sharing payment rather than two); at the other extreme, a "global payment" that includes all services from all providers in a single bundle can potentially lead to dramatic changes in what services are delivered and who delivers them.

Depending on how they are structured, bundled payments can potentially help achieve one or more of four distinct goals:

- Bundling *multiple services* delivered by the *same provider* into a single payment can encourage greater *efficiency* in the delivery of care, since the provider will no longer be paid more for delivering more of the services covered by the bundle. This type of bundle can also allow the provider more *flexibility* to deliver innovative services if the bundled payment no longer limits the provider to delivering services that meet the narrow definitions of the individual services that were previously paid for separately.
- Bundling services delivered by *two or more providers* into a single payment can encourage greater coordination among those providers, since the providers have to agree on which services will be delivered and how the payment should be divided among them. This type of bundle can also encourage greater efficiency if one or more of the providers is delivering services that are not essential to a good outcome.
- Bundling a treatment with any services required to *address complications* of the treatment can encourage higher quality of care, since the providers will not receive additional compensation for costs incurred in treating complications. Such a bundle is a way of implementing a **Warranted Payment**.
- Bundling *all services* associated with a particular procedure or treatment of a particular condition into a single payment can provide greater predictability for purchasers and patients regarding their cost for delivery of that procedure or treatment of that condition and improve their ability to compare costs and value between different providers that deliver the same procedure or treat the same condition.

The more services that are bundled into a single payment and the more different kinds of patients for whom the bundled payment is made, the greater the need there will be for **risk adjustment** as part of the bundled payment, since different patients may need different combinations of services for reasons beyond the control of the provider.

In addition, a bundled payment involving services delivered by two or more independent providers can cause problems under the federal Stark Law and other federal Fraud and Abuse laws unless waivers are granted in law or by enforcement agencies.

**Partial Bundle.** A partial bundle is a bundled payment that includes some, but not all, services that are related to delivery of a particular treatment or management of a particular health condition. For example, payments to hospitals under the Medicare Inpatient Prospective Payment System are increasingly seen as partial bundles; although they bundle together all of the services delivered by the hospital as part of a patient's inpatient stay, they do not bundle the physician services that occurred at the same time as the hospital services and they do not include any post-acute care services. Global surgi-

cal fees paid to surgeons are also partial bundles, since they bundle post-surgery visits to patients made by the surgeon into a single payment, but they do not bundle visits made by other physicians.

**Bundled Payment vs. Episode Payment.** An episode payment is generally a bundled payment, since typically multiple services are delivered as part of a single episode of care. However, a bundled payment need not be an episode payment; the bundle could involve only a portion of an episode of care (or it could involve multiple episodes of care). For example, an episode of care for surgery performed in the hospital is typically viewed as including both the services provided during the hospital stay as well as any services related to the surgery that occur for a period of time after discharge from the hospital. However, a bundled payment could be defined as all of the services that occur during the hospital stay without including services that occur after discharge in the bundle (as was done in the Medicare Acute Care Episode Demonstration), and a bundled payment can be defined as all of the post-acute care services that occur after discharge without including the initial hospitalization in the bundle (as is being done in Model 3 of the Bundled Payments for Care Improvement demonstration).

**Bundled Payment vs. Shared Savings.** In a bundled payment model, a single new payment replaces two or more separate payments and a specific price is set for the bundle. The provider or providers accepting the bundle know in advance how much money they will receive for delivering services within the bundle, they have the flexibility to determine which and how many services are to be delivered within the payment, including (depending on how the bundle is defined) the flexibility to deliver different types of services in different ways, and they are accountable for holding the costs of the services actually delivered below the price of the bundle. In contrast, in a shared savings model focused on the same services, the provider(s) are initially paid for services the same way as they are today, and so the providers may not be paid at all for delivering a different service or delivering a service in a different way, causing short-term losses. In addition, whereas the price of a bundle can be set in advance based on the expected cost to deliver appropriate services and the bundle price for some patients could be higher than current spending if outcomes are better, shared savings payments are only made if spending is lower, even if outcomes can be improved with no change in spending. However, a bundled payment requires knowing enough about how care can be delivered to determine whether a bundled price will be adequate, whereas in a shared savings model, a provider can be assured of the same revenues if care remains the same.

**Bundled Payment vs. Fee for Service Payment.** Contrary to popular belief, bundled payments are not a radical change from fee-for-service payments. In fact, many payments in typical fee-for-service systems are already bundled to some extent. For example, the payment that is typically made for a physician office visit (an “evaluation and management” service) is intended to cover multiple tasks the physician performs before the visit and after the visit as well as what is done during the visit, and the time during the visit is intended to cover multiple activities. The fee-for-service payment made to surgeons for surgery is typically a “global fee” which bundles together the surgery itself and the separate visits the surgeon has with the patient before and after the surgery. If the surgeon accepts the global fee, the surgeon is not permitted to bill separately for office visits with the patients to follow up on the surgery and therefore does not get paid differently based on how many post-surgical visits he or she has with the patient.

**Bundled Payments for Care Improvement (BPCI).** Bundled Payments for Care Improvement (BPCI) is a demonstration project operated by the Center for Medicare and Medicaid Innovation (CMMI) that enables a provider or group of providers to receive a bundled payment for a range of different procedures and conditions with the bundled payments structured in one of four different ways. All of the BPCI bundled payments are triggered by a hospitalization. The four different models are:

**BPCI Model 1.** In Model 1 of the Bundled Payments for Care Improvement demonstration, if a hospital accepts a discounted payment under the Inpatient Prospective Payment System, the hospital is permitted to make gaining-sharing payments to physicians based on internal cost savings the hospital generates. There is no actual change in the way the providers are paid by Medicare under this model, merely a change in the amount of payment to the hospital.

**BPCI Model 2.** In Model 2 of the Bundled Payments for Care Improvement demonstration, a budget is defined for a clinical condition, with the budget covering an episode of care that includes the acute care hospital stay, the physician services, and any post-acute care services or hospital readmissions that occur 30-90 days after discharge from the hospital. If the total Medicare payments for services during the episode are below the budget, the entity that is accountable in the demonstration receives the difference, and if the total payments are higher than the budget, the entity is responsible for paying Medicare for the difference. An entity participating in the demonstration can do so for one or more of 48 different clinical conditions. BPCI Model 2 uses a retrospective reconciliation process to ensure spending matches the budget; there is no change in the way the providers are initially paid for their services.

**BPCI Model 3.** In Model 3 of the Bundled Payments for Care Improvement demonstration, a budget is defined for a clinical condition, with the budget cov-

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ering an episode of care that begins after the patient is discharged from the hospital and includes any post-acute care services or hospital readmissions that occur 30-90 days after discharge from the hospital. If the total Medicare payments for services during the episode are below the budget, the entity that is accountable in the demonstration receives the difference, and if the total payments are higher than the budget, the entity is responsible for paying Medicare for the difference. An entity participating in the demonstration can do so for one or more of 48 different clinical conditions. BPCI Model 3 uses a retrospective reconciliation process to ensure spending matches the budget; there is no change in the way the providers are initially paid for their services.

**BPCI Model 4.** In Model 4 of the Bundled Payments for Care Improvement demonstration, a single bundled payment is made to a hospital to cover the hospital services and all physician services during the hospital stay and any related readmissions for 30 days after hospital discharge (but not post-acute care services, which continue to be paid separately). Bundled payments can be defined for one or more of 48 different clinical conditions. BPCI Model 4 is a prospective bundled payment which replaces the current payments to the hospital under IPPS and physician payments under PFS.

**Bundled Payment Discount.** A bundled payment discount is the amount by which a bundled payment is lower than the estimated payments that would have been made under the existing payment system. For example, if a bundled payment is being made to a hospital and surgeon for delivery of surgical services in the hospital, the amount of the bundled payment might be set at 5% (the bundled payment discount) below the sum of the hospital payment under the Inpatient Prospective Payment System and the physician payment under the Physician Fee Schedule.

**Buy-and-Bill.** Buy-and-bill is a method of paying physicians and hospitals for pharmaceuticals administered to patients in an outpatient setting. It is called buy-and-bill because the provider buys a drug from a manufacturer or wholesaler using the provider's own resources and then after the provider administers the drug to a patient, the provider bills the payer for a payment amount that is established in a fee schedule, not based on the actual cost to the provider to acquire the drug. The methodology used by Medicare and most commercial payers to set the payment rates for individual drugs is known as ASP+x%: the provider is paid the Average Sales Price for the drug two quarters earlier plus an additional percentage (6% extra in the Medicare program, typically more in commercial insurance contracts).



**CAH.** See Critical Access Hospital

**CAP.** See Competitive Acquisition Program.

**Capitation.** A payment model in which a healthcare provider is paid based on the number of individuals cared for, rather than on the number of services provided to those individuals. (The term capitation means that the payment is made "per person" or "per capita" rather than "per service.") A capitation payment may or may not be "global." In global capitation, the provider is expected to deliver or arrange for all healthcare services the patient needs of any kind, but a capitation payment may also be defined to cover a specific menu of services or the services delivered by a subset of providers (the specific services that are covered are defined in a Division of Financial Responsibility). Alternatively, the capitation payment may be expected to cover all services except those of a specific type (i.e., some services are "carved out"). A capitation payment model needs to define a trigger (i.e., the circumstances that justify a particular provider receiving the payment), the payments may differ for different patients (e.g., based on a risk adjustment system), and if multiple providers will be involved, a method of determining the accountable provider is needed. In many traditional global capitation models, the trigger is the selection of a primary care physician, the group which employs that physician is the accountable provider, and the payments are not risk adjusted, but different triggers can be used and the payments can be risk adjusted.

**Condition-Specific Capitation.** Condition-specific capitation is a form of capitation that is designed to cover only services provided for care of a particular health condition or combination of conditions. Condition-specific capitation is a form of Condition-Based Payment; in condition-specific capitation, a single payment or a single monthly payment is made for each patient who has the condition.

**Contact Capitation.** Contact capitation is a form of capitation that is triggered by a patient's initial visit to a particular provider and is intended to cover all services delivered by that provider for a period of time or all services associated with the condition for which the patient is seeking care from the provider. Contact capitation systems that were used in the 1990s paid a specific per patient amount to a physician group for all of the services that physician group provided to a patient who came to the

group seeking services for a particular health problem.

**Global Capitation.** Global capitation is a form of capitation in which the payment for each patient is intended to cover all services the patient needs for all of their health problems.

**Partial Capitation.** Partial capitation is a form of capitation in which some services, but not all, are to be delivered in return for a capitation payment, and other services are to be paid for separately. For example, professional services capitation is a form of partial capitation – a physician group or Independent Practice Association accepts a capitation payment to cover all professional services delivered by its physicians, including physician services delivered in hospitals, but the hospitals are still paid separately for their portion of hospital stays. The Affordable Care Act authorized the use of partial capitation payments to Accountable Care Organizations, but this portion of the law has not been implemented by CMS.

**Percent of Premium Capitation.** Percent of premium capitation is a capitation payment made by a health insurance plan to a provider based on a pre-defined percentage of the insurance premiums collected for the health plan members assigned to the provider. Under percent-of-premium capitation, the provider is not only at risk for what kinds of health problems the patient has and how efficiently the provider treats those problems, but it is also at risk for how well the premiums set by the health plan match the costs of treating the health problems of the members the health plan insures.

**Primary Care Capitation.** In a primary care capitation payment model, a per patient payment is made to a primary care practice to cover all services delivered by the primary care practice, but not to cover any services delivered by other providers. Under most primary care capitation systems, the primary care practice receives a monthly payment for each patient enrolled with the practice and does not bill separately for individual office visits with those patients.

**Professional Services Capitation.** Professional services capitation is a form of capitation in which the payment for each patient only covers professional services delivered by physicians or other clinicians, not services delivered by hospitals or other institutional providers. Professional services capitation is one type of partial capitation.

**Risk-Adjusted Capitation.** Risk-adjusted capitation is a form of capitation in which the amount of payment made for a particular individual differs depending on a measure of the types, volume, or cost that individual is expected to need. See **Risk Adjustment** for additional information.

**Capitation vs. Global Payment.** A capitation payment need not be “global;” for example, if a patient needs surgery, a Professional Services Capitation payment would only cover the payments to the surgeon, the anesthesiologist, and other physicians involved with the surgery, but not the payment to the hospital where the surgery was performed. Conversely, a global payment need not be paid using a “capitation” methodology; for example, a hospital might receive a global payment in the form of an annual budget payment that is expected to cover all of the services it delivers, regardless of how many individuals are in the community served by the hospital or how many services the hospital delivers to those community residents.

**Carve-Out.** A carve-out is a set of services that is paid for in a way that differs from the way payment is made for other services. For example, a single global payment might be paid to a provider for all services, except for a list of specific services or conditions that would still be paid on a traditional fee-for-service basis or through individual bundled payments. A carve-out may apply to the delivery of services as well as to payment. For example, many purchasers and payers have “carved out” behavioral health services and require that patients receive them from a different set of providers than the providers who deliver physical health services to the patients; the behavioral health providers are paid separately and in different ways than the providers who deliver physical health services.

**Case Mix.** Case mix is a general term used to describe the types of patients cared for by a provider during a period of time. A case mix index is often calculated to assess whether a particular provider is caring for patients who have more complex needs or who need more expensive services.

**Case-Mix Groups (CMGs).** Case Mix Groups (CMGs) is a risk adjustment system used in the Medicare payment system for Inpatient Rehabilitation Facilities (the Inpatient Rehabilitation Facility Prospective Payment System). There are 92 different CMG categories, and the patient is assigned to a category based on the diagnosis that led to their need for rehabilitation, their comorbidities, their age, and their functional and cognitive status.

**Case Mix Index.** The Case-Mix Index for a hospital measures the relative severity of the needs of its patients. The Case Mix Index is calculated by determining the DRG weight for each patient discharged from the hospital, adding all of those weights together, and dividing the sum by the total number of discharges.

**Case Rate.** A case rate is a generic term describing a single payment for all or most of the services a provider delivers for a particular patient “case.” Although there is no one way to define a “case,” the term connotes care associated with a particular condition or procedure. For example, a single payment for a hos-

pital stay (such as the DRG payments made in the Medicare Inpatient Prospective Payment System) and a global surgical fee are typically described as case rates.

**CC.** CC is an abbreviation for Complications and Comorbidities. See **Diagnosis Related Groups**.

**CCO.** See **Coordinated Care Organization**.

**Center for Medicare and Medicaid Innovation (CMMI).**

The Center for Medicare and Medicaid Innovation (CMMI) was created by the Affordable Care Act to test payment models “where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures,” with a focus on “models expected to reduce program costs while preserving or enhancing the quality of care received by individuals.” The law also permits the Secretary to implement a payment model more broadly, including nationally, if the Secretary determines the payment model is expected to “reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending” and if the Chief Actuary of CMS certifies that the expansion would reduce or not result in any increase in net federal spending.

The law contains the following list of 24 “innovative payment and service delivery” models that CMMI is specifically authorized to test on a demonstration basis, although CMMI is not limited to testing these models nor is it explicitly required to test any of them.

1. Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women’s unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.
2. Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.
3. Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following: (1) an inability to perform 2 or more activities of daily living; or (2) cognitive impairment, including dementia.
4. Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.
5. Supporting care coordination for chronically ill individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.
6. Varying payment to physicians who order advanced diagnostic imaging services according to

the physician’s adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

7. Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.
8. Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management activities.
9. Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936 (c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.
10. Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.
11. Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.
12. Aligning nationally recognized, evidence-based guidelines of cancer care with Medicare payment incentives in the areas of treatment planning and follow-up care planning for individuals with cancer, including the identification of gaps in applicable quality measures.
13. Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.
14. Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.
15. Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for (1) developing, documenting, and disseminating best practices and proven care methods; (2) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and (3) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.
16. Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

17. Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.
18. Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint activity deliver a full spectrum of integrated and comprehensive health care services to individuals while also incorporating innovative methods for the clinical training of future health care professionals.
19. Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization), telehealth services (1) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and (2) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.
20. Utilizing a diverse network of providers of services and suppliers to improve care coordination for individuals with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project.
21. Focusing primarily on physicians' services furnished by physicians who are not primary care practitioners.
22. Focusing on practices of 15 or fewer professionals.
23. Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.
24. Focusing primarily on Medicaid, working in conjunction with the Center for Medicaid and CHIP Services.

**Centers for Medicare and Medicaid Services (CMS).** The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare and Medicaid programs and carrying out other functions with respect to healthcare and health insurance.

**Center of Excellence.** The term Center of Excellence is generally used to describe a particular service line of a specific provider that has been determined in some way to provide higher quality services at the same or lower cost than other providers.

**Center of Excellence Contract.** In a Center of Excellence contract, a purchaser or payer contracts with a provider that has been designated as a Center of Excellence to provide a specific set of services to the purchaser or payer's members under a payment model for the provider and a benefit design for the patient that differ from those used for other providers. For example, an individual member of the purchaser or payer who obtains a service from a Center of Excellence may have lower cost-sharing or no cost-sharing at all for using the service and may receive reimbursement for costs involved in traveling to and from the Center of Excellence.

**CG-CAHPS (Clinician and Group Survey – Consumer Assessment of Healthcare Providers and Services).** CG-CAHPS is one of a family of CAHPS surveys that ask consumers and patients to rate their experiences receiving care in a variety of healthcare settings. The CG-CAHPS survey is specifically designed for services delivered in physician offices. A growing number of payers are using results of CAHPS surveys as a performance measure in payment models. See also **H-CAHPS**.

**Charge.** The charge for a service is the payment amount that a provider states that it wishes to receive in return for delivery of the service. In general, third-party payers require or negotiate with a provider to accept a payment for a service that is lower than the charge. The actual payment is known as the allowed amount, and the difference between the allowed amount and the charge is the provider's discount. Self-pay patients may be required to pay the full charge unless they can negotiate a discount with the provider.

**Chargemaster.** A list of the charges for all services in a hospital is known as a Chargemaster.

**Cherry-Picking.** Cherry-picking is a colloquial term used to describe a situation in which a healthcare provider or payer seeks out patients for whom the cost of services is expected to be less than the payment for those services or the premium received for their health insurance. See also **Lemon-Dropping**.

**Civil Monetary Penalty.** The federal Civil Monetary Penalty statute imposes financial penalties on hospitals that make payments to physicians as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. The law has been interpreted by the Office of Inspector General (OIG) as prohibiting such payments even if the services being reduced are not medically necessary or appropriate. Consequently, gain-sharing programs designed to reward physicians for reducing unnecessary services or unnecessary elements of services could make a hospital liable for civil money penalties. (Gainsharing arrangements may also be in violation of the federal Anti-Kickback statute and the Stark law.) Although the law applies only to Medicare or Medicaid beneficiaries, the OIG has viewed it as prohibiting such payments even for commercially insured patients, since the assumption

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is that incenting changes in practice for commercial patients would likely also result in changes in practice for Medicare or Medicaid patients, or that the amounts of payment incentives for changing practices, even though applied only to commercial payments, would be set at levels designed to incent the changes for all patients. For more information, see **Fraud and Abuse Laws**.

**CIN.** See **Clinically Integrated Network**.

**Claim.** An invoice submitted by a provider to a payer seeking payment for services delivered to a patient. Claims from physicians are filed using a CMS-1500 form and claims from hospitals are filed using a CMS-1450/UB-04 claims form.

**Claims Data.** Information that is recorded on the forms used to submit claims for payment. Two key types of information recorded on claims forms are (1) one or more procedure codes describing specific services the patient received, and (2) one or more diagnosis codes describing the problem that was being treated. The focus of the claims form is on the services delivered for payment, and so the diagnosis codes recorded on the claims form are not intended to be a comprehensive description of the patient's health problems and other characteristics, but to describe the reasons for delivering the service for which payment is being sought.

**Claims Runout.** If information is being collected from claims data about services that were delivered during a specific period of time, the claims runout is an additional period of time that is allowed after the end of the period in which services are being measured in order to allow claims for those services to be filed. For example, if the claims runout is 90 days, then a measure of how many services were delivered or how much was spent on services during a calendar year is not calculated until at least 90 days after the end of the year. A longer claims runout provides more complete and accurate information about the measurement period, while a shorter claims runout provides information more quickly. (For more information, see **Completion Factor** and **IBNR**.) The term claims runout (or claims runoff) is also used to define the deadline or maximum period of time in which a claim must be submitted after a service is rendered in order to receive payment from a payer.

**Clean Period.** A "clean period" is a term used to define a specific length of time in which an individual receives no healthcare services related to a particular condition or treatment. If an episode of care is defined as all services related to a particular condition or procedure regardless of when the services were delivered, an episode grouper needs to have a way of determining when the episode has ended, so the episode grouper may be programmed to look for a clean period in order to make a determination that the episode has ended. Any service that occurs after the clean period is then assumed to be part of a new or differ-

ent episode.

**Clinical Data.** Clinical data is information that is recorded about a patient and their care in a patient's medical chart, in an electronic health record, or a clinical data registry. Two key types of information in clinical data are the types of services that a patient receives and the types of health problems a patient has. Clinical data generally have information about more services and more health problems than are available from claims data, since they will include services that are not eligible for individual payment and therefore are not described on claims forms, and they will also include information about health problems that were not explicitly treated by the provider and may not be recorded on a claims form.

**Clinically Integrated Network (CIN).** A clinically integrated network is a term used to describe a collection of providers from different specialties who create processes and systems for managing and coordinating the care they deliver to individual patients. If a clinically integrated network meets specific standards established by the Federal Trade Commission (FTC), the providers in the network can jointly negotiate with payers in ways that could otherwise be deemed to be a violation of anti-trust laws, even if they are not taking financial risk. The things that a network must do to show it is clinically integrated under FTC rules include:

- Developing and using detailed, evidence-based clinical practice guidelines;
- Limiting participation in the network to providers who are committed to following the clinical practice guidelines;
- Measuring the participating providers' compliance with the guidelines; and
- Enforcing use of the clinical guidelines.

**Clinical Pathway.** A Clinical Pathway (often called a "pathway" for short) is a set of appropriate use criteria and other clinical practice guidelines defining what types of services or procedures should be delivered to or ordered for specific patients. For example, a number of clinical pathways have been developed to guide decisions about the appropriate types of chemotherapy to use in treating cancer.

**Clinical Pathway Program.** A Clinical Pathway Program is a program designed to encourage providers to use a clinical pathway in choosing the services and procedures they deliver or order for patients. For example, in oncology, many payers require oncologists to use a clinical pathway in order for the oncologists to receive payment for treating cancer patients.

**Clinical Practice Guidelines.** Clinical practice guidelines are recommendations developed by a medical society or other organization to help physicians or other providers to deliver care efficiently and effectively. Guidelines will generally be based on evidence where it exists, but where evidence does not exist, guidelines may simply codify professional judgments about which

treatments should be delivered. See also **Appropriate Use Criteria** and **Clinical Pathway**.

**Clinical Resource Groups (CRG).** Clinical Risk Groups (CRG) is a risk adjustment system developed by 3M Health Information Systems that uses a patient's diagnoses and past medical interventions to determine whether the patient has chronic conditions or acute conditions or both and the severity of those conditions. This information is then used to assign the patient to one of 269 different "Base CRGs" and to one of up to 6 different severity levels, for a total of 1,080 potential different groupings.

**CMG.** See **Case-Mix Groups**.

**CMMI.** See **Center for Medicare and Medicaid Innovation**.

**CMS.** See **Centers for Medicare and Medicaid Services**.

**CMS-1450.** The CMS-1450 is the claims form used by hospitals to submit claims to Medicare for payment of healthcare services. The same form is known as a UB-04 for claims submitted to commercial payers.

**CMS-1500.** The CMS-1500 is the claims form used by physicians and other non-institutional providers to submit claims to payers for payment of healthcare services. (Hospitals submit claims using the UB-04 claims form.)

**Co-Insurance.** Co-insurance is a form of cost-sharing; the co-insurance amount is calculated as a percentage of the total allowed amount for a service. The patient is required to pay the co-insurance amount to a provider in order to receive a service; the remainder of the payment to the provider is then paid by the insurance plan or other payer. The patient is expected to pay an additional co-insurance amount each time an additional service is rendered (if the service requires co-insurance).

**Comorbidity.** A comorbidity is a health condition other than the condition being treated that may affect the cost of the treatment or the outcomes that can be achieved.

**Competitive Acquisition Program.** The Competitive Acquisition Program was a program created by Congress that was intended to control the cost of drugs administered in physician offices. CMS implemented the program in 2006 but suspended the program at the end of 2008 due to lack of participation by vendors and other problems.

**Composite Measure.** A composite measure is a measure of quality, utilization, or spending that is calculated based on performance on two or more other measures. There are two basic approaches to constructing composite measures:

**All or Nothing Composite.** In an all-or-nothing compo-

site, if the performance threshold is not reached for a patient on one of the measures in the composite, then the provider is deemed not to have achieved adequate performance for that patient on the composite measure. For example, in a composite measure of diabetes care called the D5 that is based on five separate individual measures, a 30% score for a provider means that adequate performance was achieved on all five of the measures for 30% of the patients, and for 70% of the patients, adequate performance was not achieved on at least one of the 5 measures.

**Weighted Average Composite.** A weighted composite measure is constructed by multiplying each individual measure by a measure weight and then summing the products to create a composite measure score. A weighted average composite will generally have higher scores than an all-or-nothing composite, since the weighted average composite gives a provider "partial credit" for a patient if adequate performance was achieved on some measures but not others. The relative rankings of providers on a weighted average composite will also depend on the measure weights if different providers have different levels of performance on different measures in the composite.

**Comprehensive Care Payment.** A Comprehensive Care Payment is a payment that is intended to support comprehensive services for a particular condition or group of conditions. A Comprehensive Care Payment is a form of Condition-Based Payment, but whereas a Condition-Based Payment could be designed to support a subset of the care needed for a condition, a Comprehensive Care Payment would support the full range of services the patient needs. For example, whereas a Condition-Based Payment for pregnancy might be limited to delivery of the baby (although it would not be based on the type of delivery in the way current physician and hospital payments are designed), a Comprehensive Care Payment would include prenatal care, delivery, and postpartum care services. (A global obstetrical fee covers that full range of services, but only includes the physician's services, not the hospital's services, whereas a Comprehensive Care Payment would include the services of all providers.)

**Completion Factor.** A completion factor is an adjustment made to a measure that was calculated based on claims data in order to compensate for claims that had not yet been filed by the time the measure was calculated. For example, if it is estimated that the claims for services that were delivered during the calendar year but submitted for payment more than 90 days after the end of the calendar year (i.e., services that are Incurred But Not Reported) represent 2% of the total amount that will ultimately be paid for all services delivered during the year, then the spending calculated based on the claims that were filed by 90 days after the end of the year (i.e., the Claims Runout period) would be increased by 2% to estimate what the spending would be once all claims were filed. See **Claims Runout** and **IBNR**.

**Comprehensive Primary Care Initiative (CPCI).** The Comprehensive Primary Care Initiative is a demonstration project implemented by the Center for Medicare and Medicaid Innovation in collaboration with private health plans in seven geographic regions to evaluate the impact of a specific change in the way primary care practices are paid. The primary care practices receive a per member per month (PMPM) payment in addition to current fee-for-service payments and can receive an additional shared savings payment if the total spending on all of the patients in all of the participating practices in their geographic region is lower than the spending in a comparison group of patients.

**Concierge Medicine.** Concierge medicine describes a mode of care delivery by a physician practice that provides more time with patients and more rapid response to requests for assistance than is possible under typical physician payment schedules, including longer office visits, phone calls, 24-hour access, etc. Typically, a patient pays a monthly, quarterly, or annual fee of some kind for concierge care in addition to fees for individual services, or the concierge fee may cover some services (such as office visits) but not other services.

**Condition-Based Payment.** Condition-based payment is a payment that is triggered by a patient's health condition, rather than by delivery of a specific procedure or service delivered to address the condition. The "condition" may consist of more than one disease, particularly if the treatments for the diseases must be closely coordinated. For example, a condition-based payment could be paid for pregnancy care, rather than paying for a particular form of delivery; a condition-based payment could be paid for care of knee osteoarthritis, rather than for knee surgery, physical therapy, etc.; and a condition-based payment could be paid for management of heart failure and emphysema over a period of time.

Because patients with more severe conditions will likely need more services and because providers will have greater difficulty achieving good outcomes for them, condition-based payment models will generally need to incorporate some form of risk adjustment structure. (In a fee-for-service or treatment-based payment model, the services delivered serve as an implicit risk adjustment system, because a patient with greater needs will receive more services and that will generate higher payment. In a condition-based payment system, more direct measures of the patient's needs must be used, such as the diagnoses assigned to the patient.)

**Condition-Based Payment Code.** A billing code that indicates that a physician or other provider is managing the care of a health condition for a particular patient for a particular period of time and will serve as the Accountable Provider for a Condition-Based Payment for that condition for that period of time.

**Contact Capitation.** See **Capitation**.

**Conversion Factor.** A conversion factor is a dollar amount that is multiplied by a relative value unit (RVU) or payment weight assigned to a particular service or bundle in order to determine the amount that will be paid to a provider for delivering that service or bundle. For example, in the Medicare Physician Fee Schedule, two different services will be assigned two different RVUs, and those RVUs will be multiplied by the same conversion factor to determine the actual dollar amounts that Medicare will pay for those services. In the Medicare Inpatient Prospective Payment System, the payment for a hospitalization is determined by multiplying the weight for the DRG assigned to the patient by a conversion factor determined through a formula. The use of a Conversion Factor allows an entire set of payments to be uniformly updated for inflation while leaving the relative values among the services unchanged.

**Contribution Margin.** The contribution margin from a service is the difference between the payment received for delivery of the service and the variable cost to the provider of delivering that service. The total contribution margin from all services is used to cover the provider's fixed costs, and then any funds remaining represent the provider's **margin**.

**Coordinated Care Organization (CCO).** A Coordinated Care Organization is a regional entity in the State of Oregon that includes both payers and providers and takes responsibility for managing the quality and cost of care for Medicaid patients living within the CCO's defined region.

**Co-Payment.** A co-payment is a form of cost-sharing. It is a fixed dollar amount that a patient is required to pay to a provider in order to receive a particular service; the remainder of the payment to the provider is then paid by the insurance plan or other payer. The patient is expected to pay an additional co-payment each time an additional service is rendered (if the service requires a co-payment).

**Cost.** In terms of healthcare services and payment, the term "cost" is used to mean two very different things depending on the context in which it is used:

1. The cost of a healthcare service *to a patient, payer, or purchaser* is the amount that individual or entity pays a provider in return for the service being delivered. It is less confusing if this is referred to as a payer's *spending*, because the payer may also incur other costs that are not directly associated with healthcare services, such as administrative costs.
2. The cost of a healthcare service *to a provider* is the amount that provider pays to its employees, suppliers, etc. in order to deliver the service. Although this involves spending by the provider for services delivered by others, it is less confusing if this is referred to as the provider's *cost of delivering services*.

It is desirable to use different terms for these two concepts – *spending* for the first and *cost* for the

second— because the payer’s spending may be either higher or lower than the provider’s cost. A provider may be paid more than it costs to deliver a service, in which case the provider also generates a profit margin. A payer may pay less than it costs providers to deliver a service, in which case the providers lose money.

**Fixed Cost.** The fixed cost of delivering a service is the component of costs incurred by a provider that does not vary in proportion to the number of services delivered. For example, a hospital must spend money to furnish, equip, and maintain a surgery suite in order to do any surgeries at all; these costs will not change if one more or one fewer surgery is performed. Fixed costs are only “fixed” in the short run, however.

**Semi-Variable Cost.** The semi-variable cost of delivering a service includes aspects of cost that increase or decrease only if there are sufficiently large changes in the number of services delivered. For example, on a hospital nursing unit, an increase or decrease of one patient will generally not result in a change in the number of nurses needed to staff the unit, but if there is a large enough decrease in the number of patients, the hospital may need fewer nurses to safely staff the unit.

**Variable Cost.** The variable cost of delivering a service includes the aspects of costs incurred by a provider that vary in proportion to the number of services delivered. For example, a hospital must purchase a knee implant device for each surgery to replace a patient’s knee, but it does not need to purchase an implant if no surgery is performed, so the implant is a variable cost. If one fewer surgery is performed, the hospital’s costs will decrease because it will need to acquire one fewer knee implant, and if more surgeries are performed, the hospital will need to spend more on knee implants.

**Cost-Based Reimbursement.** In a cost-based reimbursement system, a provider calculates the total amount it spent to deliver one or more healthcare services for a patient, and the payer reimburses the provider for those costs. If costs cannot be specifically associated with an individual patient, the provider would calculate the total costs for delivering those services to all patients and then the payer would pay a percentage of those costs based on the percentage of the provider’s total patients who are insured by that payer. For example, Medicare payments to Critical Access Hospitals are calculated as 101% of the portion of the hospital’s costs attributable to Medicare beneficiaries who received services from the hospital.

**Cost-Sharing.** Cost-sharing is the amount that a patient pays out-of-pocket to a healthcare provider in return for a service, with no reimbursement from a third-party payer. The four principal approaches to cost-sharing are co-payments, co-insurance, deductibles, and balance billing.

**Cost-Shift.** “Cost-shift” is generally used to denote situations in which a particular payer pays less for a service than it actually costs a provider to deliver that service, but rather than incurring a loss or not delivering the service at all, the provider charges another payer more than the service actually costs (or charges more for a different service than that service costs) in order to offset losses from the payments made by the first payer. In effect, the provider has “shifted” the costs associated with services for the first payer to the second payer or from the one service line to the other service line.

**Cost-to-Charge Ratio.** The cost-to-charge ratio is calculated by dividing a provider’s reported total expenses during a period of time by the sum of the charges associated with all of the services delivered during that period of time. The cost-to-charge ratio is often used to estimate the cost of a specific service from the provider’s charge for that service by multiplying the charge by the cost-to-charge ratio. However, in general, the amount a provider charges for a particular service bears no systematic relationship to the cost of delivering that service (moreover, the cost of delivering the service will depend on the volume of services delivered), so service-specific costs estimated in this way are likely inaccurate.

**Covered Service.** A covered service is a healthcare service that a patient’s health insurance plan will pay a healthcare provider to deliver.

**CPCI.** See **Comprehensive Primary Care Initiative.**

**CPR.** See **Customary, Prevailing, and Reasonable.**

**CPT®.** See **Current Procedural Terminology.**

**CPT Editorial Panel.** The CPT Editorial Panel is a committee appointed and staffed by the American Medical Association to oversee the addition, deletion, and modification of CPT Codes.

**CRG.** See **Clinical Resource Groups.**

**Critical Access Hospital.** A Critical Access Hospital is a hospital with fewer than 25 acute inpatient beds located in a rural area and distant from other hospitals. In contrast to larger hospitals that are paid through the Medicare Inpatient Prospective Payment System, Critical Access Hospitals are paid using a cost-based reimbursement model.

**Current Procedural Terminology (CPT®).** Current Procedural Terminology is a listing of definitions and alphanumeric codes for reporting medical services and procedures performed by physicians. It is maintained by the American Medical Association under the supervision of the CPT Editorial Panel. The CPT system was first developed in 1966; in 2000, it was designated by the U.S. Department of Health and Human Services as the national coding standard for services and procedures delivered by physicians and other health care

professionals.

**CPT® Category I.** CPT® Category I consists of the principal codes used to document services that are delivered by physicians and that are used to bill for payment for those services. Examples of CPT Category I Codes are:

- 99203: Office or other outpatient visit for the evaluation of a new patient which involves a detailed history, a detailed examination, and medical decision making of low complexity.
- 27590: Amputation of the leg through the femur.

**CPT® Category II.** CPT® Category II codes are codes used for performance measurement. They facilitate documentation that a particular task was performed (e.g., that the patient's blood pressure was measured) as part of an evaluation and management service that is billable using a CPT Category I code, or documentation of a patient condition, test result, or treatment outcome (e.g., whether the patient's blood pressure was high or low). A CPT Category II code is not intended to be used as a billing code for payment, but a payment model may be structured to modify the payment amount for a service described by a CPT Category I code based on whether a CPT Category II code indicates that a task was performed as part of that service, an outcome was achieved as a result of that service, or a particular patient condition was present. Examples of CPT Category II codes are:

- 2000F: Blood pressure measured
- 3074F: Most recent systolic blood pressure less than 130mm Hg

**CPT® Category III.** CPT® Category III codes are temporary codes for emerging technology, services, and procedures. They are designed to allow data collection for these services in a systematic way. Examples of CPT Category III codes are:

- 0071T: Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue.
- 0223T: Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report.

**Customary, Prevailing, and Reasonable (CPR).** Prior to the creation of the Resource Based Relative Value Scale (RBRVS), Medicare payments to physicians were based on Customary, Prevailing, and Reasonable (CPR) charges. The CPR system was based on the UCR (usual, customary, and reasonable) concept, but it included specific metrics for determining "customary," "prevailing," and "reasonable." ("Customary" was defined as the median of an individual physician's charges for a service over a particular period of time; "prevailing" was defined as the 90<sup>th</sup> percentile of the customary charges for all physicians in the same specialty in a geographic area, and "reasonable" was defined as the lowest of the actual fee, the customary charge, and the prevailing charge.)

# D

**Deductible.** A deductible is a form of cost-sharing. Under a health plan with a deductible, the patient is required to pay 100% of the cost of all services until the patient's total spending reaches the deductible, at which point other cost-sharing rules such as co-payments and co-insurance apply. Some services, such as preventive care services, may be exempt from the deductible requirement, and for those services the patient may be expected to pay other forms of cost-sharing, or the patient may have no cost-sharing at all.

**Delivery System Reform Incentive Payment (DSRIP) Program.** A Delivery System Reform Incentive Payment Program is a special pool of funds that can be used by a state Medicaid program to encourage or support changes in care delivery by hospitals and other providers to Medicaid beneficiaries and other low-income individuals. The programs are created on a state by state basis through Section 1115 Medicaid waivers approved by the Centers for Medicare and Medicaid Services.

**Denominator Exclusion.** In a performance measure, if the measure focuses on a particular subset of patients, or if there is a reason why performance should not be measured for a particular patient or a patient with particular characteristics, patients who should not be measured are excluded from both the numerator and denominator of the measure. For example, if one is calculating the percentage of diabetic patients who have had their blood pressure measured, then non-diabetic patients are excluded from the denominator as well as the numerator.

**Designated State Health Program (DSHP).** A program approved in some states under Section 1115 Waivers to allow Federal Medicaid funding to be used for services that are not typically eligible for such funding.

**Diagnosis Related Groups (DRGs).** Diagnosis Related Groups (DRGs) is a system of classifying patients into categories based on their expected relative use of inpatient hospital services. A version of DRGs called MS-DRGs is used as part of the Medicare Inpatient Prospective Payment System (IPPS) to pay hospitals for inpatient admissions of Medicare beneficiaries, and a version called APR-DRGs is used by many commercial health insurance plans to pay hospitals for admissions of their members. DRGs are a clinical

category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories. The weight assigned to a DRG may differ for different payers if they have different patient populations, since weights are typically determined by calculating the average costs for caring for patients in each category relative to all patients in a population of patients.

In current versions of DRGs, there may be two or three different DRGs defined for any major condition or procedure, based on whether the patient has other health problems (called comorbidities) that would affect services and spending for treatment of that specific condition or delivery of that specific procedure, or if the patient experiences complications during the hospital stay. If there are three DRGs for patients with a specific condition or surgical procedure, one of the DRGs is for patients without complications or comorbidities (abbreviated as “w/o CC/MCC”), a second DRG is for patients with complications or comorbidities that are not classified as major (abbreviated as “w CC”) and a third DRG is for patients with major complications or comorbidities (abbreviated as “w MCC”). If there are only two DRGs for a condition or procedure, one is used for patients without major complications (abbreviated as “w/o MCC”) and one is for patients with major complications (abbreviated as “w MCC”).

DRGs can be used as a risk adjustment system for both payment and performance measurement; for example, DRGs are used to calculate an overall risk score for a hospital called a Case Mix Index, which is the sum of the DRG weights for all patients discharged from the hospital divided by the total number of discharges. DRGs are also used as bundled payments/case rates; in the Medicare IPPS and other payment models, the hospital receives a single “DRG payment” for a patient admitted to the hospital that is intended to cover all of the hospital’s costs of caring for that patient, with the payment amount for each patient determined by multiplying the DRG weight by a conversion factor.

**Direct Contracting.** Direct contracting is an arrangement between a purchaser and a provider to deliver health care services for the purchaser’s members in return for payment specified in a contract with the purchaser rather than in a contract with a separate health insurance company. A direct contract may be focused on particular types of services, e.g., the purchaser may agree to pay a provider for knee replacement surgeries performed on the purchaser’s members, or a direct contract may involve an agreement by the provider to deliver or arrange for all or most types of health services for the purchaser’s members. In general, in order to have direct contracting for a broad range of services, the provider will need to have a provider-owned health plan that can manage the benefits and payments or the purchaser and pro-

vider will need to jointly agree to use a third-party administrator to manage the terms of the contract.

**Direct Primary Care.** Direct Primary Care (DPC) is a term used to describe a payment model in which a primary care practice charges a monthly, quarterly, or annual fee to a patient that covers all or most of the services the primary care practice provides to the patient, including patient visits, laboratory testing, care management, etc., and there are no separate fees charged for individual services. Direct primary care is a bundled capitation payment, but with the payment coming from the patient rather than a health plan. In contrast, “concierge medicine” is typically a structure where a patient pays a fee of some kind in addition to fees for individual services, with the additional fee assuring that the patient will receive services that would not otherwise be possible under current fee schedules, including longer visits, phone calls, 24-hour access, etc.

**Discounted Payment.** A discounted payment is a payment to a provider for a service from one payer that is lower than the amount other payers pay for the same service.

**Dispensing Fee.** A dispensing fee is a payment to a pharmacy from a pharmaceutical insurance plan or other payer for each medication that the pharmacy dispenses to a patient insured by the plan or paid for by the payer. The payment is intended to cover the costs of the pharmacy’s operations other than the cost of acquiring the drug itself. The dispensing fee is paid in addition to whatever mechanism is defined for paying the pharmacy for its cost of acquiring the drug.

**Disproportionate Share Hospital.** A hospital which has a higher-than-average number of Medicaid patients or a large number of low-income patients is classified as a “Disproportionate Share Hospital” and is eligible to receive additional payments.

**Division of Financial Responsibility (DOFR).** A division of financial responsibility (DOFR) is an agreement between a payer and a provider, or between a payer and multiple providers, as to which services delivered by which providers are to be covered by a bundled payment or capitation model that covers some but not all services or providers. For example, the DOFR for a professional services capitation payment model would define which services are considered “professional services” that are covered by the capitation payment and which services would be paid separately. A DOFR will typically use service/procedure billing codes and diagnosis codes to define which services will be paid through the bundled payment and which will be paid in a different way.

**Doughnut Hole.** A “doughnut hole” is a feature of a benefit design in which a patient who has received services that exceed a certain threshold of spending is responsible for higher cost-sharing for subsequent services than the patient was responsible for paying

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prior to that point, but where the cost-sharing then declines again after a second threshold of spending is met. The Medicare Part D drug insurance program has had a “doughnut hole” that requires seniors to pay almost the full cost of drugs for a period of time after they have reached a certain spending level on drugs.

**Downside Risk.** See Risk.

**DRG.** See Diagnosis Related Group.

**DRG Grouper.** A DRG grouper is a computer program that takes all of the diagnosis codes and procedure codes assigned to a patient during a hospital stay and uses them to assign the patient to a particular Diagnosis Related Group (DRG) based on the official rules for making such assignments.

**DRG Weight.** A DRG weight is a value assigned to a specific Diagnosis Related Group (DRG) that indicates the relative amount of resources or spending that is expected to be used for patients classified in that DRG. An advantage of a clinical category system such as DRGs is that the same categories can be used for payments to different providers or different patient populations but with different weights based on their different costs. For example, Medicare uses the same MS-DRG categories for paying both acute care hospitals and long term care hospitals, but different weights are assigned to the same MS-DRG in each payment system because of the different costs of care in the two different types of facilities.

**DSH.** See Disproportionate Share Hospital.

**DSRIP.** See Delivery System Reform Incentive Payment.

**Dual Eligible.** An individual is said to be “dual-eligible” if he or she is eligible for both Medicare and Medicaid benefits. Although they are often discussed as though they were a homogeneous class of individuals, dual eligibles are very diverse because of the different ways that individuals can become eligible for both Medicare and Medicaid. For example, dual eligibles include young, disabled adults; poor, but relatively healthy older adults; and frail elderly living in nursing homes who have exhausted their incomes paying for long-term care services that are not covered by Medicare.

# E

**E&M.** See Evaluation and Management Services.

**ECR®.** See Evidence-Informed Case Rate.

**Encounter.** An encounter is an interaction between a provider and a patient. In a capitation payment model or other payment model that does not tie payment to the specific number or types of services delivered, a payer may still wish to know what services were delivered, so instead of submitting a claim for each service (since a claim is generally associated with a payment), a provider may be asked to submit a form documenting an encounter. Encounters include services that would be eligible for payment under a fee-for-service payment model, but they may also include other services or interactions that are not typically paid for under fee-for-service, such as telephone calls or e-mails with patients.

**End-Stage Renal Disease Prospective Payment System (ESRD PPS).** The End-Stage Renal Disease Prospective Payment System (ESRD PPS) is the payment system Medicare uses to pay outpatient dialysis centers for care of patients with end-stage renal disease (ESRD). Under the ESRD PPS, a separate payment is made for each dialysis treatment. The payment is a bundled payment that covers the costs of administering dialysis to a patient and the costs of ESRD-related drugs, laboratory services, and medical equipment and supplies. Oral-only ESRD-related drugs are excluded from the bundle but scheduled to be added in 2024. The payment covers two different methods of dialysis – hemodialysis and peritoneal dialysis – and covers dialysis whether it is administered in a dialysis center or in the patient's home.

The amount of payment for a dialysis treatment is determined by adjusting a national base payment rate for geographic differences in costs using the Hospital Wage Index, then further adjusting for characteristics of the patient (age, body mass index, body surface area, and the presence of six specific comorbidities). The payment is also increased for treatments during the first four months of dialysis for a patient and for treatment at low-volume dialysis facilities. An additional outlier payment is paid if the cost of treating the patient exceeds an outlier threshold, and an additional payment is made for training patients to self-administer dialysis. The payments are reduced by up to 2% based on dialysis facilities' achievement and improvement on specified quality

measures.

The ESRD PPS is a single-provider treatment-based bundled payment. It bundles together a series of services related to a single treatment. The bundle does not include the cost of physician services associated with the dialysis treatment. Although the number of services included in the bundle has increased over time, the bundled payment does not include any costs of complications of treatment and it does not cover an episode of care longer than the treatment itself. It includes a pay-for-performance penalty component based on quality.

**Episode.** The word “episode” is used in two somewhat different ways in the context of payment models:

- *The care delivered during a fixed period of time.* A common use of the word episode is to describe a period of time in which multiple services are delivered, all of which are related to a specific health problem or group of problems. The time period may be arbitrarily defined with no relation to the actual length of the patient’s treatment (e.g., a month, 60 days, or a year) and the episode may or may not include either the beginning or the end of a patient’s care for the condition or the delivery of the procedure involved.
- *The complete set of related services for a condition or a procedure.* The word episode is also used to describe all of the services that are needed to care for a particular condition or to complete the delivery of a procedure involving multiple services over a period of time. For example, if a patient receives surgery, the episode could include the surgery itself and any follow-up care that is related to the surgery or to complications of the surgery. To distinguish this from the other use of the word, this might be more clearly described as a “complete episode.”

An episode can be defined to be triggered by the presence of a particular patient condition (e.g., diabetes) or by the delivery of a particular service or procedure (e.g., heart surgery). A “complete episode” is ordinarily only defined in relation to an acute condition that appears at a particular point in time and is resolved at a later point in time. When the term episode has been used to describe the services related to a chronic condition that continues indefinitely, it has typically been defined as the services related to that condition that occur during a calendar year, even though other services related to the same condition were provided before and/or after the episode period. Limiting episodes to a year or less facilitates the use of payment contracts that are one year in length since many patients change health plans from year to year.

**Episode (of Care) Payment.** An “episode payment” or “episode of care payment” is a payment intended to cover all or most of the services delivered during an episode of care. The services covered by the episode payment will depend on how the episode of care is defined. For example, an Episode of Care Payment for knee surgery might be defined to include the ser-

vices related to the surgery itself, the services delivered in the hospital for recovery from the surgery, the rehabilitation services the patient receives during and after discharge from the hospital to regain the ability to use the repaired knee, and services needed to address any infections or other complications that arise from the surgery. If the episode is not a “complete episode” but rather an arbitrary period of time, then the episode payment covers the services that occur during that period of time, and services that occur before or after that time period are paid with an additional episode payment or through some other means.

**Episode Grouper.** An episode grouper is an algorithm, typically implemented as part of a software system, that retrospectively examines individual claims for services and determines whether they fall within the definition of one or more episodes of care. Since claims forms are not designed to indicate the type of episode for which a service was delivered, episode groupers typically rely heavily on the diagnosis and procedure codes recorded on claims and on the relative timing of various services to determine which types of episodes have occurred and how to assign individual claims to those episodes; this can result in errors in determining which types of episodes have occurred and can cause services to be erroneously assigned to episodes.

**Episode Length.** The episode length is the number of days or months defined to be included in an episode of care. If a provider is accepting an Episode (of Care) Payment, the episode length is the period of time in which services are expected to be covered by the episode payment rather than billed separately for individual payments. An episode length can be defined as a fixed or variable amount. In a fixed-length episode, the episode is the same fixed length of time for all patients, e.g., a year, and any related services that occur during that time period are included in the episode. A variant of this approach is to define an episode as a fixed length of time after completion of a particular service; for example, the episode length might be defined as 90 days after discharge from the hospital, in which case the actual length of the episode will depend on the length of time the patient spent in the hospital. In a variable length episode, the length of the episode varies from patient to patient. For example, if the episode is defined as ending when all related services have been delivered, then the length of the episode for a patient will depend on how long it took to deliver all of those services, whether the patient experienced complications that required additional services, etc. Variable length episodes are often terminated after a “clean period” occurs in which no related services are delivered. (See **Clean Period.**)

**Episode Spending Measure.** An episode spending measure calculates how much was spent on services for a patient during an episode of care. The providers who deliver the services to the patient may be paid under traditional fee-for-service payment models, and

the episode spending measure may then be used to modify the amount of the fee-for-service payments to a provider in some way based on whether the amount of spending in the episodes in which that provider was involved is viewed to be high or low. For example, CMS is using several episode spending measures in its Hospital Value-Based Purchasing Program and Physician Value-Based Modifier Program to increase and decrease payments to hospitals and physicians based on the levels of spending in the episodes they were involved in relative to the levels of spending on similar episodes that other hospitals and physicians were involved in.

Some payers are using “episode spending measures” that include services that may be unrelated to the hospitalization or other service that triggered the episode. For example, the Medicare Spending Per Beneficiary measure includes the spending on all services received by a Medicare beneficiary during the 30 days following their discharge from the hospital, including services for conditions different from those that were treated during the hospital stay and services for conditions that may have first developed after the patient was discharged from the hospital.

**ESRD PPS.** See **End Stage Renal Disease Prospective Payment System.**

**Evaluation and Management Services (E&M).** The Current Procedural Terminology (CPT®) system defines codes for a range of different services that are collectively referred to as Evaluation and Management Services. The most commonly used Evaluation and Management (E&M) Services codes are for patient visits to a physician for evaluation of a symptom or management of a condition. If the physician carries out a specific test or performs a particular procedure during the visit, a separate procedure code would be billed for that service.

**Evidence-Based Medicine.** The term “evidence-based medicine” is used to describe the processes for determining which healthcare services a patient should receive based on explicit consideration of research showing whether a service is effective or which services are more effective. Contrary to popular belief, there is rarely evidence that “proves” a treatment will work or that a particular service is the best possible way to treat a patient; most evidence merely indicates that one treatment is more effective than others, on average, for a group of patients with particular characteristics. There are also different levels of evidence, with different levels of confidence as to the reliability of the results.

**Evidence-Informed Case Rate (ECR).** An Evidence-Informed Case Rate is a methodology developed by the Health Care Incentives Improvement Institute (HCII) for defining an appropriate amount of spending on a particular health condition. ECRs have been defined for both acute conditions and chronic conditions, and each ECR defines an episode of care that includes services related to the triggering condition

delivered over a period of time. A key element of the ECR is the identification of services within the episode of care that are classified as Potentially Avoidable Complications (PACs), so that performance measures and payments can be defined separately for PAC services. ECRs incorporate a regression-based risk adjustment system for determining how the spending level should vary based on patient comorbidities.

ECRs are used as part of the PROMETHEUS payment model but they can also be used for measuring spending as part of a pay-for-performance system or other payment model. Many of the payments based on ECRs are a form of Condition-Based Payment, since many ECRs are triggered by a patient’s condition (as defined by diagnosis codes recorded on claims forms) rather than by the specific procedures delivered.

**Exclusion (of Outliers).** Exclusion is a statistical process that completely drops the most extreme values from a distribution. For example, in any group of patients with a particular condition, some patients may have unusual problems that require a large number of expensive services for that condition (“outlier patients”). If a provider is given a fixed payment to pay for as many services as the patients need for the condition, the small number of patients requiring the large number of expensive services could cause losses for the provider. This problem can be mitigated by not requiring the provider to be responsible for the costs of the patients who are excluded. The threshold for exclusion can be set at a relative level (e.g., patients with costs above the 99<sup>th</sup> percentile) or at an absolute level (e.g., patients with costs above \$100,000). See also **Exclusion vs. Outlier Payment vs. Truncation vs. Winsorization.**

**Exclusion (of Services).** In a global payment model, some specific services may still be paid separately and thereby are excluded from the global payment arrangement. See also **Carve Out.**

**Exclusion vs. Outlier Payment vs. Truncation vs. Winsorization.** If a provider is given a fixed payment to pay for as many services as patients need, outlier patients (i.e., patients who need an unusually large number of services or unusually expensive services) can cause losses for the provider. Exclusion of the outlier patient means the provider is not expected to pay for any of the services to the outlier patient from the fixed payment. Truncation means that the provider is only expected to pay up to a fixed amount for such patients (e.g., \$100,000). Winsorization means that the provider is only expected to pay up to the amount at a particular point in the distribution of spending for all patients (e.g., the 99<sup>th</sup> percentile). An outlier payment is an additional payment to the provider to cover a portion of the costs of the services needed by the patient.

# F

**Facility Fee.** A facility fee is an additional charge for a healthcare service when it is delivered in a hospital or other facility that bills for its services separately from the physician or other provider who actually performs the service.

**Facility-Independent Payment.** A facility-independent payment pays the same amount in the same way for a particular service or procedure regardless of the type of facility where the service or procedure is delivered, instead of separate payment systems or different payment amounts for the same service depending on whether it performed in a hospital or an ambulatory surgery center or physician office. A facility-independent payment may require a different risk adjustment system than facility-specific payments in order to distinguish patient characteristics that may require use of a more expensive setting for care.

**Federally-Qualified Health Center Prospective Payment System (FQHC PPS).** A Federally Qualified Health Center (FQHC) is an outpatient clinic that serves low-income populations and meets specific federal requirements. Under the Federally-Qualified Health Center Prospective Payment System (FQHC PPS), Medicare pays an FQHC a bundled payment for each patient visit to the clinic instead of separate payments for individual services under the Physician Fee Schedule. Different types of visits are paid different amounts, and CMS has established a series of HCPCS G-Codes that FQHCs use to indicate what type of visit a patient received. For example, G0466 indicates that the visit was made by a new patient, G0467 indicates that the visit was made by an established patient, and G0469 indicates that the visit was for a new patient who received a qualified mental health service during the visit. Although the payments under the FQHC PPS are not tied directly to specific types of services, the patient must still make a visit to the clinic in order for the clinic to receive a payment.

**Fee for Service Payment.** A fee-for-service payment model is one in which a specific amount is paid when a particular service is delivered, and generally where the payment amount differs depending on which specific service is delivered.

Although fee-for-service payment systems are criticized for “rewarding volume over value,” many alternative payment models have similar characteristics. For example, most bundled payment and episode pay-

ment systems are triggered by the delivery of a service, so they still pay more if that service is delivered more frequently. Moreover, many of the services paid for under fee-for-service payment models are already bundled in some way (for more information, see Fee for Service Payment vs. Bundled Payment).

The problems with existing fee-for-service systems that need to be corrected by alternative payment models tend to fall in to two broad categories:

- *Lack of payment or inadequate payment for high-value services.* Despite the name, most fee-for-service payment system only pay fees for a subset of services that are of value to patients. For example, Medicare and most health plans don't pay:
  - ◆ for physicians to respond to a patient phone call about a symptom or problem, even though those phone calls can avoid far more expensive visits to the emergency room.
  - ◆ for primary care physicians and specialists to coordinate care by telephone or email, even though lack of care coordination will result in the payers paying for duplicate tests and the problems caused by conflicting medications.
  - ◆ for services delivered by nurses and other non-physician staff or for non-medical services that could help patients manage chronic conditions better and avoid expensive hospitalizations.
- *Financial penalties for delivering a different mix of services.* Under the fee for service system, providers lose revenue if they perform fewer procedures or lower-cost procedures, but their costs for delivering the remaining services generally do not decrease proportionately, and that can cause operating losses for the providers. Most fundamentally, under the fee for service system, providers don't get paid at all when their patients stay healthy and don't need health care services.

**First Dollar Shared Savings.** In a shared savings payment model, if the provider's share of savings is calculated based on the total amount of savings generated, it is said to receive “first dollar shared savings.” This is in contrast to a structure where the payer keeps all of the initial savings until a certain threshold is reached and only then shares additional savings with the provider. However, even a first dollar shared savings model may not guarantee that a provider will receive a share of savings no matter how the small the savings are. For example, in the Medicare Shared Savings Program, the savings must exceed the Minimum Savings Rate in order for an Accountable Care Organization to be eligible for any shared savings payment, but if the Minimum Savings Rate is achieved, then the share of savings is calculated based on the total savings achieved.

**FMAP.** FMAP is an abbreviation for Federal Medical Assistance Percentage, which is the percentage of a state's Medicaid spending that the Federal government will pay for.

**FQHC.** FQHC is an abbreviation for Federally Qualified

Health Center.

**Fraud and Abuse Laws.** The federal government and many state governments have enacted a series of laws designed to control fraud and abuse in healthcare payment. In some cases, the concerns about potential abuses under current payment systems may not exist (or may be significantly less) under a different payment model. However, because the fraud and abuse law is not tied to a particular payment model, the restrictions in the law can serve as a barrier to delivering care or distributing funds in different ways under the different payment model. The principal federal fraud and abuse laws are:

- The Anti-Kickback statute;
- The Civil Monetary Penalty statute; and
- The Ethics in Patient Referrals Act, commonly known as the “Stark Law.”

The Affordable Care Act authorized CMS to grant waivers of these and other laws to providers participating in alternative payment models where necessary.

**Formulary.** In health insurance, a formulary is a list of pharmaceuticals that a health insurance plan will pay for. If a physician orders a medication that is not on the formulary, the physician will need approval from the payer to use the medication or the patient may have to pay the full cost of the medication.

For a hospital or other provider, a formulary is a list of pharmaceuticals that will be maintained in inventory and used in patient care.

**Fully-Insured.** An employer or other purchaser is said to be fully-insured if they purchase a health insurance policy for each of their employees or members and pay premiums to a health insurance company to cover the costs of claims for healthcare services. For contrast, see **Self-Insured**.

# G

**GAF.** See **Geographic Adjustment Factor**.

**Gain-Sharing.** A gain-sharing payment is made by one provider to another provider if the first provider experiences savings or higher profits due to actions taken by the second provider. For example, if a physician redesigns care delivery in a way that reduces the

costs the hospital incurs and thereby increases the hospital’s profit margin, the hospital could make a gain-sharing payment to the physician from those increased profits. A gain-sharing arrangement will generally require agreement between the two providers as to how costs and “gains” are to be measured. See also **Fraud and Abuse Laws and Shared Savings vs. Gain-Sharing**.

**G-Code.** A G-Code is a subset of the Level II codes that CMS creates and maintains as part of the Health Care Common Procedure Coding System (HCPCS). G-codes define procedures and professional services that Medicare will pay for but that have not been incorporated into the CPT coding system. Examples of G-Codes are:

- G0008: Administration of influenza virus vaccine.
- G0257: Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility.

**Geographic Adjustment Factor (GAF).** A Geographic Adjustment Factor is a number that indicates how much more will be paid for a service in one geographic area compared to other geographic areas based on differences in the cost of living and cost of purchasing services needed in the delivery of medical care. In the Medicare Program, payments to hospitals and other providers are adjusted by the Hospital Wage Index, and physician payments are adjusted using three separate factors used called Geographic Practice Cost Indices (GPCIs).

**Geographic Practice Cost Index (GPCI).** In the Medicare Physician Fee Schedule, in order to determine the actual dollar payment to an individual physician for a service, the Work, PE, and PLI RVUs are each adjusted by a corresponding Geographic Practice Cost Index that is intended to reflect differences in the costs of living, operating a practice, and obtaining insurance in different geographic areas of the country.

**Global Budget.** A global budget is an amount of money that is expected to cover all or most of the services that a patient needs from all providers during a particular period of time. In a global budget payment model, providers continue to bill for and be paid through the payment models that are typically used for the services. After the end of the time period for which the global budget is defined, all of the payments made to all providers for services covered by the global budget are tabulated and compared to the global budget in a retrospective reconciliation process. If the total payments are below the global budget, the payer pays the difference to the provider or organization that has accepted accountability for the budget, and if the total payments exceed the budget, then the accountable provider is responsible for reimbursing the payer for the overage.

**Global Fee.** A global fee is a single payment made to one provider for performing a group of services over a period of time (the global period) instead of paying

the provider individual fees for the individual services. For example, surgeons receive a global surgical fee which covers a visit with a patient before the surgery is performed and visits with the patient after the surgery is completed, and a surgeon receiving the global fee does not bill for separate fees for the individual visits. Similarly, obstetricians receive a global fee that covers prenatal care, delivery, and post-partum care, and the obstetrician receiving the fee does not bill separately for the individual prenatal and post-partum care visits.

**Global Budget vs. Shared Savings.** A key difference between a Global Budget and a typical Shared Savings program is that the Global Budget is defined prospectively while the target spending level needed to receive shared savings is defined retrospectively. Under a Global Budget, the accountable provider knows in advance what level of spending will be within the Global Budget and can monitor spending and take actions to help keep spending under that level. In contrast, under a Shared Savings Program, the provider does not know in advance what the target spending level is; “savings” are declared to have been achieved if spending on the accountable provider’s patients has decreased more or increased less than spending has changed for other providers’ patients, but the latter is only known after the fact.

**Global Payment.** A global payment is a payment that covers all or most of the services that a patient needs from all providers during a particular period of time. The term “global payment” is generally used in reference to a payment that covers multiple episodes of care for multiple types of conditions, whereas the term “episode payment” is used for a payment that is limited to a particular time period or to care associated with a particular procedure, and the term “condition-based payment” is used for a payment that is limited to a specific patient health condition or group of conditions.

**Risk-Adjusted Global Payment.** In a risk-adjusted global payment model, the amount of global payment a provider receives is adjusted up or down based on the risk or acuity level of the individuals whose care is to be covered by the global payment.

**Global Payment vs. Global Budget.** In many cases, particularly when independent providers are involved with a “global payment,” the payment will actually be implemented using a global budget process, since this avoids the need for the provider who is accountable for the global payment to pay claims from other providers that deliver services that are to be covered by the global payment. If the accountable provider has a provider-owned health plan, then it is in a better position to accept a global payment and directly pay claims from other providers.

**Global Payment vs. Global Fee.** A global payment usually refers to a payment that supports services delivered by multiple providers, whereas a “global fee” usually refers to a bundle of services delivered by one provider.

**Global Period.** A Global Period is a period of time in which services delivered by a provider are covered by a Global Fee rather than separately billed for individual service fees.

**GPCI.** See **Geographic Practice Cost Index.**



**HAC.** See **Hospital-Acquired Condition.**

**HCAHPS (Hospital Survey – Consumer Assessment of Healthcare Providers and Services).** HCAHPS is one of a family of CAHPS surveys that ask consumers and patients to rate their experiences receiving care in a variety of healthcare settings. The HCAHPS survey is specifically designed for services delivered in hospitals. A growing number of payers are using results of CAHPS surveys as a performance measure in payment models. See also **CG-CAHPS.**

**HCPCS.** See **Health Care Common Procedure Coding System.**

**Health Care Common Procedure Coding System (HCPCS).** The Health Care Common Procedure Coding System is a comprehensive set of billing codes maintained by the Centers for Medicare and Medicaid Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HCPCS Level I codes are the Current Procedural Terminology (CPT) codes developed and maintained by the American Medical Association, and HCPCS Level II codes are additional billing codes for additional services and medications not covered by the CPT system.

**Herfindahl-Hirschman Index.** The Herfindahl-Hirschman Index is a measure of the concentration of buyers or sellers in a geographic area. It is often used by economists and anti-trust enforcement agencies to assess whether a consolidation of providers or payers in a state or region, or an organizational arrangement to allow joint contracting with a group of providers (such

as an Accountable Care Organization), would be likely to excessively limit competition in a particular community.

**HHA.** HHA is an abbreviation for Home Health Agency.

**HHRG.** See Home Health Resource Groups.

**Hierarchical Condition Categories (HCCs).** Hierarchical Condition Categories (HCCs) is a risk adjustment system developed by the Centers for Medicare and Medicaid System to pay Medicare Advantage plans that is now also being used in many of the payment models being implemented by CMS, such as the Medicare Shared Savings Program. The HCC system uses information about the diagnoses reported on claims forms for an individual patient during the preceding year in order to calculate a single numeric “risk score” for that patient. These risk scores are averaged across all of the patients associated with a provider or health plan to determine the Risk Adjustment Factor (RAF) for that group of patients. Then the total spending during the year for a group of patients is divided by their RAF score to determine the risk-adjusted spending.

The HCC system is a regression-based risk adjustment system; CMS changes the weights for individual conditions significantly from year to year based on which factors achieve the best results in regression-based predictions of actual spending in the most recent year, not based on changes in clinical evidence about what patients need. CMS also implements HCCs as a prospective risk adjustment system that does not consider any health problems that occur during the performance year in determining the risk score for a patient; only diagnosis codes for health problems that occurred prior to the current year are considered. Moreover, the HCC system explicitly gives zero weight to many acute conditions, even though these conditions would likely result in a need for services during the year in which they occurred and could also affect service needs in the subsequent year. The HCC system uses only diagnosis information from claims data, and it does not consider many factors other than health conditions that can affect patient needs.

**HMO (Health Maintenance Organization).** A Health Maintenance Organization (HMO) is an entity that accepts a fixed premium or capitation payment for individuals enrolled in the HMO and takes responsibility for delivering or arranging for all of the covered healthcare services for those individuals through a defined group or network of providers. Typically an HMO requires that a patient have a referral from a primary care physician in the HMO before the patient can receive a non-emergency service from a specialist in the network, in contrast to a Preferred Provider Organization (PPO) in which the patient can obtain most services from specialists in the PPO network without a referral or prior approval.

**Network Model HMO.** A network model HMO is the most common form of HMO. It is usually created

by a health insurance plan contracting with multiple physician practices and hospitals to serve as the HMO providers. In a network model HMO, the HMO does not directly employ any of those providers.

**Staff Model HMO.** In a staff model HMO, a physician group serves as the HMO and takes the payment directly from the patient, rather than contracting through a separate health insurance plan. In a staff model HMO, most of the physicians are employed by the HMO.

**Home Health Prospective Payment System (HH PPS).**

The Home Health Prospective Payment System (HH PPS) is the system Medicare uses to pay Home Health Agencies (HHAs). Home health agencies are paid with a single payment to cover all of the services that are delivered during a 60-day “episode.” Since different patients will need different amounts of service within a 60 day period, patients are assigned to one of 153 Home Health Resource Groups (HHRGs) based on their health problems, functional status, and number of home health visits provided. The Home Health Agency’s payment for a patient is based on the HHRG assigned. Different HHRGs are assigned in some cases if the patient is receiving the first or second episode of services or the third or subsequent episode, which means that the payment may differ for the same services depending on how long the patient has been receiving services. Different HHAs also receive different payment amounts for the same HHRG based on a geographic adjustment factor. The HHA can receive an additional Outlier Payment if the patient requires unusually costly services, and the HHA is paid on a per-visit basis if the patient receives fewer than 5 visits.

**Home Health Resource Groups (HHRG).** Home Health Resource Groups is a categorical risk adjustment system used in the Medicare Home Health Prospective Payment System (HH PPS). Patients are assigned to one of 153 Home Health Resource Groups (HHRGs) based on their health problems, functional status, and number of home health visits provided.

**Hospice Services Payment.** In the Medicare program, a hospice agency is paid a flat daily rate for each day that a beneficiary is enrolled in the hospice program. There are four different payment levels, depending on the type of care being provided – Routine Home Care (RHC), Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIC). The payment rate for an individual patient is also adjusted by a geographic adjustment factor based on the location of the patient (not the location of the hospice agency, unlike the geographic adjustments for other providers).

Hospice payment is a form of capitation payment, since a fixed payment is made per beneficiary per day (at the RHC rate) regardless of how many services are provided on a given day (or whether any services are provided at all on a given day). A higher payment is only made if a service is provided which qualifies for

the CHC, IRC, or GIC payment levels (and this typically only happens on a very small proportion of the days a patient is in hospice care). Hospice payment is also a bundled payment, since the payment is intended to cover a range of services that would otherwise be paid for separately under other Medicare payment programs, including home health services, drugs, physical, occupational, and speech therapy, and inpatient care. Moreover, the hospice payment is a prospective bundle, since after a Medicare beneficiary enrolls in hospice, providers are no longer eligible to receive direct payments from Medicare for delivering these kinds of services to the patient (if they are related to the hospice diagnosis) and any payments for those services must come through the hospice agency from the hospice payment.

**Hospital-Acquired Condition (HAC).** The Deficit Reduction Act of 2005 required CMS to develop a list of hospital-acquired conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when the hospital-acquired condition is present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. Since 2008, these conditions can no longer be used in determining the DRG for a hospital admission unless there is a specific indication that the condition was “present on admission.” In some cases, this can cause the hospital to receive a lower payment than it might otherwise, but if additional complications resulted from the hospital-acquired condition, these complications can still result in an increased payment to the hospital. The current list of Hospital-Acquired Conditions includes:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
- Manifestations of Poor Glycemic Control
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
- Iatrogenic Pneumothorax with Venous Catheterization

**Hospital-Acquired Condition Reduction Program.** Beginning in October 2014, CMS began implementing the Hospital-Acquired Condition Reduction Program, which reduces Medicare payments for inpatient stays

in hospitals that have the highest rates of certain hospital-acquired conditions (HACs). The worst performing quartile of hospitals is identified by calculating a Total HAC score based on the hospital’s performance on three quality measures (Patient Safety Indicator 90 composite, central-line associated bloodstream infection, and catheter associated urinary tract infection). If a hospital has a Total HAC score above the 75th percentile of the distribution of Total HAC scores for all hospitals, the hospital’s payments are reduced by 1% for all of its patients.

**Hospital Readmissions Reduction Program.** Since October 2012, CMS has reduced payments to a hospital for its inpatient admissions if the hospital is determined to have “excess” readmissions. A readmission is an admission to the same or another acute care hospital within 30 days of discharge, other than for specifically planned readmissions such as for chemotherapy or rehabilitation, and a hospital has “excess readmissions” if its rate of readmissions is higher than an expected readmission rate. Initially, the program measured readmissions only for Medicare patients with diagnoses of acute myocardial infarction (heart attack), heart failure, or pneumonia. If the hospital is determined to have excess readmissions, the payments for all of its patients are reduced, not just those in the categories where readmissions were high. The maximum penalty was initially capped at 1 percent and can now be as high as 3 percent per year. (The hospital is still paid for the readmissions themselves; the penalty is a reduction in payment for all admissions, including the readmissions.)

**Hospital Value-Based Purchasing Program (Hospital VBP).** Since October 2012, CMS has modified payments to hospitals based on their performance on a series of quality and spending measures under the Medicare Hospital Value-Based Purchasing (Hospital VBP) Program. There are three steps in the VBP:

- First, all DRG payments to all hospitals are reduced across-the-board by a percentage that increases each year until it reaches 2% in 2017 and subsequent years.
- Second, each hospital’s performance on a series of quality and spending measures is determined and compared to its own previous performance and the current performance of other hospitals to calculate a score for the hospital.
- Third, each hospital’s score is converted (using a “linear exchange function”) into a percentage increase that is then applied to its DRG payment.

The net effect of the reductions in the first step and the increases in the third step is that some hospitals will see a net increase in their payments and some hospitals will see a net reduction in their payments through the Hospital VBP program, in addition to any increases or decreases they experience through other changes in Medicare payments.

**Hospital Wage Index (HWI).** The Hospital Wage Index (HWI) is a Geographic Adjustment Factor used by Medicare to adjust payments to hospitals, skilled

nursing facilities, and other providers to account for differences in the wage rates in their local labor markets. The hospital wage index for a labor market area is calculated by taking the average hourly wage (AHW) paid to full-time, part-time, and contract workers by all hospitals in the labor market area that are paid through the Medicare IPPS, and dividing that average by the AHW for all IPPS hospitals nationwide. The HWI for each labor market area is then used to adjust the payment rate for each patient discharged from a hospital in that labor market area, so that hospitals in areas with higher average wage rates receive higher payments from Medicare.



**IBNR (Incurred But Not Reported).** If providers have delivered services but have not yet submitted claims for those services to the payer who is obligated to pay the claims, then the claims are described as “Incurred But Not Reported (IBNR).” If a payer has agreed to pay claims for services rendered from a fixed premium (or if a provider has agreed to accept a bundled payment and pay other providers for specific types of services they render), then IBNR claims represent a liability that the payer or provider is obligated to pay, but the payer/provider does not know the amount of the liability until the claims are actually filed. Consequently, in order for the payer (or the provider managing a multi-provider bundled payment) to know whether its expenses will be lower or higher than its revenues, it needs a way to estimate IBNR.

**ICD-9 CM.** ICD-9 is the International Classification of Diseases, 9<sup>th</sup> Edition, Clinical Modification. It is the official national mechanism in the United States for coding diagnoses on claims forms until a transition is made to ICD-10. Alphanumeric codes are assigned to diseases as well as some of the causes of health problems. Examples of ICD-9-CM diagnosis codes include:

- 162.5 Malignant Neoplasm of Lower Lobe, Bronchus or Lung
- 428.32 Chronic Diastolic Heart Failure
- E916 Struck accidentally by falling object

ICD-9-CM also defines procedure codes that are used by hospitals for billing purposes. Examples include:

- 37.51 Heart Transplantation
- 84.17 Amputation of leg above knee

**ICD-10-CM.** ICD-10 is the International Classification of Diseases, 10<sup>th</sup> Edition, Clinical Modification. It has more detailed coding for some diagnoses than ICD-9-CM, and it only contains diagnosis codes; procedure codes are included in ICD-10-PCS. Examples of ICD-10-CM diagnosis codes include:

- C34.31 Malignant Neoplasm of Lower Lobe, Right Bronchus or Lung
- 150.32 Chronic Diastolic Heart Failure

**ICD-10-PCS.** ICD-10-PCS contains an updated set of the procedure codes that were previously included as Volume III of ICD-9-CM. These procedure codes are used by hospitals for billing purposes.

**IME.** See Indirect Medical Education Adjustment

**Improvement.** In a payment model where the amount of payment is based on performance on one or more measures of quality or spending, “improvement” is used to refer to the change in the provider’s level of performance in a performance period compared to the provider’s performance in a baseline period. In contrast, “achievement” is a measure of how the provider’s level of performance compares to a benchmark that is established based on what other providers have achieved or can achieve. Since a provider that failed to meet an achievement threshold may still have significantly improved its performance, many pay-for-performance systems are based on both achievement and improvement.

**Improvement Threshold.** In a pay for performance system, an improvement threshold is a level of improvement that must be reached in order to qualify for a payment or an adjustment in payment.

**Independent Practice Association (IPA).** An Independent Practice Association is an organization consisting of two or more independent physician practices that work jointly in some way. Some IPAs accept payment contracts on behalf of their members, others provide mechanisms for multiple practices to share infrastructure costs or staff that would otherwise not be affordable for small practices.

**Indirect Medical Education (IME) Adjustment.** Under the Medicare Inpatient Prospective Payment System, hospitals that have medical residents in approved graduate medical education (GME) programs receive higher payments for each Medicare patient who receives care in the hospital. The Indirect Medical Education (IME) adjustment increases the DRG payment amount for each patient by a specific percentage called the IME adjustment factor. The size of the adjustment factor is based on the ratio of the number of medical residents to the number of beds in the hospital.

**Infrastructure.** “Infrastructure” is a generic term used to describe systems and services that a provider needs to have in order to deliver quality care to patients. The term is used to refer to fixed assets such as com-

puter equipment, software systems such as electronic health records or data analysis software, or personnel such as nurse care managers.

**Infrastructure Payment.** An infrastructure payment is a payment that is specifically designed to support the costs of “infrastructure” that a provider uses to deliver or manage care. In some cases, payer have required that the payment only be used for specific kinds of “infrastructure,” whereas in others, the payment is made because of a recognition that a provider needs adequate payment to support the infrastructure required to deliver high-quality care but no restrictions are placed on how the provider can spend the payment.

**Innovation Center.** See **Center for Medicare and Medicaid Innovation.**

**In-Office Ancillary Services Exception.** The In-Office Ancillary Services Exception (IOASE) is a provision of the federal Stark Law that exempts physician practices from the general prohibition on referral to providers in which physicians have a financial interest. It applies in the case of ancillary services delivered in a physician’s office or practice site by the physician, by another physician who is a member of the same practice, or by an individual supervised by the physician

**Inpatient Prospective Payment System (IPPS).** The Inpatient Prospective Payment System (IPPS) is the payment system used by Medicare to pay most large acute care hospitals for inpatient hospitalizations. (Critical Access Hospitals are paid on a cost-based retrospective reimbursement system.) In the IPPS, a hospital is paid a case rate for each patient, i.e., it receives a single payment for the patient’s entire stay. The case rate is determined by taking a conversion factor called the base rate, adjusting it for geographic cost differences using the Hospital Wage Index for the area where the hospital is located, and then multiplying the adjusted rate by on the weight of the MS- DRG (Medicare Severity Diagnosis Related Group) to which the patient is assigned based on the diagnoses recorded for the patient and the procedures performed. The case rate is further adjusted through three other programs:

- Under the Hospital Readmissions Reduction Program, the hospital’s payments for all patients are reduced if the hospital’s readmission rates for specific kinds of conditions are higher than a benchmark level;
- Under the Hospital-Acquired Condition Reduction Program, the DRG for a patient is revised to exclude consideration of certain hospital-acquired conditions that were not present when the patient was admitted to the hospital, and if the hospital has a high rate of hospital-acquired conditions, its payments for all patients are reduced by 1%.
- Under the Hospital Value-Based Purchasing Program, the hospital’s payments for all patients are adjusted up or down using a Value-Based Incentive

Payment Adjustment that is calculated by evaluating the hospital’s performance relative to benchmarks on several measures of the quality of care in the hospital and the total cost of services for the hospital’s patients.

Selected hospitals receive still further adjustments to their payments:

- teaching hospitals receive an additional Indirect Medical Education (IME) payment
- hospitals with large numbers of low-income patients receive an additional Disproportionate Share (DSH) payment.
- rural hospitals designated as Sole Community Hospitals receive the greater of the IPPS case rate payment or a payment based on their costs in a base year trended forward to the current year and adjusted for the hospitals’ current case mix.
- some hospitals with low volumes of patients receive a Low-Volume Payment Adjustment.

A hospital can receive an additional Outlier Payment for an individual patient if the patient requires unusually costly services; it can receive an additional payment it has used certain new technologies for care of the patient; and it can receive additional payments for bad debts resulting from patients’ non-payment of cost-sharing amounts. If a patient has a very short stay and is transferred to another acute care hospital or to post-acute care, the hospital will be paid on a per diem basis (i.e., based on the number of days the patient was in the hospital) rather than based on the case rate it would otherwise qualify for based on the patient’s characteristics and the services delivered.

**Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS).** The Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) is the system Medicare uses to pay Inpatient Psychiatric Facilities. In contrast to the Inpatient Prospective Payment System, which pays an acute care hospital a single case rate (the DRG payment) regardless of the length of stay, an Inpatient Psychiatric Facility (IPF) receives an additional payment for each day the patient stays in the hospital, i.e., the hospital is paid on a per diem basis. The amount of payment for each day decreases the longer the patient is in the hospital, but the total payment still increases the longer the patient stays. The per diem amount is also adjusted based on the patient’s characteristics, the nature of the facility, and the location of the facility. The hospital receives additional payments if electroconvulsive therapies are delivered and the hospital can receive an outlier payment if the patient requires unusually expensive services.

**Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).** The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) is the system used by Medicare to pay inpatient rehabilitation facilities (IRFs). Similar to the Inpatient Prospective Payment System for acute care hospitals, the IRF PPS pays IRFs a case rate for each patient, i.e., a single payment for the patient’s entire stay. The case rate is determined by taking a conversion factor called the

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base rate, adjusting it for geographic cost differences based on where the IRF is located, and then multiplying the adjusted rate by the weight of the Case-Mix Group (CMG) to which the patient is assigned. There are 92 different CMG categories, and the patient is assigned to a category based on the diagnosis that led to the need for rehabilitation, their comorbidities, their age, and their functional and cognitive status. The facility can receive an additional Outlier Payment if the patient requires unusually costly services. For patients who have short stays, a lower payment is made.

**Intermediate Outcome Measure.** An intermediate outcome measure is a form of quality measure that determines whether specific kinds of results were achieved from healthcare services that are viewed as valuable solely or primarily because they have been shown to lead to other desirable outcomes. For example, a low hemoglobin A1c (HbA1c) level for a patient is an intermediate outcome measure that is viewed as desirable because it reduces the risk of other complications of diabetes, such as blindness and amputations. Compare the definitions of **Process Measure** and **Outcome Measure**.

**Internal Cost Savings.** Internal cost savings is the amount by which a provider's cost decreases for the services delivered in return for a particular payment if a different mix of services is used within the payment bundle or if changes are made in the way individual services are delivered. If the provider achieves higher internal cost savings in delivering services for the same payment amount, its margin will increase. A payer will not directly benefit from a provider's internal cost savings unless the payment agreement explicitly provides for a way to reduce the payer's payment. For example, in Model 1 of the Bundled Payments for Care Improvement Initiative, CMS requires a hospital to accept a lower Medicare payment in return for the ability to gain-share internal cost savings with physicians.

**IPA.** See **Independent Practice Association**.

**IPF.** IPF is an abbreviation for Inpatient Psychiatric Facility. See **Inpatient Psychiatric Facility Prospective Payment System**.

**IPPS.** See **Inpatient Prospective Payment System**.

## J

**J-Code.** A J-Code is a subset of the Level II codes that CMS creates and maintains as part of the Health Care Common Procedure Coding System (HCPCS). J-codes define specific types of drugs that Medicare will pay physicians to administer.

## L

**Lemon-Dropping.** Lemon-dropping is a colloquial term used to describe a situation in which a payer or healthcare provider avoids insuring or caring for a patient for whom the cost of services is expected to exceed the payment for those services or the premium received for their health insurance. See also **Cherry-Picking**.

**Length of Stay (LOS).** Length of stay is the amount of time that a patient spends in a hospital or other facility in order to receive a particular service or group of services.

**Limiting Charge.** In the Medicare program, the Limiting Charge is the maximum amount that a physician can charge a Medicare Beneficiary for a service if the physician is a Non-Participating Physician. A non-participating physician is paid 95% of the Medicare approved amount for participating physicians, the Limiting Charge is 115% of that amount, and the difference between Medicare's payment to the physician and the Limiting Charge can be Balance Billed to the patient.

**Linear Exchange Function.** A "linear exchange function" is a formula for translating a provider's performance score on one or more measures of quality or spending into a change in the provider's payment. In the Medicare Hospital Value-Based Purchasing Program, hospitals are assigned a Total Performance Score

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between 0 and 100 based on the hospital's performance on a series of different measures, and then a linear exchange function is used to convert the Total Performance Score into the Value-Based Incentive Payment Adjustment.

**Long-Term Care Hospital Prospective Payment System (LTCH PPS).** The Long-Term Care Hospital Prospective Payment System is the payment system Medicare uses to pay long-term care hospitals. Similar to the Inpatient Prospective Payment System for acute care hospitals, the LTCH PPS pays LTCHs a case rate for each patient, i.e., a single payment for the patient's entire stay. The case rate is determined by taking a conversion factor called the base rate, adjusting it for geographic cost differences based on where the LTCH is located, and then multiplying the adjusted rate by the weight of the MS-LTC-DRG (Medicare Severity Long-Term Care Diagnosis Related Group) to which the patient is assigned. The facility can receive an additional Outlier Payment if the patient requires unusually costly services. For patients who have short stays, an alternative methodology is used to determine the payment based on actual costs and length of stay.

**Look-Back Period.** A look-back period is a prior period of time for which data are collected to compute a measure. For example, a quality measure may be based on actions taken by a provider or a patient's test results that occurred during a specific number of months prior to the date the measure is calculated. Attribution methodologies typically include a look-back period for determining which provider had the largest number of visits or delivered the largest number of services to a patient.

**LOS.** See **Length of Stay**.

**Low-Volume Hospital Payment Adjustment.** In the Medicare Low-Volume Hospital Payment Adjustment program, certain small hospitals in rural areas have received higher payments than they would otherwise receive. This program was created to compensate for the fact that all else being equal, a hospital that delivers a particular type of service to a small number of patients will have higher average costs per patient than hospitals that treat larger numbers of patients because the hospital's fixed costs of delivering the service will have to be allocated to a smaller number of patients.

# M

**Managed Care Organization (MCO).** In the Medicaid program, states are permitted to contract with Managed Care Organizations to pay providers for services to Medicaid recipients rather than the state paying the providers directly.

**Margin.** The difference between total revenues and expenses for an organization or service line. See also **Contribution Margin**.

**Market Basket.** In order to update payment rates from year to year, the Office of the Actuary within the Centers for Medicare and Medicaid Services (CMS) calculates a "market basket" for each of its payment systems that is designed to measure the price changes each type of provider (hospitals, skilled nursing facilities, home health agencies, etc.) experiences for the supplies and services it purchases. Market basket levels are released quarterly.

**MCC.** MCC is an abbreviation for Major Complications and Comorbidities that is used in the DRG system. See **Diagnosis Related Groups**.

**MCO.** See **Managed Care Organization**.

**Measure Weight.** In a payment model that defines a performance score based on a provider's performance on multiple measures, each measure is assigned a measure weight to specify how performance on that measure will be adjusted in order to combine it with performance on other measures in calculating an overall performance score. A measure weight is partly an indication of a measure's relative importance in assessing overall performance (since a measure with a higher measure weight will have a greater impact on the total performance score) and partly a method of adjusting for differences in the measurement scales for different measures (e.g., if the performance level on one measure can vary from 0 to 10 and the performance level on another measure can vary from 0 to 100, then if the measures are viewed as equally important, the first measure will need to have a weight that is 10 times the weight for the second measure).

**Medical Home.** A medical home is a generic term used to describe a physician practice which operates in ways consistent with one or more of the principles of the Patient-Centered Medical Home. Although a

“medical home” was originally intended to apply to primary care practices, it has also been used to refer to specialty practices that provide care to patients with a particular health problem in ways that are consistent with one or more of the principles of the Patient-Centered Medical Home.

**Medical Home Payment.** A wide range of different “medical home payment models” have been created by payers to assist or encourage primary care practices, and in some cases specialty physician practices, to deliver care consistent with one or more of the principles of the Patient-Centered Medical Home. These payment models have generally been structured in one of the following ways.

- **Additional or increased payment based on accreditation or certification.** In this payment model, the physician practice receives additional payment if it is accredited or certified by the payer or by an independent organization as meeting specific standards for the way it delivers care. Different mechanisms are used to deliver the additional payment; in some payment models, the practice receives higher payments for existing billing codes (typically evaluation and management service codes), while in other payment models, the practice receives a PMPM payment for each of the payer’s patients.
- **Payment for infrastructure.** In this payment model, the physician practice receives payment to cover all or part of the cost of “infrastructure” that the practice uses to deliver care to patients. For example, the practice might receive payment to cover all or part of the costs of purchasing and installing an electronic medical record system.
- **New payments for specific services.** In this payment model, the physician practice receives payment designed to support specific services, such as hiring a nurse care manager to provide services to patients with chronic diseases. Different mechanisms are used to deliver the additional payment: in some systems, the practice is permitted to bill for services that would otherwise not be eligible for payment (e.g., the practice is permitted to bill for time spent by a nurse in providing education to chronic disease patients) and in other systems, the practice receives a PMPM payment but it is required to use the payment on the specified services. Some payers, instead of providing payments to a practice to hire staff such as care managers, have hired the staff directly on the payer’s payroll and assigned them to work at the physician practice office.
- **New, flexible payments.** In this payment model, the physician practice receives a payment, such as a PMPM payment, in addition to existing fee-for-service or other payments it receives, with the flexibility to use the payment in a wide range of ways.
- **Pay-for-performance payments.** In this payment model, the physician practice receives additional payment if it achieves specific performance levels on measures of quality or spending.

- **Shared savings payments.** In this payment model, the physician practice receives additional payment based on a portion of savings that the payer determines it has achieved as a result of improved delivery of services.
- **Combination payments.** A combination of one or more of the above mechanisms can also be used. For example, in the Medicare Comprehensive Primary Care Initiative, in addition to current payments under the Medicare Physician Fee Schedule, participating primary care practices receive a risk-adjusted PMPM payment that can be used for a wide range of services, and they can also receive a shared savings payment if spending for all of the patients in the all of the participating practices in the state or region is lower than spending for patients in non-participating practices.

**Medical Loss Ratio (MLR).** The “medical loss ratio” is a term used in health insurance that means the total amount a health plan spends on payments for healthcare services divided by the total premium revenues received to cover those payments. The medical loss ratio is typically described as a percentage, the ratio must be lower than 100% in order for the insurance plan to remain solvent, since administrative expenses and profits are not included in the “medical loss,” and a health plan must also retain some portion of premiums as a reserve against variations in the medical loss ratio. The Affordable Care Act established minimum thresholds for the Medical Loss Ratios of commercial insurance plans.

Although not typically used in the context of payment models, the concept of Medical Loss Ratio is equally applicable to payments, since the entity that manages a multi-provider bundled payment must ensure that the payments to all providers are lower than the amount of payment, while also leaving enough funds to cover any administrative costs associated with managing the payment and to provide a reserve for variations in the need for services within the payment amount. Moreover, if a payer begins using more accountable payment models to pay providers, the payer will be transferring some portion of its administrative costs and risks to the providers, which will affect medical loss ratios for both the payer and the provider and require different judgments about whether those ratios are too high or low.

**Medical Neighborhood.** A “medical neighborhood” is a set of specialists and other providers who provide healthcare services to the patients who are part of a primary care medical home.

**Medically Unlikely Edit (MUE).** A Medically Unlikely Edit is part of the National Correct Coding Initiative and defines combinations of services or types of services that are unlikely to occur and may indicate an error in coding or potential fraudulent billing.

**Medicare Economic Index (MEI).** The Medicare Economic Index (MEI) is a method of measuring inflation in the cost of operating a medical practice. It is concep-

tually similar to the Consumer Price Index and the Producer Price Index used for other industries, but it is based on the cost of items that are relevant to medical practices. CMS calculates and publishes the MEI on a quarterly basis.

**Medicare Shared Savings Program (MSSP).** The Medicare Shared Savings Program is a payment program established by the Affordable Care Act (in Section 1899 of the Social Security Act) that providers can voluntarily choose to participate in if they meet the qualifications for an Accountable Care Organization (ACO) established in the statute and in regulations promulgated by CMS. Although the Shared Savings Program authorizes the use of shared savings as one method of payment to ACOs, it also authorized the use of “Other Payment Models,” including a partial capitation model. See **Shared Savings** for more information.

**Medicare Spending Per Beneficiary (MSPB).** Medicare Spending Per Beneficiary is one of the performance measures used to determine the Value-Based Incentive Payment Adjustment for a hospital and to determine the Value-Based Payment Modifier for a physician practice. Total Medicare Part A and Part B spending (i.e., payments for institutional and professional services, but not for prescription drugs) are tabulated for a hospitalized patient from the point 3 days prior to hospital admission through the point 30 days after discharge from the hospital, and then the sum is risk adjusted for patient characteristics using the HCC risk adjustment system and further adjusted using standardized payments.

In the Value-Based Incentive Payment for a hospital, the Medicare Spending Per Beneficiary measure is calculated for all patients discharged from the hospital, and then the average is compared to the average for the measure for all hospitals. In the Value-Based Payment Modifier for physician practices, a hospitalization is attributed to the physician group that provided the plurality of professional services during the hospital stay (as measured by the total payments for the services), and the MSPB is calculated for that hospitalization. The average of the MSPB measures for all patients attributed to the physician practice is then compared to the average for all physician practices after adjusting for the mix of specialties in the practice.

**MEI.** See **Medicare Economic Index**.

**Merit-Based Incentive Payment System (MIPS).** The Merit-Based Incentive Payment System is a Medicare pay-for-performance system for physicians created by the Medicare Access and CHIP Reauthorization Act (MACRA) that is to be implemented beginning in 2019. It consolidates several existing Medicare pay-for-performance programs – the EHR Incentive program, the Physician Quality Reporting System, and the Value-Based Payment Modifier – into a single pay-for-performance program that will be based on four categories of performance measures: quality, resource

use, clinical practice improvement activities, and meaningful use of certified EHR technology. Physicians will receive either increases or decreases in their payments under the Physician Fee Schedule based on their performance in the MIPS program; because the program is supposed to be budget-neutral, the magnitude of any increases received by physicians who qualify for increases will depend on the number of physicians receiving decreases in payments and the magnitude of those reductions.

Physicians participating in Alternative Payment Models that meet the criteria defined in MACRA are exempt from the MIPS payment adjustments and also receive a bonus payment equal to 5% of their Medicare payments under the Physician Fee Schedule.

**Minimum Loss Rate.** In a Shared Savings program, the minimum loss rate is the minimum amount that the actual spending must be above the benchmark in order for the provider to be obligated to pay the payer a share of the increased spending the payer has incurred. A minimum loss rate is typically used to avoid a provider having to make payments to a payer based simply on random variation in spending. For more information, see **Minimum Savings Rate**.

**Minimum Savings Rate (MSR).** In a Shared Savings program, the minimum savings rate (MSR) is the minimum amount that the actual spending must be below the benchmark in order for the provider to qualify for a shared saving payment. A minimum savings rate can be used for two separate purposes:

- to avoid the payer making a shared savings payment to a provider based simply on random variation in spending. For example, in the Medicare Shared Savings Program, higher minimum savings rates are used for Accountable Care Organizations with fewer attributed beneficiaries, since the likelihood of random variation in patient needs causing reductions in spending is higher when there are fewer patients.
- to increase the proportion of savings retained by the payer when small amounts of savings are achieved. In a first dollar shared savings model, the provider receives a share of all savings, including the savings in the minimum savings rate, but otherwise, the payer retains the savings in the minimum savings rate and then shares any additional savings above that.

**MIPS.** See **Merit-Based Incentive Payment**.

**MLR.** MLR is an abbreviation for **Medical Loss Ratio** but also sometimes refers to a **Minimum Loss Rate**.

**Modifier.** A modifier is an additional code appended to a billing code to communicate additional information about the circumstances in which the service was delivered. The modifier is often used to indicate that the payment for the service should be different than what is paid for the unmodified code. For example, Modifier 33 is added to CPT codes to indicate that a service was preventative in nature and that patient

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cost-sharing does not apply.

**MS-DRG (Medicare Severity Diagnosis Related Groups).**

MS-DRGs are the version of DRGs used in the Medicare Inpatient Prospective Payment System. In the current MS-DRG system, there are 751 different MS-DRGs to which an inpatient admission can be assigned.

**MS-LTC-DRGs (Medicare Severity Long-Term Care Diagnosis Related Groups).**

MS-LTC-DRGs are used to determine payments to Long-Term Care Hospitals in the Medicare Long-Term Care Hospital Prospective Payment System. They have the same definitions and structure as MS-DRGs, but the payment weights are different in order to reflect the differences in costs for patients in long-term care hospitals instead of acute care hospitals. See Long-Term Care Hospital Prospective Payment System.

**MSPB.** See Medicare Spending Per Beneficiary.

**MSR.** See Minimum Savings Rate.

**MSSP.** See Medicare Shared Savings Program.

**Multi-Provider Bundle.** A multi-provider bundle is a bundled payment that includes services delivered by multiple providers. Multi-provider bundles are more complicated to administer than single-provider bundles because an entity needs to be defined to receive the payment on behalf of all of the providers and a method is needed to allocate the bundled payment among the individual providers. One approach is to treat the bundled payment as a budget, allow each provider to continue billing and being paid for their individual services under fee-for-service models, and then retrospectively reconciling the bundled payment budget after all of the services have been delivered. An alternative is to treat the bundled payment as a prospective payment, designate one provider or an entity jointly formed by all of the providers to accept the bundled payment, and then they develop a mechanism for allocating the bundled payment among the individual providers.

**Musculoskeletal Medical Home.** A "musculoskeletal medical home" is a provider such as an orthopedic physician practice that delivers care to individuals with musculoskeletal problems (such as osteoarthritis of the joints) in ways that are consistent with one or more of the principles of the Patient-Centered Medical Home.

# N

**Narrow Network.** A narrow network is a network of providers that is smaller than the network available to a patient under a different insurance plan or payment model. The choice of which providers are in the narrow network may be based on their willingness to accept lower payments, their scores on measures of quality or cost, their willingness or ability to coordinate care, or other factors.

**National Correct Coding Initiative (NCCI).** The National Correct Coding Initiative is a program operated by CMS that is designed to avoid payment for inappropriate or duplicative services. NCCI defines a series of rules that are applied when a payer processes healthcare claims in order to identify codes that should generally not be billed at the same time or combinations of codes that are not consistent with typical or appropriate patterns of care.

**NCCI.** See National Correct Coding Initiative.

**Net Payment Reconciliation Amount.** In a retrospective reconciliation process, the Net Payment Reconciliation Amount is the amount of money that must be transferred between a payer and a provider to ensure that the total payment is equal to the agreed-upon amount.

**Network.** In healthcare delivery and payment, a network consists of two or more providers who will deliver services in return for agreed-upon payment and cost-sharing amounts for patients who are covered under a particular health insurance plan or who are receiving services as part of a bundled or global payment.

**Network Adequacy.** The adequacy of a network is the ability of the providers in the network to achieve certain standards in the way they deliver services to the patients who are being required or encouraged to use the network. The most basic standard of adequacy is to have at least one provider in the network who can deliver each service that a patient could potentially need under the insurance plan or payment. However, adequacy requirements can also include the distance a patient must travel to receive care from a provider who can deliver the service the patient needs, the quality of care the providers in the network deliver, etc.

**Next Generation ACO.** See **Accountable Care Organization.**

**Non-Covered Service.** A non-covered service is a healthcare service that a patient's health insurance plan will not pay any healthcare provider to deliver. If the patient wants the service, they would need to pay a provider for the service using the patient's own funds.

**Non-PAR.** See **Non-Participating Physician.**

**Non-Participating Physician.** A physician or other clinician who has not agreed to accept Assignment for all services delivered to Medicare beneficiaries. Non-Participating Physicians may choose to accept assignment on a service-by-service basis. See **Assignment.**

**Non-Preferred Provider.** A provider that is not designated as a Preferred Provider. See **Preferred Provider.**



**OCM.** See **Oncology Care Model**

**Oncology Care Model (OCM).** The Oncology Care Model (OCM) is a demonstration project announced by the Center for Medicare and Medicaid Innovation in 2015 that is intended to improve the quality and reduce the cost of care for cancer patients. As proposed, OCM would initially be a combination of a supplemental capitation payment and either an upside-only shared savings model or a shared-risk model.

- An oncology practice participating in the program would be able to bill for a new \$160 payment each month for a six month "episode" following the initiation of chemotherapy for a patient, regardless of how many months during the six month period the patient continues to receive chemotherapy. This payment would be in addition to all existing fee-for-service payments. If the patient continues to receive chemotherapy more than 6 months after the initial chemotherapy treatment, then the oncology practice could again bill for a \$160 monthly payment for another six-month episode.
- If the oncology practice chooses the upside-only shared savings option, it would be eligible to receive an additional payment if the average total Medicare spending for the practice's patients (on all services, not just oncology services) during the six month episodes is more than 4% lower than an expected level of spending. The expected level of

spending would be based on the average spending for the practice's patients during 6-month episodes during a baseline period, trended forward and risk-adjusted using a methodology CMMI has not yet announced. The amount of the payment to the practice would be based on the difference between the actual spending and 96% of expected spending and also on the practice's performance on a series of quality measures. Although the practice would not be liable for any payments to CMS if spending levels increased, it would be terminated from the OCM program if spending was not reduced by at least the 4% target level.

- If the oncology practice chooses the shared-risk option, it would be eligible to receive an additional payment if actual spending during the episodes averaged at least 2.75% below expected spending levels, but it would also be liable to pay CMMI a portion of any spending that is more than 2.75% of the expected spending level.

**Oncology Medical Home.** An "oncology medical home" is a general term being used to describe an oncology practice that delivers care to individuals with cancer in ways that are consistent with one or more of the principles of the Patient-Centered Medical Home. A key issue that oncology medical homes are seeking to address is to better manage complications of chemotherapy to reduce the rate at which their patients make emergency room visits and are hospitalized for complications.

**OOP.** See **Out-of-Pocket Maximum.**

**OPPS.** See **Outpatient Prospective Payment System.**

**Outcome Measure.** An outcome measure is a form of quality measure that assesses the result of healthcare services in terms of patient health, quality of life, or functionality. See also **Intermediate Outcome Measure** and **Process Measure.**

**Outlier Patient.** An outlier patient is a patient who receives or requires a much larger number of services or much more expensive services than other patients. See **Exclusion, Truncation, Winsorization, and Outlier Payment** for methods by which payment models adjust payments for outlier patients.

**Outlier Payment.** An outlier payment is an additional payment made to a provider to cover all or part of the additional costs of services delivered to an outlier patient. For example, in the Medicare Inpatient Prospective Payment System, a hospital receives a payment for each patient based on the Diagnosis Related Group (DRG) to which the patient is assigned, but if the cost of treating a particular patient exceeds the DRG payment by a minimum amount, the hospital will receive an additional outlier payment from Medicare for that patient.

**Out-of-Network.** Out-of-network care is a healthcare service delivered by a provider that is not part of the network of providers that a patient is being encouraged or

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required to use. Typically, a patient is expected to pay more (or to pay the full cost) if they receive a service from an out-of-network provider.

**Out-of-Pocket Maximum.** In a health insurance plan, if the cumulative amount of cost-sharing payments (i.e., co-payments, co-insurance, and deductibles) paid by a patient for healthcare services during a year (or other period of time) reaches the out-of-pocket maximum or out-of-pocket limit, the health plan then pays 100% of the payments for services to providers for the remainder of the year (or whatever time period the maximum applies).

**Outpatient Prospective Payment System (OPPS).** The Outpatient Prospective Payment System (OPPS) is the payment system used by Medicare to pay most large acute care hospitals for outpatient services. Prior to 2000, Medicare paid for outpatient services based on hospitals' costs. (Critical Access Hospitals are still paid on a cost-based retrospective reimbursement system for inpatient and outpatient services.) The OPPS bases payments on the same CPT and HCPCS codes that are used in the Physician Fee Schedule, but the payment amount is based on the Ambulatory Patient Classification (APC) to which the code is assigned. Moreover, if multiple services in the same Ambulatory Patient Classification are delivered at the same time, only one payment is made, so the OPPS is a "partial bundled" payment model. As in the Inpatient Prospective Payment System, the payment amount for the same service differs from hospital to hospital based on geographic adjustments using the Hospital Wage Index, and a hospital can receive an Outlier Payment for patients who required unusually costly services. Additional payments are made for services delivered in Sole Community Hospitals, cancer hospitals, and children's hospitals and for use of new technologies.

In general, the payment rate for a service under the OPPS is higher than if the same service is delivered in a physician's office (this is called a Site-of-Service Differential), but under the OPPS, services in the same APC will not receive separate payments if they are delivered at the same time, whereas if the services are delivered in a physician's office, separate payments will be made for each service. As a result, it is difficult to directly compare the costs of services delivered in an outpatient hospital department to services delivered in physician offices without knowing what combination of services each uses to treat the same condition or deliver the same procedure.

**Overuse.** Overuse is the use of a particular service more often than is necessary or justified based on evidence about its effectiveness.

# P

**PAC.** The abbreviation PAC has been used to mean both "post-acute care" and "potentially avoidable complication."

**Partial Bundle.** See **Bundled Payment**.

**Partial Capitation.** See **Capitation**.

**Participating Physician.** A physician who agrees to accept Medicare Physician Fee Schedule payments as payment in full for services delivered to Medicare beneficiaries. (This is described as "Accepting Assignment.")

**Pathway.** See **Clinical Pathway**.

**Patient-Centered Medical Home.** A Patient-Centered Medical Home is a primary care practice that is structured and operated consistent with a set of principles jointly developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). The principles are:

- *Personal physician* - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- *Physician directed medical practice* - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- *Whole person orientation* - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.
- *Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and

want it in a culturally and linguistically appropriate manner.

- *Quality and safety* are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family; evidence-based medicine and clinical decision-support tools guide decision making; physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement; patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met; information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model; and patients and families participate in quality improvement activities at the practice level.
- *Enhanced access* to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- *Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit; it should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources; it should support adoption and use of health information technology for quality improvement; it should support provision of enhanced communication access such as secure e-mail and telephone consultation; it should recognize the value of physician work associated with remote monitoring of clinical data using technology; it should allow for separate fee-for-service payments for face-to-face visits (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); it should recognize case mix differences in the patient population being treated within the practice; it should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting; and it should allow for additional payments for achieving measurable and continuous quality improvements.

**Patient-Centered Oncology Payment (PCOP).** Patient-Centered Oncology Payment (PCOP) is a family of alternative payment models developed by the American

Society of Clinical Oncology to support higher quality, more affordable care for cancer patients, including "oncology medical home" services.

The basic PCOP payment model has two key elements that differ from current payment systems for oncology:

- An oncology practice could receive payments for four additional billing codes for payments to support services not covered by existing billing codes:
  - ◆ New Patient Treatment Planning (a \$750 payment for each patient);
  - ◆ Care Management During Treatment (a \$200 payment each month for each patient);
  - ◆ Care Management During Active Monitoring (a \$50 payment each month for each patient during treatment holidays and for up to six months following the end of treatment); and
  - ◆ Participation in Clinical Trials (a \$100 per month payment for each patient while treatment is underway and for six months afterward for trials in which practice support is not available).
- The payments for the additional billing codes would be adjusted based on the oncology practice's performance in four areas:
  - ◆ Avoiding emergency department visits and hospital admissions for complications of cancer treatment;
  - ◆ Following evidence-based guidelines for the appropriate use of drugs, laboratory testing, and imaging studies, and using lower-cost drugs, tests, and imaging where evidence shows they are equivalent to higher-cost treatments and tests;
  - ◆ Following evidence-based guidelines for high quality care near the end of a patient's life;
  - ◆ Providing care consistent with standards of quality defined by ASCO.

Two optional versions of PCOP bundle the new billing codes with existing billing codes and payments for other services:

- **Consolidated Payments for Oncology Practice Services** replaces the existing E&M and infusion payments the practice is receiving with three new sets of bundled billing codes (New Patient Payment, several levels of Treatment Month Payment, and several levels of Active Monitoring Month Payment),
- **Virtual Budgets for Oncology Care** defines virtual monthly budgets that cover not only the services delivered by the oncology practice but one or more other categories of services, such as hospital admissions, laboratory tests, imaging studies, and/or drugs.

**Patient-Reported Outcome (PRO).** A Patient-Reported Outcome is a measure of a patient's health status or ability to function for which the data are collected and reported primarily or exclusively by the patient, not by a physician or other healthcare provider. The patient's report may be obtained by a healthcare

provider for use in a payment model, but the information in the report is generated by the patient, not through measurements made by the provider.

**Payer.** A payer is a generic term used to describe an organization that transfers funds to a provider to compensate it for the delivery of healthcare services. A payer transfers funds directly to the provider rather than through an intermediary. For example, health insurance companies are payers, and self-pay patients are also payers.

**Payer vs. Purchaser.** In traditional health insurance arrangements, the purchaser is the individual or organization that pays premiums for a health insurance policy, and the payer is the health insurance company that pays claims under the policy. Self-insured employers are purchasers, but they are not typically payers, since they will usually engage a Third-Party Administrator to actually pay claims from providers. However, in some direct contracting arrangements between employers and providers, the self-insured employer may be both a purchaser and a payer. The distinction between purchasers and payers is important for many reasons:

- all else being equal, when three entities are involved – a purchaser, a payer, and a provider – spending associated with healthcare services will be higher because of the administrative costs incurred by all three entities to manage their respective relationships.
- if a provider reduces costs and accepts lower payments from a payer, the savings from those payments may or may not be passed on to the purchaser depending on the nature of the relationship between the purchaser and payer. For example, the premiums paid to a payer by a fully-insured purchaser may not decrease even if providers are paid less by the payer, whereas the savings from lower payments to providers will be passed on to self-insured purchasers.
- a payer may have financial reserves to cover random variation in spending on healthcare services that a purchaser does not.

**Pay-for-Performance (P4P).** In a pay-for-performance payment model, the amount that a provider is paid for its services is changed in some way based on one or more aspects of the provider's performance. For example, in a pay-for-performance system intended to encourage higher-quality care, providers with higher scores on one or more measures of quality may receive higher fees than other providers.

A pay-for-performance system can provide rewards (either increases in payments for individual services or lump-sum bonus payments), penalties (such as reductions in payments for services), or both. A bonus or penalty can be either retrospective (a bonus is paid or a penalty is imposed at the end of a performance period) or prospective (future payments to the provider are higher or lower based on performance in a prior period). Some P4P systems with retrospective penalties avoid the need to collect penalties from providers by imposing a "withhold" on the provider's payments

at the beginning of the performance year; a provider with good performance then receives both the withhold amount and a bonus payment and a provider with poor performance forfeits the withhold. In some P4P systems, payments for all providers are simply reduced across the board and then some providers are given increased payments based on performance; in these systems, the net effect on an individual provider depends on the size of the initial reduction and the size of the increases. For example, the Medicare Hospital Value-Based Purchasing Program reduces all payments to hospitals and then hospitals receive performance-based payment increases that may be more or less than the amount by which their payment was reduced.

A pay-for-performance system can be designed to reward or penalize absolute achievement (i.e., performance relative to a fixed achievement threshold), relative achievement (i.e., performance relative to other providers), improvement (i.e., the provider's current performance relative to its own performance in an earlier, baseline period), or some combination of the three.

In a pure pay for performance system, there is no change in the basic method by which the provider is paid for services delivered. Services that can currently be billed for payment can continue to be billed and paid at the same payment rates, and services that cannot be billed for payment still cannot be billed or paid directly. In a retrospective P4P model, any additional payment awarded for high performance is paid after the services that resulted in the high performance have already been delivered. This means that if the provider has to deliver services that are not paid for directly in order to achieve the high performance level, they will have to have a way of paying for those services until the pay-for-performance bonus is paid, and the bonus payment may or may not be sufficient to cover those costs. In some payment models, a pay-for-performance program is combined with other payment changes, such as use of medical home payments, in order to give providers additional resources to deliver additional or different services than they do today but also encourage them to do so in ways that achieve higher performance on one or more measures of quality or spending.

For additional information, see **Performance Period**, **Performance Score**, **Performance Standard**, **Performance Threshold**, and **Withhold**.

**Pay for Achievement.** Pay for achievement is a form of pay-for performance in which rewards or penalties are based on the extent to which a provider's performance reaches a specified performance standard.

**Pay for Improvement.** Pay for improvement is a form of pay-for-performance in which rewards or penalties are based on the extent to which a provider's performance is better than it was in an earlier period of time.

**Tournament Pay for Performance.** A pay-for-performance model that rewards or penalizes a provider based on how its performance compares

to how other providers performed during the same performance period is sometimes referred to as “tournament” pay for performance, since a provider does not know in advance what performance level will be viewed as high or low, and whether it “wins” or “loses” (in terms of bonuses or penalties) will depend on how other providers perform. Tournament models can discourage providers from sharing information on how to improve care because a provider is more likely to receive higher payments if other providers perform poorly.

**Pay for Reporting.** In a pay for reporting system, a provider’s payments are modified based on whether they report certain kinds of information to the payer (e.g., quality measures), but the payments are not modified based on the actual performance on those measures. Some payers have used pay for reporting systems as a first step in moving to a pay-for-performance system, since it is difficult to establish performance benchmarks in a P4P system without having baseline data on how providers perform on the measures that are going to be used.

**Payment Model.** A “payment model” is a description of a method for paying providers for healthcare services. A payment model defines methodologies for determining payment amounts rather than the exact amounts that will be paid to specific providers for specific patients. A payment model is typically implemented through a contract between a payer and a provider that may include additional specifications regarding the patients who will receive services covered by the payment model, the parameters that will be used to convert the methodologies of the payment model into actual payment amounts, etc.

A payment model has four fundamental elements or building blocks:

- A definition of the services that will be covered by a single payment and the level of flexibility that the provider has in determining which services can be delivered;
- The mechanism(s), if any, for controlling utilization and spending;
- The mechanism(s), if any, for ensuring good quality and outcomes; and
- The mechanism(s) for ensuring adequacy of payment.

There are multiple ways that each of these building blocks can be structured, and some approaches to payment may address multiple building blocks simultaneously. For example, “bundling” payments can both provide greater flexibility for a provider in choosing the specific services to be delivered and can provide a mechanism for controlling utilization and spending on the services included in the bundle.

**Payment System.** A payment system is a payment model that has been implemented by a payer and is being used to pay providers for services.

**Payment Update.** A payment update is a change in the dollar amount of payments under a payment model to reflect changes in the costs of delivering services over time.

**PBPM.** PBPM is an abbreviation for Per Beneficiary Per Month, which is a term used in the Medicare program that means the same thing as Per Member Per Month (PMPM) in commercial insurance.

**PBPY.** PBPY is an abbreviation for Per Beneficiary Per Year.

**PCOP.** See **Patient-Centered Oncology Payment.**

**PDL.** PDL is an abbreviation for Preferred Drug List. See **Formulary** for more information.

**Per Diem.** A per diem payment is a payment that is made for each calendar day on which services are provided to a particular patient. For example, if a payer pays a hospital on a per diem basis, the total payment to the hospital for an individual patient would depend on how many days the patient spent in the hospital before being discharged, but not on how many services were delivered on any of those days. The amount of the per diem payment need not be the same for all days and all patients. For example, Medicare pays Inpatient Psychiatric Facilities on a per diem basis (see Inpatient Psychiatric Facility Prospective Payment System), but the per diem payments are higher for earlier days in a patient’s stay than for later days, and the per diem payment on any day varies from patient to patient based on the characteristics of the patient.

**Performance Period.** A period of time during which a provider’s performance on quality or cost measures is calculated. In many payment models, the provider’s performance during the performance period is compared to performance during a Baseline Period to determine whether improvements have occurred.

**Performance Score.** In many payment models, a provider’s performance is evaluated based on multiple measures of quality or spending. Rather than making separate adjustments to payment based on the provider’s performance on each individual measure, a performance score may be defined by multiplying the performance levels on each measure by a measure weight and then summing the products to calculate a single performance score that is then used to modify payment.

**Performance Standard.** A performance standard is a term generally used to describe a minimum level of performance that must be achieved by a provider in order to participate in a payment model or to continue participating in the payment model.

**Performance Threshold.** A performance threshold is a term generally used to describe a level of performance which must be reached by a provider in order

to qualify for an increase in payment or to avoid a payment reduction.

**Performance Year.** See **Performance Period.**

**Per Member Per Month Payment (PMPM).** A “per member per month” payment is a form of capitation payment that is made to a healthcare provider each month for each of the members of a health insurance plan who are assigned or attributed to that provider. The key characteristic of the PMPM payment is that it does not vary based on how many services a particular patient receives. The size and purpose of the payment can vary dramatically, and the payment can be made in addition to service-based payments or it can be paid in place of service-based payments (i.e., a provider would receive a PMPM payment and no longer be able to bill for one or more other types of services). Payments are generally made monthly because the membership of a particular health plan can change frequently and to also allow individuals to change providers. A PMPY – Per Member Per Year – payment is similar, but the payment covers services delivered over a 12 month period or a calendar year rather than services for a single month.

**PFS.** See **Physician Fee Schedule.**

**PHO.** See **Physician-Hospital Organization.**

**Physician Fee Schedule (PFS).** The Physician Fee Schedule is the system Medicare uses to pay physicians. In the PFS, the RVU weights assigned to CPT codes through the Resource Based Relative Value System (RBRVS) are multiplied by Geographic Practice Cost Indices specific to the community where a physician practices and by an overall national Conversion Factor in order to establish the dollar amounts that Medicare will pay for the delivery of the services defined by the CPT codes. Additional adjustments are made depending on whether the service is being delivered by a physician or other health professional, whether the physician is a Participating Physician, whether the services is delivered in a Health Professional Shortage Area (HPSA), and whether any special adjustments have been created for specific providers (such as primary care providers). Medicare will also pay for certain services that are not included in CPT codes by using HCPCS Level II codes. CMS assigns payment amounts to HCPCS Level II codes using various methods; for example, payments for drugs (J-codes) are established using the ASP+x% payment model.

Many private payers use the Medicare Physician Fee Schedule to set their own payment rates, but they may use a different Conversion Factor than Medicare. This is often done by simply defining the payer's fee schedule as a percentage of the Medicare fee schedule, e.g., the payments are “120% of Medicare.”

**Physician-Focused Payment Model Technical Advisory Committee.** The Physician-Focused Payment Model Technical Advisory Committee is established by the

Medicare Access and Chip Reauthorization Act (MACRA) to provide recommendations to the U.S. Secretary of Health and Human Services as to whether proposals for physician-focused payment models submitted by individuals and organizations to the Committee meet the criteria that will be established by the Secretary in regulations.

**Physician-Hospital Organization (PHO).** A Physician-Hospital Organization is an organizational mechanism that allows a hospital and one or more physician practices to each remain independent but to jointly manage payment contracts or share certain kinds of services.

**Pioneer ACO.** See **Accountable Care Organization.**

**Population-Based Payment.** The term “population-based payment” is a generic term used to describe a capitation payment that is paid for each individual in population of patients independent of the services they receive. A population-based payment may either be paid in addition to existing fee-for-service payments or in place of some or all of the fee-for-service payments. See **Capitation** for more information.

**Population Health Management.** Population health management describes an approach to care delivery that is designed to help the individuals in a defined population avoid illness as well as to treat their illnesses when they occur. For example, population health management services include proactive efforts to ensure individuals receive preventive screenings, and to help them improve their health, to help them manage chronic conditions effectively. The “population” whose health is managed is a group of individuals who are defined or selected in some way other than through them seeking services to address health problems, e.g., a population could be all of the employees of an employer, all of the residents of a community, or all of the members of a health insurance plan.

**Post-Acute Care.** Post-Acute Care is a general term describing healthcare services that are delivered to a patient following their discharge from a hospital or the completion of other acute care services, and that are related in some way to the condition that was treated or the procedure that was used as part of the acute care services. Post-acute care services may be delivered in an institution, such as a Skilled Nursing Facility, in the patient's home, such as through Home Health Services, or in an ambulatory care setting such as a physician's office.

**PPO.** See **Preferred Provider Organization.**

**P4P.** See **Pay for Performance.**

**PMPM.** See **Per Member Per Month Payment.**

**PMPY.** PMPY is an abbreviation for “per member per year” payment. See **Per Member Per Month Payment** for more information.

**Potentially Avoidable Complication.** A Potentially Avoidable Complication is a problem experienced by a patient during treatment that could potentially have been avoided if care had been delivered in a different way. As part of its Evidence-Informed Case Rates (ECRs), the Health Care Incentives Improvement Institute (HCII3) has developed specific definitions for the potentially avoidable complications associated with each of a range of conditions and procedures and it has developed computer software that can identify such complications from information in claims data. The rate of potentially avoidable complications can be used as a performance measure in pay-for-performance systems as well as a method of implementing a payment model with a warranty for such complications.

**Potentially Preventable Event.** A Potentially Preventable Event is a problem experienced by a patient or a service delivered by a healthcare provider that could potentially have been prevented if care had been delivered in a different way. 3M Information Systems has developed detailed definitions for a series of different Potentially Preventable Events, including “Potentially Preventable (Initial) Hospital Admissions,” “Potentially Preventable Emergency Department Visits,” “Potentially Preventable Complications,” and “Potentially Preventable Readmissions.”

**Pre-Authorization or Prior Authorization.** Pre-authorization or prior authorization is a process whereby a provider must seek explicit approval from a payer before delivering a particular service to a patient in order to receive payment for delivering that service.

**Predictive Modeling.** A predictive modeling system is a mathematical algorithm that uses information about a patient’s characteristics to predict future spending or outcomes for the patient. The typical purpose of predictive modeling is to identify patients who are likely to have high spending or poor outcomes so that additional or different services can be targeted to those patients in an effort to reduce spending or improve outcomes. Many predictive modeling systems are simply a variant of a risk adjustment system.

**Preferred Provider.** A preferred provider is a provider that a patient is encouraged to use because the services delivered by the provider are of higher quality or lower cost than other providers.

**Preferred Provider Organization (PPO).** A PPO is a type of health insurance plan in which patients have lower cost-sharing or fewer restrictions if they receive services from a network of “preferred providers” who have contracted with the plan. Typically, providers are expected to accept lower payments for services from the payer (i.e., they give the payer a discount) in order to be designated as “preferred providers.”

**Present on Admission (POA) Indicator.** The Present on Admission Indicator is a letter code entered onto a

hospital billing form to indicate whether a particular diagnosis code entered on the billing form reflected a health condition that existed when the patient was admitted to the hospital or whether the condition developed after admission and during the course of the hospital stay. If the POA Indicator is not present, diagnosis codes for Hospital-Acquired Conditions (HACs) are excluded when determining the DRG payment level for a patient who has been hospitalized and the rate of HACs is compared to other hospitals to determine whether a payment penalty will be applied.

**Primary Care.** Primary care is the principal source of healthcare services for an individual, particularly preventive healthcare services. Most people will receive primary care from a physician or other provider who specializes in primary care services, but some patients who have serious health problems may receive their primary care from a specialist.

**Primary Care Medical Home.** See **Medical Home.**

**Procedure Code.** A procedure code is a combination of letters and numbers used to uniquely identify a particular healthcare service for purposes of record-keeping and billing for payment. For purposes of payment, services performed by physicians and services performed in physician offices and hospital outpatient departments are coded using CPT and HCPCS codes; services performed by hospital staff during hospital inpatient stays are coded on claims forms using the ICD system. Because physicians and hospitals generally bill separately for their services, the exact same service delivered to the same patient will be coded one way on the physician’s claim form and a different way on the hospital’s claim form. There is not a one-to-one crosswalk between the two systems, in many cases, CPT codes are more detailed than ICD procedure codes, but there are also ICD procedure codes for services for which there is no corresponding CPT code. A third method of coding procedures called SNOMED-CT (Systematized Nomenclature for Medicine – Clinical Terms) is used in electronic health record systems.

**Process Measure.** A type of quality measure based on whether a provider delivered a particular service or followed a particular process in delivering a service. A process measure indicates whether something was done, not what the outcome was.

**PROMETHEUS Payment.** PROMETHEUS is an acronym for “Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability, and Sustainability.” PROMETHEUS Payment was originally developed with support from the Robert Wood Johnson Foundation and is based on a series of Evidence-Informed Case Rates that are now being maintained by the Health Care Incentives Improvement Institute (HCII3). For more information, see **Evidence-Informed Case Rate.**

**Prospective Attribution.** See **Attribution.**

**Prospective Payment.** Prospective payment is a generic term for a payment model in which the amount of payment for delivery of a particular service or care of a particular condition is defined prior to the delivery or the service or care of the condition and the amount of payment does not change depending on the actual cost of delivering the service or caring for the condition. In contrast, in a cost-based reimbursement system, the amount of payment is determined retrospectively after services are delivered based on the actual costs incurred in delivering the services. In the Medicare program, large hospitals are paid under the Inpatient Prospective Payment System, which is so named because it replaced the cost-based reimbursement system under which most hospitals had been paid prior to 1983. (Hospitals designated as Critical Access Hospitals are still paid through cost-based reimbursement.)

**Prospective Payment vs. Bundled Payment.** A prospective payment does not need to be a “bundled” payment; indeed, most fee for service payments are “prospective payments” because the payment amount for the service is defined in advance and does not change regardless of how much it costs a provider to deliver the service. Even though a payment is “prospective” it is generally paid retrospectively, i.e., after the service is delivered. Moreover, depending on the nature of the prospective payment model, the amount of payment to the provider may depend on what service or services were delivered and the characteristics of the patient who received them, so the exact payment amount may not be known prospectively, but the rules for determining the payment amount will be defined before the services are delivered. For example, in the Medicare Inpatient Prospective Payment System, the amount of payment a hospital receives for a patient is not determined until after the patient is discharged, since the payment is based on a Diagnosis Related Group (DRG) and the DRG is determined based on the diagnoses assigned and procedures performed during the hospital stay. See also **Retrospective Reconciliation and Cost-Based Reimbursement**.

**Prospective Payment vs. Case Rate.** A prospective payment model may or may not be a case rate system. Because the term “prospective payment” is most commonly known in conjunction with the Medicare Inpatient Prospective Payment System which pays hospitals based on a case rate system, “prospective payment” is often viewed as a synonym for a case rate. However, Medicare has different Prospective Payment Systems for other providers that do not use case rates; for example, the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and the Skilled Nursing Facility Prospective Payment System (SNF PPS) pay IPFs and SNFs on a per diem basis.

**Prospective Bundled Payment vs. Retrospective Reconciliation.** In a prospective bundled payment, the provider or other entity that receives the payment is responsible for paying any other providers who deliver services as part of the bundle from the prospective payment. In other words, the recipient of the prospective bundled payment becomes the payer for any other providers who deliver services in the bundle. In contrast, in a bundled payment with retrospective reconciliation, the providers of services within the bundle may be paid directly by a third-party payer under standard fee-for-service arrangements, and then after the payer’s total spending on services within the bundle is reconciled against the bundled payment amount, the entity that has agreed to accept the bundled payment either receives an additional payment from the payer (the Net Reconciliation Payment Amount) or the entity must make a payment to the payer.

**Provider.** Under federal law, the term “provider” means any individual or organization that furnishes, bills for, or is paid for healthcare services, including physicians, hospitals, skilled nursing facilities, home health agencies, etc. In some contexts, the word “provider” is used more narrowly to describe individuals such as physicians and nurse practitioners who deliver healthcare services, not hospitals or other institutions.

**Provider-Owned Health Plan.** A provider-owned health plan is a health insurance company that is owned by a healthcare provider. A provider-owned health plan may offer health insurance products that primarily or exclusively require plan members to receive covered healthcare services from the provider, or it may offer health insurance products that permit plan members to receive services from a broader network of providers. A provider’s financial risk under any given payment model is lower in a contract with its own health plan than with a separate third-party payer, because any differences between the amounts of payments for services and the costs of those services will ultimately go to the provider organization. However, if the provider-owned health plan is selling insurance products in return for a fixed premium, the provider is taking on more insurance risk through the health plan than it would under typical contracts with a separate health insurance company. A provider-owned health plan also enables a provider to enter into direct contracts with employers and other purchasers where the purchaser retains insurance risk and the provider accepts performance risk.

**Provider-Sponsored Health Plan.** A health plan that is owned or significantly controlled by one or more healthcare providers. See **Provider-Owned Health Plan**.

**Purchaser.** Purchaser is a term used to describe an individual or organization that purchases health insurance or healthcare services on behalf of itself or individuals affiliated with it (e.g., its employees) using funds not derived from health insurance premiums or other pay-

ments specifically intended to cover the individual or organization's spending on healthcare services. A purchaser may pay for healthcare services directly or through a third-party payer, such as a health insurance plan. For example, a self-insured employer is a purchaser, because the employer uses funds generated through its business operations to pay for healthcare services for its employees. The federal government's Medicare program is a purchaser, because it uses general tax revenues to pay for a significant portion of services to Medicare beneficiaries. See **Payer vs. Purchaser** for the differences between payers and purchasers.

# Q

**QE.** See **Qualified Entity**.

**Qualified Entity (QE).** A Qualified Entity is an organization that is authorized by federal law to receive Medicare claims data and to use it for public reporting of performance measures about healthcare providers and for analysis of opportunities to improve healthcare quality and affordability.

**Quality and Resource Use Reports (QRUR).** CMS produces Quality and Resource Use Reports for physician practices to enable them to compare the quality measures and spending measures for their patients to the patients of other physician practices.

**Quality Gate.** A quality gate is a threshold level on one or more quality measures that a provider must meet in order to receive a supplemental payment, such as a Shared Savings payment.

**QRUR.** See **Quality and Resource Use Reports**.

# R

**RBRVS.** See **Resource Based Relative Value Scale**.

**Rebasing.** Rebasing is a process by which a new baseline performance level is established. For example, in a shared savings payment contract between a payer and a provider, savings may initially be calculated based on a comparison of spending in each performance year relative to spending in a baseline year that occurred just before the contract began. When the contract is up for renewal, the payer may want to reset the baseline spending level to the last year of the previous contract, and then calculate savings based on comparisons of spending in future years to the new baseline year. However, this means that the provider would no longer receive credit for any savings that were generated between the original baseline year and the new baseline year.

**Reconciliation.** See **Retrospective Reconciliation**.

**Reference Price.** A reference price is a payment amount that a payer believes is sufficient to enable patients to obtain a particular service or bundle of services from at least one provider. In a payment model that uses reference prices, the payer indicates that it will pay no more than the reference price for a particular service, but the patient can still receive the service from a provider that charges more than the reference price by paying the provider the difference between the reference price and the provider's charge (i.e., a balance billing amount). If the payer will only pay for the service at providers who agree to charge the reference price without balance billing, the payer has merely created a narrow network consisting of provider who agree to be paid at or below the reference price amount.

**Regional Health Improvement Collaborative.** A Regional Health Improvement Collaborative is a non-profit multi-stakeholder organization that implements initiatives to improve the quality and affordability of healthcare services in a state or substate region. An RHIC does not deliver or pay for care, and it is governed by a multi-stakeholder group including balanced representation from purchasers, payers, providers, and patients.

**Regression to the Mean.** Regression to the mean describes the expectation that when a provider's performance on a measure of quality, utilization, or spend-

ing is affected by random variables beyond the provider's control, a higher-than-average score on the measure during one measurement period will likely be followed by a lower score in the subsequent measurement period, and a low score will likely be followed by a higher score, even if there is no change in the underlying processes used to deliver services that would affect the measure. A corollary of this is that if one provider is measured to be better than another provider in one performance period, their relative positions may be reversed in the subsequent period simply due to random variation, and not due to any conscious effort by the poorer-performing provider to improve. Regression to the mean is a problem in shared savings payment models and pay-for-performance payment models because measures of savings and performance may reflect random variation as well as conscious action by providers to reduce spending or improve performance. Many shared savings payment models include minimum savings rate provisions in an effort to avoid making shared savings payments based on random variation. See **Minimum Savings Rate** and **Minimum Loss Rate**.

**Reinsurance.** Reinsurance is an insurance policy purchased by a payer or provider to cover a portion of its risk under a health plan or payment model. The form of reinsurance commonly used in healthcare is Stop-Loss Insurance.

**Reinsurer.** A reinsurer is an insurance company that offers reinsurance policies.

**Relative Value Scale Update Committee (RUC).** The Relative Value Scale Update Committee (RUC) is a 29-member committee staffed by the American Medical Association (AMA) that makes recommendations to CMS regarding the Relative Value Unit (RVU) that should be assigned to a CPT code.

**Relative Value Unit (RVU).** A Relative Value Unit (RVU) is a number that is assigned to a particular service as part of the Resource Based Relative Value Scale (RBRVS) to measure the resources associated with delivering that service relative to other services. In the Medicare Physician Fee Schedule, the RVU for a service is multiplied by a conversion factor to determine the actual payment amount for the service.

**Work RVU (wRVU).** The Work RVU for a service is a measure of the relative amount of work required by a physician to deliver the service compared to other services. Physician work is defined as a combination of the time required to perform the service, the technical skills and physical effort involved, the mental effort and judgment required, and the psychological stress associated with concern about risk to the patient. In addition to its use in determining payments under the Physician Fee Schedule, many organizations who employ physicians use wRVUs to measure the relative workload of physicians in order to determine their compensation.

**Practice Expense (PE) RVU.** The Practice Expense RVU for a service is a measure of the relative ex-

penses incurred by a physician practice when a physician delivers the service, other than the expenses for compensation to the physician and professional liability insurance costs.

**Non-Facility Practice Expense RVU.** The Non-Facility Practice Expense RVU is a measure of the expenses incurred by the practice when the physician performs the service in the practice's own office and not in a hospital or other facility that charges a separate Facility Fee.

**Facility Practice Expense RVU.** The Facility Practice Expense RVU is a measure of the expenses incurred by the practice when the physician performs the service in a hospital or other facility, rather than in the physician's own practice office.

**Professional Liability Insurance (PLI) RVU.** The Professional Liability Insurance RVU is a measure of the professional liability insurance costs associated with delivering a particular service.

**Total RVU.** The Total RVU is the sum of the Work RVU, the Practice Expense RVU, and the Professional Liability Insurance RVU. There are two Total RVU amounts, a Non-Facility Total RVU and a Facility RVU, depending on whether the service is performed in a facility that charges a Facility Fee or not. The Medicare payment for a service is based on the Total RVU multiplied by the Conversion Factor, after adjusting the individual RVUs using the applicable Geographic Practice Cost Indices.

**Reserve.** For a provider, a reserve is a pool of funds that the provider maintains in order to cover the costs of services if the total cost of the services exceeds the total amount of payments the provider receives. For a payer, a reserve is a pool of funds that the payer maintains in order to pay for claims for services delivered by providers when the total premiums received for the insured members fall short of the cost of the claims for covered services delivered to those insured members.

**Resource Based Relative Value Scale (RBRVS).** The Resource Based Relative Value Scale payment system for physicians was phased into the Medicare program between 1992 and 1996 and replaced the Customary, Prevailing, and Reasonable (CPR) system. The RBRVS defines Relative Value Units (RVUs) for each of the services defined in CPT codes, and the RVUs are then multiplied by a conversion factor to determine the dollar amount Medicare will pay for the services under the Physician Fee Schedule. Many payers other than Medicare use the RBRVS to establish their payments for physician services, but other payers may use a different conversion factor to determine the dollar amount of payment for a service from the RVU for that service.

**Resource Use.** Resource use is a measure of the relative amount of resources needed to deliver a particular set of services to patients. A resource use meas-

ure is calculated by estimating the relative amount of resources needed to deliver a particular service compared to other services, multiplying the number of each type of service by the resource use measure for that service, and then totaling all of the products together. The “resource use” for an individual service may or may not be defined based on the cost to a provider of delivering that service.

**Resource Utilization Group (RUG).** Resource Utilization Groups (RUGs) is a risk-adjustment system used to adjust Medicare per diem payments to Skilled Nursing Facilities based on the type and intensity of rehabilitation and other services delivered to the patient, the patient’s health conditions, and the patient’s ability to carry out activities of daily living. There are 66 RUGs to which patients can be assigned, each of which has a specific weight used to adjust the payment amount. See **Skilled Nursing Facility Prospective Payment System (SNF PPS)**.

**Retrospective Reconciliation.** One way to implement a prospective payment model is to make preliminary payments to the provider on some other basis, then sum the preliminary payments made, compare the total to the prospective payment amount, and make a transfer of funds (the Net Payment Reconciliation Amount) between the provider and the payer so that the provider has received only the prospective payment amount. This process is called “retrospective reconciliation,” since it reconciles the preliminary payments against the prospective payment amount so that the actual total payments to the provider equal the prospective payment. For example, in order to implement a multi-provider bundled payment or an episode payment, each provider might continue to bill and be paid for services under the standard fee-for-service system, but then all of those payments would be totaled and compared to the prospective payment amount; if the total is less than the prospective payment, the difference would be paid to the providers, and if the total is greater than the prospective payment, the providers would have to refund the difference to the payer. (Alternatively, the payer could create a withhold on the provider’s fee-for-service payments, and then return all or part of the withhold if the fee-for-service payments are below the prospective payment amount.)

**Revenue Cycle.** Revenue cycle is a term used by financial professionals in the healthcare industry to describe the complete process needed to prepare claims for payment for the services they deliver and obtain payment for those claims. Different payment models will affect the revenue cycle in different ways and changes in cash flow under different payment models can create financial advantages or disadvantages for a provider beyond the nominal comparison between the amount of payment and the service costs. For example, in a typical shared savings program, there is no change in the basic payment model, so if a provider begins delivering a new service for which there is no direct payment, the provider’s costs will increase but there will be no immediate change in

the provider’s revenue, so the change in care delivery will reduce the provider’s margins in the short run. If the delivery of the new service reduces overall spending and results in a shared savings payment, the shared savings payment will be received well after the service was delivered, so the provider may incur financing costs during the time between when the costs were incurred and when the shared savings payment was ultimately received.

**RHC.** See **Rural Health Clinic**.

**RHIC.** See **Regional Health Improvement Collaborative**.

**Risk (for Payers).** A payer is taking risk when it accepts fixed premium payments for a group of members in return for an obligation to pay for services to those members that may require spending exceeding the total premium revenue received.

**Risk (for Providers).** In the context of payment models, a provider is said to be taking “risk” if the provider agrees to take responsibility for delivering or arranging for the delivery of healthcare services to one or more patients in return for payment and if the total payments for those healthcare services may differ from the total cost of delivering those healthcare services in ways that cannot be definitively determined in advance. Virtually any payment model other than cost-based reimbursement has some degree of risk. Even fee-for-service payment involves risk for providers, because the fee for each service is fixed in advance, but the time and cost required to deliver the services to a group of patients may be higher or lower than the revenues received from the fee-for-service payments.

**Downside Risk.** A provider is said to have downside risk if the provider could incur costs that are greater than the payments received.

**Insurance Risk.** Insurance risk describes the components of risk resulting from factors related to patient health status or other factors that are beyond the control of a provider. For example, the risk that a provider will have patients whose health problems are more serious than average is an insurance risk.

**One-Sided Risk.** “One-sided risk” means that the payment model gives the provider either upside risk or downside risk, but not both. The term “one-sided risk” is typically being used to describe a payment model such as shared savings that only has “upside risk.” However, pay-for-performance systems that include only penalties and no bonuses are one-sided risk payment models that involve only downside risk.

**Performance Risk.** Performance risk describes the components of risk resulting from factors that are within the control of the provider. For example, the risk that a provider will cause a patient to be infected during treatment and the risk that a provider will order unnecessary services during treatment are

performance risks, since these are factors that could be controlled by the provider, and under a bundled or warrantied payment system, they could cause a provider's costs to increase without corresponding increases in revenue.

**Shared Risk.** Shared risk is a generic term for a payment model in which a payer and provider share responsibility in some way when the funds available for payment differ from the costs of delivering services.

**Two-Sided Risk.** Two-sided risk means that the payment model gives the provider both upside risk and downside risk.

**Upside Risk.** A provider is said to have upside risk if the provider could receive payments for services that are more than the costs incurred, i.e., if the provider could generate a (positive) margin for delivering those services, or if it could achieve a higher margin than it achieves today. The "risk" is simply the uncertainty the provider has regarding whether there will be a margin and how large it will be.

**Insurance Risk vs. Performance Risk.** The definition of what is insurance risk and what is performance risk depends on which of the factors that can cause the costs of care to increase for particular patients can be controlled by a particular provider and which cannot. In the short run, providers cannot prevent health problems from occurring, so the discovery of a health problem in a patient is an insurance risk. Conversely, a provider can take steps to avoid errors or other problems that result in higher costs, so those are performance risks. For example, if a provider is responsible for caring for the health problems of a group of patients within a global payment, and a higher than expected number of those patients are diagnosed with cancer, that is an insurance risk, because the cancer diagnosis likely could not have been prevented by the provider, and a principal reason why people obtain health insurance is to protect them against the costs of unexpected, expensive health problems. However, if the provider uses unnecessary drugs or unnecessarily expensive drugs to treat those cancers, that is a performance risk, because the provider could have treated the cancers at lower cost without compromising the quality of care. If a provider is managing a patient population over an extended period of time, some factors that would otherwise be considered insurance risk could be considered performance risks; for example, if patients are found to have advanced colon cancer that could have been detected and addressed earlier through appropriate colonoscopies, then the advanced colon cancer could be viewed as a performance risk for a provider that had the opportunity to arrange for better colon cancer screening, and only the early-stage cancer would be a true insurance risk.

**Risk Adjustment.** Risk adjustment systems are used in payment models to avoid holding providers accountable for factors affecting performance levels or costs that they cannot control. (Other terms used to describe a concept similar to "risk adjustment" include "acuity adjustment," "severity adjustment," and "case-mix adjustment.") Risk adjustment systems are used in two different ways in payment models:

- a risk adjustment system may be used to increase or decrease the amount of payment for a service or bundle of services based on characteristics of the patient and other factors that are expected to require more or less spending for that patient.
- a risk adjustment system may be used to adjust one or more of the measures of performance on quality, utilization, or spending that are used to determine a provider's payment. Since patient characteristics and factors may affect different measures in different ways, multiple risk adjustment systems could be used for different measures.

There are a variety of different risk adjustment systems used in payment models. Some risk adjustment systems are focused on particular types of services; for example, Diagnosis Related Groups (DRGs) are designed to risk adjust payments for inpatient hospital admissions and Home Health Resource Groups (HHRGs) are designed to risk adjust payments for home health agency services. Other risk adjustment systems, such as Hierarchical Condition Categories (HCCs), Clinical Resource Groups (CRGs), and Adjusted Clinical Groups (ACGs) are designed to risk adjust total spending on a patient population. In some cases, individualized risk adjustment systems have been developed for specific procedures, conditions, or episodes of care.

Most risk adjustment systems are calibrated based on their ability to predict current levels of spending or provider performance for a patient or group of patients, with no distinction among factors affecting spending or performance that a provider can or cannot control. For example, a risk adjustment system will generally assign a higher risk score to a patient if the amount that is typically spent on that patient is higher, even if those patients did not actually need all of the services they received. Similarly, a risk adjustment system for a quality measure will assign a higher risk score to patients for whom providers generally have lower quality scores, even if the factors leading to the low quality scores could have been changed by the providers. Consequently, a risk adjustment system may be adjusting away factors that providers can control while leaving them at risk for factors they cannot control.

**Claims-Based Risk Adjustment.** A claims-based risk adjustment system is a risk adjustment system that is based only on data recorded on healthcare claims data. Various studies have shown that factors about patients that are not recorded on claims data, such as the patient's functional status and access to community resources, can have a significant impact on spending and quality performance levels.

**Clinical Category Risk Adjustment.** In a clinical category risk adjustment system, individuals are classified into groups based on differences in characteristics that are viewed as affecting spending or other performance measures. For example, individuals with one chronic condition may be placed into a different category than individuals with multiple chronic conditions, since, all else being equal, individuals with multiple chronic conditions will require more healthcare services and have poorer outcomes than those with only one chronic condition. A clinical category will typically be defined based on multiple characteristics, which means that there could potentially be hundreds of different categories to which a patient could be assigned based on different combinations of those characteristics. Each category is then assigned a weight indicating how much higher or lower spending or some other performance measure is expected to be for patients in that category than for patients in other categories. For example, the Diagnosis Related Group (DRG) system used by Medicare and many other payers to pay for inpatient hospital care is a clinical category risk adjustment system.

**Concurrent Risk Adjustment.** In a concurrent risk adjustment system, the information used in determining a risk score for a patient or assigning a patient to a risk category can include information about changes in a patient's characteristics that occurred during the time period in which spending or performance is being measured. For example, if a patient has just been diagnosed with cancer or has just broken a bone, that information can be used in a concurrent risk adjustment system to modify the payment for the patient, since all else being equal, a patient with cancer or a broken bone will need more healthcare services than a patient without those problems.

**Prospective Risk Adjustment.** In a prospective risk adjustment system, the information used in determining a risk score for a patient or assigning a patient to a risk category only includes information about a patient's characteristics prior to the period for which payment is being made or performance is being measured. For example, if a patient has just been diagnosed with cancer or has just broken a bone, that information cannot be used in a prospective risk adjustment system until the following year (or whatever period of time is used to calculate risk scores) and the payment for the patient in the current year will be the same as it would have been if the patient had not been diagnosed with cancer or broken a bone, even though, all else being equal, a patient with cancer or a broken bone will need more healthcare services than a patient without those problems.

**Regression-Based Risk-Adjustment.** A regression-based risk adjustment system uses linear regression analysis to develop a formula for assigning risk scores to patients. The regression analysis chooses the patient characteristics and the weightings of those characteristics that are statistically best at predicting spending in the year for which the regression analysis was performed. Each patient is then assigned a risk score by measuring them on each of the characteristics selected by the regression model, multiplying those individual measures by the weights assigned in the regression analysis, and then adding the products together to create an overall score. For example, the Hierarchical Condition Category (HCC) risk adjustment system used in the Medicare program is a regression-based risk adjustment system.

**Prospective Risk Adjustment vs. Concurrent Risk Adjustment.** Concurrent risk adjustment systems are more likely to accurately predict spending and performance in caring for patients than prospective risk adjustment systems, because they can incorporate the most current information about the patient's health conditions. However, concurrent risk adjustment systems make it more difficult to predict what will be spent (since all of the factors affecting risk scores are not known in advance), and concurrent systems are more likely to be affected by upcoding.

**Regression-Based Risk Adjustment vs. Clinical Category Risk Adjustment.** A regression-based risk adjustment system will base a patient's risk score on factors and weightings that were statistically best at predicting spending (or whatever performance measure was being analyzed) even if clinical logic would suggest that different factors should be important or that factors should be weighted differently. Moreover, the risk scores in a regression-based risk adjustment are calculated using a primarily linear formula even if clinical logic would suggest a non-linear relationship between spending and the factors used to calculate the risk scores (or between the factors and whatever performance measure is being analyzed). A clinical category system does not require linear relationships among the factors and can more easily incorporate clinical logic in the selection and weighting of the factors, but the more factors that are used and the finer the distinctions that are made based on how patients score on the individual measures, the larger the number of clinical categories that must be defined.

**Risk Corridor.** A risk corridor in a payment model is a method of limiting the financial risk a provider faces if a large number of patients need above-average numbers of services or if an unexpectedly large number of patients need expensive services. These situations could occur because of random variation in patient characteristics that are not captured effectively by a risk adjustment system, particularly for

providers with relatively small number of patients, or because of non-random but unexpected factors, such as a significant increase in the price of an essential drug or medical device. A risk corridor can also be used to protect a payer against paying much more for care than it costs a provider to deliver care if the provider develops a much more efficient way of delivering care after a payment arrangement has been finalized.

A risk corridor has two elements: (1) a specific range of values for the difference between the payer's payment and the provider's costs of delivering services in return for that payment, and (2) a formula for allocating the portion of the gap between payment and costs in that range between the payer and provider. For example, the provider and payer might agree that if the total cost of services for all of the patients being cared for under a particular treatment bundle, condition-based payment, or population-based payment exceeds 110 percent of the total payments that are made for all of those patients, the payer will make an additional payment to the provider to cover all or part of the costs above the 110 percent threshold. (The payer and provider could also agree that if the total cost turns out to be significantly lower than the total payments that are made, the provider will return to the payer all or part of the payments that are made beyond a certain percentage above the costs incurred.)

A payment model can have multiple risk corridors, not just one. For example, one risk corridor might define how the payer and provider will share excess costs if the costs are between 110% and 120% of payments, and a second risk corridor might define what will be done if costs are more than 120% of payments.

**Risk Limit.** A risk limit is a cap on how much risk a provider accepts before additional payments are made to cover its costs. In many payment models, risk limits are implicit rather than explicit; for example, in the Medicare Inpatient Prospective Payment System, hospitals can receive an Outlier Payment to cover a portion of the costs of an unusually expensive patient. The cost threshold that triggers the Outlier Payment is, in effect, a Risk Limit for the hospital, since the hospital's risk in accepting a fixed DRG payment for patients with varying needs is limited by the ability to obtain an Outlier Payment if costs reach a certain level.

**Risk Score.** A risk score is a numeric value assigned to a particular patient in a risk adjustment system that indicates the relative level of spending that will be required for that patient or the relative level of quality or outcomes that can be achieved in the delivery of care to that patient relative to other patients.

**Risk Stratification.** Risk stratification is a way of adjusting payments for differences in patient characteristics by assigning patients to two or more categories based on characteristics that influence the costs of care and then adjusting the payment for a particular patient based on the category to which the patient is as-

signed. Risk stratification can be done using either a regression-based risk adjustment system or a clinical category risk adjustment system. If a regression-based risk adjustment system is used, the stratification categories are defined based on ranges of risk scores; if a clinical category risk adjustment system is used, the categories defined in the system can serve as the stratification categories. For example, the DRG system used by Medicare and other payers to pay hospitals is a risk stratification system based on a clinical category risk adjustment system.

**Risk Scores vs. Risk Stratification.** In risk adjustment systems that use a risk score, the payment for the patient is adjusted up or down in proportion to the risk score. This presumes a linear relationship between the risk adjustment score and the payment, i.e., if one patient has a 50% higher score than another, the payment for the first patient would be 50% higher than the second patient. In a risk stratification system, the amount of adjustment to the payment is particular to the category to which the patient is assigned, and there need be no systematic relationship between the payment adjustment associated with one category and the payment adjustment associated with another category.

A risk stratification system is easier to incorporate into standard billing and claims payment systems because a billing code can be defined for each patient category in the risk stratification system. However, this may require the creation of many billing codes if there are many different risk categories. Using a risk score requires the use of only one billing code, but then a special mechanism is needed to adjust the amount of payment for that code because claims payment systems are designed to pay the same amount to a provider for each billing code.

**Risk Corridor vs. Risk Adjustment vs. Outlier Payment.** Risk adjustment, risk corridors, and outlier payments are different and complementary methods of controlling a provider's risk in accepting a specific amount of payment without knowing exactly how many services it will need to deliver or pay for. A payment model may need to use all three components in order to adequately separate insurance risk and performance risk.

- *Risk adjustment* is a mechanism of increasing payment to a provider if it delivers care to patients who have particular characteristics that are *expected* to require additional services or more expensive services, regardless of whether they *actually* receive such services.
- An *outlier payment* is an additional payment made to a provider when the cost of services *actually received* by an *individual patient* exceeds a certain threshold.
- A *risk corridor* defines circumstances in which a provider will receive higher payments if the *aggregate cost of services actually received* by a *group of patients* exceeds a certain threshold. (The risk corridor may also define circumstances in which a provider will receive lower payments or return money to the payer if a group of patients receive services whose aggregate cost is lower than a threshold.)

**RUC.** See **Relative Value Scale Update Committee.**

**RUG.** See **Resource Utilization Group.**

**Rural Health Clinic (RHC).** A Rural Health Clinic (RHC) is a medical clinic specifically designated as such based on its location in a non-urbanized area designated as having a shortage of health professionals. Medicare pays RHCs an “all-inclusive rate” (AIR) based on their costs, but there is a maximum payment per visit for RHCs that are not part of a small hospital.

**RVU.** See **Relative Value Unit.**

# S

**S-Code.** An S-Code is a subset of the Level II codes that CMS creates and maintains as part of the Health Care Common Procedure Coding System (HCPCS). S-codes are created for procedures and professional services that have not been incorporated into the CPT coding system, and that private payers but not Medicare will pay for. Examples of S-Codes include:

- S0315: Disease management program; initial assessment and initiation into the program
- S0317: Disease management program; per diem
- S0353: Treatment planning and care coordination management for cancer; initial treatment

**Section 1115A.** Section 1115A of the Social Security Act was added as part of the Affordable Care Act to establish the Center for Medicare and Medicaid Innovation (CMMI) to test payment models “where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures,” with a focus on “models expected to reduce program costs while preserving or enhancing the quality of care received by individuals.” See Center for Medicare and Medicaid Innovation.

**Section 1115 Waiver.** A Section 1115 waiver is a waiver granted by CMS to a state under Section 1115 of the Social Security Act to allow it to spend Medicaid funds in different ways than what would otherwise be required.

**Self-Funded Employer.** A self-funded employer is a business that is self-insured for the healthcare services for which it has agreed to pay for its employees.

**Self-Insured.** An employer or other purchaser is said to be self-insured if it takes direct responsibility for paying claims for healthcare services for its employees or members rather than purchasing health insurance policies from a separate health insurance company for each employee as a way of paying for those services. The majority of individuals in the U.S. who have employer-sponsored health insurance are part of a self-insured plan. Most self-insured employers are not completely self-insured; in addition to maintaining some level of financial reserve to cover claims costs, they generally purchase stop-loss insurance to protect them against large claims expenses (see **Stop-Loss**). Also, most self-insured employers do not pay the claims themselves, but they hire a Third Party Administrator (TPA) to pay those claims (under what is known as an Administrative Services Only contract) and then the self-insured employer pays the TPA for the actual cost of the claims plus an administrative fee. The TPA may or may not be a company that also sells health insurance policies. See **Fully-Insured** for comparison.

**Self-Pay.** A self-pay patient pays a provider for its entire charge for a service from the patient's own funds, rather than relying on an insurance company or other third-party payer to pay for all or part of the provider's charge for the service. If the patient has a health insurance plan with a deductible, the patient may pay for a service out of the patient's own funds, but the patient may only have to pay the payment amount that the insurance company has negotiated for that service from the provider.

**Shared Risk.** See **Risk.**

**Shared Savings.** “Shared savings” generally describes a payment arrangement between a payer and a provider in which the total amount of payment to the provider for its services is related in some way to how much the payer is spending in aggregate on those services or on a broader set of services and how that aggregate spending compares to a benchmark. There are many different ways to define a shared savings program, but most shared savings programs fall into one of two categories:

- In the most common form of shared savings program, including the programs being implemented in the Medicare Shared Savings program, the payer determines the actual amount it spent during a period of time on healthcare services for a group of patients cared for by a particular provider, compares that spending amount to an estimate of what the payer expected to have spent on those services to those patients, and if the actual spending is lower than the expected amount (i.e., the payer determines that it has achieved savings), the payer makes a supplemental payment to the provider which is proportional to the amount of savings, i.e., the payer shares its savings with the provider.
- In some programs that are called “shared savings,” a provider is determined to qualify for a shared savings payment if the payer's spending on its patients is lower than the payer's spending on other provid-

ers' patients, even if the provider in question did not actually reduce spending below the level that would have been expected based on that provider's past performance. It would be more accurate to describe these programs as a "pay for performance program based on spending," since the provider is being paid based on the fact that its spending has been and continues to be lower than what is achieved by other providers, not based on achieving savings beyond the current or expected level of spending.

There are three basic components to a Shared Savings Program, each of which can be structured in many different ways.

- A definition of which services for which patients are included in the spending being analyzed. In many cases, spending is based on services for patients who are "attributed" to a particular provider.
- A method of calculating a comparison spending level (the benchmark) for determining whether the amount of actual spending qualifies for an additional "shared savings" payment. The formula for setting a benchmark may involve trending a baseline spending level for the same provider, comparing the provider's spending to other providers or communities, or a combination of the two.
- A formula for determining the amount of the shared savings payment to the provider. For example, the formula may include a minimum savings rate, a quality gate, and other elements.

In a pure Shared Savings Program, there is no change in the basic method by which the provider is paid for services delivered. Services that can currently be billed for payment can continue to be billed and paid at the same payment rates, and services that cannot be billed for payment still cannot be billed or paid directly. In some payment models, a Shared Savings Program is combined with other payment changes, such as use of medical home payments, in order to enable providers to deliver additional or different services than they do today but also encourage them to do so in ways that reduce total spending on their patients. In some Shared Savings Programs, a provider that qualifies for a shared savings payment receives that payment by submitting claims for a billing code that it could not previously use, but this billing code is not intended to represent payment for a particular service.

**SIM.** See **State Innovation Model**.

**Site-Neutral.** A payment for a service is said to be site-neutral if the amount of payment does not differ based on the type of facility or site where the service is performed, e.g., the payment is the same whether the service is performed in a physician's office or a hospital outpatient department.

**Site-of-Service Differential.** A site of service differential is a difference in the amount of payment for the same service depending on where the service is performed. In the Medicare program, if a service is performed by a physician in a hospital outpatient department, the hospital is paid under the Outpatient Prospective Payment

**Shared Savings vs. Gain-Sharing.** The term "gain-sharing" is typically used to describe an arrangement between two or more providers for dividing any surplus or profits that are generated when providers' cost of delivering services is less than the amount of payment. "Shared savings" is typically used to describe an arrangement in which a payer makes an additional payment to one or more providers if the payer spends less in total payments than it would have otherwise expected to spend. For example, suppose a hospital and surgeon change the way surgery is delivered so that the costs to the hospital are reduced (e.g., the surgeon decides to use less expensive medical devices during surgery) and more patients are able to recover from surgery at home rather than going to a skilled nursing facility after discharge. The standard payment to the hospital would not change because lower-cost medical devices are used, but the hospital's costs would decrease, and the hospital could agree to make a gain-sharing payment to the physician from the additional profit margin the hospital would generate. In contrast, if the physician and hospital redesigned care delivery so that fewer patients used skilled nursing facilities or patients had shorter stays in skilled nursing facilities, the standard payments to the hospital and physician would not change so there would be no new opportunity for gain-sharing between the hospital and physician, but the payer's spending on skilled nursing facilities would decrease, and the payer could agree to make a shared-savings payment to the hospital and/or physician using a portion of the savings the payer received.

System and the physician is paid under the Physician Fee Schedule (using the Facility payment rate), whereas if the same service can be performed in the physician's office, there is only a payment to the physician under the Physician Fee Schedule (using the higher Non-Facility payment rate). (The payment to the hospital outpatient department is known as a Facility Fee and is billed separately from the physician's fee for performing the service.) It is important to note that the payment to the *physician* may be higher if the service is performed in the physician's office than in the hospital, but if the service is performed in the hospital, both the physician and the hospital are paid separately, and the combined payment is generally higher if the service is performed at the hospital than in the physician's office. Consequently, determining the site-of-service differential requires comparing combinations of payments from two different payment models or fee schedules.

**Skilled Nursing Facility (SNF).** A Skilled Nursing Facility is an institution that provides 24-hour nursing services and other medical services for patients who require nursing care but do not require inpatient hospitalization.

**Skilled Nursing Facility Prospective Payment System (SNF PPS).** The Skilled Nursing Facility Prospective Payment System (SNF PPS) is the system Medicare uses to pay Skilled Nursing Facilities (SNFs). Under

this payment model, a SNF receives an additional payment for each day that a patient is in the SNF (i.e., a per diem payment). The daily payment amount is adjusted for geographic differences in costs to establish a base payment rate for each facility. The base payment rate is then adjusted for each patient based on differences in patient characteristics and the types of services delivered using Resource Utilization Groups (RUGs). Each day of care is assigned to one of 66 RUGs based on the type and intensity of rehabilitation and other services delivered to the patient, the patient's health conditions, and the patient's ability to carry out activities of daily living. Each RUG has a specific weight that is multiplied by the facility's base payment rate to determine the payment amount for that patient on that day.

**SNF.** See **Skilled Nursing Facility**.

**Sole Community Hospital.** In the Medicare program, a sole community hospital is a hospital that meets one of a series of criteria based on its distance from other hospitals, the travel time to other hospitals, and the proportion of inpatient care it provides for the residents of the hospital's service area. Payments for Sole Community Hospitals are based partially on the Inpatient Prospective Payment System and Outpatient Prospective Payment System, but special adjustments are made in the amounts of payments they receive.

**Spending.** See **Cost**.

**Specialist.** A Specialist is a physician who delivers services in a particular area of medicine and does not deliver primary care to patients other than those with a medical problem in the physician's area of specialty.

**Standardized Payment.** Because Medicare payments to providers are adjusted based on geographic cost differences (see **Geographic Adjustment Factor**) and other factors that are unrelated to the type of service delivered, the total spending for one provider or one community may differ from the total spending for another provider or another community even though the same number and types of services are delivered by both. To eliminate these unrelated differences, Medicare spending measures are often calculated using a single standardized payment for each service rather than the actual payment amounts. A similar approach can be used in comparing spending by private payers, since private payers pay different amounts for the same service in different communities and when the services are delivered by different providers.

**Stark Law.** The federal Ethics in Patient Referrals Act, commonly known as the "Stark Law," prohibits physicians from referring Medicare and Medicaid patients to entities such as hospitals with which the physicians have a financial relationship (i.e., an ownership interest or a compensation arrangement) for the provision of "designated health services" except in a number of specifically exempt circumstances, e.g. where the physician is an employee of the entity, or for services

meeting the In-Office Ancillary Services Exemption. In addition to the federal law, a number of states have enacted laws or regulations that also prohibit some types of self-referrals, including for services reimbursable by private health plans.

The Stark law and similar state self-referral statutes or regulations are intended to avoid having financial considerations influence physicians' referral decisions. However, under a system that bundles payments to physicians and hospitals (or to physicians and other types of entities) to enable and encourage the delivery of coordinated services, physicians will inherently need to refer their patients to the provider with which they have the bundled payment arrangement, and this may violate state and/or federal self-referral laws or regulations. Moreover, because the laws or regulations typically have exemptions for employment arrangements, they can create a disadvantage for organizational structures in which physicians are independent compared to health systems that employ physicians.

For more information, see **Fraud and Abuse Laws**.

**State Action Exemption.** Under the "state action" doctrine of antitrust law, a state can encourage and facilitate joint efforts by healthcare payers (e.g., aligning payment methods and amounts) and joint efforts by providers (e.g., forming an Accountable Care Organization) without antitrust liability if the state (1) has a clearly articulated state policy supporting the need for common approaches, and (2) engages in active supervision of the activities that might otherwise cause antitrust concerns.

**State Innovation Model (SIM).** The State Innovation Models (SIM) Initiative is a program operated by the Center for Medicare and Medicaid Innovation that provides grants and technical assistance to state governments to facilitate planning and implementation of multi-payer payment reforms and delivery reforms in the state that will reduce costs and improve the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

**Step Therapy.** A Step Therapy requirement in a health plan requires a provider to treat a patient's condition with a lower-cost therapy to determine whether it is effective before the health plan will cover the cost of a higher-cost therapy.

**Stinting.** Stinting means delivering fewer healthcare services than a patient needs to properly address their health problem(s).

**Stop-Loss.** A stop-loss is a provision in a payment contract that limits the amount that the provider must spend on healthcare services, either for an individual patient or in aggregate for all patients. If costs exceed the threshold for triggering the stop-loss provision (referred to as the attachment point), the provider will receive an additional payment from the payer to cover all or part of those costs.

Stop-loss insurance is a form of reinsurance that protects a provider against unexpectedly high costs of delivering services by making a stop-loss payment when costs exceed a stop-loss threshold. A provider who accepts a bundled payment from a payer may wish to purchase stop-loss insurance to cover unexpectedly high costs of services or high numbers or costs of claims from the other providers. Self-insured purchasers also purchase stop-loss insurance to protect them from high claims costs.

**Aggregate Stop-Loss.** An Aggregate Stop-Loss provision or reinsurance policy provides for additional payment if the total cost of services for a group of patients exceeds a specific amount. For example, if the Aggregate Stop-Loss is 110% of payments, then the provider will receive an additional payment if the total cost of services for all patients exceeds 110% of the total payments made for those patients. An Aggregate Stop-Loss provision/policy does not provide any additional payment to a provider with individual patients requiring expensive services if a sufficient number of other patients require fewer or lower-cost services. An aggregate stop-loss provision is equivalent to a risk corridor.

**Individual Stop-Loss.** An Individual Stop-Loss provision or reinsurance policy provides for additional payment if the cost of services for an individual patient exceeds a specific amount (the "Attachment Point"). For example, if the Individual Stop-Loss is \$100,000, then the provider will receive an additional payment if the cost of services for an individual patient exceeds \$100,000. An Individual Stop-Loss provision/policy does not provide any additional payment to a provider with a large number of patients who need many expensive services if none of the patients individually costs more than the individual stop-loss level. An individual stop-loss provision is equivalent to an outlier payment.

**Swing Bed.** In a hospital, a "swing bed" can be used either for patients who need acute care inpatient services or for patients who need skilled nursing facility (SNF) services.



**TCOC.** See Total Cost of Care.

**Third-Party Administrator (TPA).** A Third-Party Administrator is an organization that receives and pays claims on

behalf of a self-funded employer or other self-insured purchaser, but does not take any direct risk related to the cost of those claims. The claims-processing and other services are delivered by the TPA under an Administrative Services Only (ASO) contract with the purchaser.

**Tie-Breaker.** In many attribution methodologies, a patient or service is attributed to the provider based on which provider was highest on a measure such as the number of visits with the patient, the number of services delivered, etc. If two providers each were highest on that measure, then a second measure – the tie-breaker – is used to determine which of the two providers will be selected for attribution. For example, if a patient had the same number of visits during the year with two different providers, then the tie-breaker might be to identify the provider who had the most recent visit with the patient.

**Tiered Cost-Sharing.** In a tiered cost-sharing system, providers or services are divided into two or more groups ("tiers") based on one or more measures of cost or quality. When a patient uses a provider or receives a service, the patient's cost-sharing will depend on the tier to which the provider or service is assigned. For example, the patient might be required to pay a higher co-payment for seeing a physician with lower quality scores, or the patient might be required to pay a higher proportion of the cost of a drug that is more expensive or less effective than another drug.

**Tiered Network.** A tiered network is a network of providers in which the providers are divided into two or more tiers based on measures of cost or quality, and different cost-sharing requirements or other rules apply depending on which tier a provider is in. In a tiered network, all providers are generally considered to be "in-network" but with different cost-sharing requirements. A narrow network is an extreme form of a tiered network in which there are two "tiers" – in-network providers and out-of-network providers – and there is a large difference in cost-sharing requirements and benefits between in-network and out-of-network providers.

**Total Cost of Care.** The term "Total Cost of Care" is used to refer to the total amount that is spent on healthcare services for a group of individuals by one or more payers. It is technically a measure of *spending*, since it represents the cost to the payers based on the amounts they pay for the services, which may be more or less than the actual costs incurred by the providers who deliver those services.

**Total Per Capita Cost.** The Total Per Capita Cost is a measure calculated by dividing a payer's total spending on a group of patients by the number of individuals insured by the payer. Total Per Capita Cost for Medicare beneficiaries is a measure being used by Medicare in the Physician Value-Based Payment Modifier program.

**Tournament Pay for Performance.** See **Pay-for-Performance**.

**TPA.** See **Third-Party Administrator**.

**Track 1 ACO.** See **Accountable Care Organization**.

**Track 2 ACO.** See **Accountable Care Organization**.

**Track 3 ACO.** See **Accountable Care Organization**.

**Treatment-Based Bundled Payment.** A treatment-based bundled payment is a payment that is triggered by delivery of a particular type of treatment (e.g., surgery or chemotherapy) and involves multiple services related to that treatment. In contrast, condition-based payment is a payment that is triggered by the appearance or existence of a health problem.

**Trend (noun).** The trend in spending or premiums is the rate at which they have increased or decreased over a period of time.

**Trend (verb).** In many payment methodologies, a measure of spending calculated during a baseline time period is “trended” forward to estimate what the spending would be expected to be during a performance period if no changes are made in the way care is delivered. For example, if the average spending per person in a base year was \$10,000, and if the average annual inflation in spending was expected to be 3% per year, the \$10,000 baseline amount could be trended forward by 3% per year to estimate that spending five years later would be expected to be \$11,593 per person. (If actual spending in the fifth year was lower than \$11,593, it would indicate that “savings” were generated, even though the amount of spending would still be higher than it was in the base year.) There are many different methodologies that can be used to do the trending; for example, in the Medicare Shared Savings Program, CMS has trended baseline spending measures using a blend of the percentage growth in spending and the absolute growth in per-beneficiary spending.

**Trigger.** In order for a provider to receive a payment, something must be done to “trigger” the receipt of the payment. In fee-for-service payment, the trigger is the delivery of a service – a provider delivers a service for which a patient or payer has previously agreed they will pay, and then the provider invoices the payer (by submitting a claim). In a capitation payment model, the payment is not based on specific services (indeed, the capitation payment may be paid even if no services are delivered at all), so the trigger is something that associates the patient with the provider – typically a formal assignment of the patient to the provider or a statistical rule attributing the patient to the provider. In a condition-based payment model, the trigger is a combination of the presence of the condition and an indication that the provider will be treating that condition.

**Truncation.** Truncation is a statistical process that takes the most extreme values in a distribution and limits them to a fixed, pre-determined amount. For example, in any group of patients with a particular condition, some patients may have unusual problems that require a large number of expensive services for that condition (“outlier patients”). If a provider is given a fixed payment to pay for as many services as the patients need for the condition, the small number of patients requiring the large number of expensive services could cause losses for the provider. This problem can be mitigated by requiring the provider to only be responsible for the truncated spending on these patients, i.e., the provider would pay up \$100,000 of spending, and then the payer would pay for spending on the expensive patients above \$100,000. The patient remains a high cost patient for the provider, but not as high cost as the patient would have been without truncation. See also **Exclusion** and **Winsorization**.



**UB-04.** The UB-04 is the standard form used for submitting claims to payers for payment of hospital services. Its content and design is maintained by the National Uniform Billing Committee. The UB-04 form is called a CMS-1450 form in the Medicare program.

**UCR.** See **Usual, Customary, and Reasonable**.

**Underinsured.** Individuals are frequently being described as “underinsured” if they have health insurance but the cost-sharing requirements in the benefit design are such that the patient cannot afford to pay the cost-sharing for necessary services.

**Underuse.** Underuse is the use of a particular service less often than is necessary or justified based on evidence about its effectiveness.

**UPL.** See **Upper Payment Limit**.

**Upcoding.** Upcoding is a term used to describe assigning a diagnosis code to a patient or using a billing code for a service that results in a higher payment for a provider than the payment that would result from using an alternative diagnosis or billing code that would be appropriate for the patient or service. In cases where payments to a health plan are risk adjusted, such as in the Medicare Advantage program, upcoding of diagnosis codes by providers can result in

higher payments to the health plan but not to the providers. Upcoding does not necessarily mean that the codes used are inaccurate or inappropriate; in many cases there are multiple codes that can be used for the same patient condition or service and there is ambiguity about which code is appropriate to use in specific circumstances. However, if the weight assigned to a service or a diagnosis in a payment or risk adjustment system was based on one pattern of coding, then the weights may no longer be accurate if the pattern of coding changes.

**Update.** See **Payment Update**.

**Uplift.** An “uplift” is an increase in the amount of payment for one or more services beyond the amount that would otherwise be paid. In some prospective pay-for-performance systems, a provider who meets the performance criteria will receive an uplift in the payment rates for certain services, i.e., the provider will receive a higher payment when they bill for those services.

**Upper Payment Limit (UPL).** In the Medicaid program, states have discretion as to the amount providers are paid, but the federal government will only share the costs of payments up to the Upper Payment Limit.

**Upside-Only Shared Savings.** See **Shared Savings**.

**Usual, Customary, and Reasonable (UCR).** The “Usual, Customary, and Reasonable” amount is the amount that healthcare providers in a particular geographic region routinely charge for the same service to self-pay patients. Many payers used the UCR payment system to pay physicians before the creation of the Resource Based Relative Value Scale (RBRVS).

**Utilization (by Patient).** Utilization by a patient is the number of times that the patient receives a particular service. For example, a patient who visits the emergency room frequently is said to have high utilization of emergency services.

**Utilization vs. Resource Use vs. Spending.** A Utilization measure for a provider describes the total number of services that are delivered to or ordered for a group of patients by the provider; it does not distinguish whether the individual services delivered or ordered by the provider were more costly or higher-priced than those delivered by another provider. A Resource Use measure describes the relative time and costs associated with the services delivered to or ordered for a group of patients, but it does not distinguish whether there are differences in the prices for services that had the same costs or required the same number of resources. A Spending measure describes the total amount paid by a payer for the services delivered to a group of patients; one provider may have higher spending than another provider but lower Resource Use if the first provider is paid more for the same services than the second provider or if the first provider orders services from other providers who have higher prices than those from whom the second provider orders services.

**Utilization (by Provider).** Utilization by a provider is a measure of the number of times the provider delivers or orders a particular service for a group of patients. For example, a physician who orders imaging studies frequently is said to have high utilization of imaging studies.



**Value.** In healthcare, the word “value” has been used for over two decades in the Relative Value Units (RVUs) defined in the Resource-Based Relative Value Scale (RBRVS) to establish payments for physicians. In RBRVS, “value” is defined as the costs of the resources required to provide a service, including the physician’s time and the complexity of the service as well as out-of-pocket expenses such as office rent, equipment costs, insurance costs, etc.

More recently, the term “value” is widely being used to describe the combined assessment of both the quality and cost of a healthcare service or group of services. Conceptually, a “high-value” service is one that has high quality and low cost. However, because quality and cost are measured on fundamentally different scales and different people will convert one to the other in different ways (i.e., some people will be willing to pay more for an increment of quality than others), value is inherently a relative and partially subjective concept. Although one can objectively say that a service is “higher value” than another service if the first service has higher quality and the same cost, or if it has the same quality and lower cost, a subjective judgment is required if one service has both higher quality and higher cost than another service.

Because of this, value cannot be defined as “quality divided by cost” as many have suggested. For example, assume that Provider 1 delivers cancer treatment to a group of patients at a total cost of \$25,000 per patient and Provider 2 delivers a different type of cancer treatment to patients with similar characteristics at a total cost of \$50,000. The patients treated by Provider 1 live an average of 5 years, and patients treated by Provider 2 live an average of 8 years. Dividing the outcome by the cost shows that Provider 1 delivers 10.4 weeks of life per thousand dollars of treatment, while Provider 2 delivers only 8.3 weeks of life per thousand dollars of treatment. If one defines “value” as “outcomes/cost,” Provider 1 would be the higher-value provider, yet most people would likely say the opposite, since Provider 2 gives people an average of three extra years of life at an additional cost of

only \$25,000. If the two providers had different survival rates at the same treatment cost, or the same survival rates at different costs, the ratio wouldn't be needed to make the comparison, but when costs and outcomes both differ, the ratio is not very helpful in determining which provider has higher "value."

**Value-Based Incentive Payment Adjustment.** In the Medicare Hospital Value-Based Payment Program, the value-based incentive payment adjustment is a percentage amount assigned to each hospital in each year based on the hospital's scores on a series of performance measures. The hospital's payments are then adjusted up or down by the percentage in the value-based incentive payment adjustment.

**Value-Based Insurance Design (VBID).** The term Value-Based Insurance Design is used to describe provisions of a health insurance plan's benefit design that are explicitly structured to encourage plan members to use higher quality services, lower cost services, or both or to encourage patient or provider behaviors that lead to better outcomes. This may include elements such as reducing patient cost-sharing for services deemed to be of high value, eliminating coverage for services deemed to be of low value, or encouraging or requiring patients to use providers designated as Centers of Excellence for specific types of services.

**Value-Based Payment Modifier.** The Value-Based Payment Modifier is a program established by Congress to adjust the Medicare payment for a service delivered by a physician to a Medicare beneficiary based on measures of the quality of care and the cost of care delivered by the physician during a performance period.

**Value-Based Payment.** Value-based payment is a generic term used to describe a payment model where the amount of payment for a service depends in some way on the quality or cost of the service that is delivered. There is no accepted minimum standard as to how much the payment must vary or what type of value measure must be used, so some payment models have been described as "value-based" even though there is very little difference in the amount of payments based on differences in quality or cost.

**Value-Based Purchasing.** Value-Based Purchasing is a generic term used to indicate that a purchaser is contracting for healthcare services in ways that are designed to improve quality, reduce costs, or both. Value-Based Purchasing may include the use of some form of Value-Based Payment, but it also can include Value-Based Insurance Design, Narrow Networks, and other approaches.

**Value Modifier.** See **Value-Based Payment Modifier.**

**VM.** See **Value-Based Payment Modifier.**

**Volume-Based Adjustment.** A volume-based adjustment is a mechanism by which the amount of payment to a

provider explicitly differs based on the number of patients the provider cares for or the number of services or procedures the provider delivers. To the extent that providers incur fixed costs to deliver a particular service or to care for patients with a particular condition, the average cost of the service and the average cost per patient will be higher for a provider that delivers fewer of the services or cares for fewer patients with the condition, so the payment amount per service or per patient will need to be higher in order to cover the total costs of delivering the service. For example, Medicare has used a Low-Volume Adjustment to increase payments to hospitals with small numbers of patients.



**Warranted Payment.** A warranted payment is an agreement by a provider to deliver the services needed to address one or more complications of treatment without billing for or receiving additional payment for those services. For example, a provider accepting a warranted payment for surgical infections might agree that it would cover the costs of any hospital readmissions required to address infections from the surgery without receiving any additional payment. A warranted payment is not an outcome guarantee, i.e., the provider is not guaranteeing that the warranted events will not occur, the provider is merely agreeing that if one of those events does occur, there will be no additional payment for the services needed to address that event. Most warranted payments will involve a "limited warranty," i.e., they will define the specific circumstances in which the warranty applies and those in which it does not.

**Weight.** In a payment model, a weight is a value assigned to a payment category or payment code that defines how large or small the payment for patients or services in that category or code should be relative to payments for patients or services in other categories or code. The weight is then multiplied by a conversion factor to determine the actual dollar amount of payment for that service. For example, in the Medicare Inpatient Prospective Payment System, each MS-DRG category is assigned a weight based on the level of hospital services and spending that are expected for patients in that category. The weight is multiplied by a conversion factor to determine how much a hospital will receive in dollars for a patient classified in that MS-DRG category.

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In a performance measurement or risk adjustment system that is used as part of a payment model, a weight is a value that is multiplied by a particular measure or risk adjustment factor in order to combine that measure or factor with other factors in determining an overall performance score or risk score. A measure or factor with higher weight will have a greater influence on the overall performance or risk score.

Two different payment models may use the same payment categories or risk adjustment factors, but they may apply different weights to those categories or factors reflecting differences in expected costs, spending, or performance on the particular patients for whom they are paying or the particular services for which they are paying. If one payment model uses bundles that include more services than a second payment model, both systems may choose to risk adjust the payments using the same factors, but the risk adjustment weights will likely be different. For example, the Medicare Inpatient Prospective Payment System and Long Term Care Hospital Prospective Payment System both use the same DRG categories, but different weights are assigned to the categories in each system to reflect the different costs expected for patients with similar characteristics depending on whether they are receiving acute inpatient care or long-term hospital care.

**Winsorization.** Winsorization is a statistical process that takes the most extreme values in a distribution and replaces them with smaller values that are “closer” to the average for the distribution, e.g., any values above the 99<sup>th</sup> percentile in a distribution are replaced by the exact value at the 99<sup>th</sup> percentile. For example, in any group of patients with a particular condition, some patients may have unusual problems that require a large number of expensive services for that condition (“outlier patients”). If a provider is given a fixed payment to pay for as many services as the patients need for the condition, the small number of patients requiring the large number of expensive services could cause losses for the provider. This problem can be mitigated by requiring the provider to only be responsible for the Winsorized spending on these patients, i.e., the provider would pay up to the amount of spending at the 99<sup>th</sup> percentile of the spending distribution for all patients, and then the payer would pay for spending on the expensive patients above the 99<sup>th</sup> percentile amount. The patient remains a high cost patient for the provider, but not as high cost as the patient would have been without Winsorization. See also **Truncation** and **Exclusion**.

**Withhold.** In a pay-for-performance system that includes penalties for poor performance, a payer may reduce payments to the provider during the performance period below what the provider would otherwise expect to receive (the reduction is the “withhold” amount); the payer then makes a supplemental payment at the end of the performance period if the provider’s performance met a performance threshold, and the supplemental payment may be less than, equal to, or greater than the withhold amount. The use of a withhold avoids requiring the provider to make a penalty pay-

ment to the payer if the provider’s performance is poor; the provider simply receives less money because it forfeits all or part of the withhold.



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bill sponsor  
Sen. Kelly



## Seven Best Practices:

- 1. Electronic Health Information** – Adoption of an electronic emergency department information system on a statewide basis to create and act on a common, integrated plan of care related to patients with high needs (5 or more visits in a rolling calendar year) by all emergency rooms, payors, mental health clinics, and is sent to primary care providers.
- 2. Patient Education** – Dissemination of patient education materials by hospitals and payors to help patients understand and utilize the appropriate resources for care. This would include plans sharing with patients and providers where they can get off hours coverage for primary or urgent care including through nurse call lines and having this information easily available on their web sites.
- 3. Identify Frequent Users of the Emergency Department and EMS** – Frequent emergency department (ER) or EMS users are identified as those patients seen or transported to the ER five (5) times within the past 12 months. Hospitals should identify those frequent ER users upon arrival to the emergency department and develop and coordinate case management, including utilization of care plans. Plans, EMS, and mental health clinics will work with patients with five or more visits to identify and overcome core issue which is documented in statewide information system.
- 4. Develop Patient Care Plans for Frequent ER Users** – A process to assist frequent ER users with their care plans, such as contacting the primary care provider within 72-96 hours and/or notifying the PCP of an ER visit if no follow-up is required. Payors will provide the information system with the names of the primary care or group for Medicaid patients and provider fax number.
- 5. Narcotic Guidelines** – Reduce drug-seeking and drug-dispensing to frequent ER users through implementation of guidelines that incorporate the WA-ACEP guidelines.
- 6. Prescription Monitoring** – ER Physician enrollment in the state's Prescription Monitoring Program (PMP). The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances ensuring coordination of prescription drug prescribing practices.
- 7. Use of Feedback Information** – Designation of a hospital emergency department physician and hospital staff responsible for reviewing the reports of frequent ER users to ensure interventions are working, including a process of reporting to executive leadership.

# Washington State Medicaid: Implementation and Impact of “ER is for Emergencies” Program

May 4, 2015 | The Brookings Institution

## Executive Summary

The “ER is for Emergencies” program was developed through a collaborative effort between the Washington State American College of Emergency Physician, the Washington State Medical Association, and the Washington State Hospital Association. Driven by concerns about costs associated with high ED use, this plan started in 2012 and aims to improve management of emergency department (ED) conditions and address overutilization through “seven best practices” that include interoperable health information exchange (HIE) technology referred to as the Emergency Department Information Exchange (EDIE), patient education on appropriate ED use, identification of frequent users of the ED and prehospital care, development of patient care plans, implementation narcotic guidelines, participation in prescription monitoring program, and use of feedback information.

EDIE integrates into existing ED electronic health records (EHR) to push basic information about resource utilization to providers such as past visit dates and chief complaints. In addition, EDIE includes a prescription management program and clinical pathways. For high utilizing patients, EDIE also includes care plans and case managers to work individually to follow-up with patients after discharge and help connect them to outside resources.

The ER is for Emergencies program is able to integrate the entire state with robust utilization to break down barriers between institutions and streamline information delivery. In the first year of the program, Medicaid ED costs fell by nearly \$34 million through a reduction in ED visits. ED visits by Medicaid patients declined by nearly 10%, with rates of visits by high utilizers (5+ visits/year) declining by approximately 11%. For less serious conditions, the visit rate decreased by more than 14% over the year.

Finally, visits resulting in the prescription of controlled substances fell by 25% for the Medicaid population.<sup>2</sup> While this program may have helped avoid less effective payment reductions affecting emergency departments, sustaining and expanding such programs may require further payment changes to enable emergency departments to share in the overall savings from initiatives like this one.

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## Washington State Medicaid: Implementation and Impact of “ER is for Emergencies” Program

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### I. Program Overview

The recession of 2008 triggered a significant uptick in job losses and the subsequent loss of employer sponsored health insurance, swelling Medicaid rolls. This loss of tax revenue and increased spending caused many states to take a serious look at Medicaid spending.<sup>1</sup> In Washington State, several factors such as the poor interoperability of health information technology, gaps in access to primary care physicians, and the lack of communication and integration among providers and facilities led to high utilization of hospital-based emergency departments (EDs). In a single calendar year, some patients had over 100 visits to as many as 30 EDs throughout the state.

To address the high ED utilization, Washington State Medicaid, a part of the Washington Health Care Authority (HCA), introduced a plan in 2011 to limit the number of non-emergency visits to EDs to three visits per year. Deemed the “Three Visit Rule,” Washington State Medicaid would no longer reimburse hospitals and physicians for conditions that were considered potentially treatable in alternative settings. The plan would have reduced ED payments by \$36 million a year in the state, or an average of \$375,000 per ED. The plan would have applied to more than 700 conditions; including not only low-acuity conditions but also potentially emergent conditions such as chest pain, abdominal pain, and seizures.

While that plan was not ultimately implemented, the Washington Governor called for the state’s hospitals and physicians to develop a set of best practices that could be deployed rapidly and adopted statewide in place of the Three Visit Rule.<sup>1</sup> In April 2012, the Washington State American College of Emergency Physicians, the Washington State Medical Association, and the Washington State Hospital Association came together to collaboratively develop a way to better manage ED services and reduce over-utilization without dangerous denials of coverage and care.<sup>3</sup>

The high utilization was driven by a combination of drug seeking behavior, mental health challenges, and a fragmented health care delivery system. Indeed, it was found that 85% of frequent users of EDs had serious mental health issues and approximately 48% had substance abuse problems. Thus, the program targeted high utilizers by addressing their social, mental health, and substance abuse needs instead of just denying coverage.

Implementation of the ER is for Emergencies program began on July 1, 2012. If hospitals failed to comply with the plan, the HCA could reinstate its policy of nonpayment for ED visits determined to be nonemergency.<sup>1</sup> The program has since expanded to actively address all payers and patients with medical co-morbidities resulting in high ED utilization. The program includes seven best practices:<sup>4</sup>

1. Develop and use interoperable health information exchange (HIE) technology
2. Educate all patients about appropriate use of EDs
3. Identify frequent users of the ED and prehospital care
4. Develop patient care plans for frequent users
5. Implement narcotic guidelines to reduce narcotic seeking behaviors by patients
6. Participate in prescription monitoring program
7. Use of feedback information

## II. Care Delivery Redesign

There are 3 main ways to reduce acute care costs: 1) preventing acute health problems and the associated care from happening in the first place; 2) create and expand less costly (and hopefully more convenient) alternatives to ED care so people with acute problems use less expensive hospital-based care; and 3) improve the function of the acute care system itself. In conceptualizing the Washington State approach to acute care services, it is important to understand several elements including care delivery redesign that incorporates all three of the strategies mentioned above, as well as the underlying incentives and information systems that support these services.

**Provide referrals for low-acuity visits.** ED's established systems for referrals for minor conditions that can safely wait to be seen to primary care providers within a 72-hour window. The care managers in the individual facilities have been tasked with arranging follow up in real time for primary care visits for high-utilizers of emergency services.

**Identify frequent users of the ED and EMS and develop care plans.** Case managers in the ED identify high utilizers (many with unmet psychosocial needs) defined as the patients with more than 5 ER visits or transports in the prior year. Frequent users are often part of the Patient Review and Coordination (PRC) effort. Once identified, hospitals receive a client list to identify patients upon arrival. Care plans are created and these patients receive coordinated case management.<sup>5</sup> PRC patients receive an individualized care plan that is integrated into the Emergency Department Information Exchange (EDIE) to help improve consistency of care amongst multiple providers and settings. In addition, case managers follow up with these patients within 72 hours of discharge and help them connect with primary care and outside providers to integrate the care plans to actively manage patients.

**Implement narcotic guidelines to reduce drug-seeking behaviors by patients and participate in prescription drug monitoring.** The Emergency Department Opioid Abuse Work Group sponsored by the Washington State Department of Health developed ED Opioid Prescribing Guidelines.<sup>6</sup> The guidelines include 17 recommendations ranging from not providing replacement prescriptions for controlled substances that were lost, destroyed, or stolen to limiting prescriptions to no more than 30 pills. EDIE also includes an integrated prescription management program that allows providers to track the utilization and standard plans for narcotic and controlled substance administration. Providers have more detailed information, including utilization patterns and a standard state plan for pain management, and clinical pathways for narcotics are included within the workflow.

**Use of feedback information.** The multi-organization supervising group reviews the data provided through EDIE at monthly meetings. Quality metrics, including rate of utilization, are calculated annually, with additional occasional spot checks. When outliers of practice are identified, the responsible organizations are tasked with follow up with those providers. Each hospital also gets monthly metric feedback on their rate as compared to others that has helped drive the group towards the mean via self-regulation. Each hospital has staff responsible for reviewing the reports to ensure the interventions are working and reporting back to executive leadership.

**Educate all patients about appropriate use of EDs.** The ER is for Emergencies program aims to educate patients about appropriate use of emergency services. As part of this aim, EDs distribute information to patients. Brochures are distributed that help patients choose the best place to go for health care.<sup>7</sup> Educational posters are displayed in hospitals that providers could use as a starting point to have a shared conversation with the patient.

### III. Physician Payment and Information System Reforms

**Payments.** In Washington State, there was a clear threat of non-payment to hospitals that led to enhanced efforts to reform ED use. This pressure caused Washington State's EDs and hospitals to organize and ultimately improve care. To implement the seven best practices, providers and hospitals needed to allocate resources, and the hospitals paid in to develop a statewide health information exchange described below. In order to implement the program, a multi-disciplinary, team based approach of providers from different specialties and other clinical and non-clinical support staff such as nurses and social workers was used. The scope of care managers has expanded in many places to help address the combined psychosocial needs of the patient that are not actively being addressed.

**Information Systems.** In order provide EDs with important information about prior care, an interoperable health information exchange was created and supported by hospitals. EDIE allows ED physicians to view limited, ED relevant data about their patients. Information is pushed to ED physicians; it does not require any additional effort to view. EDIE is integrated into the existing electronic health records (EHRs) similarly to any patient note within the EHR system. The EDIE system allows real-time monitoring of emergency service utilization across the state by individual user and aggregate data for payers including the state. EDIE shares visit date, location, and chief complaint of prior patient visits. As of March 2014, 98 hospitals are sharing ED information electronically.<sup>8</sup>

### IV. Costs of Implementation and Results

The ER is for Emergencies program produced some compelling results in the first year of the program, based on a report from the HCA to the legislature. On top of nearly \$34 million of savings in emergency costs in 2013.<sup>8</sup>

- More than 420 primary care providers received notifications when their patients enter the ED.
- Standardized care plans are available via an EDIE in more than 90 emergency rooms across the state so all ED providers have access to care guidelines.
- Rate of ED visits declined by 9.9%
- Rate of visits by frequent clients (5+ visits annually) decreased by 10.7%
- Rate of visits resulting in a scheduled drug prescription decreased by 24.0%
- Rate of visits with a low acuity diagnosis decreased by 14.2%

The State of Washington did not provide any additional funding to hospitals to directly fund implementation of the program. Instead, the hospitals participated in the program because there was not only the promise to improve patient care, but there was the consequence of potentially returning to a less favored reimbursement reduction – the Three Visit Rule – if hospitals did not participate in the ER is for Emergencies Program. Had less than 75% of the hospitals participated, then all hospitals would have been subject to the Three Visit Rule no-payment plan and were at risk for \$32 million a year in lost Medicaid payments (this is less than the \$36 projected during the first year of the plan). Ultimately, 100% of hospitals participated.

However, there are some upfront and ongoing costs required by hospitals to implement elements of the seven best practices. Hospitals were required to pay the \$10,000 to \$20,000 per site in upfront costs to integrate EDIE, along with the annual program cost of \$10,000 to \$15,000 per year. Many hospitals also re-tasked a social worker from elsewhere in their system to become a care manager to high-utilizing ED

patients. Some payers have care managers working out of their offices. However, physician payments have not changed from a per patient basis.

## V. Challenges, Policy Solutions, and Next Steps

Like with many health care innovations, the main challenge for developing and instituting ER is for Emergencies was engaging individuals and organizations that were originally resistant to change. However, the ER is for Emergencies program was a collaborative effort between many sets of stakeholders, including some groups that are not often included in the conversations, like emergency physicians themselves. Therefore, the program was attractive to those affected, and emergency physician buy-in to this program was relatively easy since it requires little additional work and provides them with important information to improve patients' care.

While the threat of returning to the Three Visit Rule provided impetus for all stakeholders to move forward in a constructive way, other payment models that reward providers for care coordination and improving care may be similarly effective. Possible approaches include a per-member, per-month (PMPM) capitated payment or shared savings arrangement tied to resulting cost reductions that can help support ED physicians to provide services not paid for under traditional Medicaid fee-for-service. These payments would need to be tied to quality measures to ensure providers maintain or improve quality of care while reducing unnecessary ED utilization.

The success for the initial year of the program has led to continued growth and the collaborative group continues to look for new ways to improve the care delivery system overall. The private Medicaid Health Maintenance Organization (HMO) contractors are now integrated and leaders of the program are reaching out to the private insurance market to participate. In addition, surrounding states, including Oregon, have joined the program to help develop an even broader network to expand these efforts. Further, the program is working with payers on new patient populations, including patients with chronic disease states that have high costs or high frequency of utilization, such as congestive heart failure. A shared savings or PMPM payment might be utilized here, not only to help encourage programs like ER is for Emergencies, but to enhance efforts to reduce overall costs and improve care that may require additional resources.

### ENDNOTES

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March 21, 2016

Honorable Mark Neuman  
Honorable Steve Thompson  
House Finance Committee  
State Capitol, 5<sup>th</sup> Floor  
Juneau, AK 99801

Dear Representatives Neuman and Thompson:

We thank you in advance for the opportunity to provide written comments to the proposed Senate Bill No. 74 (FIN) ("The Bill"). In our opinion, there are several positive aspects to the proposed legislation. On the other hand, the Bill as proposed, includes several provisions that will result in unintended consequences, severely impacting Alaskans and local businesses.

We have taken the liberty of proposing certain changes to The Bill, in order to mitigate some of these unintended consequences. Please note these comments below:

**Sec. 10, Chapter 58: FALSE CLAIMS, PENALTIES AND LEGAL FEES ISSUE:**

We believe that the addition of penalties, interest, cost, attorneys fees, etc. to Sec. 09.58.010, in any case less than actual "fraud" can result in very significant negative consequences and potential abuse of power on the part of private auditors or the Department.

As you will note, the language in that section refers to "false" claims. This term is not properly defined, and as such it can easily be misinterpreted. In many cases, the concept of "overpayment" due to "false" claims is combined with the concept of "fraud" or "fraudulent claims". However, these two concepts are different from each other and to treat them in like manner gives rise to significant conflict between providers and the Department.

This is especially true, since the private auditors used by the Department to conduct audits will often have perverse incentives, since they are often compensated by the total amount of their own initial finding of liability due to "overpayment". As such, these auditors have all the upside and no downside whatsoever, to throw a variety of potential overpayment claims at providers, just to see what sticks at some future time.

"Overpayment" due to "false" claims is often subject to a wide range of interpretations, where well-meaning people can disagree as to the actual requirements of a single provision in the regulations. Unfortunately, in the past where we have asked the Department for their

interpretation of a particular provision, we have either received no response or the most extreme interpretation possible.

As a result, while the proposed language in the bill related to penalties, interest, attorney fees, etc. may on its face seem innocuous (after all who would disagree that “fraud” should be punishable with penalties), in practice when fraud gets lumped in with “overpayment”, things get very messy. In those cases, if the State has such huge leverage over providers, it completely changes the dynamics of settlement discussions between providers and the Department.

**Proposed change of language in Sec. 10, 09.58.010 (a)(1) through (5):**

*Remove the term “false” from the sections, and limit the penalties to cases of “fraud”.*

**Add subsection (e) to 09.58.010 (f):**

**“If a Provider submits specific questions seeking clarification from The Department regarding the interpretation of a regulation or a requirement, wherein such inquiry can avoid a future claim of “overpayment”, the Department shall provide specific response within 45 days of receipt of such inquiry.”**

**Sec. 17: PHARMACY MANAGED CARE LANGUAGE:** Section 17 proposes to amend AS 47.05 by adding new section 47.05.270 requiring the adoption of regulations to design and implement the medical assistance reform program. The proposed language is intended to maximize the benefit that pharmacy initiatives can add to the program. Again, we full-heartedly support the shift to policies that produce better outcomes, better care, and lower costs. In fact, we want to expand this language to include pharmacy services that have an absolutely irrefutable 10x1 return on ROI, relative to lower hospitalization, lower readmissions and better overall health outcomes. As such, we propose the addition of the following language:

**Proposed added language for 47.05.270(a)(6):**

**“ (a)(6) pharmacy initiatives, *including paid Comprehensive Medication Review, use of pharmacy transitional services by hospitals, and other services with a proven record of reducing hospitalization and readmissions*”.**

**Sec. 18: CONTROLLED SUBSTANCE DATABASE CHECK ISSUE:** Section 18 proposes that AS 17.30.200(k) be amended. We note that Class V drugs were removed. That’s a positive

change. However, for a "Long Term Care" pharmacy which provides high volume of medication to chronically-ill patients who are under the supervision of physicians, the requirement of including all schedule III and IV medication seems excessively burdensome. We propose the following addition, in order to account for "long term care" patients under the care of physicians and a clinical "Long Term Care" pharmacy:

**Proposed added exception (E) to Sec. 18. AS 17.30.200(k)4(E):**

**"by a clinical pharmacy *providing medication reconciliation and other medication review processes, and that dispenses medication in compliance packaging designed to manage access and adherence, except as it relates to* schedule [IA or IIA CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE II] controlled substance under federal law."**

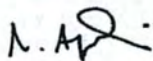
**Sec. 23: COMPETITIVE BID ISSUE:** Section 23 proposed to amend AS 47.05.015 to clarify the department's ability to enter into a competitively bid contract for durable medical equipment. We concur with the clarification, but believe it must be to a company serving Alaskan patients in all aspects of durable medical equipment. If select portions of service are allowed to be removed, with only very low or negative margin services remaining, local providers will be forced to stop providing those services, negatively impacting Alaskans. This is a simple policy issue: There is simply no way that the State can expect Alaskan companies to be left with a few crumbs, while still being able to serve the needs of the residents, while the high volume items are outsourced to an out-of-state provider.

**Proposed added language to 47.05.015(e):**

**"(e) Notwithstanding (c) of this section, the department may enter into a contract *with an Alaska-based Medicaid and Medicare-enrolled provider* through the competitive bidding process under AS 36.30 (State Procurement Code) for medical assistance..."**

Thank you for your attention to these very important matters.

Best regards,



Dan Afrasiabi  
CEO

cc Senator Pete Kelly

Alaska Mental Health Board  
Advisory Board on Alcoholism and Drug Abuse  
431 N. Franklin St. Suite 200  
Juneau, Alaska, 99801



March 21, 2016

Senator Pete Kelly  
Alaska Capitol Room 518  
Juneau, Alaska 99801

Re: SB 74 – Prescription Drug Monitoring Program

Senator Kelly:

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board appreciate your work – and that of the Senate Finance subcommittee on Medicaid Reform – on SB 74. The Boards support SB 74 and look forward to partnering with the Department of Health and Social Services and Legislature in its implementation. The Boards express specific support for the provisions of SB 74 that strengthen the Prescription Drug Monitoring Program in Alaska.

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases designed to monitor prescribing of controlled substances for suspected abuse or diversion of prescription medications. PDMPs give physicians and pharmacists an additional tool to help understand a patient's controlled substance prescription history. PDMPs help identify patients at higher risk of becoming dependent, being subjected to abuse or coercion related to their medications, or engaging in diversion of medications.

Alaska's rising numbers of overdose deaths are a result of a heroin epidemic driven by prescription opioid abuse and dependence. PDMPs are among the most promising state-level interventions available to improve opioid prescribing, inform clinical practice, and protect patients at risk. However, Alaska is ranked among the lowest states for implementation of a PDMP by the Centers for Disease Control and Prevention (*see 2015 Prevention Status Report*).

A PDMP is only useful if health care providers check the system before prescribing and dispensing medications. If significant time passes between dispensing the medication and submission of data to the PDMP, the utility of the system is lost. SB 74 balances the need for timely reporting with the limited resources available to prescribers and pharmacists. It requires that data be updated weekly, bringing Alaska into alignment with the policies of 24 other states (23 states require “real-time” updates within 24 hours, and 4 – currently including Alaska – either have no or much longer report requirements).

Clinical practice guidelines encourage reviewing a PDMP prior to prescribing certain medications to improve prescribing practices and reduce the number of people who misuse, abuse, or overdose from these powerful drugs – while still ensuring that patients have access to safe, effective pain management. The CDC recommends requiring prescribers to check the PDMP before initial prescriptions of opioids and benzodiazepines, and every three months thereafter. SB 74 again balances public health and safety considerations with the day-to-day

needs of health care practices and pharmacies by mandating participation but allowing delegation of authority to appropriate staff. Allowing delegation of authority, combined with the upgrades and efficiencies to the actual PDMP system implemented by the Board of Pharmacy, should minimize the impact of requiring participation in the program to health care providers and pharmacists.

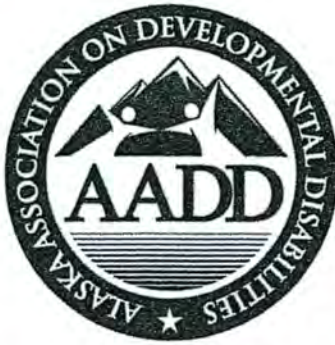
The Boards appreciate that SB 74 balances patients' privacy against the need for an effective public health response to the impact of opioid and heroin addiction on our communities. Concerns that access to this information may lead to increased victimization do not seem to have occurred in other states. PDMPs are subject to the same security requirements as other electronic health information systems. Only licensed and regulated health professionals are included in the expanded access in SB 74 – people we already trust with our health information. While SB 74 gives access to the PDMP to appropriate public health officials, the database is expressly exempted from state public information standards and the records are regularly purged every two years. Use of PDMPs helps states reduce drug trafficking, prevent waste of resources due to “doctor shopping” for narcotics, reduce costs due to substance abuse, and prevent emergency visits due to accidental or intentional overdose and misuse.

The Boards appreciate the careful consideration each and every provision in SB 74 has received, and support the efforts made to balance the state's interest in public health and safety – and costs associated with providing such services – with the rights of patients and the interests of health care professionals.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Kate Burkhart". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

J. Kate Burkhart  
Executive Director



**The Alaska Association on Developmental Disabilities**

P.O.Box 241742  
Anchorage, Alaska 99524-1742

*To facilitate a united provider voice for best practices, advocacy, partnerships and networking.*

March 18, 2016

House Finance Committee and House Representatives  
State Capitol  
Juneau, AK 99801

**SB74 REQUESTED AMENDMENTS**

Dear State House Representatives,

The Alaska Association on Developmental Disabilities (AADD) is the voice of over 30 providers offering developmental disability services through the Home and Community Based waiver system statewide. The members of the association offer services to individuals of all ages, and generally supports of the Medicaid Reform measures designed to improve quality and sustainability of these services.

As medical assistance providers, AADD requests the following amendments to the current version of SB74 regarding the Medicaid False Claims Act:

**1. Self-reporting protections for providers.**

**Sec 3. AS 09.58.010 (b) (p7) to read:**

A beneficiary of an intentional or inadvertent submission of a false or fraudulent claim under the medical assistance program who later discovers the claim is false or fraudulent shall disclose the false or fraudulent claim to the state not later than 60 days after discovering the false claim. **The department of health and social services may not assess interest or penalties on an overpayment self- identified and repaid by a medical assistance provider under this section.**

2. More precise definition of "agent" as used in Sec. 09.58.010(e).

Page 14, Sec. 10, Sec. 09.58.100 Definitions

Add the following definition of "agent"

**"agent with apparent authority" does not include someone acting in violation of the policies or instruction of the principal provider without that provider's knowledge.**

3. Protections from liability from actions of rogue employees.

Page 8, Sec. 10, Sec. 09.58.010(e) to read:

**Sec. 09.58.010 False claims for medical assistance; civil penalty.**

(e) A corporation, partnership, or other individual is liable under this chapter for acts of its agents if the agent acted with apparent authority, regardless of whether the agent acted, in whole or in part, to benefit the principal and regardless of whether the principal adopted or ratified the agent's claims, representations, statement, or other action or conduct, **unless the evidence shows that the agent or apparent agent acted with intent to deceive the principal.**

4. Conceptual amendment for increased auditor qualifications.

Public testimony at Senate hearings suggested that Medicaid provider auditors be required to have some knowledge of the State and Federal Medicaid law necessary to conduct accurate audits.

5. Request for clarification of the meaning of Sec. 09.10.075 re statute of limitations.

Page 6, Sec. 8

**Sec. 09.10.075. Actions related to claims based on medical assistance payment fraud.**

Except as provided in AS 09.58.070, a person may not bring an action under AS 09.58.010 - 09.58.060, unless the action is commenced by the earlier of (1) six years after the act or omission was committed, or (2) three years after the date when facts material to the action were known, or reasonably should have been known, by the attorney general or the Department of Health and Social Services, but in no event more than 10 years after the date the violation under AS 09.58.010 occurred.

Question: Does this mean the both the state and private parties have at most six years to act or that the private parties have six years and the state has at most ten years?

Sincerely,



Michael Bailey  
AADD Vice President



## **Alaska Dental Society, Inc.**

9170 Jewel Lake Road, Suite 203  
Anchorage, Alaska 99502-5390  
(907) 563-3003 • FAX: 563-3009  
akdental@alaska.net

### **House Finance Members**

The Alaska Dental Society (ADS) would like to request committee changes to SB74. In general we feel the bill is a good first step towards addressing deficiencies within the healthcare system but focuses, almost exclusively, on providers while ignoring the other major components of the healthcare system – the payers and the recipients (patients).

We believe the current bill would benefit from the following changes:

The sections detailing changes to AS 09.10 should be balanced to encourage reporting of fraud and protection for those who come forward with protections for providers. Currently, as written, the changes incentivize employees to report fraud. Our concern is there is no penalty for false allegations under this section. An employee could maliciously make a claim under this section against a provider in retaliation for being terminated or a personal relationship that turned negative without consequences. In addition, it is not clear as written, if an employer has recourse if false allegations are made or if the “whistle blower” protections extend to false allegations leaving an employer in the uncomfortable situation of being unable to terminate an employee for filing false allegations.

The changes to AS 47.05 increase the penalties for overpayments under the Medicaid system. The ADS believes the Legislature should recognize, as other states including Louisiana and Nebraska have, that identified overpayments should be balanced with underpayments. Given the large volume of claims administered by providers billing errors will occur. Considering only the overpayments, while ignoring the underpayments, is an injustice to providers. The ADS believes auditors should be equally incentivized to discover overpayments and underpayments and the balance of the underpayments and overpayments used to calculate interest and penalties.

The ADS is generally supportive of the changes to AS 17.30 dealing with the prescription database. We feel some changes would benefit the intent of this legislation, however. We believe the period of exemption from mandatory look up should be extended to 48 hours after surgery. Our hope is with implementation of this legislation there will be an opportunity to change prescribing patterns to less “prophylactic” prescriptions for pain medication post-surgery to a more “as needed” basis. Inevitably with those changes will be more after hour’s calls for pain medication leaving providers in a challenging position to do mandatory lookups. We also feel a missing component to the changes is responsibility on the part of patients. Currently providers have patients fill out detailed medical and drug histories before prescribing narcotics. A mandatory lookup is only necessary if 1. Patients cannot remember they are taking narcotics (a small percentage if it even exists) 2. Patients are lying to seek additional medication.

By criminalizing this behavior – it can be considered fraud by deceit – it provides another weapon in the arsenal to stop this behavior. While we are not suggesting it should be the first weapon used, it would provide a mechanism to identify, educate and if necessary remediate individuals engaged in this behavior.

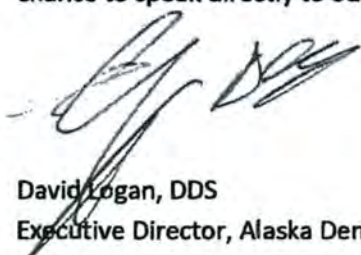
The self-audits proposed under AS 47.05.235 are difficult to evaluate. Most providers have management software to run reports but without details on how the reporting would occur – and past history from the division of utilizing forms and structure not in the industry norm – this could range anywhere from a minor inconvenience to a burden that causes providers to drop from the system.

The ADS believes the sections detailing changes to AS 47.07.030 and AS 47.030.038 would benefit from inclusion of case management including education and , if necessary, removal of benefits for “super utilizers” of controlled substances for medical assistance recipients. The removal of benefits would require approval for a test project but that is being utilized elsewhere in this legislation and should be considered as part of an overhaul of the current Medicaid system and a step towards patient accountability and controlling costs.

The ADS has detailed some small changes above towards increasing patient accountability in health care. We are disappointed, however, no changes to the current payment system administered by the State of Alaska are proposed. The current administrative burden on providers is 2 to 3 times higher for the Medicaid system than private pay systems. The proposed changes in this bill add to that burden without any mitigation.

Our primary concern, however, is the lack of any “reform” to the current system for selecting an administrator for the payment process. The problems with the current administrator, Xerox, have been well detailed. The ADS suggests formation of a review committee to examine, in a non-punitive fashion, the history of how the contract was awarded to Xerox, examine the timelines and benchmarks that were met and not met, and evaluate whether the MMIS system should be maintained and if not how to get out from under it. The findings of the committee should be reviewed by the legislature and turned into binding legislation on the administration for future contracts. The review committee should consist of members of the legislature, HSS departmental personnel and representatives of the 5 largest provider groups by Medicaid billings.

We appreciate your consideration of the proposed changes to SB74 and welcome any questions or a chance to speak directly to our proposals.



David Logan, DDS  
Executive Director, Alaska Dental Society

<b>Date/Time</b>	<b>Topic</b>	<b>Presenter</b>	<b>Organization</b>
<b>Monday, Mar 21</b>	Introduction	Heather Shaduck	Sponsor's Office
		Stacie Kraley	Dept. of Law
<b>Tuesday, Mar 22</b>	Fraud, False Claims, Penalties	(AP) Andrew Peterson	Medicaid Fraud Control Unit
		(DJ) Doug Jones	Health Care Services
		(KR) Stacie Kraley	Dept. of Law
		(KC) Lynne Keilman-Cruz	DHSS (SDS)
<b>Wednesday, Mar 23</b>	Super-utilizers, Emergency Room Management	Anne Zink, M.D.	MatSu ER doc; President, American College of Emergency Physicians Alaska Chapter
		Becky Hultberg	Alaska State Hospital & Nursing Home Assoc.
		Carl Heine, MD	Juneau ER Doc; Past President, American College of Emergency Physicians Alaska Chapter
	Margaret Brodie	DHSS (Update re current Super Utilizers Program)	
<b>Thursday, Mar 24</b>	Managed Care, Accountable Care and Organizations	LeAnn Behrens	President, Medical Health Plan, Texas, Amerigroup
		Sabrina Gibson	Chief Medical Actuary, WellCare Health Plans, Inc.
		Jocelyn Pemberton, MBA, CMPE	E.D. Alaska Hospitalist Group, LLC
		Nancy Merriman	Alaska Primary Care Associates
		Rich Davis	Central Peninsula Hospital
	Thea Agnew Bembem	Agnew Beck	
<b>Monday, Mar 28</b>	Behavioral Health	Charlie Curie	CEO, The Curie Group (AMHTA expert)
		Jeff Jessee	AMHT
		Karen Forrest	DHSS

		Randall Burns	DHSS
		Thea Agnew Bemben	Agnew::Beck
		Kate Burkhardt	ED, Advisory Board on Alcoholism & Drug Abuse
		<del>Tom Chard</del>	<del>ED, Alaska Behavioral Health Associates</del>
<b>Monday, Mar 28</b>	Federal Overview, Waivers, and Options	Jerry Moses	Contact Alaska Native Tribal Health Consortium
		Shane Spotts	Health Management Associates (contractor for 1915 i/k)
		Valerie Davidson	DHSS
		Jon Sherwood	DHSS
		Duane Mayes	DHSS - 1915 i/k
<b>Tuesday, Mar 29</b>	Fiscal Notes	Jon Sherwood	
	Public Testimony	5:00 PM- 7:00 PM	
<b>Wednesday, Mar 30</b>	Telemedicine	Stewart Ferguson	Chief Technology Officer, ANTHC
		Rebecca Madison	Board Member of Northwest Telehealth/ Alaska eHealth Network
		Henry DePhillips	Medical Director, Teledoc
		Wallace Adamson	Strategic Partnership
	Prescription Drug Database	Jay Butler	Chief Medical Officer
		Dr. Erin Narus	State Medical Pharmacist
		Janey Hovington	Boards & Commission
		Carl Heine, MD	Juneau ER Doc; Past President, American College of Emergency Physicians Alaska Chapter
		Brian Howes	Senior Investigator, AK CCED Div of Corp Business

# Alaska State Legislature

SENATOR PETE KELLY

SESSION:  
Alaska State Capitol  
Juneau, AK 99801  
Phone: (907) 465-3709  
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1292 Sadler Way Suite 308  
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## Sponsor Statement – CS Senate Bill 74 (FIN)

CS for Senate Bill 74 begins the process of reform and cost containment needed to slow the growth of the Alaska Medicaid program. Medicaid has grown to over \$1.6 Billion of the annual operating budget as of FY2016 authorized levels, and has accounted for 22% of the total UGF increases over the last ten years. The current and former administrations have testified the Medicaid program, as it stands, is not sustainable. Low oil prices and billions of dollars in revenue shortfalls have forced us to change how we do business. In July 2013, the Medicaid Budget Group of the Department of Health and Social Services reported the total spending on Medicaid services will reach \$6.3 billion in 2032, including \$2.8 billion in state matching funds. If we don't act now to bend the growth curve of Medicaid, many of our most vulnerable Alaskans will be without critical health care services they need.

CSSB 74 takes a measured approach by setting a framework for a medical assistance reform program into statute (Section 28). This program requires the Department of Health and Social Services to expand the use of telehealth, enhances fraud prevention, enforcement, and recovery, undertake additional pharmacy initiatives, reduce the cost of the state's home and community-based services with a new waiver program, provide electronic explanation of benefits to recipients, as well as referrals to a range of community and social supports.

The new reform program will also look at payment redesign (Section 28). Alaska has some of the highest Medicaid rates in the nation and has not employed many of the rate innovations of other states or those of Medicare. These innovations frequently streamline the payment process while eliminating billing and payment irregularities and errors. In addition to Medicare and many insurance carriers, 47 of 50 states employ the Diagnosis Related Group (DRG) Medicaid payment mechanism. With two of the remaining three in stages of implementation by July 2015, payment blueprints exist for us to employ.

The use of telehealth for primary care, urgent care, and behavioral health will also be expanded under CSSB 74 (Sections 1-7, 28, 31) addressing rising healthcare costs and limited patient access. A study by Alaska Native Tribal Health Consortium (ANTHC) found telehealth averted the need for travel significantly. The barrier requirement that physicians must be physically located in the State of Alaska in order to provide diagnosis, treatment, or prescriptions over telehealth is removed (Section 4). All physicians using telehealth must still be licensed by Alaska Medical Board.

As per this bill, the professional boards for Licensed Professional Counselors (Section 1), Martial and Family Therapists (Section 2), Psychologists and Psychological Associate Examiners (Section 6), and Social Work Examiners (Section 7) will now not be able to sanction providers from practicing telehealth. These boards are tasked with establishing a standard of care protocol and patient consent requirements.

Fraud prevention and prosecution is further enhanced throughout CSSB 74. Currently DHSS and the Department of Law have no remedies to address fraud that falls below a criminal act but is above the threshold of a simple overpayment. The Alaska Medical Assistance False Claim and Reporting Act (Section 10) is one new tool to fill that gap. This act, if approved by the Office of Inspector General, will allow the state to keep an enhanced recovery rate of 55% of Medicaid payments instead of the current 50%.

Under this Act, individuals can disclose evidence of fraud to the Attorney General for investigation. Individuals will receive Whistleblower protections as well as a portion of the recoveries if the fraud is proven. Providers are protected in this process by a three year sunset around the private plaintiff provisions to assure frivolous lawsuits remain in check (Section 36). The Attorney General can also dismiss private plaintiff claims found without merit. DHSS will now have the added tool of assessing civil penalties on Medicaid providers that commit fraud (Section 28). Additionally, DHSS will be able to ask the Court for a probable cause remedy to seize certain real or personal property of a fraudulent Medicaid provider (Section 28). The legislature would now receive an annual report relating to Medicaid fraud, abuse, errors, and vulnerabilities from DHSS and the attorney general (Section 32).

The legislation provides for an enhanced computerized eligibility verification system that will operate in conjunction with, but separate from, the AIRES eligibility system (Section 24). These systems will scan records and databases across the nation and ensure only eligible Alaskans receive benefits. The annualized savings from the use of the system must exceed the cost for implementation.

CSSB 74 directs DHSS to partner with third-party entities on projects that will direct individuals to the right care, in the right place at the right time, while also testing out innovation payment models on a wider scale (Section 31). DHSS and a statewide hospital organization will design and implement a demonstration project to reduce non-urgent use of emergency departments by Medicaid recipients. DHSS will also contract with third parties to implement coordinated care projects. This process will bring forward the best proposals for Alaska from groups such as managed care organizations, accountable care organizations, and provider-led entities. These projects are meant to be sustainable to achieve consistent results across regions while assigning individuals to primary care providers and coordinating benefits. New payment models will be a part of these projects, which can include global payments, bundled payments, capitated payments, and shared savings and risk. A third-party actuary will be utilized to review projects and recommend implementation on an expanded regional or statewide basis. Coordinated care Medicaid programs are a proven tool to provide better health care for recipients and a higher functioning system in many other states.

Over the last twenty years, the use of prescription opioid pain reliever use has increased dramatically along with overdose deaths and addiction. In 2015, 54 Alaskans died from prescription opioid drug overdose and 33 individuals died from heroin. Opioids have become a gateway drug for heroin, and both have become epidemics for our state. Opioids need to be monitored to ensure they are used in safe and appropriate manner to control pain and reduce doctor shopping. The Prescription Drug Monitoring Program or the PDMP is the state's tool to monitor these drugs. CSSB 74 incorporates recommendations from the Controlled Substances Advisory Committee (CSAC) that were made in January 2016 (Sections 13 – 19). The PDMP will now be mandatory for prescribers and pharmacists to register and check a patient's prescription records before dispensing, prescribing, or administering a controlled substance that is a Federal Schedule II, III, or IV drug. Licensed practitioners and pharmacists can now delegate access to a supervised employee or clinical staff streamlining use of the database (Section 15). There are also carve outs for checking the PDMP in an inpatient setting, emergent situations, in and emergency room, or before, during, or within the first 24 hours of surgery (Section 18).

For years, the legislature has heard how fragmented our behavioral health system of care has become through piecemeal change creating silos and requirements restricting access to care. These barriers are reduced through the Medicaid reform program (Section 28) which requires DHSS in coordination with the Alaska Mental Health Trust Authority to efficiently manage a comprehensive and integrated behavioral health system with evidence based, data driven practices and measurable outcomes. Grantee status requirements for outpatient community mental health clinics and drug and alcohol treatment centers are removed (Sections 33 & 34). Not only will this increase the number of providers available to provide behavioral health services, but it brings the state into compliance with federal policies by the Centers for Medicaid and Medicare (CMS).

CSSB 74 begins the process to explore privatization (Section 40). The department is directed to conduct feasibility studies at Alaska Psychiatric Institute, Alaska Pioneer Homes, and select facilities of the Division of Juvenile Justice (DJJ). There are various options for privatization the department can explore through the studies that would result in the best options for Alaskan consumers while ensuring state dollars are stretched as far as possible. Some options include turning over DJJ facilities to local tribal organizations in order to create a residential psychiatric treatment center; turning an entirely GF program into a tribal run Medicaid reimbursable program providing culturally relevant services. The Department of Administration is directed to conduct a feasibility study for creating a health care authority to coordinate health care plans and consolidate purchasing effectiveness for health care paid directly or indirectly by the State, including Medicaid.

The call to reform Medicaid is not new. In the fall of 2010 the Medicaid Task force convened and developed a report for the Governor in May 2011. The Medicaid Reform Advisory Group was created in December 2013, and worked up until the transition to the new administration. While several of the reform measures of these groups were implemented and helped to contain costs, we must build on their efforts and go even further. CSSB 74 gives the legislature the ability to fundamentally review how the state is doing business in the Medicaid program. In these serious budget times, reform cannot wait.

ALASKA STATE LEGISLATURE  
SENATE FINANCE COMMITTEE

Senator Anna MacKinnon, Co-Chair  
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CS for SENATE BILL 74(FIN) (*Version U.A*)  
SECTIONAL ANALYSIS

**Section 1** (*page 2-3*) ***Telehealth for Licensed Professional Counselors***

**AS 08.29.400**

Amends by prohibiting the Board of Licensed Professional Counselors from imposing disciplinary sanctions on a licensee for using telehealth technologies in the evaluation, diagnosis or treatment of a person when physically separated from the person if the licensee or another licensed health care provider is available to provide follow-up care, the licensee follows patient consent protocols for sending medical records of the encounter to the person's primary care provider, the licensee meets the requirements established by the board in regulation; and, requiring the board to adopt regulations on telehealth services establishing standards of care, training, confidentiality, supervision, practice, and related issues.

**Section 2** (*page 3*) ***Telehealth for Marital and Family Therapists***

**AS 08.63.210**

Amends by prohibiting the Board of Marital and Family Therapy from imposing disciplinary sanctions on a licensee for using telehealth technologies in the evaluation, diagnosis or treatment of a person when physically separated from the person if the licensee or another licensed health care provider is available to provide follow-up care, and the licensee follows patient consent protocols for sending medical records of the encounter to the person's primary care provider, the licensee meets the requirements established by the board in regulation; and, requiring the board to adopt regulations on telehealth services establishing standards of care, training, confidentiality, supervision, practice, and related issues.

**Section 3** (*page 3-4*) ***Telehealth for Physicians***

**AS 08.64.101**

Amends by adding to the duties of the State Medical Board a requirement to adopt regulations establishing guidelines for a physician who renders a diagnosis, provides treatment, or prescribes, dispenses, or administers a prescription drug to a person without conducting an in-person physical examination as allowed under AS 08.64.364; and, provides that the guidelines must include a nationally recognized model policy for standards of care of a patient who is at a different location than the physician.

**Section 4** (page 4) *Telehealth for Physicians*

**AS 08.64.364(a)**

Amends by prohibiting the State Medical Board from imposing disciplinary sanctions on a physician for rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug that is not a controlled substance without an in-person physical examination if the physician or another licensed health care provider, or physician in the physician's group practice is available for follow-up care, and the physician follows patient consent protocols for sending medical records of the encounter to the person's primary care provider; and removes the requirement that the physician is located in the state.

**Section 5** (page 4-5) *Telehealth for Physicians*

**AS 08.64.364**

Amends by prohibiting the State Medical Board from imposing disciplinary sanctions on a physician for prescribing, dispensing, or administering a prescription drug that is a controlled substance or botulinum toxin if the requirements of Section 4 are met, and the physician prescribes, dispenses, or administers the controlled substance when an appropriate licensed health care provider is present with the patient to assist the physician with examination, diagnosis, and treatment; and providing that a physician may not prescribe an abortion-inducing drug unless the physician complies with AS 18.16.010; or prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the physician does not have a prior physician-patient relationship.

**Section 6** (page 5) *Telehealth for Psychologists & Psychological Associate Examiners*

**AS 08.64.204**

Amends by prohibiting the Board of Psychologist and Psychological Associate Examiners from imposing disciplinary sanctions on a licensee for using telehealth technologies in the evaluation, diagnosis or treatment of a person when physically separated from the person if the licensee or another licensed health care provider is available to provide follow-up care, and the licensee follows patient consent protocols for sending medical records of the encounter to the person's primary care provider, the licensee meets the requirements established by the board in regulation; and, requiring the board to adopt regulations on telehealth services establishing standards of care, training, confidentiality, supervision, practice, and related issues.

**Section 7** (page 5-6) *Telehealth for Social Workers*

**AS 08.95.050**

Amends by prohibiting the Board of Social Work Examiners from imposing disciplinary sanctions on a licensee for using telehealth technologies in the evaluation, diagnosis or treatment of a person when physically separated from the person if the licensee or another licensed health care provider is available to provide follow-up care, and the licensee follows patient consent protocols for sending medical records of the encounter to the person's primary care provider, the licensee meets the requirements established by the board in regulation; and, requiring the board to adopt regulations on telehealth services establishing standards of care, training, confidentiality, supervision, practice, and related issues.

**Section 8** (page 6)

**AS 09.10.075. Actions related to claims based on medical assistance payment fraud.**

Adopts a new section which establishes time limits in which a person may or may not bring an action under new sections AS 09.58.010-09.58.950, the Alaska Medicaid False Claims Act, and a statute of limitations. An action may be brought within six years of when the act or omission was committed, or three years after the date when the act or omission was known or reasonably should have been known by the attorney general and department, but no action may be brought for a violation more than ten years after the date of violation.

**Section 9** (page 6)

**AS 09.10.120(a).**

Amends to include reference to new subsection AS 09.10.075, creating an exception for Medicaid fraud action time limits.

**Section 10** (page 6-15)

**Chapter 58. Alaska Medical Assistance False Claim and Reporting Act**

Establishes the Alaska Medicaid False Claims Act. This language is to comply with Office of Inspector General guidelines for false claims act certification. This allows the state to increase its match on recoveries by five percent for a (45/55 split in favor of the state).

**AS 09.58.010. False claims for medical assistance; civil penalty.**

This is a general provision which identifies the five types of claims that would give rise to a false claim under this section (*for full list see page 7, lines 1-15*). 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.

**AS 09.58.020. Private plaintiff; civil action.**

Provides that a private citizen (relator) can bring a Medicaid False Claims Act case. If a relator brings an action, they must serve the attorney general's office and disclose the evidence upon which the complaint is filed. The relator's action is filed under seal for at least sixty days to allow the attorney general's office to investigate the claim. The attorney general can get an extension of time if the sixty days is not sufficient. After investigation, the attorney general must do one of the following:

- (1) Intervene in the matter and take control of the action;
  - (2) Notify the court that it will not be intervening, but allow the relator to proceed;
- or
- (3) Dismiss the action if the evidence does not support a false claim.

**AS 09.58.025. Subpoenas.**

Gives the attorney general the authority to issue subpoenas to assist in its investigation of a false claim.

**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.

**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.

**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.

**AS 09.58.070. Employee protection for retaliation.**

Provides whistleblower protection for employees who report false claims to the State.

**AS 09.58.080. Regulations.**

Provides authority for the attorney general to adopt regulations to implement this new cause of action.

**AS 09.58.090. Special provision.**

Requires a minimum threshold in fraud damage to the state in the amount of \$5500.

**AS 09.58.100. Definitions**

**AS 09.58.110. Short title.**

**Section 11** (page 15)

**AS 09.58.25 Subpoenas.**

Gives the attorney general the authority to issue subpoenas to assist in its investigation of a false claim after the provisions related to private plaintiffs (AS.09.58.020) sunset per section 36 of this bill. The effective date of this section is July 1, 2019 to coincide with the sunset as provided by section 51 of this bill.

**Section 12** (page 15)

**AS 09.58.070(b)**

Allows the Whistleblower protections under Sec. 09.58.070 of the Alaska Medical Assistance False Claim and Reporting Act to continue and conforms to the sunset added by Section 36 of this bill by removing the provisions AS. 09.58.020 that refers to private plaintiffs. The effective date of this section is July 1, 2019 to coincide with the sunset as provided by section 51 of this bill.

**Section 13** (page 15) *Prescription Drug Monitoring Program (PDMP)*

**AS 17.30.200(a)**

Amends by only requiring data collection for prescribing, administering or dispensing II, III, and IV federal controlled substances for the controlled substance prescription database.

**Section 14** (page 16) *Prescription Drug Monitoring Program (PDMP)*

**AS 17.30.200(b)**

Amends by only requiring data collection for prescribing, administering or dispensing II, III, and IV federal controlled substances for the controlled substance prescription database and amends by requiring that the database be updated on at least a weekly basis.

**Section 15** (page 16-18) *Prescription Drug Monitoring Program (PDMP)*

**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 database access to the State of Alaska Medicaid Pharmacy Program;

(8) Adds a new section to authorize database access to the State of Alaska Medicaid Drug Utilization Review Committee for utilization review of prescription drugs provided to recipients of medical assistance;

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

(10) Adds a new section to authorize de-identified 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.

**Section 16** (page 18) *Prescription Drug Monitoring Program (PDMP)*

**AS 17.30.200(e)**

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

**Section 17** (page 18) *Prescription Drug Monitoring Program (PDMP)*

**AS 17.30.200(h)**

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

**Section 18** (page 19) *Prescription Drug Monitoring Program (PDMP)*

**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 controlled substance prescription database when prescribing, administering or dispensing a federal II, III or IV controlled substance to a patient and allows for an exemption for inpatient, emergent situations, in an emergency room, and immediately before, during, or within the first 24 hours of surgery.

**Section 19** (page 19-20) *Prescription Drug Monitoring Program (PDMP)*

**AS 17.30.200**

Adding new subsections to

- (o) Require prescribers and pharmacists to review the PDMP database when prescribing or dispensing a federal II, III or IV 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 update the PDMP database on at least a weekly basis.

**Section 20** (page 20) *Program Receipts*

**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.

**Section 21** (page 20) *Medicaid False Claims proceedings not Public Records*

**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.

**Section 22** (page 20)

**AS 44.33.381. Telemedicine business registry.**

Amends by adding a new section establishing within the Department of Commerce, Community, and Economic Development a telemedicine business registry of businesses performing telemedicine services in the state.

**Section 23** (page 20) *Competitive Bidding for Durable Medical Equipment*

**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 that can be delivered on a statewide basis.

**Section 24** (page 21)

**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.

**Section 25** (page 21-22) *Audits*

**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.

**Section 26** (page 22-23) *Interest and Penalties on Overpayments*

**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.

**Section 27** (page 23)

**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 a bi-annual review or audit of a statistically valid sample of claims, unless the provider is being audited under AS 47.05.200(a), 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.

**Section 28** (page 23-28)

**AS 47.05.250. Civil penalties.**

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.

**AS 47.05.270. Medical assistance reform program.**

**AS 47.05.270 (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 telehealth for primary care, behavioral health and urgent care;
- 4) Enhancing fraud prevention, detection, and enforcement;
- 5) Reducing the cost of behavioral health, senior, and disabilities services provided to Medicaid recipients 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, readmissions, and outcome failures, bundled payments, or global payments;
- 9) Stakeholder involvement in setting annual targets for quality and cost-effectiveness; and

- 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 supported by evidence-based practices that encourage wellness and disease prevention.

**AS 47.05.270 (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 housing, employment and criminal justice issues.

**AS 47.05.270 (c):** Has the department identify the areas of the state where improvements in access to telehealth 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 telehealth facilities and equipment.

**AS 47.05.270 (d):** Requires the department to prepare and submit a report to the legislature regarding reforms, savings and costs related to the Medicaid program on or before November 15 of each year.

**AS 47.05.270 (e):** Provides a definition for telehealth.

**Section 29** (page 28-29) *Primary Care Case Management*

**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' appropriate use of primary and preventive care, while decreasing the use of specialty care and hospital emergency department services. An exemption applies to recipients with chronic, acute, or terminal medical conditions.

**Section 30** (page 29-30) *Waivers*

**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 areas. The demonstration project may include managed care organizations, community care organizations, patient-centered medical homes, or other innovative payment models. This section also requires DHSS to apply for an 1115 waiver for a demonstration project focused on improving the state's behavioral health system.

**Section 31** (page 30-34)

**AS 47.07.038. Collaborative, hospital-based project to reduce use of emergency department services.**

Requires the department to partner with 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. Coordinated care demonstration projects**

**AS 47.07.039 (a)**

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 consideration must include three or more of the following:

- (1) Comprehensive primary-care-based management, including behavioral health services and coordination of long-term services and support;
- (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, services, and utilization management;
- (8) Local accountability for health and resource allocation.

**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 Commissioner of DHSS or their designee;
- 2) The Commissioner of Administration or their designee;
- 3) The CEO of the Alaska Mental Health Trust Authority or their designee;
- 4) Two representatives of stakeholder groups, appointed by the Governor for staggered three-year terms;
- 5) A Non-voting member of the Senate appointed by the Senate President; and
- 6) A Non-voting member of the House of Representatives appointed by the Speaker of the House of Representatives.

**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. Allows for fee structures including but not limited to global payments, bundled payments, capitated payments, and shared savings and risk. Requires DHSS to work with the division of insurance, DCCED to streamline the application process for a company to obtain a certificate of authority as needed to participate in a demonstration project.

***AS 47.07.039(d)***

Requires any project under (a) to include cost-saving measures including the expanded use of telehealth 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 actuary shall submit a final report to the DHSS for any project that has been in operation for at least one year.

***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 November 15, 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 telehealth in AS 47.05.270(e)

**Section 32** *(page 34-35)*

**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.

**Section 33** *(page 35) Removal of Grantee Requirement*

**47.07.900(4)**

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

**Section 34** *(page 35) Removal of Grantee Requirement*

**AS 47.07.900(17)**

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

**Section 35** *(page 35) Alaska Pioneer Home Payment Assistance*

**AS 47.55.020(e)**

Amends by requiring individuals applying for Pioneer Home payment assistance to show proof of having applied to Medicaid.

**Section 36** (page 35) ***Sunset on Private Plaintiff Provisions***

Repeals AS 09.58.020 (Private plaintiff; civil action), AS 09.58.030 (rights in false or fraudulent claims), AS 09.58.040 (award to false or fraudulent claim plaintiff), AS 58.050 (certain actions barred), and AS 09.58.060 (state not liable for attorney fees, costs, and other expenses) effective July 1, 2019

**Section 37** (page 35-37)

**Uncodified: Indirect Court Rule Amendments.**

Adds a new section to outline court rule amendments as a result of the enactment of section 10 and repealed by section 36.

**Section 38** (page 37)

**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.

**Section 39** (page 37-38)

**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.

**Section 40** (page 38-39)

**Uncodified: Feasibility Studies for the Provision of Specified State Services.**

(a) Requires DHSS to conduct a study analyzing the feasibility of privatizing the Alaska Pioneers' Homes and select facilities of the division of juvenile justice.

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

(c) Requires the Department of Administration to conduct a study analyzing the feasibility of creating a health care Authority to coordinate health care plans and consolidate purchasing effectiveness for all state employees, retired state employees, retired teachers, Medicaid Assistance recipients, University of Alaska employees, employees of state corporations, and school district employees.

(d) Provides a definition for "school district"

**Section 41** (page 39)

**Uncodified: Medicaid State Plan; Waivers; Instructions; Notice to Revisor of Statutes.**

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

**Section 42** (page 39-40)

**Uncodified: Transitions: Regulations.**

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

**Section 43** (page 40)

**Uncodified: Conditional effect.**

Conditional effects.

Provides that AS 09.58.020, AS 09.58.030, AS 09.58.40, AS 47.505.260 are effective conditional on Section 37, the indirect court rule change, receiving a two-thirds majority vote. The new sections do not take effect unless the bill receive the necessary two-thirds vote.

**Section 44-47** (page 41)

**Effective Dates**

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

**Section 48** (page 41)

**Effective Dates**

Provides an immediate effective date for Sections 40, 41, 42(a), and 43.

**Section 49** (page 41)

**Effective Dates**

Provides for a July 1, 2017 effective date for Sections 13-19 relating to the Prescription Drug Monitoring Program (PDMP).

**Section 50** (page 41)

**Effective Dates**

Provides an effective date of July 1, 2016 for Section 42(b).

**Section 51** (page 41)

**Effective Dates**

Provides a delayed effective date of July 1, 2019 for Sections 11 and 12 to conform with the sunset provisions in Section 36.

(1395B)

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ALASKA STATE LEGISLATURE  
HOUSE FINANCE COMMITTEE

State Capitol, Room 519

Rep. Mark Neuman, Co-Chair

Rep. Steve Thompson, Co-Chair

Monday, March 21, 2016

1:30 PM

SB 74-MEDICAID REFORM;TELEMEDICINE;DRUG DATABASE

Sen. Kelly - Heather Shadduck, Staff

16 Fiscal Notes See Fiscal Note Sheet

PK

Testifying in Person:

Heather Shadduck, Staff, Sen. Kelly

Stacie Kraly, Attorney VI, Civil IDivision, Department of Law

AS

KR

Available for Question from Department of Health and Social Services  
in Person:

Valerie Davidson, Commissioner, Department of Health and Social  
Services

Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy

Karen Forrest, Deputy Commissioner,

Sean O'Brien, Director, Division of Public Assistance

VD

JS

Available for Question from Department of Health and Social Services via  
teleconference:

Dr. Jay Butler, Chief Medical Officer

Randall Burns, Director, Division of Behavioral Health)

Duane Mayes, Director, Division of Senior and Disabilities Services

Margaret Brodie, Director, Division of Health Care Services

Jared Kosin, Director, Office Rate Review



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### **House Finance Members**

The Alaska Dental Society (ADS) would like to request committee changes to SB74. In general we feel the bill is a good first step towards addressing deficiencies within the healthcare system but focuses, almost exclusively, on providers while ignoring the other major components of the healthcare system – the payers and the recipients (patients).

We believe the current bill would benefit from the following changes:

The sections detailing changes to AS 09.10 should be balanced to encourage reporting of fraud and protection for those who come forward with protections for providers. Currently, as written, the changes incentivize employees to report fraud. Our concern is there is no penalty for false allegations under this section. An employee could maliciously make a claim under this section against a provider in retaliation for being terminated or a personal relationship that turned negative without consequences. In addition, it is not clear as written, if an employer has recourse if false allegations are made or if the "whistle blower" protections extend to false allegations leaving an employer in the uncomfortable situation of being unable to terminate an employee for filing false allegations.

The changes to AS 47.05 increase the penalties for overpayments under the Medicaid system. The ADS believes the Legislature should recognize, as other states including Louisiana and Nebraska have, that identified overpayments should be balanced with underpayments. Given the large volume of claims administered by providers billing errors will occur. Considering only the overpayments, while ignoring the underpayments, is an injustice to providers. The ADS believes auditors should be equally incentivized to discover overpayments and underpayments and the balance of the underpayments and overpayments used to calculate interest and penalties.

The ADS is generally supportive of the changes to AS 17.30 dealing with the prescription database. We feel some changes would benefit the intent of this legislation, however. We believe the period of exemption from mandatory look up should be extended to 48 hours after surgery. Our hope is with implementation of this legislation there will be an opportunity to change prescribing patterns to less "prophylactic" prescriptions for pain medication post-surgery to a more "as needed" basis. Inevitably with those changes will be more after hour's calls for pain medication leaving providers in a challenging position to do mandatory lookups. We also feel a missing component to the changes is responsibility on the part of patients. Currently providers have patients fill out detailed medical and drug histories before prescribing narcotics. A mandatory lookup is only necessary if 1. Patients cannot remember they are taking narcotics (a small percentage if it even exists) 2. Patients are lying to seek additional medication.

By criminalizing this behavior – it can be considered fraud by deceit – it provides another weapon in the arsenal to stop this behavior. While we are not suggesting it should be the first weapon used, it would provide a mechanism to identify, educate and if necessary remediate individuals engaged in this behavior.


The self-audits proposed under AS 47.05.235 are difficult to evaluate. Most providers have management software to run reports but without details on how the reporting would occur – and past history from the division of utilizing forms and structure not in the industry norm – this could range anywhere from a minor inconvenience to a burden that causes providers to drop from the system.

The ADS believes the sections detailing changes to AS 47.07.030 and AS 47.030.038 would benefit from inclusion of case management including education and , if necessary, removal of benefits for “super utilizers” of controlled substances for medical assistance recipients. The removal of benefits would require approval for a test project but that is being utilized elsewhere in this legislation and should be considered as part of an overhaul of the current Medicaid system and a step towards patient accountability and controlling costs.

The ADS has detailed some small changes above towards increasing patient accountability in health care. We are disappointed, however, no changes to the current payment system administered by the State of Alaska are proposed. The current administrative burden on providers is 2 to 3 times higher for the Medicaid system than private pay systems. The proposed changes in this bill add to that burden without any mitigation.

Our primary concern, however, is the lack of any “reform” to the current system for selecting an administrator for the payment process. The problems with the current administer, Xerox, have been well detailed. The ADS suggests formation of a review committee to examine, in a non-punitive fashion, the history of how the contract was awarded to Xerox, examine the timelines and benchmarks that were met and not met, and evaluate whether the MMIS system should be maintained and if not how to get out from under it. The findings of the committee should be reviewed by the legislature and turned into binding legislation on the administration for future contracts. The review committee should consist of members of the legislature, HSS departmental personnel and representatives of the 5 largest provider groups by Medicaid billings.

We appreciate your consideration of the proposed changes to SB74 and welcome any questions or a chance to speak directly to our proposals.



David Logan, DDS  
Executive Director, Alaska Dental Society

**FY2015 Medicaid Optional and Mandatory Services Claim Activity**

Medicaid Services, excluding Waivers and CAMA								
MMIS Category of Service	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments <sup>(1)</sup>	Recipients <sup>(2)</sup>	Cost per Client	Mandatory / Optional	Net Claim Payments <sup>(1)</sup>	Recipients <sup>(2)</sup>	Cost per Client
ADVANCED NURSE PRACTITIONER	M	\$ 6,867,854	17,892	\$ 384	M	\$ 5,422,405	19,673	\$ 276
EPSDT SCREENING	M	\$ 12,151	68	\$ -	M	\$ 13,076,051	22,152	\$ 590
FAMILY PLANNING SERVICES	M	\$ 2,421,479	4,515	\$ 536	M	\$ 816,403	2,016	\$ 405
FQHC	M	\$ 5,310,908	6,555	\$ 810	M	\$ 2,309,820	3,712	\$ 622
HOME HEALTH SERVICES	M	\$ 1,261,254	324	\$ 3,893	M	\$ 23,549	15	\$ 1,570
ICF SERVICES	M	\$ 91,701,381	728	\$ 125,963	M	\$ 146,569	2	\$ 73,285
INPATIENT HOSPITAL SERVICES	M	\$ 91,102,019	9,416	\$ 9,675	M	\$ 87,918,582	7,220	\$ 12,177
LABORATORY SERVICES	M	\$ 3,002,059	14,280	\$ 210	M	\$ 470,097	5,292	\$ 89
MIDWIFERY SERVICES	M	\$ 3,250,549	3,971	\$ 819	M	\$ 635,312	1,282	\$ 496
OUTPATIENT HOSPITAL SERVICES	M	\$ 85,647,494	37,325	\$ 2,295	M	\$ 54,209,154	38,088	\$ 1,423
OUTPATIENT SURGERY SERVICE	M	\$ 3,014,335	2,288	\$ 1,317	M	\$ 2,067,553	1,807	\$ 1,144
PHYSICIAN IHS CLINIC	M	\$ 26,455,129	11,714	\$ 2,258	M	\$ 24,503,359	18,270	\$ 1,341
PHYSICIAN SERVICES	M	\$ 82,010,903	48,015	\$ 1,708	M	\$ 46,867,077	60,489	\$ 775
RURAL HEALTH SERVICES	M	\$ -	-	\$ -	M	\$ 16	1	\$ 16
SHORT TERM LTC SERVICES	M	\$ 2,304,625	106	\$ 21,742	M	\$ -	-	\$ -
SNF SERVICES	M	\$ 43,031,529	863	\$ 49,863	M	\$ 60,984	2	\$ 30,492
TRANSPORTATION SERVICES <sup>(4)</sup>	M	\$ 31,867,639	16,741	\$ 1,904	M	\$ 35,843,961	15,574	\$ 2,302
X-RAY SERVICES	M	\$ 19,186	81	\$ 237	M	\$ -	-	\$ -
ACCOMMODATION SERVICES <sup>(4)</sup>	M	\$ 6,718,608	6,945	\$ 967	M	\$ 5,010,588	8,097	\$ 619
CARE COORDINATION	O	\$ -	-	\$ -	M	\$ -	-	\$ -
CASE MANGEMENT SERVICES	O	\$ 85,438	102	\$ 838	M	\$ 1,915,063	1,475	\$ 1,298
CHIROPRACTIC SERVICES	O	\$ 139,809	727	\$ 192	M	\$ 277,275	1,043	\$ 266
DENTAL SERVICES	O	\$ 29,241,160	22,669	\$ 1,290	M	\$ 48,806,714	44,743	\$ 1,091
DME SERVICES	O	\$ 5,546,752	7,383	\$ 751	M	\$ 1,808,311	3,521	\$ 514
DRUG ABUSE CENTER	O	\$ 5,386,390	584	\$ 9,223	M	\$ 3,340,085	217	\$ 15,392
ESRD SERVICES	O	\$ 7,419,790	312	\$ 23,781	M	\$ 24,897	3	\$ 8,299
HEARING SERVICES	O	\$ 1,965,037	1,582	\$ 1,242	M	\$ 526,088	1,123	\$ 468
HOSPICE CARE	O	\$ 685,851	89	\$ 7,706	M	\$ -	-	\$ -
ICF/DD SERVICES	O	\$ 1,565,102	9	\$ 173,900	M	\$ 1,142,373	9	\$ 126,930
INPATIENT PSYCHIATRIC SERVICES	O	\$ 268,146	95	\$ 2,823	M	\$ 46,825,935	1,066	\$ 43,927
MEDICAL SUPPLIES SERVICES	O	\$ 7,778,640	8,108	\$ 959	M	\$ 5,157,236	5,774	\$ 893
MENTAL HEALTH SERVICES	O	\$ 35,740,465	6,407	\$ 5,578	M	\$ 84,395,149	7,078	\$ 11,924
NUTRITION SERVICES	O	\$ 29,638	516	\$ 57	M	\$ -	-	\$ -
NUTRITION SERVICES UNDER 21	O	\$ -	-	\$ -	M	\$ 73,791	1,848	\$ 40
OCCUPATIONAL THERAPY	O	\$ 260,150	279	\$ 932	M	\$ 5,623,007	1,591	\$ 3,534
PERSONAL CARE SERVICES	O	\$ 86,644,531	4,632	\$ 18,706	M	\$ 2,308,065	110	\$ 20,982
PODIATRY	O	\$ 155,738	1,297	\$ 120	M	\$ 169,176	358	\$ 473
PRESCRIBED DRUGS	O	\$ 48,191,765	32,684	\$ 1,474	M	\$ 22,575,667	43,385	\$ 520
PRIVATE DUTY NURSING	O	\$ -	-	\$ -	M	\$ 6,492,768	40	\$ 162,319
PROSTHETICS AND ORTHOTICS	O	\$ 718,679	605	\$ 1,188	M	\$ 559,564	503	\$ 1,112
PSYCHOLOGY SERVICES	O	\$ 540,214	526	\$ 1,027	M	\$ 2,483,611	1,314	\$ 1,890
REHABILITATIVE SERVICES	O	\$ 3,080,370	3,053	\$ 1,009	M	\$ 21,114,796	5,193	\$ 4,066
RESIDENTIAL HABILITATION	O	\$ -	-	\$ -	M	\$ -	-	\$ -
RESPIRE CARE	O	\$ -	-	\$ -	M	\$ -	-	\$ -
VISION SERVICES	O	\$ 3,527,389	16,158	\$ 218	M	\$ 3,841,775	16,075	\$ 239
<b>Mandatory Services <sup>(3)</sup></b>	<b>M</b>	<b>\$ 485,999,100</b>	<b>56,159</b>	<b>\$ 8,654</b>	<b>M</b>	<b>\$ 538,842,828</b>	<b>77,684</b>	<b>\$ 6,936</b>
<b>Optional Services (excluding waivers) <sup>(3)</sup></b>	<b>O</b>	<b>\$ 238,971,053</b>	<b>49,996</b>	<b>\$ 4,780</b>	<b>O</b>			<b>\$ -</b>
<b>ALL Non-Waivers Services <sup>(3)</sup></b>	<b>M + O</b>	<b>\$ 724,970,153</b>	<b>60,862</b>	<b>\$ 11,912</b>	<b>M + O</b>	<b>\$ 538,842,828</b>	<b>77,684</b>	<b>\$ 6,936</b>

Wavier services, notes, and sources are on the following page.

## FY2015 Medicaid Optional and Mandatory Services Claim Activity

MMIS Category of Service	Medicaid Waiver Services Only							
	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments <sup>(1)</sup>	Recipients <sup>(2)</sup>	Cost per Client	Mandatory / Optional	Net Claim Payments <sup>(1)</sup>	Recipients <sup>(2)</sup>	Cost per Client
ADULT DAY CARE	O	\$ 4,958,681	440	\$ 11,270	O	\$ -	-	\$ -
CARE COORDINATION	O	\$ 10,875,331	4,194	\$ 2,593	O	\$ 2,509,001	1,431	\$ 1,753
CHORE SERVICES	O	\$ 3,688,233	526	\$ 7,012	O	\$ 7,659	4	\$ 1,915
DAY HABILITATION	O	\$ 35,722,664	1,311	\$ 27,248	O	\$ 10,607,583	658	\$ 16,121
ENVIRONMENTAL MODIFICATIONS	O	\$ 1,023,996	151	\$ 6,781	O	\$ 169,031	23	\$ 7,349
INTENSIVE ACTIVE TREATMENT/THERAPY	O	\$ 626,856	119	\$ 5,268	O	\$ 1,353,099	283	\$ 4,781
MEALS	O	\$ 3,715,771	694	\$ 5,354	O	\$ -	-	\$ -
PROFESSIONAL CI	O	\$ -	-	\$ -	O	\$ -	-	\$ -
RESIDENTIAL HABILITATION	O	\$ 101,592,550	1,252	\$ 81,144	O	\$ 17,672,646	566	\$ 31,224
RESIDENTIAL SUPPORTED LIVING	O	\$ 48,058,026	1,171	\$ 41,040	O	\$ -	-	\$ -
RESPIRE CARE	O	\$ 11,391,792	1,372	\$ 8,303	O	\$ 3,201,045	518	\$ 6,180
SPECIALIZED EQUIPMENT AND SUPPLIES	O	\$ 523,021	812	\$ 644	O	\$ 28,459	15	\$ 1,897
SPECIALIZED PRIVATE DUTY NURSING	O	\$ 1,036,717	5	\$ 207,343	O	\$ 81,858	-	\$ -
SUPPORTED EMPLOYMENT	O	\$ 8,355,524	442	\$ 18,904	O	\$ -	13	\$ -
TRANSPORTATION	O	\$ 2,867,108	1,143	\$ 2,508	O	\$ 12,167	6	\$ 4,427
<b>ALL Waiver Services <sup>(3)</sup></b>	<b>O</b>	<b>\$234,436,270</b>	<b>4,505</b>	<b>\$52,039</b>	<b>O</b>	<b>\$35,642,547</b>	<b>898</b>	<b>\$39,691</b>

Source: MMIS Enterprise/COGNOS data systems as of January 26, 2016.

These data are based on the date a claim was paid. Please keep in mind that Medicaid providers can submit claims up to one year after the date of service. As such, these data should be viewed as provisional and subject to revision. In addition, these data reflect a large number of claims from SFY2014 that were reprocessed in SFY2015. MMIS Category of Service approximates the types of required and optional services offered under Alaska Medicaid.

1) Payments are net total payments.

2) Recipient figures are unduplicated within each Category of Service.

3) Recipient figures for major categories (such as Mandatory Services, Optional Services, etc.) are unduplicated within major category.

The average annual cost per client is the net total payments divided by the unduplicated annual recipients.

Many Medicaid recipients use both required and optional services over the course of a year.

4) The Centers for Medicare and Medicaid Services (CMS) considers non-emergency Medicaid transportation, including accommodations, to be optional services. However, in order to provide access to medically necessary health care, these services are mandatory for Alaska.

Non-Waiver services are on the prior page.

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
Adult Day Care Care Coordination Chore Day Habilitation Environmental Modification Intensive Active Treatment/Therapy Meals Residential Habilitation Residential Supported Living Respite Care Specialized Equipment & Supplies Specialized Private Duty Nursing Supported Employment Transportation	Home and Community Based Waiver Services	AS 47.07.030(c) AS 47.07.045	May	Supports a less costly and more patient-centered alternative to recipients who meet the nursing home level of care  Not enough nursing home beds in Alaska  Keeps patient in community and close to family	Lack of nursing home beds available to cover patient demand  Increased nursing home cost  Increase in lack of access to care for a high-needs population  Lawsuit potential for failure to meet Supreme Court Olmstead decision requiring least restrictive setting	No
Drug Abuse Centers Mental Health Services Rehabilitative Services Residential Habilitation	Community Mental Health	AS 47.07.030(b) AS 47.07.900(4)	May	Provides outpatient treatment options to a high-needs population in the most appropriate, least restrictive, and lowest cost setting  Provides proactive preventive and maintenance care, avoiding or reducing the need for reactive higher cost care (eg, inpatient psychiatric hospital)	Exacerbation of treatable, or otherwise manageable conditions to the extent that hospitalization is required  Lack of inpatient psychiatric hospital beds, which impacts access to care  Increase in out of state care and related transportation costs for services that are not available in state  Increased incarcerations for initial and repeat offenses	Yes <sup>1</sup>
Case Management Services		AS 47.07.030(b) AS 47.07.90(19)	May	Provides a full range of case management for children with disabilities	Increase in duplication of services, inpatient hospital stays, ER visits, medication management issues	Yes <sup>1</sup>
Chiropractic Services		AS 47.07.030(b) AS 47.07.900(3)	May	Provides chiropractic services to individuals under age 21 and dual Medicare/Medicaid eligible recipients	Potential increase to some mandatory services  Expenditures are required for EPSDT and Medicare Cost Sharing	Yes <sup>1</sup>

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
<i>Dental Services</i>	Enhanced Adult Dental & Denture Services	AS 47.07.030(b) AS 47.07.067	Shall (47.07.067) (subject to appropriation)	Provides preventive and restorative care to reduce the need for more expensive and painful emergent care	<p>Increase in dental-related ER visits resulting from lack of preventive/restorative care</p> <p>Recipients who need restorative care, including dentures, may experience difficulty obtaining employment, particularly in positions that require face to face interaction with the public</p> <p>Lack of preventive dental care can later result in the need for more expensive and painful emergent dental care</p> <p>Lack of preventive dental care can result in non-dental health conditions (eg individuals with periodontal disease have a higher incidence of diabetes and heart disease) which would increase expenditures for other Medicaid services</p>	No
<i>Durable Medical Equipment (DME) Services</i>	Includes Respiratory Therapy	AS 47.07.030(b)	May	<p>Provides long-term-use equipment: hospital beds, mobility devices, commodes, oxygen concentrators, wheelchairs, etc</p> <p>Respiratory therapy assessments and equipment provided through a DME supplier</p>	<p>Decreased or total lack of independent mobility</p> <p>Decreased independence, difficulty obtaining and maintaining employment</p> <p>Increased costly inpatient stays due to reliance upon oxygen</p>	Yes <sup>1</sup>

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
<i>End Stage Renal Disease</i>		AS 47.07.030(c)	May	Provides services for treatment of end stage kidney disease  Medicaid covers the first 3 months of care and then cost is typically covered by Medicare for dual eligible recipients (Most patients become Medicare eligible due to terminal aspect of this disease process)	Increased speed of disease progression resulting in other acute and/or chronic conditions such as multiple organ failure and exacerbation of diabetic related conditions  Significantly increased cost for ER and inpatient services  Earlier death than would occur with treatment	Yes <sup>1</sup>
<i>Hearing Services</i>	Audiology (Adult)	AS 47.07.030(b)	May	Provides hearing assessment treatment to improve the recipient's ability to hear	Difficulty obtaining employment in positions that require oral communication	Yes <sup>1</sup>
	Hearing Aid Supplies	AS 47.07.030(b)	May	Provides assistive hearing devices (hearing aids) to improve or create the recipient's ability to hear	Difficulty obtaining employment in positions that require oral communication	No
<i>Hospice Care</i>		AS 47.07.030(b)	May	Provides end of life care that focuses on pain management, attending to the emotional needs of the patient	The pain management aspect, including drugs, of hospice care would have to be provided by private duty nurses, personal care attendant, hospitals, skilled nursing facilities, and other providers  Lack of respite care and other vital support for family members	Yes <sup>1</sup>
<i>Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD)</i>		AS 47.07.030(b) AS 47.07.900(11)(A)	May	Provides inpatient long-term care for individuals with intellectual disabilities who are unable to live alone or in other community settings	Increased burden on family and community, as there are few other treatment settings for individuals with extremely challenging behaviors  Increased cost and patient load in other program areas	No

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
<i>Inpatient Psychiatric Services</i>	Under 21 or over 65 years of age	AS 47.07.030(b) AS 47.07.900(11)(A)	May	No other appropriate service options or funding available to this population	Few or no alternatives to this type of care  Increase in homelessness and incarceration	No
<i>Medical Supplies</i>		AS 47.07.030(b)	May	Short-term-use and disposable supplies: blood sugar test strips, incontinence products (including diapers, catheters) protective gloves, wipes, bandages, etc.	Significantly increased risk of infection for both patient and caregiver  Higher utilization of physician office visits, ER visits, labs and x-rays  Decreased independence  Increased out of pocket expense for patient  Increased out of pocket expense for caregiver	No
<i>Nutrition Services</i>		AS 47.07.030(b)	May (for pregnant women)	Provides services for individuals who are at high risk nutritionally and those who are pregnant	Increased risk of diabetes, low birth weight, and other pregnancy complications  Increased cost of mandatory services as a result of complications	Yes <sup>1</sup>

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
<i>Occupational Therapy (Adult)</i>	Occupational Therapy Physical Therapy Speech Therapy	AS 47.07.030(b)	May	Provides specialized assistance to recipients experiencing physical, developmental, or mental health issues to effectively increase independent living  Provides physical therapy to rehabilitate, restore or learn new methods for physical functionality related to illness or trauma  Speech therapy for stroke victims	Delayed or no recovery from illness or trauma  Decreased independence, difficulty obtaining and maintaining employment  May decrease ability to communicate with others  May experience difficulty obtaining employment	Yes <sup>1</sup>
<i>Personal Care Services</i>		AS 47.07.030(b) AS 47.07.900(15)	May	Provides assistance with activities of daily living which help enable independent living, reducing the need for assisted living and nursing home care	Increased risk of decubitus, infection, emergency room care, inpatient hospital stays	No
<i>Podiatry</i>		AS 47.07.030(c)	May	Provides podiatry services to individuals under age 21 and dual Medicare/Medicaid eligible recipients	Potential increase to some mandatory services  Expenditures are required for EPSDT and Medicare Cost Sharing	Yes <sup>1</sup>

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
<i>Prescription Drugs</i>		AS 47.07.030(b)	May	Provides therapeutic drug treatment for acute and chronic conditions  Drug therapy improves therapeutic outcomes including those that preserve life, for disabling physical and mental health conditions	Increase in more costly care - ER visits, inpatient hospital, specialized inpatient, and long term nursing care  Higher incidence of life-threatening conditions  Higher incidence of death outcomes  Increased need for alternate housing options for mental health and substance abuse conditions  Decreased life span for treatable diseases like hyper and hypo thyroid, thyroid cancers, diabetes, COPD, heart disease, hypertension, oral health issues, etc	Yes <sup>1</sup>
<i>Private Duty Nursing (Adult)</i>		AS 47.07.030(c)	May	1:1 medical care for individuals who require clinical treatment that can be managed outside the facility setting	Increase in more costly care - ER visits, inpatient hospital, specialized inpatient, and long term nursing care  Removes recipient from home	No
<i>Prosthetics and Orthotics</i>		AS 47.07.030(b)	May	Provides individuals with customized devices to replace or enhance missing or deformed body parts	Increased need for other support services (PCA services, high cost DME equipment - wheelchairs and other medical supplies)  Decreased or total lack of mobility  Decreased independence, difficulty obtaining and maintaining employment	Yes <sup>1</sup>

Category of Service	Additional Information	Statutory Authority	May/ Shall Provide	Purpose of Service	Impact if not available	Medicare Cost-Sharing Requirement <sup>1</sup>
<i>Psychology Services</i>		AS 47.07.030(b) AS 47.07.900(16)	May	Provides medically necessary psychological testing to determine the status of the patient's mental, intellectual, and emotional functioning	The program would have to pay for other mental health providers to provide testing services  Therapeutic treatment plans are dependent upon appropriate and adequate testing	Yes <sup>1</sup>
<i>Vision Services</i>	Vision Exams Corrective Lenses Frames	AS 47.07.030(b) AS 47.07.900(10)	May	Provides adults with exam necessary to receive corrective lenses/glasses and detection of eye disease	Decreased independence, difficulty obtaining and maintaining employment  Greater impact to elderly and disabled individuals (Medicare does not provide vision services)  Undetected eye disease which could result in high medical cost	No

<sup>1</sup> Medicaid must pay cost sharing for any service that Medicare covers for dual eligibles. Dual eligibles are enrolled in both Medicaid and Medicare.

**Note 1:** Centers for Medicare and Medicaid Services (CMS) considers non-emergency Medicaid transportation, including accommodations, to be optional services. However, in order to provide access to medically necessary health care, these services are mandatory for Alaska.

**Note 2:** Certain services listed above are indicated as "adult". These services are mandatory for children under the Early and Periodic Screening and Diagnostic Testing (EPSDT) mandate.

**Note 3:** For all optional services, those provided through a tribal health facility to an American Indian / Alaska Native include no general fund expenditures.

# LEGISLATIVE RESEARCH SERVICES

29<sup>th</sup> Alaska Legislature  
LRS Report 16.144  
February 23, 2016



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## Potential Cost Shifting Scenarios from Eliminating Medicaid Personal Care Assistance and Home and Community Based Services Waiver Programs

Chuck Burnham, Manager

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*You asked about the potential cost impacts of eliminating the Medicaid Personal Care Assistance (PCA) and Home and Community Based Services (HCBS) waiver programs.<sup>1</sup>*

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Our research indicates that moving virtually any substantial portion of recipients of Personal Care Assistance (PCA) and/or those receiving Home and Community Based Services (HCBS) through Medicaid would ultimately cost the State of Alaska hundreds of millions of dollars in additional spending annually. In particular, participants in the HCBS program, by definition, qualify for an institutional level of care under Medicaid rules. Although costs per participant are much higher for HCBS than for PCA services, those expenses are still less than half of the cost for nursing home or intermediate care facilities for those with intellectual and developmental disabilities.

In addition to increases in direct costs, the elimination of PCA / HCBS would generate a great deal of demand for long-term care facilities on a statewide system that is already operating near capacity. Given that the private sector is expected to struggle in meeting the demands for institutional care brought about by Alaska's rapidly growing senior population, the absence of Medicaid programs designed to keep people in their homes could force the state to directly participate in the construction and administration of long-term care facilities with capital and operating costs potentially reaching hundreds of millions of dollars.

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### Background and Methodology

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Two previous efforts by this agency to estimate the primary cost impacts of eliminating the PCA and HCBS programs used differing foundational data. The first, LRS Report 04.155 focused on the projected rapid growth in the portion of the Alaska population over the age of 65. Later, LRS Report 10.153 used the projections of consultancies that were hired to forecast program participation. Ultimately, our 2004 estimate, which examined only the PCA program, substantially understated future program participation. By contrast, data produced by the Lewin Group and ECONorthwest dramatically overestimated program enrollment for both PCA and HCBS services. The reasons for these missed projections are manifold and complex, and include the inherent difficulties of making projections based on limited data and in ever-changing circumstances.

Another significant factor in changes to participation rates and costs has been cost control and efficiency measures put in place by the Alaska Department of Health and Social Services (DHSS), including controls on program utilization and

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<sup>1</sup> This report is part of a series by this agency looking at the same question. This installment assumes the reader has a basic understanding of the services provided by the PCA and HCBS programs. Earlier reports, which provide additional detail, include LRS 04.155 (<http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2004/04-155m.pdf>) and LRS 10.153 (<http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2010/10-153m.pdf>). Although all of these reports reach the same broad conclusion—that eliminating the PCA and HCBS would likely substantially increase costs to the state—due to differences in data availability and the resulting variations in methodology, caution should be employed when comparing results. Further, as a result of changes in policy that have altered program participation rates and costs, which we will briefly discuss in this report, projections from previous reports have varied significantly from actual program experience. Additional information on the PCA and HCBS programs is available on the Alaska Department of Health and Social Services website at <http://dhss.alaska.gov/dsds/Pages/default.aspx>.

significantly increased efforts at preventing and countering waste, fraud, and abuse.<sup>2</sup> The DHSS attributes recent substantial declines in program enrollment and costs to these changes. Significantly, the PCA program saw declines in persons served from 5,280 in fiscal year (FY) 2013 to 4,414 in FY 2015, while total program spending fell from roughly \$125.8 million to \$88.7 million over the same time period. Annual costs per participant also dropped from \$23,800 to \$20,100.

Based on past experience, we hold little confidence in the accuracy of projected program participation rates and, in any case, DHSS did not provide us with projections past 2020, perhaps in recognition of the rapidly moving nature of those targets. As a result, in this report we focus on the near past rather than the future to inform the broad impact on costs that would likely arise should the PCA and HCBS programs be eliminated. Specifically, we use data from FY 2015 to roughly estimate the costs if certain portions of participants served by these programs had instead been receiving institutional care in nursing homes.

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### Direct Cost Shifting

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The attached table shows participant counts and total costs for FY 2015. It also shows our estimates of the difference in expenditures if certain percentages of participants in both programs would instead have been receiving care in a nursing home. It is unlikely that equal proportions of PCA and HCBS enrollees would move to an institutional level of care were the programs to be discontinued. Instead, we believe it reasonable to assume that those who currently require higher intensity care would be the most likely to move to nursing homes. By definition, individuals receiving HCBS are those who would otherwise require institutional care. Therefore, our table provides calculations for moving 35 to 75 percent of FY 2015 HCBS recipients to nursing homes. Conversely, we assume relatively few individuals who would otherwise be receiving only PCA services would have moved to an institutional level of care; therefore, we use a range of 15 to 35 percent of those participants to calculate the cost shift to nursing homes.

Clearly, we have no means of precisely estimating what portion of program recipients would move to institutional care were these home care programs eliminated; however, as our calculations show, even if only 15 percent of FY 2015 PCA and 35 percent of HCBS recipients were to have instead been in nursing homes funded by Medicaid, program costs would have nearly doubled, increasing by over \$335 million. At the current 50 percent federal medical assistance percentage (FMAP) rate, the state's portion of those costs would have been over \$167 million.<sup>3</sup> We believe it likely that a much higher percentage of HCBS recipients would have been institutionalized were the program not in operation in FY 2015. Had that figure been 75 percent of participants, actual spending for *just the HCBS cohort* would have increased by over \$482 million above actual spending. In its February 19, 2016, presentation to the Senate Health and Social Services Committee, the Division of Senior and Disability Services stated that were all HCBS recipients moved to institutional care, the total costs to Medicaid of nursing home and intermediate care facilities would exceed \$1 billion.<sup>4</sup>

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<sup>2</sup> A number of these efforts were presented by the Department to the Senate Health and Social Services Committee on February 19, 2016. Minutes and audio of this hearing are available online at [http://www.akleg.gov/basis/get\\_minutes.asp?session=29&comm=HSS&chamb=B&date1=20150219&date2=20160219](http://www.akleg.gov/basis/get_minutes.asp?session=29&comm=HSS&chamb=B&date1=20150219&date2=20160219). Documents provided by DHSS for the hearing are available at [http://www.akleg.gov/basis/get\\_documents.asp?chamber=SDHS&session=29&bill=&date1=20160219&time2=1100](http://www.akleg.gov/basis/get_documents.asp?chamber=SDHS&session=29&bill=&date1=20160219&time2=1100).

<sup>3</sup> As you know, services for individuals enrolled through Medicaid expansion under the Affordable Care Act are eligible for increased federal reimbursement rates; however, the DHSS informed us that the expansion population is generally healthier than the average Medicaid recipient. As a result, the Department does not expect those enrolled under expansion to receive HCBS services, and expect only one percent of that cohort to receive services through the PCA program. We therefore find the differences in reimbursement rates due to the ACA to be insignificant in relation to overall spending on the programs and exclude consideration of the expansion population from this report.

<sup>4</sup> These data are available on page 28 of the DHSS presentation to the committee, which can be viewed at [http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=40896](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=40896). The costs for nursing home and intermediate nursing facility care are similar at an estimated FY 2015 average \$187,000 and \$186,000, respectively. For the sake of simplicity, and because many times more institutionalized Medicaid participants are served by nursing homes, we use the higher figure in our calculations. For the sake of comparison, FY 2015 average costs for PCA recipients was \$20,100 and roughly \$88,000 for the blended average for all individuals receiving care under HCBS waivers.

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## Other Potential Costs to the State

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As we discussed in earlier reports, outside of direct Medicaid spending, primary among potential costs associated with eliminating the PCA and HCBS programs are the capital and operating expenditures required to construct and administer sufficient institutional care facilities to accommodate residents who otherwise would have been served in their homes and communities through the existing programs.

It has long been known that Alaska's rapidly growing population of seniors aged 65 years and over will strain the ability of the state to provide sufficient long-term care facilities to meet demand.<sup>5</sup> Specifically, the Alaska Department of Labor and Workforce Development projects that the state's population aged 65 and over will more than double from 63,832 in the year 2012 to 144,623 in 2032. Seniors will also nearly double as a percentage of the total population over this time period, from about 8.7 percent to 16.6 percent. With nursing homes in Alaska maintaining an average occupancy rate of approximately 90 percent in recent years, it appears reasonable to conclude that any shifting of HCBS and PCA enrollees to institutional care will further burden a system that is already projected to struggle in meeting demand. It is unclear based on current economic conditions that private providers can meet this demand, which would further lead one to conclude that the state may have to incentivize private sector participation in creating additional long-term care capacity or begin directly building institutional care facilities.

The costs to the state for such an undertaking are difficult to estimate due to variations in demand and the cost of construction and operation among geographical areas. In our 2009 report, we attempted to provide a ballpark figure based on the estimated construction and operations costs of a 60-bed Veterans Home in Anchorage.<sup>6</sup> In 2015 dollars, the estimated costs for such a facility is \$12.6 million for construction with first-year operating expenses of \$3.75 million, which would increase with inflation thereafter.<sup>7</sup> If, for example, 75 percent of 2015 HCBS recipients were moved to nursing homes with comparable construction and operations costs, Alaska would have needed to construct 61 facilities at a cost of over \$768 million with first-year operating costs in excess of \$228 million. Clearly, these figures should not be viewed as real-world projections. Instead we intend this simplistic calculation to be illustrative of the daunting prospect of moving so many additional Alaskans to institutional care, and the scale of spending that would likely accompany such an effort.

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## Costs to Families, the Private Sector, and Local Economies

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Although private sector costs are outside the scope of our inquiry, it is nonetheless important to mention that those costs would likely be substantial. The recipients of PCA and HCBS and their families have, by their enrollment in the programs, at least tacitly expressed their collective desire to remain out of institutional care facilities. It seems likely that at least some of these individuals would avoid moving to such facilities where any other viable option exists. Consequently, the elimination of PCA and HCBS would likely force a certain portion of program participants' families, many of whom are already stressed by the challenges of providing care to loved ones, to make additional sacrifices in order to keep those family members in their homes and local communities. Although difficult to identify and measure precisely, it appears reasonable to assume that those sacrifices might include committing additional funds to pay for care directly, giving up a job or business, quitting school or apprenticeship programs, or other actions that would be detrimental to family finances and local economies in order to commit additional time to care giving.

We hope this is helpful. If you have questions or need additional information, please let us know.

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<sup>5</sup> See, for example, "Alaska Long-Term Care and Cost Study," Final Report, *Public Consulting Group*, February 2006, pp. 166-167; <http://www.hss.state.ak.us/hspc/files/pcg.pdf>.

<sup>6</sup> "Alaska State Veterans Home Feasibility Study," McDowell Group, July 2003, p. 2; <http://www.akrepublicans.org/samuels/23/pdfs/samu2003070901p.pdf>.

<sup>7</sup> Inflation adjustments are Legislative Research calculations using Anchorage consumer price index data compiled by the Alaska Department of Labor and Workforce Development, <http://laborstats.alaska.gov/cpi/cpi.htm>.

Potential Increase to Medicaid Expenditures as a Result of Moving Participants from Medicaid Home Health Programs to Nursing Home Care							
Program	Participants <sup>1</sup>			FY 15 Total Costs <sup>1</sup>	Projected Cost <i>Increase</i> if Programs are Eliminated and Selected Portions of Participants Move to Nursing Home Care <sup>2</sup> (State share of increase is 50 percent of costs listed here)		
	2005	2015	Increase		15%	25%	35%
	Personal Care Assistance	2,700	4,414		1,714	\$88,688,200	\$110,509,470
Home and Community Based Services	3,573	4,871	1,298	\$267,937,800	35%	50%	75%
					\$225,028,720	\$321,469,600	\$482,204,400
<b>Net Total<sup>3</sup></b>	<b>6,273</b>	<b>9,285</b>	<b>3,012</b>	<b>\$356,626,000</b>	<b>\$335,538,190</b>	<b>\$505,652,050</b>	<b>\$740,059,830</b>

**Notes and Sources:** 1) 2015 participant figures and FY 15 total costs are from a document presented by the Alaska Department of Health and Social Services, Division of Senior and Disabilities Services (DSDS), presentation to the Senate Health and Social Services Committee on February 19, 2015, which can be viewed at [http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=40896](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=40896).

2) The DSDS presentation also provides the costs for nursing home and intermediate nursing facility care, which were similar for FY 2015, at an average of \$187,000 and \$186,000, respectively. For the sake of simplicity, and because many times more institutionalized Medicaid participants are served by nursing homes, we use the higher figure in our calculations. For the sake of comparison FY 2015 average costs for PCA recipients was \$20,100 and roughly \$88,000 for the blended average for all individuals receiving care under HCBS Waivers.

To make our projections, we multiplied the total number of program recipients by the percentages indicated and multiplied that figure by the FY 15 average cost of nursing home care paid per recipient by Medicaid (\$187,000). We then subtracted from that figure the product of multiplying actual FY 15 program costs by the percentage in question to reach our totals.

3) Net total are the sum of adding each vertical column of PCA and HCBS figures. In the case of projected costs in the far three columns to the right, those figures represent *only cost increases above actual FY 2015 expenditures* as a result of shifting the given percentages of program employees to nursing home care. So, the third column from the right assumes that 15 percent of PCA recipients and 35 percent of HCBS participants would have been in nursing home care in FY 2015, increasing total Medicaid costs by roughly \$335.5 million.

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**From:** Jane Pierson  
**Sent:** Wednesday, March 23, 2016 9:40 AM  
**To:** House Finance Legislation  
**Subject:** FW: HFIN Question about PCCM - section 29

Helen,

Can you please distribute?

Thanks,

Jane

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**From:** Newman, Anthony (HSS) [mailto:anthony.newman@alaska.gov]  
**Sent:** Tuesday, March 22, 2016 6:58 PM  
**To:** Heather Shaddock <Heather.Shaddock@akleg.gov>; Jane Pierson <Jane.Pierson@akleg.gov>  
**Cc:** Davidson, Valerie J (HSS) <val.davidson@alaska.gov>; Sherwood, Jon (HSS) <jon.sherwood@alaska.gov>; Brodie, Margaret C (HSS) <margaret.brodie@alaska.gov>; Dunkin, Susan M (HSS) <susan.dunkin@alaska.gov>; Martin, Monique R (HSS) <monique.martin@alaska.gov>; Peterson, Darwin R (GOV) <darwin.peterson@alaska.gov>; McClanahan, Natasha S (GOV) <natasha.mcclanahan@alaska.gov>; Wilcox, Lacy J (GOV) <lacy.wilcox@alaska.gov>  
**Subject:** FW: HFIN Question about PCCM - section 29

Jane and Heather:

This is in response to Rep. Wilson's question yesterday in the House Finance hearing on SB 74:

***Is the Primary Care Case Management system required under Section 29 mandated for Medicaid enrollees, or is it optional for them? Will Medicaid enrollees be required to participate?***

Section 29 of SB 74 requires the department to establish a Primary Care Case Management (PCCM) system in which certain Medicaid enrollees would be required to enroll. The only group of Medicaid enrollees specifically required to enroll in PCCM under this Section is enrollees with multiple hospitalizations (with some exceptions). This Section authorizes the department to establish enrollment criteria and determine eligibility for PCCM services, so there is a potential for additional enrollees who meet other criteria defined by the department to be required to enroll.

The department's preliminary plan for implementing this Section is to contract with one or more PCCM agencies to provide case management services for enrollees. Enrollment in this program would be voluntary from the enrollee's perspective at first, except for those with multiple hospitalizations. Over time, as the department evaluates the effectiveness of the program and identifies other groups of enrollees who could benefit from this service, the department may phase in mandatory participation for additional groups.

Please share this response with Rep. Wilson and other committee members.

Thank you,

Tony

**Tony Newman** | Legislative Liaison

Office of the Commissioner | Alaska Department of Health and Social Services

350 Main Street, Room 404 | Juneau AK 99811

(desk) [907.465.1611](tel:907.465.1611) | (cell) [907.321.3989](tel:907.321.3989)

[anthony.newman@alaska.gov](mailto:anthony.newman@alaska.gov)

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**From:** Sherwood, Jon (HSS)  
**Sent:** Tuesday, March 22, 2016 9:21 AM  
**To:** Shadduck, Heather R (LAA)  
**Cc:** Newman, Anthony (HSS); Brodie, Margaret C (HSS)  
**Subject:** RE: HFIN Question about PCCM - section 29

Heather,

I would agree with your take on this. This provision is intended to get some people into a case management system with tighter utilization controls. Under the language of the law, we would expect this participation (for an identified subgroup of the Medicaid population) to be required to choose or be assigned a case manager and some services would require a referral from the case manager before paying. It specifically identifies people with frequent hospitalizations as a required target population.

This specific option is different from, though not incompatible with, the goal of ensuring that everyone has a primary care provider. You could easily build a tiered model of care management around primary care; in fact, the health homes option in Section 30 envisions just such a tiered model.

I think we should be able to put something together. I will work with Tony to make sure that we get you what you need.

Jon

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**From:** Heather Shadduck [<mailto:Heather.Shadduck@akleg.gov>]  
**Sent:** Monday, March 21, 2016 7:00 PM  
**To:** Sherwood, Jon (HSS); Brodie, Margaret C (HSS)  
**Cc:** Newman, Anthony (HSS)  
**Subject:** HFIN Question about PCCM - section 29

Hi Jon and Margaret –

I think the only question I was really thrown a loop by was Rep. Wilson's about every provider being enrolled in PCCM per section 29. I think this would still technically be an "optional service" but mandatory for specific Medicaid recipients that the division of HCS identifies. How are you envisioning this? I think this PCCM is different than our intent that everyone has an actual primary care provider.

If you want to write up a response page or something that can be provided to the HFIN committee, I can submit it.

Excluding the PDMP provisions, I believe the other follow up questions were from Stacie and Dept of Law at this time.

Thanks!

Heather Shadduck  
Staff to Senator Pete Kelly

*Session Mailing Address – January - April:*  
Alaska State Capitol

March 28, 2016

The Honorable Representatives Mark Neuman and Steve Thompson  
Co-Chairs, House Finance Committee  
Honorable Members of the House Finance Committee  
Alaska State Capitol  
Juneau, AK

RE: Senate Bill 74, Sections 14, 15, 18 and 19

Representatives Neuman and Thompson and members of the House Finance Committee:

On behalf of the members of the National Association of Chain Drug Stores (NACDS) operating in Alaska, I respectfully ask you to consider our suggested amendments to Senate Bill 74 – Medicaid Reform.

NACDS Members in Alaska operate 64 store fronts and employ over 10,000 Alaska residents. In addition, they pay over \$12 million in state taxes.

While we sincerely appreciate all the work the Senate and House have dedicated to the passage of Senate Bill 74, as community pharmacies, we have serious concerns about some of the requirements in sections 14, 18 and 19.

We supported and worked hard on original passage of the law implementing the controlled substance prescription database. We believe the information reported to the database has been a significant deterrent in manipulating prescribers and dispensers for the purposes of acquiring legal drugs for illicit purposes. It also has allowed pharmacists and practitioners to better manage their patient's health care regimen.

In Section 14, we would like to offer the database be updated "within one business day from when the prescription is sold". We believe with the current prescription drug abuse more timely reporting could be helpful. The more timely the information is reported and available, the better prescribing decisions can be made by the practitioners.

We would also ask that the language in subsection 8 be amended to delete the nebulous reference to "other appropriate identifying information".

In Section 15, we offer our support for the expansion of who may access the prescription drug database. Allowing prescribers and pharmacists to delegate authority to addition **licensed** personnel will ensure the appropriate review of the patient's controlled substance prescription history. We believe it is important due to the sensitive nature of the information that any delegation of access to the database be to a licensed person in the unfortunate event disciplinary action is necessary.

In Section 18, we would respectfully ask that pharmacists not be included in the requirement to check the database prior to the dispensing of a prescription since the increase reporting timeframe will give the prescribers the information they need when checking the database prior to issuing a prescription. The need for pharmacists to check the database is redundant when the prescriber is required to do so prior to issuing a prescription. It is not the intent of NACDS and its members to eliminate pharmacists checking the database prior to dispensing when they believe there is reason to be concerned with a patient presenting a prescription. Pharmacists check today, and will continue to do so whenever they believe something may not be appropriate. We are asking for the elimination of the mandate to check the database when that function has already been performed per this bill in the prescriber's office.

Pharmacists today perform a large number of patient services such as immunizations, disease management and screening for cholesterol, blood pressure, and diabetes, just to name a few. To take them away from direct patient care by requiring checking the database each time a prescription comes in for a controlled substance is a burdensome use of their time and training.

We would also respectfully request that the exemption for "emergency room" checking of the database be eliminated as this is a frequent stop for those inclined to abuse controlled substances.

The database could be checked during ER triage so it is done prior to the ER physician or nurse practitioner actually seeing the patient.

In Section 19, we would again like to ask to increase the reporting frequency to "within one business day from when the prescription is sold" to be consistent with Section 14.

We appreciate your consideration of our comments and proposed changes to pertinent sections of Senate Bill 74.

Sincerely,

Lis Houchen  
Regional Director, State Government Affairs  
[lhouchen@nacds.org](mailto:lhouchen@nacds.org)  
360.480.6990

**\*Sec. 14.** AS 17.30.200(b) is amended to read:

(b) The pharmacist-in-charge of each licensed or registered pharmacy, regarding each schedule [IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III, or IV [, OR V] controlled substance under federal law dispensed by a pharmacist under the supervision of the pharmacist-in-charge, and each practitioner who directly dispenses a schedule [IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III, or IV [, OR V] controlled substance under federal law other than those administered in a patient at a health care facility, shall submit to the board, by a procedure and in a format established by the board, the following information for inclusion in the database ~~[on at least a weekly basis]~~ **within one business day from when the prescription is sold:**

- (1) the name of the prescribing practitioner and practitioner's federal Drug Enforcement Administration registration number or other appropriate identifier;
- (2) the date of the prescription;
- (3) the date the prescription was filled and the method of payment; this paragraph does not authorize the board to include individual credit care or other account numbers in the database;
- (4) the name, address, and date of birth of the person for whom the prescription was written;
- (5) the name and national drug code of the controlled substance;
- (6) the quantity and strength of the controlled substance dispensed;
- (7) the name of the drug outlet dispensing the controlled substance; and
- (8) the name of the pharmacist or practitioner dispensing the controlled substance [~~and other appropriate identifying information~~].

**\*Sec. 15.** AS 17.30.200(d) is amended to read:

(d) The database and information contained within the database are confidential, are not public records, and are not subject to public disclosure. The board shall undertake to ensure the security and confidentiality of the database and the information contained within the database. The board may allow access to the database only to the following persons, and in accordance with the limitations provided and regulation of the board:

- (1) personnel of the board regarding inquiries concerning licensees or registrant of the board or personnel of another board or agency concerning a practitioner under a search warrant, subpoena, or order issued by an administrative law judge or a court;

- (2) authorized board personnel or contractors as required for operational and review purposes;
- (3) a licensed practitioner having authority to prescribe controlled substances or ~~an~~ licensed agent or licensed employee of the practitioner whom the practitioner has authorized to access the database on the practitioner's behalf, to the extent the information relates specifically to a current patient of the practitioner to whom the practitioner is prescribing or considering prescribing a controlled substance;
- (4) a licensed or registered pharmacist having authority to dispense controlled substances or ~~an~~ licensed agent or licensed employee of the pharmacist whom the pharmacist has authorized to access the database on the pharmacist's behalf, to the extent the information relates specifically to a current patient to whom the pharmacist is dispensing or considering dispensing a controlled substance;
- (5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database under a search warrant, subpoena, or order issued by a court establishing probable cause for the access and use of the information; [AND]
- (6) an individual who is the recipient of a controlled substance prescription entered into the database may receive information contained in the database concerning the individual on providing evidence satisfactory to the board that the individual requesting the information is in fact the person about whom the data entry was made and on payment of a fee set by the board under AS 37.10.050 that does not exceed \$10;
- (7) a licensed pharmacist employed by the Department of Health and Social Services who is responsible for administering prescription drug coverage for the medical assistance program under AS 47.07, to the extent that the information relates specifically to prescription drug coverage under the program;**
- (8) a licensed pharmacist, licensed practitioner, or authorized employee of the Department of Health and Social Services responsible for utilization review of prescription drugs for the medical assistance program under AS 47.07, to the extent that the information relates specifically to utilization review of prescription drugs provided to recipients of medical assistance;**

**(9) the state medical examiner, to the extent that the information relates specifically to investigating the cause and manner of a person's death; and**

**(10) an authorized employee of the Department of Health and Social Services may receive information from the database that does not disclose the identity of a patient, prescriber, dispenser, or dispenser location, for the purpose of identifying and monitoring public health issues in the state; however, the information provided under this paragraph may include the region of the state in which a patient, prescriber, and dispenser are located and the specialty of the prescriber.**

**\*Sec. 18.** AS 17.30.200(k) is amended to read:

- (k) In the regulations adopted under this section, the board shall provide
- (1) that prescription information in the database [SHALL] be purged from the database after two years have elapsed from the date the prescription was dispensed;
  - (2) a method for an individual to challenge information in the database about the individual that the person believes is incorrect or was incorrectly entered by a dispenser;
  - (3) a procedure and time frame for registration with the database;**
  - (4) that a [pharmacist-or] practitioner review the information in the database to check a patient's prescription records before dispensing, prescribing, or administering a controlled substance to the patient; the regulations must provide that a [pharmacist-or] practitioner is not required to review the information in the database before dispensing, prescribing, or administering a controlled substance to a person who is receiving treatment**
    - (A) in an outpatient setting;**
    - (B) at the scene of an emergency or in an ambulance; in this subparagraph, "ambulance" had the meaning given in AS 18.08.200;**
    - ~~(C) in an emergency room;~~ or**
    - ~~(D)~~ (C) immediately before, during, or within the first 24 hours after surgery.**

**\*Sec. 19.** AS 17.30.200 is amended by adding new subsections to read:

(o) A pharmacist who dispenses or a practitioner who prescribes, administers, or directly dispenses a schedule II, III, or IV controlled substance under federal law shall register with the database by a procedure and in a format established by the board.

(p) The board shall promptly notify the State Medical Board, the Board of Nursing, the Board of Dental Examiners, and the Board of Examiners in Optometry when a practitioner registers with the database under (o) of this section.

(q) The board is authorized to provide unsolicited notification to a pharmacist or practitioner if a patient has received one or more prescriptions for controlled substances in quantities or with a frequency inconsistent with generally recognized standards of safe practice.

(r) The board shall update the data base [~~on at least a weekly basis~~] within one business day of the prescription being sold with the information submitted to the board under (o) of this section.

March 28, 2016

Alaska State Legislature  
Juneau, Alaska

RE: SB 74, Sections regarding the prescription drug database

I am a retired community pharmacist from Fairbanks, Alaska. I served on the Alaska Board of Pharmacy for two terms in the 1980's and again from 1998-2004. During my tenure as President of the Board, we began work on the statutes setting up the controlled substance prescription database. As an active member of the Alaska Pharmacists Association, I also testified on the importance of having such a database to help deter some of the controlled substance prescription drug misuse and abuse in our state. Now that it has been implemented, I believe it has been very helpful for both prescribers and pharmacists to check on those patients who try to manipulate the system to acquire legal drugs for illegal purposes.

I do have some concerns with some of the proposed changes, though:

- I think it important to allow prescribers and pharmacists to delegate authority to access the database, but, I feel that that delegated authority should only be to **licensed** personnel. This is sensitive information and it should be handled appropriately.
- I don't think pharmacists should be included in the **requirement** to check the database prior to dispensing if the prescriber is required to do so. Pharmacists will check the database as a matter of course if they have concerns with the patient presenting the prescription, i.e. someone they are not familiar with, someone who wishes to pay cash rather than bill their insurance, or someone who seems to be getting inappropriate quantities of controlled substances.
- I do not feel that Emergency Rooms should be exempt from checking the database since this is often where "doctor shoppers" go to get additional prescriptions for controlled substances.

Thank you for considering my comments,

Margaret D. Soden  
PO Box 61328  
Fairbanks AK 99706-1328  
margaretdsoden@gmail.com

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**From:**  
**Sent:** Tuesday, March 29, 2016 10:13 AM  
**To:**  
**Subject:** FW: HB 344 SB 74

One more email and I'll shut up.

My wife corrected me. The current drug database does contain information of other scheduled drugs. I forgot that as I have found the database really only helpful for patients abusing schedule II medications.

John Nolte, MD

-----Original Message-----

From: John Nolte [mailto:johnnolte@gmail.com]

Sent: Monday, March 28, 2016 10:26 PM

Subject: Re: HB 344 SB 74

Hello Legislators,

I have received some feedback from my letter I'd like to pass on to all.

>> I apologize, I read an incorrect version of the bill regarding class V drugs which are not included in the current version, however - classes 2,3,4 includes 28 meds we prescribe regularly. I figure this will cost about an hour of time per full clinic day - if the database is always up and the connection isn't slowed.

I am aware the database was started in 2008 but it was voluntary, very helpful, and did not include threats against providers and pharmacist or include schedule III - IV drugs. The federal regulations changed several schedule III drugs to schedule II - inconveniencing many patients.

>>

>> The new telehealth bill does set two sets of standards by not requiring physical examinations - it says clearly in the bill that these standards will be national standards. The only requirement is that they send records to us (to pick up the pieces) and "the requirement that a licensed healthcare provider be available". That is unbelievably vague and an unenforceable loophole. What defines an available licensed provider? Is it an orthopedist at Anchorage Fracture when the patient has a mental health problem? Does "available" mean the provider has an opening in 6 weeks. Or perhaps it is a family physician, the patient waits 6 weeks and the doctor then says he doesn't do OB. Does that absolve the "Teledoc" from responsibility dictated by a "doctor patient relationship"? That requirement is a joke. I have notes from Teledocs who have "treated" my patients and sent me "records". I will be happy to produce them if desired. The notes

are substandard. Perhaps if the doctors knew the patients, the note might be acceptable, but from the note, I can't tell if the person talking to and treating my patient is a doctor, PA or NP. There is no mention of the qualifications of the provider.

>>

>> Yes there are more boards and demo projects set up in this bills but MDs are not on all these committees.

>

>> There has always been a differential pay for Medicaid patients. Medicaid pays 100% federal rate to ANMC for Alaska natives. It does save the state money but increases costs to us as taxpayers. Providers pay will be cut as we are 50% state and 50% federal the state. The State will cut our current \$64 rate while the \$601 federal rate ANMC gets goes up every year and is not subject to state cuts.

>>

>> Many Legislators are wrong about what this bill will do as it will not help patients but be a very expensive invasion of privacy and government data collection on us and our patients.

>> ER and surgeons ARE excluded in this bill from consulting the Database prior to prescribing.

>> <http://www.legis.state.ak.us/PDF/29/Bills/SB0074E.PDF>.

>>

>> Sincerely

>> John Nolte, MD

To All State Legislators:

27 March 2016

I am writing to you today to express my deep concern with the requirements of the Alaska Drug Database legislation. The registry was initially "sold" as a way to help stem the rising tide of prescription pain medication – primarily opioids. Suddenly now, the Database is to include schedules: I, II, III, IV, V. Sched III, IV and V have a low likelihood of being abused. These are medications like testosterone, cough syrup, weight loss, ADD/ADHD, seizure, sleeping, anti - anxiety, and pain medications (which are all schedule 2,3,4 medications). Before I can prescribe them to children and adults I have to stop, log into a database (which may or may not be up) to do what? To view the fact that a patient gets his testosterone shot every month? That a woman with migraines gets her 30 tablets per month? The fallacy here is that non-medical people believe the lie that there are "generally recognized standards of safe practice" that show how many tablets of all these medicines an individual can fill in a specified period of time. I would like to see a book based on scientific outcomes that tells me how many tablets of a given medication I should give Ms Jones.

(q) The board is authorized to provide unsolicited notification to a pharmacist  
31 or practitioner if a patient has received one or more prescriptions for controlled  
01 substances in quantities or with a frequency inconsistent with generally recognized  
02 standards of safe practice.

Standards can be applied to populations or study groups but cannot be applied to individual people. People work out of town, people travel and need medications "in case", people live in the bush, people forget their meds or lose them and someone who isn't a physician, hasn't seen touched or talked to the patient is going to determine that they know better how much medicine any given patient requires.

This bill, increases government involvement in personal health care, and is an invasion of health privacy for children and adults to be listed on a controlled substance registry for non-narcotic or limited time medications. The FBI, CIA, DoD, and Premera all cannot keep their databases secure. Now every pharmacy, tech, clinic, medical assistant will pose a potential weak link in healthcare privacy. I know many of you will end up on that database – is that what you really want? The latest craze is hackers taking databases hostage and demanding payment to un-hijack or not disclose information. It's only a matter of time.....

What are the unintended consequences? When one of you calls on a Saturday and needs a refill of cough medication because you are heading out that evening to Juneau, even though I take after hours call for my patients – I'm not going to prescribe controlled drugs because I can't log in from the Russian river to check the database on Representative so and so to make sure he isn't abusing cough medication. The regulation change last year – changed hydrocodone from a sched III to a sched II. That means that those Rx's can't be called in or faxed. Patients with the flu, cough, broken bones, post op surgeries etc., now have to drive to a doctor's office, pick up the Rx and wait at a pharmacy to get it filled. Unintended consequences..

Anyone who has owned a business or is a competent leader, knows that programs are more likely to work if you get buy-in from the stockholders – Practitioners, pharmacists and patients, using rewards rather than sticks. Below is a stick:

**Sec. 16. AS 17.30.200(e)** is amended to read:

18 (e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to  
19 **register or** submit information to the database as required under this section is  
20 grounds for the board to take disciplinary action against the license or registration of  
21 the pharmacy or pharmacist or for another licensing board to take disciplinary action  
22 against a practitioner.

\* Sec. 18. AS 17.30.200(k) is amended to read:

- 02 (k) In the regulations adopted under this section, the board shall provide  
03 (1) that prescription information in the database [SHALL] be purged  
04 from the database after two years have elapsed from the date the prescription was  
05 dispensed;  
06 (2) a method for an individual to challenge information in the database  
07 about the individual that the person believes is incorrect or was incorrectly entered by  
08 a dispenser;  
09 **(3) a procedure and time frame for registration with the database;**  
10 **(4) that a pharmacist or practitioner review the information in the**  
11 **database to check a patient's prescription records before dispensing, prescribing,**  
12 **or administering a controlled substance to the patient; the regulations must**  
13 **provide that a pharmacist or practitioner is not required to review the**  
14 **information in the database before dispensing, prescribing, or administering a**  
15 **controlled substance to a person who is receiving treatment**  
16 **(A) in an inpatient setting;**  
17 **(B) at the scene of an emergency or in an ambulance; in this**  
18 **subparagraph, "ambulance" has the meaning given in AS 18.08.200;**  
19 **(C) in an emergency room; or**  
20 **(D) immediately before, during, or within the first 24 hours**  
21 **after surgery.**

What is the pharmacist or practitioner suppose to review that database for? What if the practitioner reviews the database and feels a patient needs more narcotics (even people who take regular narcotics for chronic conditions: fall, break or dislocate bones, get burned etc.). Why not in emergency room? Is the pharmacist – who doesn't know the patient, hasn't obtained a medical history or examined the patient, going to be able to make an intelligent decision? They already give inappropriate medical advice to patients; refuse to fill Rxs because they don't know the real conditions for which the doctor prescribed the medications.

This bill dramatically increases medical care costs to patients, as providers will have to spend time doing this data entry as staff will not know about medications that are listed, and if they miss enter data it could be a liability for the provider. This bill causes an unnecessary waste of time (close to an hour a day) for primary care providers who already know what medications their patients are on, as 26 medications are on this list, which are prescribed regularly by primary care. This database will become enormous in short order – who is going to manage this? This legislation interferes with a providers' ability to prescribe medications in a timely manner to patients, and takes providers away from patients by forcing them to do more unnecessary burdensome paperwork.

If you are bound and determined proceed with the database, start small. Start with certain specifically abused medications. That can be expanded if needed but rarely are regulations rolled back.

Lastly, regarding telemedicine. I have already received "Teledoc notes" on several patients. All of them have been substandard. While the providers may not be disciplined by the state, it won't be long until the malpractice lawyers have a new source of income.

I hope my input helpful. Best wishes – appreciate the work you folks do.

John Nolte, MD  
Miriam Nolte, MD  
Hillside Family Medicine, LLC

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**From:** Lynette Bergh  
**Sent:** Thursday, March 24, 2016 1:21 PM  
**To:** Helen Phillips  
**Subject:** FW: SB 74

Testimony on SB 74.

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**From:** Ryan Ruggles [mailto:rruggles@anhc.org]  
**Sent:** Thursday, March 24, 2016 12:46 PM  
**To:** Rep. Steve Thompson <Rep.Steve.Thompson@akleg.gov>; Rep. Mark Neuman <Rep.Mark.Neuman@akleg.gov>; Rep. Dan Saddler <Rep.Dan.Saddler@akleg.gov>; Rep. Bryce Edgmon <Rep.Bryce.Edgmon@akleg.gov>; Rep. Les Gara <Rep.Les.Gara@akleg.gov>; Rep. Lynn Gattis <Rep.Lynn.Gattis@akleg.gov>; rep.daveguttenberg@akleg.gov; Rep. Cathy Munoz <Rep.Cathy.Munoz@akleg.gov>; Rep. Lance Pruitt <Rep.Lance.Pruitt@akleg.gov>; Rep. Tammie Wilson <Rep.Tammie.Wilson@akleg.gov>  
**Subject:** SB 74

House Finance Chairs, Vice Chair, and Members-

I am a pharmacist in the Anchorage area and my thoughts and opinions are my own.

I have been working in Anchorage since 2010, and I have previously overseen 24 different pharmacies as a Regional Manager.

I believe that this bill is addressing a problem in this state, and I respect the idea that this bill is trying to accomplish.

I am in favor of the increased access to the right people in order to help prevent opioid abuse.

I think it will increase utilization if we can delegate the access to other staff members.

I also have been aware that many providers (prescribers as well as pharmacists) are not aware of the PDMP or do not know how to get access. Making them aware could increase use.

I also believe that this needs to be a team effort between prescribers and pharmacists in order to really reduce the problem.

The DEA would state the pharmacists and prescribers have "Dual Responsibility" for controlled substances.

I do think that the wording of checking the PDMP for every Controlled Substance Rx dispensed is excessive.

If a patient has 4 refills on a medication, and I have checked on the initial fill, I am unsure that the additional checks would be helpful, especially in the instance of a seizure medication for a young child.

Additionally, if we are looking at the information that frequently, it becomes easy to miss the important information.

This, in the pharmacy world, has been known as "alert fatigue". The idea that being alerted constantly about information can lead to missing something simply because there are too many unnecessary alerts.

I would suggest and be more supportive of language resembling this:

"When a new prescription for a controlled substance, or a change in a current one occurs, the best practice is for the prescriber or delegate to check the PDMP before issuing to the patient but not required given professional judgement on the part of the prescriber."

"When a new or changed prescription for a controlled substance is filled, the best practice is for the pharmacist or delegate to check the PDMP before issuing to the patient but not required given professional judgement on the part of the pharmacist."

Change could be defined as dose, quantity, directions, or prescriber.

Please remember, that without a prescription a pharmacist cannot dispense controlled substances by laws that already exist. So encouraging prescribers to check, could remove the possibility of an Rx being filled.

Utilizing this methodology, if this procedure is met, every New patient will have their information checked. This ensures that there are checks and balances. If the prescriber misses their part, then the pharmacist should catch it. Additionally, if the prescriber is checking, and if the pharmacist misses their check, then at least a practitioner looked at the information. This method should cast a good net for limiting the problem we are facing without being overly aggressive, and affecting practices that the bill is not intending to affect.

This also allows us to utilize our professional judgement to either more frequently or less frequently check the database.

Please note, that there are many red flags that pharmacists should be aware of that could tip them off to identify potential behavior that could lead to diversion.

There are Continuing Education courses that can reflect this.

I support the more frequent uploading to the database as it becomes much more useful as a tool for pharmacists and prescribers to use.

I would be happy to answer any questions or concerns you may have.

Thank you for your time and consideration,

**Ryan Ruggles, PharmD**

**Pharmacy Manager**  
**Anchorage Neighborhood Health Center**  
**Phone: 907-743-7203 Fax 907-743-7257**  
**rruggles@anhc.org**

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UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION  
WASHINGTON, D.C. 20580

Office of Policy Planning  
Bureau of Competition  
Bureau of Economics

March 25, 2016

Representative Steve Thompson  
Co-Chair, House Finance Committee  
Alaska State Legislature  
State Capitol Room 515  
Juneau, AK 99801

Dear Representative Thompson:

The staffs of the Federal Trade Commission's ("FTC") Office of Policy Planning, Bureau of Economics, and Bureau of Competition<sup>1</sup> (collectively, "FTC staff") appreciate the opportunity to comment on certain telehealth provisions in Senate Bill 74<sup>2</sup> ("SB 74") that were transferred to SB 74 from Senate Bill 98<sup>3</sup> ("SB 98"). These provisions would allow licensed Alaska physicians located *out-of-state* to provide telehealth services in the same manner as licensed Alaska physicians located *in-state*, and would affirmatively allow certain Alaska-licensed behavioral health professionals to provide services remotely. The FTC staff offers no opinion on any aspect of SB 74 not directly addressed in this letter.

Telehealth, the use of telecommunications to provide health care services to remotely located patients,<sup>4</sup> readily crosses jurisdictional boundaries. Because of the state's vast size, rural nature, and harsh conditions, telehealth has long been a staple of Alaskan health care delivery.<sup>5</sup> FTC staff believes that the provisions in SB 74 that would allow out-of-state as well as in-state Alaska licensees to provide telehealth services without an in-person examination would represent a procompetitive improvement in Alaska's telehealth law. These provisions would likely increase the supply of telehealth providers, enhance competition, and reduce health care costs, thereby benefiting Alaskans, especially underserved populations with limited access to health care.

## I. INTEREST AND EXPERIENCE OF THE FEDERAL TRADE COMMISSION

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.<sup>6</sup> Competition is at the core of America's economy,<sup>7</sup> and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,<sup>8</sup> research,<sup>9</sup> and advocacy.<sup>10</sup>

In the 2004 FTC & U.S. Department of Justice report, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION*, the agencies considered the competitive effects of *State Restrictions on the Interstate Practice of Telemedicine*.<sup>11</sup> The central finding of that analysis is still accurate today: “When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve health care quality.”<sup>12</sup> The report also observed that “the practice of telemedicine has crystallized tensions between the states’ role in ensuring patients have access to quality care and the anticompetitive effects of protecting in-state physicians from out-of-state competition.”<sup>13</sup> Those conclusions, and the report’s recommendation to reduce barriers to telemedicine and competition from out-of-state providers,<sup>14</sup> underpin our comments in this letter.<sup>15</sup>

## **II. CURRENT ALASKA LAW ALLOWING IN-STATE PHYSICIANS TO PROVIDE TELEHEALTH SERVICES WITHOUT AN IN-PERSON EXAMINATION, AND PROPOSED EXTENSION TO OUT-OF-STATE ALASKA LICENSEES**

### **A. Current Alaska Law**

In 2014, Alaska enacted a law, ALASKA STAT. § 08.64.364 (“the law”), designed to increase the availability of telehealth services in Alaska by allowing physicians licensed and *located in* Alaska to prescribe drugs without conducting a physical examination under certain circumstances.<sup>16</sup> Specifically, the law prohibits the Alaska State Medical Board (“ASMB”) from disciplining a physician for prescribing drugs without conducting a physical examination,<sup>17</sup> even though the ASMB’s unprofessional conduct regulation authorizes the ASMB to discipline a licensee for prescribing a “medication to a person without first conducting a physical examination of that person, unless the licensee has a patient-physician or patient-physician assistant relationship with the person.”<sup>18</sup> While Section 08.64.364 expanded the availability of telehealth services in Alaska, it only applies “if the physician is *located in this state* and the physician or another licensed health care provider in the physician’s group practice is available to provide follow-up care[.]”<sup>19</sup>

### **B. Telehealth Provisions of SB 74**

SB 74 would likely expand the availability of telehealth services by eliminating the requirement that Alaska-licensed physicians be physically located in-state.<sup>20</sup> This extension would treat out-of-state physicians the same as in-state physicians, giving Alaskans access to telehealth services provided by out-of-state Alaska-licensed physicians who have met identical standards for licensure as Alaska’s in-state physicians. In addition to eliminating the in-state requirement for physicians, SB 74 would authorize regulations that would establish a standard of care for physicians prescribing medications without a physical examination. As discussed below, we suggest that legislators consider whether special standards of care are needed for telehealth.<sup>21</sup>

SB 74 would also clarify that certain behavioral health providers may use telehealth to diagnose and treat patients remotely.<sup>22</sup> Although telemedicine is often used in Alaska and elsewhere to provide behavioral health services,<sup>23</sup> current Alaska laws and regulations for these professionals have no provisions specific to telehealth. While SB 74 might encourage greater use

of telehealth by behavioral health professionals, its requirement that behavioral health professionals providing services remotely, unlike those providing services in person, share sensitive mental health records with a primary care provider could discourage its use for patients who wish to keep such records confidential.<sup>24</sup> In addition, as discussed below, we suggest that legislators consider whether special standards of care are needed for remotely provided behavioral health services.<sup>25</sup>

### **III. POTENTIAL COMPETITIVE EFFECTS OF SB 74's TELEHEALTH PROVISIONS**

Alaskans have long relied on telehealth to mitigate provider shortages and enhance access to care throughout the state. However, by allowing only physicians located in Alaska to prescribe medication without conducting a physical examination, current Alaska law unnecessarily restricts access to care from a substantial pool of providers. By eliminating the “in-state” requirement, SB 74 would potentially increase the supply of physicians and competition from lower-cost providers, reduce transportation costs, and improve access to quality care.

#### **A. Telehealth Already Expands Access to Health Care in Alaska**

Telehealth, including services from out-of-state providers, has long been a way to address health provider shortages and improve access to care in Alaska. Alaska has a longstanding and significant shortage of primary care and specialty physicians, including psychiatrists and non-physician behavioral health providers. The largest shortages are in rural Alaska.<sup>26</sup> Most of rural Alaska is designated a primary care physician Health Professional Shortage Area, with a total of 85 such designations. By meeting only 36% of the state’s need for primary care professionals, Alaska ranks 49<sup>th</sup> among the states and the District of Columbia.<sup>27</sup> Alaska’s shortage of behavioral health providers is even more extensive; almost all of Alaska is designated a Mental Health Care Health Professional Shortage Area, with the exception of small areas in the vicinity of Anchorage, Fairbanks, and Juneau. Alaska ranks 48<sup>th</sup> among the states and the District of Columbia in meeting only 23% of the state’s need for mental health professionals (some of whom are physicians).<sup>28</sup> These shortages are exacerbated by the difficulty of recruiting physicians to a region with an extreme climate that is distant from the rest of the United States.<sup>29</sup>

For decades, telehealth has played a role in responding to the challenges of provider shortages and caring for patients in remote, geographically isolated locations.<sup>30</sup> For example, the Indian Health Service (“IHS”) of the U.S. Department of Health and Human Services and the Alaska Native Tribal Health Consortium (“ANTHC”) routinely rely upon telehealth services to link community health aides at local clinics with distant primary care and specialty providers. ANTHC, which assumed responsibility for many IHS programs in Alaska, provides telehealth services through the Alaska Federal Health Care Access Network (“AFHCAN”); in 2013, about 16% of Alaska Natives received care through AFHCAN’s network.<sup>31</sup> Alaska’s hospitals also routinely offer telehealth services as a way to enhance the care of remote patients.<sup>32</sup>

Telehealth is also often used to provide behavioral health services to Alaskans because it can be readily provided through videoconferencing.<sup>33</sup> For example, the IHS Tele-Behavior Health Center of Excellence relies on remote psychiatrists to provide services to patients at its

clinics by videoconferencing.<sup>34</sup> Another provider of mental health services, the Alaska Psychiatric Institute's Telebehavioral Health Center, also relies on telehealth to provide services to about 26 towns or villages, most of which are not connected to the state's road system.<sup>35</sup> In addition, the state's Department of Corrections ("DOC"), the single largest provider of mental health care in Alaska, has used video conferencing since 2000 to facilitate counseling by psychiatrists and psychologists at prisoner facilities throughout the state.<sup>36</sup>

**B. SB 74 Is Likely to Promote Competition, Thereby Improving Access and Lowering Costs, Without Compromising Quality**

By effectively prohibiting out-of-state Alaska-licensed physicians from providing telehealth services without an in-person physical examination, ALASKA STAT. § 08.64.364 creates a significant and unnecessary barrier to the use of telehealth services in Alaska.<sup>37</sup> Only one other state, Louisiana, has a similar requirement.<sup>38</sup> A number of Alaskan authorities have expressed concerns that ALASKA STAT. § 08.64.364's requirement that the physician be located in Alaska bars qualified practitioners from providing telehealth services, exacerbating the state's shortage of physicians.<sup>39</sup> For example, before the law was enacted, a DOC representative testified that the requirement "that the physician must be physically located in the state in order to render care over the phone or by other means" would hamper DOC's ability to provide telemedicine services in Alaska.<sup>40</sup> Similarly, state authorities have raised strong concerns about limits on the ability of out-of-state practitioners to provide behavioral health services, even though such services do not ordinarily involve a physical examination. According to the Alaska Department of Health & Social Services, "many Alaska health care providers have historically contracted with psychiatrists who are licensed by the State Medical Board to practice in Alaska, but who are physically located elsewhere."<sup>41</sup> Thus, "some established providers are now unwilling to continue providing the same quality, appropriate, needed care through high-quality telehealth practice from outside the state for fear of sanction by the Board. *For this reason, it is critical to Alaska's behavioral health care system (as well as public health and safety in the state) that SB98's provision eliminating the in-state requirement from AS08.64.346(a)(2) becomes law – either through SB98 or another vehicle.*"<sup>42</sup>

By allowing out-of-state physicians licensed in Alaska to provide telehealth services to Alaskans, SB 74 would expand access to telehealth services, supporting the goal of Alaska's telehealth program "to bring quality primary care and specialty services to remote areas of the state, where it might not otherwise be feasible to do so."<sup>43</sup> A potential expansion of access to telehealth services pursuant to SB 74 would also be consistent with the recommendations of the Alaska Health Care Commission ("AHCC"), which has identified telehealth as one of its top priorities for increasing health care value as well as enhancing access to behavioral health and primary care providers.<sup>44</sup> Similarly, the Institute of Medicine supports the expanded use of telehealth throughout the United States, because "[a]ccess to high-quality primary and specialty care for beneficiaries in medically underserved metropolitan and nonmetropolitan areas would be improved by increasing the availability of telehealth technologies."<sup>45</sup>

Data on the relative numbers of in-state and out-of-state physicians licensed in Alaska support the conclusion that SB 74 could substantially expand access to telehealth services. If SB 74 eliminated ALASKA STAT. § 08.64.364's *in-state* requirement, it would approximately double

the supply of physicians who could provide telehealth services, based on estimates that approximately two thousand Alaska-licensed physicians have in-state addresses while another two thousand have out-of-state addresses.<sup>46</sup> As explained by a previous analysis of Alaska physician license records that also found that many Alaska licensees are located out-of-state, such licensees include physicians who sometimes work in-state, physicians who previously worked in-state but still maintain their Alaska license, physicians who provide telemedicine services for Alaska patients, and some who obtained a license but decided not to practice in the state.<sup>47</sup> In addition, Alaskan authorities predict that elimination of the in-state requirement would encourage out-of-state physicians who are not currently licensed in Alaska and wish to provide telehealth services to apply for Alaska licensure.<sup>48</sup> In sum, by eliminating the in-state requirement, SB 74 could immediately provide access to a variety of Alaska-licensed physicians located out-of-state, many of whom may have previously worked in Alaska and are familiar with the state's unique health care challenges.

This increase in the supply of practitioners likely has the potential to increase competition, enhance the quality of care readily available to remote patients, and reduce costs. Authoritative sources have found that health care prices in Alaska are high, in part due to insufficient competition. For example, the AHCC found that on average, "reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers—69% higher for commercial health insurers."<sup>49</sup> The AHCC attributed these high prices, in part, to "the relative lack of competition among practitioners, particularly in specialty care. . . . As a result, physicians can largely dictate the fees they are paid by commercial payers."<sup>50</sup>

By expanding the supply of telehealth services provided by Alaska-licensed but out-of-state practitioners, SB 74 could help reduce costs. Services provided by out-of-state providers are likely to cost less because of the provider's location. For example, use of an out-of-state provider could reduce costs for the Alaska Medical Assistance (Medicaid) program. If telehealth services provided by an out-of-state practitioner meet all requirements for reimbursement,<sup>51</sup> Alaska Medical Assistance reimburses such services at the lesser of the "rate established by the Medicaid agency in the state where the services were provided;" or "the rate or payment methodology established by Alaska Medical Assistance."<sup>52</sup> Accordingly, use of an out-of-state Medicaid telehealth provider would cost no more than use of a provider in Alaska, and may cost less.<sup>53</sup> Similarly, Medicare's Geographic Adjustment Factor ("GAF") for fee-for-service reimbursement of providers in Alaska is 1.29, the highest in the nation.<sup>54</sup> As a result, when an out-of-state physician provides covered telehealth services for an Alaska patient, Medicare reimbursement on average would be about 78% of what the reimbursement would have been, had the practitioner providing the services been located in Alaska.<sup>55</sup> Finally, if the relative reimbursement of in-state and out-of-state telehealth services by private sector payers is the same as what the AHCC found for overall reimbursement of physician services by commercial health insurers, private sector reimbursement of out-of-state providers of telehealth services would be only 59% of that paid to Alaska physicians.<sup>56</sup>

By eliminating the in-state requirement in ALASKA STAT. § 08.64.364, SB 74 would also facilitate the expansion of services from nationwide direct-to-consumer telehealth companies that operate in most states and have recently begun offering services to Alaskan patients or are interested in doing so.<sup>57</sup> Such companies connect patients with a provider upon consumer

request, and may offer live, interactive audio/video or audio-only interaction via computer, mobile app, and by telephone; some offer email or internet services.<sup>58</sup> These companies, which usually provide services for common minor conditions, may offer a convenient and cost-effective alternative to in-person care for many patients,<sup>59</sup> especially in Alaska, where an in-person visit might entail a long trip under adverse conditions. The advertised costs of telehealth services offered by such companies do not appear to depend upon the location of the provider, and such services typically cost considerably less than in-person services.<sup>60</sup> Use of these services may be paid for by employers, private insurance, or out-of-pocket.<sup>61</sup> To the extent that such services allow patients to avoid unnecessary and costly visits to physicians' offices, urgent care centers, or the emergency department, and to the extent they offer a safe and effective way to obtain certain types of care, these services can provide a convenient, low cost alternative while still satisfying legitimate safety and quality standards.<sup>62</sup> Therefore, expanding the availability of such services can benefit consumers.

SB 74 could also help to reduce travel costs for both patients and providers in Alaska.<sup>63</sup> Telehealth services are not only convenient for many Alaskans, they may be a virtual necessity for patients in remote areas.<sup>64</sup> For example, the Alaska Department of Corrections found that the use of telemedicine "is more efficient and cost-effective" than having psychiatrists travel to remote facilities several times a month.<sup>65</sup> Improved access to telehealth services could also lead to substantial savings in transportation costs paid by Alaska Medical Assistance (Medicaid), which spent \$76.9 million for transportation services in 2015, more than half the amount that it paid for physician services (\$143.2 million), and nearly half of what it paid for mental health services (\$159.1 million).<sup>66</sup>

In sum, by eliminating the "in-state" requirement in ALASKA STAT. § 08.64.364(a)(2), SB 74 would likely increase the supply of physicians, potentially increasing competition from lower-cost providers and improving access to quality care that would not otherwise be readily available to many Alaskans. The bill also has the potential to reduce transportation costs for patients and providers. These aspects of SB 74 are consistent with the recommendation of the AHCC to foster telehealth and design solutions to reduce barriers to its development and use.<sup>67</sup>

Proponents of the requirement that only physicians licensed in Alaska and *located in the state* be permitted to prescribe medications without conducting a physical examination characterize the requirement as a "safeguard."<sup>68</sup> FTC staff urges the legislature to carefully consider this claim to determine whether the in-state requirement is necessary to protect patient health or safety. In particular, in a state as large as Alaska, even an in-state physician may not be able to provide follow-up care in-person. Likewise, a physician in Seattle is physically closer to some parts of Alaska than a physician in Anchorage.<sup>69</sup>

It appears that the sole proffered justification for the in-state requirement is that out-of-state physicians, even if licensed in Alaska, may not be familiar with local conditions and may be unable to provide appropriate referrals.<sup>70</sup> FTC staff encourages the legislature to fully consider this purported justification.<sup>71</sup> The legislature may also wish to consider whether a remote provider's understanding of local conditions and practitioners adds value when a patient receives telehealth services at a local clinic or health care facility.

Finally, we urge the legislature to consider the potential consequences of SB 74's proposed requirements that the relevant professional boards adopt regulations establishing special standards of care for physician and behavioral health practitioners who provide services remotely. The bill would require the ASMB to "adopt regulations establishing standards of care for a physician who is rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug to a person without conducting a physical examination[.]"<sup>72</sup> A telehealth provider who has not made a physical examination is already subject to the state's licensure requirements, including an obligation to meet the state's existing standard of care. The development of additional "safeguards" solely for telehealth providers might lead to the adoption of unnecessary restrictions that would only serve to restrict competition, and thereby undermine SB 74's goal of enhancing access to telehealth services.

We encourage the Alaska legislature to consider clarifying the proposed amendments to ensure that any subsequent regulations are narrowly tailored and would not undermine this goal of SB 74. In particular, the legislature may wish to include a provision expressly acknowledging that the physician-patient relationship can be established using telehealth communications.<sup>73</sup> Similarly, we encourage the legislature to consider whether the bill's requirements that behavioral health boards "adopt regulations restricting the evaluation, diagnosis, supervision, and treatment of a person" provided remotely by establishing standards of care, including standards for supervision, practice, and other matters, could lead to regulations that undermine the availability of telemental health services, and whether they are needed.<sup>74</sup>

#### **IV. CONCLUSION**

By enacting ALASKA STAT. § 08.64.364, the Alaska legislature determined that Alaskans would benefit from increased access to telehealth services by eliminating the in-person physical examination requirement under certain circumstances. That provision did not extend to physicians licensed in Alaska, but located out-of-state. FTC staff urges the legislature to consider whether there are any legitimate health or safety justifications for prohibiting physicians licensed in Alaska, but located out of state, from providing telehealth services in the same manner as in-state physicians. By eliminating the "in-state" requirement, SB 74 would likely expand the supply of telehealth providers, promote competition, and increase access to safe and cost-effective care. It could also reduce transportation costs for Alaska patients and providers. For these reasons, the elimination of the "in-state" requirement by SB 74 appears to be a procompetitive improvement in the law that would benefit Alaska health care consumers, including its most vulnerable populations.

We appreciate your consideration of FTC staff's views.

Respectfully submitted,

Marina Lao, Director  
Office of Policy Planning

Ginger Zhe Jin, Director  
Bureau of Economics

Deborah Feinstein, Director  
Bureau of Competition

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<sup>1</sup> This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize us to submit these comments.

<sup>2</sup> S.B. 74, 29th Leg., 2nd Sess., sec. 1-7, (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016), <http://www.legis.state.ak.us/PDF/29/Bills/SB0074E.PDF>.

<sup>3</sup> S.B. 98, 29th Leg., 2nd Sess., (Alaska 2016) (L&C Committee Substitute, March 4, 2016), <http://www.akleg.gov/PDF/29/Bills/SB0098C.PDF>.

<sup>4</sup> While there is no single, universally accepted definition of telehealth or telemedicine, both terms “describe the use of medical information exchanged from one site to another via electronic communications to improve the patient’s health status.” BOARD ON HEALTH CARE SERVICES, INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 3, 134 (Tracy A. Lustig, Rapporteur) (2012) [hereinafter INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT], <http://www.nap.edu/catalog/13466/the-role-of-telehealth-in-an-evolving-health-care-environment>.

<sup>5</sup> See *infra* notes 30-36 and accompanying text. See also THE KAISER COMM. ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., PUTTING MEDICAID IN THE LARGER BUDGET CONTEXT: AN IN-DEPTH LOOK AT THREE STATES IN FY 2015 AND 2016, 4 (Oct. 2015), <http://files.kff.org/attachment/issue-brief-putting-medicaid-in-the-larger-budget-context-an-in-depth-look-at-three-states-in-fy-2015-and-2016> (“Alaska’s vast size, rural/frontier nature and arctic climate add a unique level of complexity in providing health care services to its residents.”).

<sup>6</sup> Federal Trade Commission Act, 15 U.S.C. § 45.

<sup>7</sup> *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).

<sup>8</sup> See generally FTC STAFF, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2013), <https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf>.

<sup>9</sup> See, e.g., FTC & U.S. DEP’T OF JUSTICE (“DOJ”), IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

<sup>10</sup> FTC and staff advocacy can include letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. See, e.g., FTC Staff Comment to the West Virginia House of Delegates Regarding SB 597 and the Competitive Implications of Provisions Regarding “Cooperative Agreements” Between—and Possible Exemptions From the Federal Antitrust Laws For—Health Care Providers (March 10, 2016), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf); Brief of the Fed. Trade Comm’n as Amicus Curiae, In Support of No Party, In re Nexium (Esomeprazole) Antitrust Litig., No. 15-2005 (1st. Cir. Feb. 12, 2016), [https://www.ftc.gov/system/files/documents/amicus\\_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf](https://www.ftc.gov/system/files/documents/amicus_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf); FTC STAFF, POLICY PERSPECTIVES: COMPETITION AND

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THE REGULATION OF ADVANCED PRACTICE NURSES (March 2014), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf).

<sup>11</sup> See FTC & DOJ, *supra* note 9, ch. 2, at 30 (section on “*State Restrictions on the Interstate Practice of Telemedicine*”).

<sup>12</sup> *Id.* Executive Summary, at 23.

<sup>13</sup> *Id.* ch. 2, at 32.

<sup>14</sup> *Id.* Executive Summary, at 23 (discussing uniform licensing standards and reciprocity compacts as mechanisms to reduce barriers).

<sup>15</sup> This advocacy also draws on knowledge acquired during the 2014 FTC workshop, *Examining Health Care Competition*, <https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition>. The transcript of the panel on *Innovations in Health Care Delivery*, which covered telehealth, is on pages 67-122 of the transcript of the proceedings on March 20, 2014, [https://www.ftc.gov/system/files/documents/public\\_events/200361/transcriptmar20.pdf](https://www.ftc.gov/system/files/documents/public_events/200361/transcriptmar20.pdf).

<sup>16</sup> See Alaska H.B. 281, An Act relating to prescription of drugs by a physician without a physical examination (2014) (codified at ALASKA STAT. § 08.64.364 (2015)), at <http://www.legis.state.ak.us/PDF/28/Bills/HB0281Z.PDF>. See also Rep. Lynn Gattis, HB 281 Sponsor Statement, [http://www.legis.state.ak.us/basis/get\\_documents.asp?session=28&docid=24232](http://www.legis.state.ak.us/basis/get_documents.asp?session=28&docid=24232) (explaining that the goal of HB 281 is to facilitate access to telemedicine).

<sup>17</sup> ALASKA STAT. § 08.64.364(a)(1) prohibits the ASMB from imposing “disciplinary sanctions on a physician for prescribing, dispensing, or administering a drug to a person without conducting a physical examination if (1) the prescription drug is (A) not a controlled substance; or (B) a controlled substance and is prescribed, dispensed or administered by a physician when an appropriate licensed health care provider is present with the patient to assist the physician with examination, diagnosis, and treatment.”

<sup>18</sup> ALASKA ADMIN. CODE tit. 12, § 40.967(29) (2015).

<sup>19</sup> ALASKA STAT. § 08.64.364(a)(2) (emphasis added). To allow physicians in distant practices to provide telehealth services as the law intends, the requirement of availability for follow-up care must be interpreted as care provided by telehealth technology, regardless of whether the practitioner is located in- or out-of-state. FTC staff respectfully suggests that the legislature consider clarifying the law to expressly provide that “follow-up care” may be provided remotely, by telehealth service.

<sup>20</sup> S.B. 74, 29th Leg., 2nd Sess., sec. 4, § 08.64.364(a)(2) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016). According to the sponsor of SB 98, the bill’s provisions “address[] some challenges with the implementation of [ALASKA STAT. § 08.64.364] that continue to provide barriers to the effective delivery of telemedicine healthcare services in Alaska,” by “eliminat[ing] the requirement that the physician is located in the state, and retain[ing] the requirement that physicians be licensed by the Alaska Medical Board.” Sen. Peter A. Micciche, SB 98 Sponsor Statement, [http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=51380](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51380). Because SB 74 would not modify the requirement of Alaska licensure for out-of-state physicians who provide telehealth services to Alaska patients, this FTC staff comment does not address that specific issue. We note generally, however, that the necessity of multi-state licensure for physicians who practice across state lines is often considered a barrier to the deployment of telehealth services, and that less restrictive alternatives could reduce the burdens of practicing across state lines yet maintain appropriate standards of safety, quality, and effectiveness. See *supra* notes 11-14 and accompanying text. In addition, this comment expresses no opinion on S.B. 74, 29th Leg., 2nd Sess., sec. 5, § 08.64.364(d)(1) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016).

<sup>21</sup> See *infra* notes 72-73 and accompanying text.

<sup>22</sup> SB 74 would amend the practice acts for a number of behavioral health professionals who do not have prescriptive authority and do not conduct physical examinations (professional counselors (ALASKA STAT. § 08.29.400); marriage and family therapists (ALASKA STAT. § 08.63.210); psychologists and psychological associates (ALASKA STAT. § 08.86.204); and social workers (ALASKA STAT. § 08.95.050)). These professionals are not currently prohibited

from providing telehealth services in- or out-of-state. In general, the amendments to these sections provide that the relevant board may not impose disciplinary sanctions on a licensee for the evaluation, diagnosis, or treatment of a person through audio, video, or data communications when physically separated from the person if the licensee or another licensed provider is available to provide follow-up care and if the licensee sends records of the encounter to the patient's primary care provider, with the patient's consent. The provisions requiring a patient's records to be sent to a primary care provider are similar to ALASKA STAT. § 08.64.364(a)(3), which apparently assumes that telehealth services might be sought in lieu of an in-person visit to a patient's primary care provider, and thus allows a physician to prescribe drugs without a physical examination only if the patient "consents to sending a copy of all records of the encounter to the person's primary care provider if the prescribing physician is not the person's primary care provider, and the physician sends the records to the person's primary care provider." FTC staff urges the legislature to consider whether this provision might act as a barrier to care for patients who do not have a primary care provider.

<sup>23</sup> See *infra* notes 33-36 and accompanying text; see also Adam Darkins, *U.S. Department of Veterans Affairs*, in INSTITUTE OF MEDICINE, *THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT*, *supra* note 4, at 99, 103 ("Mental health care is a major reason for implementing telehealth.").

<sup>24</sup> See, e.g., *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8-9 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Rebecca Ling, Director of Recovery Services, Cook Inlet Tribal Council), <http://www.legis.state.ak.us/PDF/29/M/SHSS2015-04-131336.PDF> (describing the "reluctance of patients to sign releases to share records with primary care physicians, which is required by the law."). FTC staff encourages the legislature to consider whether including the record transfer requirement in the practice acts of the behavioral health providers serves a valid health and safety purpose, or whether it might unnecessarily restrict telemental health services that may be more convenient and perhaps less costly than comparable in-person services.

<sup>25</sup> See *infra* note 74 and accompanying text.

<sup>26</sup> See, e.g., SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, ALASKA DEP'T OF HEALTH & SOCIAL SERVICES, *HEALTH CARE IN ALASKA* 13, 21-23 (April 14, 2014) (prepared for the Alaska Health Care Comm'n), <http://dhss.alaska.gov/dph/HealthPlanning/Documents/pdf/Health%20Care%20in%20Alaska%20-%202014%20update.pdf> (discussing concerns about current and future physician and other health professional shortages, and explaining that physicians (especially specialists) are located in urban areas); ALASKA PHYSICIAN SUPPLY TASK FORCE, *SECURING AN ADEQUATE NUMBER OF PHYSICIANS FOR ALASKA'S NEEDS* 1 (Aug. 2006), <http://www.alaska.edu/health/downloads/PSTFweb.pdf> ("Alaska has a shortage of physicians. . . . Up to 16% of rural physicians were vacant in 2004 . . . Several important specialties are in serious shortage in Alaska.").

<sup>27</sup> See The Henry J. Kaiser Family Found., *Primary Care Health Professional Shortage Areas (HPSAs)* (April 28, 2014), <http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/>; Health Resources & Services Admin., U.S. Dep't Health & Human Services, *Data Warehouse, Map Tool*, <http://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA&gt=State&cd=02&dp=PC> (accessed Mar. 3, 2016).

<sup>28</sup> See The Henry J. Kaiser Family Found., *Mental Health Care Health Professional Shortage Areas (HPSAs)* (April 28, 2014), <http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/> (reporting 63 Mental Health HPSA Designations); Health Resources & Services Admin., U.S. Dep't Health & Human Services, *Data Warehouse, Map Tool*, <http://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA&gt=State&cd=02&dp=MH> (accessed Mar. 3, 2016). Mental Health HPSA designations are based on population-to-health professional ratio of psychiatrists and "core mental health professionals," including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. See Health Resources & Services Admin., U.S. Dep't Health & Human Services, *Mental Health HPSA Designation Criteria*, <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>. See also SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, *supra* note 26, at 25 ("2012 Alaska Health Workforce Vacancy Study showed that the vacancy rates for all behavioral health occupations were about 10%, and the psychiatrist vacancy rate [was] 22% statewide.").

<sup>29</sup> See, e.g., MARK A. FOSTER & SCOTT GOLDSMITH, INSTITUTE OF SOCIAL AND ECONOMIC RESEARCH, *ALASKA'S HEALTH-CARE BILL: \$7.5 BILLION AND CLIMBING* 8 (2011),

<http://www.iser.uaa.alaska.edu/Publications/RevisedHealthcare.pdf> (explaining that Alaska is at a competitive disadvantage with other states for attracting physicians and other healthcare professionals because “[i]t’s isolated; it has long harsh winters; and many of its communities aren’t even on the road system.”).

<sup>30</sup> See, e.g., Thomas S. Nesbitt, *The Evolution of Telehealth: Where Have We Been and Where Are We Going?*, in INSTITUTE OF MEDICINE, *THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT*, *supra* note 4, at 11, 12 (“Alaska has been a model for the development and use of telemedicine for decades”).

<sup>31</sup> See, e.g., Mark Carroll, *Indian Health Service*, in INSTITUTE OF MEDICINE, *THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT*, *supra* note 4, at 104, 105 (since the 1970s, the Indian Health Service and other federal agencies have used telehealth in Alaskan village clinics and in other states); Howard Hays et al., *State of the Art and Science: The Success of Telehealth Care in the Indian Health Service*, 16 AM. MED. ASS’N J. ETHICS, 986 (2014) (AFHCAN, which has been in operation since 2001, operates at 250 sites throughout Alaska, most with a population of fewer than 300 residents).

<sup>32</sup> See Stewart Ferguson, *American Telemedicine Association*, in INSTITUTE OF MEDICINE, *THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT*, *supra* note 4, at 117 (“Alaskan hospitals embrace telehealth as part of their strategies and business plans.”); ALASKA DEP’T OF HEALTH & SOCIAL SERVICES & ALASKA STATE HOSPITAL & NURSING HOME ASS’N, *TELEHEALTH IN ALASKA HOSPITALS—IDENTIFIED ISSUES, NEEDS & OPPORTUNITIES* 7 (2014) (listing the types of telehealth services utilized by specific Alaskan hospitals (e.g., telebehavioral health, telestroke, and teledermatology), <http://dhss.alaska.gov/ahcc/Documents/meetings/201412/Public%20Comment%20Attachments%20from%20ASHNHA%20and%20Boards.pdf>).

<sup>33</sup> See, e.g., Jay H. Shore, *Critical Relationships in Telehealth with American Indians and Alaskan Natives*, in INSTITUTE OF MEDICINE, *THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT*, *supra* note 4, at 108, 109.

<sup>34</sup> Howard Hays et al., *supra* note 31, at 990.

<sup>35</sup> See, e.g., CHARLES TOWNLEY & RACHEL YALOWICH, NATIONAL ACADEMY FOR STATE HEALTH POLICY, *IMPROVING BEHAVIORAL HEALTH ACCESS & INTEGRATION USING TELEHEALTH & CONSULTATION: A HEALTH CARE SYSTEM FOR THE 21<sup>ST</sup> CENTURY* (2015), <http://www.nashp.org/wp-content/uploads/2015/11/Telemedicine.pdf>.

<sup>36</sup> See SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, *supra* note 26, at 20, 25, 30.

<sup>37</sup> Indeed, HB 281, which became ALASKA STAT. § 08.64.364, apparently provided that only physicians located in Alaska could prescribe medications without conducting a physical examination because “Alaska doctors said they wanted to protect Alaskan doctors.” *Prescription without Physical Examination: Hearing on H.B. 281 Before the S. Comm. On Health & Social Services*, 28th Leg., 2nd Sess. 13 (Alaska, April 14, 2014) (detailed minutes of hearing) (statement of Rep. Lynn Gattis), at <http://www.legis.state.ak.us/pdf/28/M/SHSS2014-04-141330.PDF>.

<sup>38</sup> See LA. REV. STAT. ANN. § 37:1271(B)(2)(b)(i), (iii) (limiting an exemption from Louisiana’s in-person patient history or physical examination requirement to licensed Louisiana physicians who maintain “a physical practice location within the state of Louisiana” or affirm to the board that they have made an arrangement with a local physician for follow-up care).

<sup>39</sup> See Dep’t of Health & Social Services (“DHSS”), 29<sup>th</sup> Alaska State Legislature—Work Draft Review, SB 98, *Prescription Without Physical Examination* (Jan. 22, 2016) [hereinafter DHSS, Work Draft Review, SB 98,] [http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=51389](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51389) (The requirement in ALASKA STAT. § 08.64.364(a)(2) that a licensee be “physically located in the state at the time the prescription is made” . . . “has, unfortunately, brought a damaging unintended consequence: it has exacerbated the state’s shortage of available psychiatric care”).

<sup>40</sup> *Prescription without Physical Examination: Hearing on H.B. 281 Before the H. Comm. On Labor & Commerce*, 28th Leg., 2nd Sess. 11-12 (Alaska, Mar. 26, 2014) (detailed minutes of hearing) (statement of Robert Lawrence, Chief Medical Officer, Inmate Health, Department of Corrections), <http://www.legis.state.ak.us/pdf/28/M/HL!C2014-03-261539.PDF> (testimony about HB 281, which became ALASKA STAT. § 08.64.364).

<sup>41</sup> DHSS, Work Draft Review, SB 98, *supra* note 39, at 1. *See also Prescription without Physical Examination: Hearing on H.B. 281 Before the H. Comm. On Labor & Commerce*, 28th Leg., 2nd Sess. 12-14 (Alaska, Mar. 26, 2014) (detailed minutes of hearing) (statement of Kate Burkhart, Executive Director, Alaska Mental Health Board, Dep't of Health & Social Services) (Alaska's community behavioral health centers and federally qualified health centers often contract with Alaska-licensed psychiatrists from the University of Washington and Children's Hospital to provide tele-psychiatry services); *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Rebecca Ling, Director of Recovery Services, Cook Inlet Tribal Council) (testimony on "the success of tele-psychiatry service for behavioral health issues provided by physicians outside the state, but licensed in Alaska. She said the services have been provided by the University of Colorado for seven years.").

<sup>42</sup> DHSS, Work Draft Review, SB 98, *supra* note 39, at 1 (emphasis in original).

<sup>43</sup> DIV. OF HEALTH CARE SERVICES, DEP'T OF HEALTH & SOCIAL SERVICES, ALASKA MEDICAID 2015 ANNUAL REPORT 43 (2016) [hereinafter, ALASKA MEDICAID 2015 ANNUAL REPORT] <http://dhss.alaska.gov/dhcs/Documents/PDF/Alaska-Medicaid-Annual-Report-SFY2015.pdf>.

<sup>44</sup> STATE OF ALASKA HEALTH CARE COMMISSION, TRANSFORMING HEALTH CARE IN ALASKA, ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION iv, 20 (2014) [hereinafter 2014 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION], <http://dhss.alaska.gov/ahcc/Documents/2014Annual%20ReportFINAL.pdf>.

<sup>45</sup> COMMITTEE ON GEOGRAPHIC ADJUSTMENT FACTORS IN MEDICARE PAYMENT, INSTITUTE OF MEDICINE, GEOGRAPHIC ADJUSTMENT IN MEDICARE PAYMENT: PHASE II, IMPLICATIONS FOR ACCESS, QUALITY, AND EFFICIENCY 84 (Margaret Edmunds & Frank A. Sloan, Eds.) (2012), <http://iom.nationalacademies.org/Reports/2012/Geographic-Adjustment-in-Medicare-Payment-Phase-II.aspx>. *See also* Hilary Daniel & Lois Snyder Sulmasy, *Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper*, 163 ANN. INT. MED. 787 (2015) ("Research shows that telemedicine can potentially reduce costs, improve health outcomes, and increase access to primary and specialty care.").

<sup>46</sup> FTC Staff analysis of active physician (MD and DO) professional licenses from the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business & Professional Licensing (March 1, 2016), <https://www.commerce.alaska.gov/CBP/Main/SearchInfo.aspx>. *See also Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Alaska State Sen. Peter Micciche, sponsor of SB 98) (because ALASKA STAT. § 08.64.364 "does not allow stateside physicians to practice telemedicine across state lines, . . . the pool of physicians that can provide this service is greatly diminished").

<sup>47</sup> *See* ALASKA PHYSICIAN SUPPLY TASK FORCE, SECURING AN ADEQUATE NUMBER OF PHYSICIANS FOR ALASKA'S NEEDS 24 (Aug. 2006) (According to the State of Alaska Division of Occupational Licensing, 1501 physicians have Alaska addresses, but "[n]early 1,000 additional physicians (MD and DO) have active licenses to practice in Alaska but do not have Alaska addresses. These include physicians who work periodically as *locum tenens* practitioners, some who visit the state to provide specialty services on an itinerant basis, physicians licensed in Alaska in order to provide telemedicine consults for Alaska patients, others who may not visit on any regular basis, some who have left the state but maintain their license, and some who have obtained a license but decided not to practice in the state.").

<sup>48</sup> *See* Alaska Dept. of Commerce, Community and Economic Development, Fiscal Note 2 (Feb. 24, 2016), [http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=51406](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51406) (SB 98 "would dramatically increase the number of applicants [for physician licensure], [and] the geographic reach of applicant licensure . . .").

<sup>49</sup> STATE OF ALASKA HEALTH CARE COMM'N, TRANSFORMING HEALTH CARE IN ALASKA, ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION iv, 13 (2011) [hereinafter 2011 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION], [http://dhss.alaska.gov/ahcc/Documents/2011\\_report%201-15-12\\_final.pdf](http://dhss.alaska.gov/ahcc/Documents/2011_report%201-15-12_final.pdf). *See also* FOSTER & GOLDSMITH, *supra* note 29, at 8 (Private insurance payments to doctors for a typical office visit are about 35% higher than the average payment in the rest of the U.S.); *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Alaska State Sen. Peter Micciche, sponsor of SB 98) (Alaska's Dep't of Health &

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<sup>59</sup> See, e.g., Mehrotra et al., *supra* note 58, at 73; Ateev Mehrotra, *The Convenience Revolution for Treatment of Low-Acuity Conditions*, 310 JAMA 35 (2013).

<sup>60</sup> See, e.g., Patrick T. Courneya, Kevin J. Palattao & Jason M. Gallagher, *HealthPartners' Online Clinic for Simple Conditions Delivers Savings of \$88 Per Episode and High Patient Approval*, 32 HEALTH AFF. 385, 386, 388-89 (2013); Daniel & Sulmasy, *supra* note 45, at App. 4 (“An e-visit typically costs approximately \$40 (vs. \$73 for an in-person visit”).

<sup>61</sup> See, e.g., Uscher-Pines & Mehrotra, *supra* note 58, at 261 (study of CALPers enrollees offered the option of using Teladoc); Daniel & Sulmasy, *supra* note 45, at App. 4 (employers and insurance companies may reimburse direct-to-patient telemedicine services).

<sup>62</sup> See, e.g., Patrick Brunett et al., *Use of voice and video internet technology as an alternative to in-person urgent care clinic visits*, 21 J. TELEMED. TELECare 219 (2015) (patient-initiated online Internet visits are an alternative to urgent and primary care). Cf. Uscher-Pines & Mehrotra, *supra* note 58, at 263 (Teladoc visits are highly likely to be less expensive than office visits and the emergency department, but “it is unclear to what extent Teladoc visits are substituting for office or ED visits and to what extent they represent new use of health care for conditions that would have resolved themselves without intervention.”).

<sup>63</sup> See ALASKA MEDICAID 2015 ANNUAL REPORT, *supra* note 43, at 43 (telehealth “brings more timely services to the patient when time is of the essence, it saves the patient the inconvenience of traveling to receive care, and it reduces Medicaid program travel expenditures..”)

<sup>64</sup> See, e.g., Innovations Exchange Team, Agency for Healthcare Research and Quality, U.S. Dep’t of Health & Human Services, *Telehealth Improves Access and Quality of Care for Alaska Natives*, <https://innovations.ahrq.gov/perspectives/telehealth-improves-access-and-quality-care-alaska-natives> (“Air travel, which is expensive and weather-dependent, is required for most village inhabitants to reach a clinic, health center, or hospital outside their village. Roads simply do not exist between most villages. Patients would typically fly on a small airplane to a regional location to connect with a jet airplane to fly to Anchorage to receive treatment . . .”).

<sup>65</sup> *Prescription without Physical Examination: Hearing on H.B. 281 Before the H. Comm. On Labor & Commerce*, 28th Leg., 2nd Sess. 38 (Mar. 17, 2014) (detailed minutes of hearing) (statement of Laura Brooks, Health Care Administrator, Department of Corrections), <http://www.akleg.gov/pdf/28/M/HL!C2014-03-171519.PDF>

<sup>66</sup> See ALASKA MEDICAID 2015 ANNUAL REPORT, *supra* note 43, at 43, 54, 56 (Alaska’s telehealth program “reduces Medicaid program travel expenditures.”). See also SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, *supra* note 26, at 29, 30 (“It has been estimated that telehealth consultations eliminated the need to travel in 75% of patients involved in specialty consultations and 25% of patients involved in primary care.”); The Innovations Exchange Team, Agency for Healthcare Research and Quality, *supra* note 64 (estimate that the AFHCAN telehealth program “saved the state of Alaska \$8.5 million in travel costs for Medicaid patients”). States that receive federal Medicaid funds are required to ensure transportation for Medicaid beneficiaries to and from medical appointments. 42 C.F.R. § 431.53.

<sup>67</sup> See 2014 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION, *supra* note 44, at iv, 12, 20-21.

<sup>68</sup> *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Mike Haugen, Executive Director, Alaska State Medical Association). See also Letter from Michael Haugen, Executive Director, Alaska State Medical Association, to the Hon. Mia Costello, Alaska State Senate 1 (Feb. 25, 2016), [http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=51405](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51405) (describing the requirement that the physician be located in Alaska as a “patient protection sideboard[]”).

<sup>69</sup> For example, Ketchikan is more than 1,600 miles from Anchorage by road, while Seattle is only about 1,100 miles from Ketchikan.

<sup>70</sup> See Letter from Michael Haugen, *supra* note 68, at 2 (“Alaska-based physicians will be better equipped to make appropriate referrals to local physicians than a physician based in the Lower 48.”).

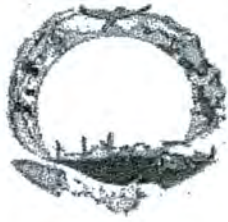
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<sup>71</sup> As discussed above, some physicians licensed in Alaska but located out-of-state have previously worked in Alaska, and could have as much knowledge of local conditions as in-state practitioners. *See supra* note 47 and accompanying text.

<sup>72</sup> S.B. 74, 29th Leg., 2nd Sess., sec. 3, § 08.64.101(6) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016).

<sup>73</sup> Although we take no position on the telemedicine policies of the Federation of State Medical Boards (“FSMB”) and the American College of Physicians (“ACP”), we note that under both policies, a physician-patient relationship can be established during a telemedicine encounter. *See* FED’N OF STATE MEDICAL BOARDS, MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE 5 (2014), [https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB\\_Telemedicine\\_Policy.pdf](https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf) (the physician-patient relationship to “be established using telemedicine technologies so long as the standard of care is met.”); Daniel & Sulmasy, *supra* note 45, at 788 (ACP takes the position that “a telemedicine encounter itself can establish a patient-physician relationship”). The FSMB policy also concluded that physicians using telemedicine may, in their professional discretion, recommend treatment and prescribe medications in the absence of a physical examination “in accordance with current standards of practice and . . . [with] the same professional accountability as prescriptions delivered during an encounter in person.” FSMB MODEL POLICY, *supra* at 8.

<sup>74</sup> S.B. 74, 29th Leg., 2nd Sess., sec. 1, § 08.29.400(c); sec. 2, § 08.63.210(d); sec. 6, § 08.86.204(d); sec. 7, § 08.95.050(c) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016). Under current law, the only supervision requirements for behavioral health practitioners are during periods of supervised practice leading to full licensure. For two of the behavioral health practitioners, such supervision may be conducted remotely. *See* ALASKA ADMIN. CODE tit. 12, § 18.115(d) (clinical social workers) ALASKA STAT. §§ 08.29.110(a)(6), 08.29.490(2) (professional counselors). The legislature may wish to consider whether to expressly allow marital and family therapists, psychologists, and psychological associates to be supervised remotely when fulfilling requirements for full licensure. *See* ALASKA STAT. § 08.63.110(b)(1) (requiring direct supervision of marital and family therapists during supervised practice leading to full licensure); ALASKA ADMIN. CODE tit. 12, § 60.080 (supervised experience for psychologists and psychological associates).



# Tanana Chiefs Conference

March 23, 2016

To: House Finance Committee Members  
Re: Tanana Chiefs Conference Concerns with Senate Bill 74 (SB 74)

Dear House Finance Committee Members,

On behalf of Tanana Chiefs Conference, I would like to express our concerns with Alaska Senate Bill 74. While this bill addresses the critically important issue of reducing prescription drug abuse in Alaska through changes to the Prescriptions Drug Monitoring Program (PDMP) we feel that there are several aspects of this bill that are onerous and will not further the achievement of this goal. We feel that the bill, as currently written, will unnecessarily increase administrative burdens on physicians and pharmacists with overly prescriptive bureaucratic requirements without decreasing the scourge of prescription opioid drug abuse.

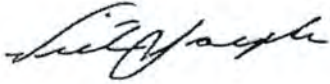
In particular, we feel that the requirement in HB344 for both pharmacists and prescribers (or their licensed/ registered "agents") to check the PDMP database prior to prescribing and dispensing all controlled substances is overly burdensome for pharmacists and prescribers, and it would NOT help stem the tide of prescription drug abuse as it is intended. **For this reason, we would respectfully ask that the language in SB 74 Version E Section 18 (AS17.30.200(k)(4) be removed from the bill.** Our pharmacy has estimated that this regulation (if passed) would require them to spend an additional 3-5 hours per day of checking the PDMP database. This would be in addition to our medical providers also spending an equivalent or greater amount of time checking the PDMP database. This will undoubtedly increase waiting times at our already busy pharmacy and also decrease appointment availability for our over-booked medical providers. We feel that professional judgment should be allowed for when prescribers/pharmacists utilize the database. The PDMP database is only one tool pharmacists and physicians use when trying to rule out possible narcotic abuse. It should not and cannot be viewed as the ONLY tool that can be used to root out prescription drug abuse. Other tools used by medical professionals to combat prescription drug abuse include pain contracts, urine drug screens, prescription insurance claim results and pill audits.

Tanana Chiefs Conference is an Alaska Native non-profit organization charged with advancing Tribal self-determination and enhancing regional Native unity. We provide services while balancing traditional Athabascan and Alaska Native values with modern demands. We work toward meeting the health and social service needs of Tribal members and beneficiaries throughout our region. As you know, opioid abuse is a national epidemic from which Alaska and the Alaska Native Community are not immune. Tanana Chiefs Conference is committed to collaborating with legislators, community members and other partners to help stem the tide of prescription opioid abuse. We feel that smart legislation, such as HB 344, is an important step in the right direction. However, the above revisions are necessary to

make this legislation as effective as possible without micromanaging the practices of Medicine or Pharmacy with heavy-handed bureaucratic regulations. Our physician's and pharmacist's professional judgement should supersede the mandatory PDMP check requirement prior to prescribing and dispensing all controlled substance prescriptions.

Again, we appreciate your efforts and leadership on this critical issue. Should there be anything that I or Tanana Chiefs Conference can do to help improve upon this legislation, please let me know.

Sincerely,  
Tanana Chiefs Conference

A handwritten signature in black ink, appearing to read "Victor Joseph". The signature is fluid and cursive, with a large initial "V" and "J".

Victor Joseph,  
TCC President and CEO

Esteemed Legislators and Guests,

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

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

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

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

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

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

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

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

Telemedicine, opioid monitoring and health information exchange without a doubt are definitely becoming mainstream and are no longer specialized projects. One major issue is that much of this data was silo'ed in the past and required providers to sign into many different systems to get the information they needed. This silo'ing of data systems means that many providers don't use the systems because

they don't have time or knowledge to search through multiple databases for all the patient data they need.

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

Cost savings are accomplished through healthier patients. By putting data in the hands of providers and, yes, also in the hands of patients, we can ensure a healthier population. It takes a team of payers, providers and patients to lower healthcare costs.

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

Thank you.

#### References:

<http://www.healthcare-informatics.com/article/telehealth-s-maine-supporters>

<http://telehealth.utmb.edu/presentations/The%20Telehealth%20Promise-Better%20Health%20Care%20and%20Cost%20Savings%20for%20the%2021st%20Century.pdf>

<http://hsc.unm.edu/community/telehealth/common/docs/benefit-cost-analysis-article.pdf>

<http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine's-impact-on-healthcare-cost-and-quality.pdf>

<http://www.radiologybusiness.com/topics/healthcare-economics/study-finds-hie-reduces-duplicate-imaging-provides-cost-savings>

Northwest Regional Telehealth Resource Center Conference March 2016, presentation by Peter Kung, System VP, SCL Health, "Virtual Health: The Rise of the Consumer and Strategies for Health Systems"

Northwest Regional Telehealth Resource Center Conference March 2016, presentation by Kristi Henderson, VP, Virtual Care & Innovation, Seton Healthcare Family, "Virtual Care: Building a Sustainable Model with Real Impact"

SB 74 Testimony provided by Thomas Behan, District 2.

Cities and especially our State are strapped for money. Medicaid may seem like a good deal now, but as the health care costs rise, and the federal government pays less to our State, the people of the State of Alaska will be responsible to pay the shortfall. Where will the State find the money other than taxpayers?

I am very much against this bill. I ask that you DO NOT pass this bill out of committee.

Thank you for hearing my testimony.

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**From:** Rep. Steve Thompson  
**Sent:** Friday, April 08, 2016 11:22 AM  
**To:** Helen Phillips  
**Cc:** Jane Pierson  
**Subject:** FW: Mental Health Budget

SB 74

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**From:** Elizabeth Ripley [mailto:eripley@healthymatsu.org]  
**Sent:** Thursday, April 07, 2016 7:07 PM  
**To:** Sen. Pete Kelly <Sen.Pete.Kelly@akleg.gov>; Sen. Anna MacKinnon <Sen.Anna.MacKinnon@akleg.gov>; Sen. Lyman Hoffman <Sen.Lyman.Hoffman@akleg.gov>; Rep. Les Gara <Rep.Les.Gara@akleg.gov>; Rep. Mark Neuman <Rep.Mark.Neuman@akleg.gov>; Rep. Steve Thompson <Rep.Steve.Thompson@akleg.gov>  
**Subject:** Mental Health Budget

Dear Legislators,

Thank you for the careful thought and hard work you have put it into the Conference Committee budget process. The Mat-Su Health Foundation urges you to consider the following as you finalize the budget:

Behavioral Health Treatment and Recovery Grants:

- **Please support the budget as submitted by the Governor and approved by the Senate.**
- While Medicaid expansion should help increase access to behavioral health services, and we advocated as such, current laws and regulations do not permit all providers to bill Medicaid. Until we rectify this, cutting behavioral health grants will only reinforce the current system that drives people to seek care in the emergency room. Our environmental scan of the crisis response system for behavioral health in Mat-Su found that the Mat-Su Regional Emergency Department has five times the number visits than our community mental health center. These visits cost Alaskans \$23M in 2013, not including doctor, EMS or police costs.

Behavioral Health Treatment and Recovery Grants Pilot Project

- **Please support the \$30 million added in the House version of the budget.**
- A comprehensive continuum of care for substance abuse services can make a real difference in Mat-Su and statewide. The specific needs of the regions or communities selected for funding under the proposed pilot program may include any level in the continuum of care: early intervention, outpatient services, intensive outpatient, partial hospitalization, residential treatment for low to high intensive needs, and medically monitored and managed inpatient detoxification services.

- Both Alaska and national experience demonstrate that alcohol and drug treatment works. Access to treatment can cut drug use in half, reduce criminal activity up to 80 percent, and reduce arrests up to 64 percent. Research also shows that the younger a person starts using drugs, the greater the likelihood of a future disorder, making prevention and early intervention key.

### Senior Community-Based Grants

- **Please support the budget as submitted by the Governor and approved by the House.**
- In 2011, MSHF produced the Mat-Su Regional Plan for Delivery of Senior Services. This invaluable report has been updated in 2016 as the Mat-Su Senior Services Environmental Scan. The updated scan reconfirms the rapid population growth by seniors in the Mat-Su valley, which has been 7.3 percent per year since 2003. In fact, the Mat-Su borough has the 2nd-fastest growing senior population in the nation.
- These grants provide services for disabled and elderly Alaskans with Alzheimer's disease and dementia. Services include Adult Day support, home-delivered meals, congregate meals, transportation, home services, and family caregiver support. The grants also help keep the doors open at the Aging and Resource Disabilities Centers and reduce Emergency Department utilization and preventable hospitalizations.
- Seniors who receive these services are often low income, homebound, and in need of assistance with daily living.

Again, thank you for your commitment and hard work!

*Elizabeth A. Ripley*

*Executive Director*

*Mat-Su Health Foundation*

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