

SB

74

<TARGET><BILL>SB 74</BILL><SUBJECT>SB
74</SUBJECT><COMM>SFIN29</COMM></TARGET>

*revised
3/7/16*

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Glover
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CS FOR SENATE BILL NO. 74(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:

Referred:

Sponsor(s): SENATORS KELLY, Giessel, Micciche, Bishop, MacKinnon, Hoffman

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 professional
 3 counselor, marriage and family therapist, psychologist, psychological associate, and
 4 social worker by audio, video, or data communications; relating to the duties of the State
 5 Medical Board; relating to limitations of actions; establishing the Alaska Medical
 6 Assistance False Claim and Reporting Act; relating to medical assistance programs
 7 administered by the Department of Health and Social Services; relating to the controlled
 8 substance prescription database; relating to the duties of the Board of Pharmacy;
 9 relating to the duties of the Department of Commerce, Community, and Economic
 10 Development; relating to accounting for program receipts; relating to public record
 11 status of records related to the Alaska Medical Assistance False Claim and Reporting
 12 Act; establishing a telemedicine business registry; relating to competitive bidding for

1 medical assistance products and services; relating to verification of eligibility for public
2 assistance programs administered by the Department of Health and Social Services;
3 relating to annual audits of state medical assistance providers; relating to reporting
4 overpayments of medical assistance payments; establishing authority to assess civil
5 penalties for violations of medical assistance program requirements; relating to seizure
6 and forfeiture of property for medical assistance fraud; relating to the duties of the
7 Department of Health and Social Services; establishing medical assistance
8 demonstration projects; relating to Alaska Pioneers' Homes and Alaska Veterans'
9 Homes; relating to the duties of the Department of Administration; relating to the
10 Alaska Mental Health Trust Authority; relating to feasibility studies for the provision of
11 specified state services; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89,
12 Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure; and
13 providing for an effective date."

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

15 * **Section 1.** AS 08.29.400 is amended by adding new subsections to read:

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

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

21 (2) the licensee requests that the person consent to sending a copy of
22 all records of the encounter to a primary care provider if the licensee is not the
23 person's primary care provider and, if the person consents, the licensee sends the
24 records to the person's primary care provider; and

25 (3) the licensee meets the requirements established by the board in
26 regulation.

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

5 * **Sec. 2.** AS 08.63.210 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, supervision, or treatment of a person through audio, video, or
8 data 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. 3.** AS 08.64.101 is amended to read:

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

23 (1) examine and issue licenses to applicants;

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

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

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

31 (5) under regulations adopted by the board, contract with private

1 professional organizations to establish an impaired medical professionals program to
2 identify, confront, evaluate, and treat persons licensed under this chapter who abuse
3 alcohol, other drugs, or other substances or are mentally ill or cognitively impaired;

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

10 * Sec. 4. AS 08.64.364(a) is amended to read:

11 (a) The board may not impose disciplinary sanctions on a physician for
12 rendering a diagnosis, providing treatment, or prescribing, dispensing, or
13 administering a prescription drug that is not a controlled substance to a person
14 without conducting a physical examination if

15 (1) [THE PRESCRIPTION DRUG IS

16 (A) NOT A CONTROLLED SUBSTANCE; OR

17 (B) A CONTROLLED SUBSTANCE AND IS PRESCRIBED,
18 DISPENSED, OR ADMINISTERED BY A PHYSICIAN WHEN AN
19 APPROPRIATE LICENSED HEALTH CARE PROVIDER IS PRESENT
20 WITH THE PATIENT TO ASSIST THE PHYSICIAN WITH
21 EXAMINATION, DIAGNOSIS, AND TREATMENT;

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

25 (2) the physician requests that [(3)] the person consent
26 [CONSENTS] to sending a copy of all records of the encounter to the person's primary
27 care provider if the prescribing physician is not the person's primary care provider,
28 and, if the patient consents, the physician sends the records to the person's primary
29 care provider.

30 * Sec. 5. AS 08.64.364 is amended by adding new subsections to read:

31 (c) The board may not impose disciplinary sanctions on a physician for

1 prescribing, dispensing, or administering a prescription drug that is a controlled
2 substance if the requirements under (a) of this section are met and the physician
3 prescribes, dispenses, or administers the controlled substance when an appropriate
4 licensed health care provider is present with the patient to assist the physician with
5 examination, diagnosis, and treatment.

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

7 (1) prescribe an abortion-inducing drug; or

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

11 * **Sec. 6.** AS 08.86.204 is amended by adding new subsections to read:

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

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

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

21 (3) the licensee meets the requirements established by the board in
22 regulation.

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

27 * **Sec. 7.** AS 08.95.050 is amended by adding new subsections to read:

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

31 (1) the licensee or another licensed health care provider is available to

1 provide follow-up care;

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

6 (3) the licensee meets the requirements established by the board in
7 regulation.

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

12 * **Sec. 8.** AS 09.10 is amended by adding a new section to read:

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

21 * **Sec. 9.** AS 09.10.120(a) is amended to read:

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

28 * **Sec. 10.** AS 09 is amended by adding a new chapter to read:

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

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

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

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

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

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

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

16 (b) A beneficiary of an intentional or inadvertent submission of a false or
17 fraudulent claim under the medical assistance program who later discovers the claim is
18 false or fraudulent shall disclose the false or fraudulent claim to the state not later than
19 60 days after discovering the false claim.

20 (c) In addition to any criminal penalties or seizure or forfeiture of property
21 under AS 47.05, a medical assistance provider or medical assistance recipient who
22 violates (a) or (b) of this section shall be liable to the state in a civil action for

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

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

25 and

26 (3) reasonable attorney fees and costs calculated under applicable court
27 rules.

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

31 (1) furnished the attorney general or the Department of Health and

1 Social Services with all information known to the person about the violation not later
2 than 30 days after the date the information was obtained;

3 (2) fully cooperated with the investigation of the violation under
4 AS 09.58.020; and

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

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

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

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

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

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

26 (1) a copy of the complaint; and

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

29 (c) A complaint filed under this section must remain under seal for at least 60
30 days and may not be served on the defendant until the court so orders. The attorney
31 general may elect to intervene and proceed with the action within 60 days after the

1 attorney general receives both the complaint and the material evidence and the
2 information required under (b) of this section. The attorney general may, for good
3 cause shown, move the court, under seal, for an extension of the time during which the
4 complaint remains under seal under this subsection.

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

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

15 (1) intervene in the action and proceed with the action on behalf of the
16 state;

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

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

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

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

30 **Sec. 09.58.025. Subpoenas.** In conducting an investigation under
31 AS 09.58.015 or 09.58.020, the attorney general may issue subpoenas to compel the

1 production of books, papers, correspondence, memoranda, and other records in
2 connection with an investigation under or the administration of AS 09.58.010 -
3 09.58.060. If a medical assistance provider or a medical assistance recipient fails or
4 refuses, without just cause, to obey a subpoena issued under this subsection, the
5 superior court may, upon application by the attorney general, issue an order requiring
6 the medical assistance provider or medical assistance recipient to appear before the
7 attorney general to produce evidence.

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

17 (b) Notwithstanding the objections of the person who brought the action, the
18 attorney general may

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

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

27 (c) If the attorney general elects not to proceed under AS 09.58.020 with the
28 action, the person who brought the action has the right to proceed and conduct the
29 action. The attorney general may request at any time during the proceedings to be
30 served with copies of all documents related to the action, including pleadings,
31 motions, and discovery. The attorney general shall pay for the reasonable copying

1 charges for documents provided under this subsection. If the person who brought the
2 action proceeds with the action, the court, without limiting the status and rights of the
3 person who brought the action, shall allow the attorney general to intervene at any
4 time.

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

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

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

31 (c) Whether or not the attorney general participates in the action, if the court

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

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

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

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

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

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

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

22 (3) based on the public disclosure of allegations or actions in a
23 criminal or civil action or an administrative hearing, or from the news media, unless
24 the action is brought by the attorney general or the person bringing the action is an
25 original source of the information that was publicly disclosed; in this paragraph, a
26 person is an original source of the information that was publicly disclosed if the
27 person has independent knowledge, including knowledge based on personal
28 investigation of the defendant's conduct, of the information on which the allegations
29 are based, and has voluntarily provided or verified the information on which the
30 allegations are based or voluntarily provided the information to the attorney general
31 before filing an action under AS 09.58.020 that is based on the information; or

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

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

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

6 **Sec. 09.58.070. Employee protection for retaliation.** (a) An employee of a
7 medical assistance provider who is discharged, demoted, suspended, threatened,
8 harassed, or discriminated against in the terms and conditions of employment by the
9 employee's employer because of lawful acts done by the employee on behalf of the
10 employee or others in furtherance of an action under AS 09.58.010 - 09.58.060,
11 including investigation for, initiation of, testimony for or assistance in an action filed
12 or to be filed under AS 09.58.010 - 09.58.060, is entitled to the same relief authorized
13 under AS 39.90.120.

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

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

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

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

29 (b) No punitive damages may be awarded in an action brought under
30 AS 09.58.010 - 09.58.060.

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

- 1 (1) "attorney general" includes a designee of the attorney general;
- 2 (2) "claim" means a request for payment of health care services or
3 equipment, whether made to a contractor, grantee, or other person, when the state
4 provides, directly or indirectly, a portion of the money, property, or services requested
5 or demanded, or when the state will, directly or indirectly, reimburse the contractor,
6 grantee, or other recipient for a portion of the money, property, or services requested
7 or demanded;
- 8 (3) "controversy" means the aggregate of one or more false claims
9 submitted by the same medical assistance provider or medical assistance recipient
10 under this chapter;
- 11 (4) "knowingly" means that a person, with or without specific intent to
12 defraud,
- 13 (A) has actual knowledge of the information;
- 14 (B) acts in deliberate ignorance of the truth or falsity of the
15 information; or
- 16 (C) acts in reckless disregard of the truth or falsity of the
17 information;
- 18 (5) "medical assistance program" means the federal-state program
19 administered by the Department of Health and Social Services under AS 47.05 and
20 AS 47.07 and regulations adopted under AS 47.05 and AS 47.07;
- 21 (6) "medical assistance provider" has the meaning given under
22 AS 47.05.290;
- 23 (7) "medical assistance recipient" has the meaning given under
24 AS 47.05.290;
- 25 (8) "obligation" means an established duty, whether or not fixed,
26 arising from
- 27 (A) an express or implied contractual grantor or grantee or
28 licensor or licensee relationship;
- 29 (B) a fee-based or similar relationship;
- 30 (C) a statute or regulation; or
- 31 (D) the retention of any overpayment.

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

3 * **Sec. 11.** AS 09.58.025, added by sec. 10 of this Act, is amended to read:

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

13 * **Sec. 12.** AS 09.58.070(b), added by sec. 10 of this Act, is amended to read:

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

22 * **Sec. 13.** AS 17.30.200(a) is amended to read:

23 (a) The controlled substance prescription database is established in the Board
24 of Pharmacy. The purpose of the database is to contain data as described in this
25 section regarding every prescription for a schedule [IA, IIA, IIIA, IVA, OR VA
26 CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III,
27 or IV [, OR V] controlled substance under federal law dispensed in the state to a
28 person other than those administered to a patient at a health care facility. The
29 Department of Commerce, Community, and Economic Development shall assist the
30 board and provide necessary staff and equipment to implement this section.

31

1 * **Sec. 14.** AS 17.30.200(b) is amended to read:

2 (b) The pharmacist-in-charge of each licensed or registered pharmacy,
3 regarding each schedule [IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE
4 UNDER STATE LAW OR A SCHEDULE I,] II, III, or IV [, OR V] controlled
5 substance under federal law dispensed by a pharmacist under the supervision of the
6 pharmacist-in-charge, and each practitioner who directly dispenses a schedule [IA,
7 IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE LAW OR A
8 SCHEDULE I,] II, III, or IV [, OR V] controlled substance under federal law other
9 than those administered to a patient at a health care facility, shall submit to the board,
10 by a procedure and in a format established by the board, the following information for
11 inclusion in the database on at least a weekly basis:

12 (1) the name of the prescribing practitioner and the practitioner's
13 federal Drug Enforcement Administration registration number or other appropriate
14 identifier;

15 (2) the date of the prescription;

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

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

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

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

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

24 and

25 (8) the name of the pharmacist or practitioner dispensing the controlled
26 substance and other appropriate identifying information.

27 * **Sec. 15.** AS 17.30.200(d) is amended to read:

28 (d) The database and the information contained within the database are
29 confidential, are not public records, and are not subject to public disclosure. The board
30 shall undertake to ensure the security and confidentiality of the database and the
31 information contained within the database. The board may allow access to the

1 database only to the following persons, and in accordance with the limitations
2 provided and regulations of the board:

3 (1) personnel of the board regarding inquiries concerning licensees or
4 registrants of the board or personnel of another board or agency concerning a
5 practitioner under a search warrant, subpoena, or order issued by an administrative law
6 judge or a court;

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

9 (3) a licensed practitioner having authority to prescribe controlled
10 substances or an agent or employee of the practitioner whom the practitioner has
11 authorized to access the database on the practitioner's behalf, to the extent the
12 information relates specifically to a current patient of the practitioner to whom the
13 practitioner is prescribing or considering prescribing a controlled substance;

14 (4) a licensed or registered pharmacist having authority to dispense
15 controlled substances or an agent or employee of the pharmacist whom the
16 pharmacist has authorized to access the database on the pharmacist's behalf, to
17 the extent the information relates specifically to a current patient to whom the
18 pharmacist is dispensing or considering dispensing a controlled substance;

19 (5) federal, state, and local law enforcement authorities may receive
20 printouts of information contained in the database under a search warrant, subpoena,
21 or order issued by a court establishing probable cause for the access and use of the
22 information; [AND]

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

29 (7) a licensed pharmacist employed by the Department of Health
30 and Social Services who is responsible for administering prescription drug
31 coverage for the medical assistance program under AS 47.07, to the extent that

1 the information relates specifically to prescription drug coverage under the
2 program;

3 (8) a licensed pharmacist, licensed practitioner, or authorized
4 employee of the Department of Health and Social Services responsible for
5 utilization review of prescription drugs for the medical assistance program under
6 AS 47.07, to the extent that the information relates specifically to utilization
7 review of prescription drugs provided to recipients of medical assistance;

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

10 (10) an authorized employee of the Department of Health and
11 Social Services may receive information from the database that does not disclose
12 the identity of a patient, prescriber, dispenser, or dispenser location, for the
13 purpose of identifying and monitoring public health issues in the state; however,
14 the information provided under this paragraph may include the region of the
15 state in which a patient, prescriber, and dispenser are located and the specialty of
16 the prescriber.

17 * 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.

23 * Sec. 17. AS 17.30.200(h) is amended to read:

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

1 * **Sec. 18.** AS 17.30.200(k) is amended to read:

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

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

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

9 **(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.**

22 * **Sec. 19.** AS 17.30.200 is amended by adding new subsections to read:

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

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

30 (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

1 substances in quantities or with a frequency inconsistent with generally recognized
2 standards of safe practice.

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

5 * **Sec. 20.** AS 37.05.146(c) is amended by adding a new paragraph to read:

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

8 * **Sec. 21.** AS 40.25.120(a) is amended by adding a new paragraph to read:

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

11 * **Sec. 22.** AS 44.33 is amended by adding a new section to read:

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

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

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

19 (c) In this section,

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

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

26 * **Sec. 23.** AS 47.05.015 is amended by adding a new subsection to read:

27 (e) Notwithstanding (c) of this section, the department may enter into a
28 contract through the competitive bidding process under AS 36.30 (State Procurement
29 Code) for medical assistance products and services offered under AS 47.07.030 if the
30 contract is for durable medical equipment or specific medical services that can be
31 delivered on a statewide basis.

1 * **Sec. 24.** AS 47.05 is amended by adding a new section to article 1 to read:

2 **Sec. 47.05.105. Enhanced computerized eligibility verification system.** (a)

3 The department shall establish an enhanced computerized income, asset, and identity
4 eligibility verification system for the purposes of verifying eligibility, eliminating
5 duplication of public assistance payments, and deterring waste and fraud in public
6 assistance programs administered by the department under AS 47.05.010. Nothing in
7 this section prohibits the department from verifying eligibility for public assistance
8 through additional procedures or authorizes the department or a third-party vendor to
9 use data to verify eligibility for a federal program if the use of that data is prohibited
10 by federal law.

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

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

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

29 * **Sec. 25.** AS 47.05.200(a) is amended to read:

30 (a) The department shall annually contract for independent audits of a
31 statewide sample of all medical assistance providers in order to identify overpayments

1 and violations of criminal statutes. The audits conducted under this section may not be
2 conducted by the department or employees of the department. The number of audits
3 under this section may not be less than 50 each year [, AS A TOTAL FOR THE
4 MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL
5 BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE
6 PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE
7 DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS
8 SECTION MAY NOT BE LESS THAN 75]. The audits under this section must
9 include both on-site audits and desk audits and must be of a variety of provider types.
10 The department may not award a contract under this subsection to an organization that
11 does not retain persons with a significant level of expertise and recent professional
12 practice in the general areas of standard accounting principles and financial auditing
13 and in the specific areas of medical records review, investigative research, and Alaska
14 health care criminal law. The contractor, in consultation with the commissioner, shall
15 select the providers to be audited and decide the ratio of desk audits and on-site audits
16 to the total number selected. In identifying providers who are subject to an audit
17 under this chapter, the department shall attempt to minimize concurrent state or
18 federal audits.

19 * Sec. 26. AS 47.05.200(b) is amended to read:

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

1 accruing from the date of the issuance of the final agency decision to recoup
2 overpayments identified in the audit. In this subsection, the date of issuance of
3 the final agency decision is the later of the date of

4 (1) the department's written notification of the decision and the
5 provider's appeal rights; or

6 (2) if timely appealed by the provider, a final agency decision
7 under AS 44.64.060.

8 * **Sec. 27.** AS 47.05 is amended by adding a new section to read:

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

10 Unless a provider is being audited under AS 47.05.200(a), an enrolled medical
11 assistance provider shall conduct a biennial review or audit of a statistically valid
12 sample of claims submitted to the department for reimbursement. If overpayments are
13 identified, the medical assistance provider shall report the overpayment to the
14 department not later than 10 business days after identification of the overpayment. The
15 report must also identify how the medical assistance provider intends to repay the
16 department. After the department receives the report, the medical assistance provider
17 and the department shall enter into an agreement establishing a schedule for
18 repayment of the identified overpayment. The agreement may authorize repayment in
19 a lump sum, a payment plan, or by offsetting future billings as approved by the
20 department.

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

23 * **Sec. 28.** AS 47.05 is amended by adding new sections to read:

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

27 (b) The department shall adopt regulations establishing a range of civil
28 penalties that the department may assess against a provider under this section. In
29 establishing the range of civil penalties, the department shall take into account
30 appropriate factors, including the seriousness of the violation, the service provided by
31 the provider, and the severity of the penalty. The regulations may not provide for a

1 civil penalty of less than \$100 or more than \$25,000 for each violation.

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

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

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

14 **Sec. 47.05.260. Seizure and forfeiture of real or personal property in**
15 **medical assistance fraud cases.** (a) Upon written application by the attorney general
16 establishing probable cause that a medical assistance provider has committed or is
17 committing medical assistance fraud under AS 47.05.210, the court may authorize the
18 seizure of real or personal property listed in (e) of this section to cover the cost of the
19 alleged fraud. The application may be made ex parte if the attorney general establishes
20 sufficient facts to show that notice to the owner of the property would lead to the
21 waste or dissipation of assets subject to seizure. If the attorney general does not
22 establish sufficient facts to show that notice to the owner would lead to the waste or
23 dissipation of assets subject to seizure, the application for seizure must be served on
24 the owners of the property.

25 (b) Upon issuance of the court order authorizing seizure, the owners of the
26 property may not take any action to dispose of the property through transfer of title or
27 sale of the property without written permission from the court. However, an innocent
28 purchaser may not be required to forfeit property purchased in good faith. The
29 purchaser bears the burden of proof to establish that the property was purchased
30 innocently and in good faith.

31 (c) If a medical assistance provider is convicted of medical assistance fraud

1 under AS 47.05.210 after property is seized under this section, the court may order
2 that the property be forfeited to the state and disposed of as directed by the court. If
3 the property has been sold, the proceeds of the sale shall be transmitted to the proper
4 state officer or employee for deposit into the general fund. The attorney general shall
5 return to the owner of the property any property seized under this section that the court
6 does not order to be forfeited as soon as practicable after the court issues a final
7 judgment in the medical assistance fraud proceeding under AS 47.05.210 and the
8 medical assistance provider pays any fine or restitution ordered by the court.

9 (d) An action for forfeiture under this section may be joined with a civil or
10 criminal action brought by the state to recover damages resulting from alleged medical
11 assistance fraud.

12 (e) Property that may be seized under this chapter includes bank accounts,
13 automobiles, boats, airplanes, stocks, bonds, the medical assistance provider's business
14 inventory, and other real or personal property owned and used to conduct the medical
15 assistance provider's business.

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

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

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

24 (3) expanding the use of telehealth for primary care, behavioral health,
25 and urgent care;

26 (4) enhancing fraud prevention, detection, and enforcement;

27 (5) reducing the cost of behavioral health, senior, and disabilities
28 services provided to recipients of medical assistance under the state's home and
29 community-based services waiver under AS 47.07.045;

30 (6) pharmacy initiatives;

31 (7) enhanced care management;

1 (8) redesigning the payment process by implementing fee agreements
2 that include one or more of the following:

3 (A) premium payments for centers of excellence;

4 (B) penalties for hospital-acquired infections, readmissions,
5 and outcome failures;

6 (C) bundled payments for specific episodes of care; or

7 (D) global payments for contracted payers, primary care
8 managers, and case managers for a recipient or for care related to a specific
9 diagnosis;

10 (9) stakeholder involvement in setting annual targets for quality and
11 cost-effectiveness;

12 (10) to the extent consistent with federal law, reducing travel costs by
13 requiring a recipient to obtain medical services in the recipient's home community, to
14 the extent appropriate services are available in the recipient's home community;

15 (11) guidelines for health care providers to develop health care
16 delivery models supported by evidence-based practices that encourage wellness and
17 disease prevention.

18 (b) The department shall, in coordination with the Alaska Mental Health Trust
19 Authority, efficiently manage a comprehensive and integrated behavioral health
20 program that uses evidence-based, data-driven practices to achieve positive outcomes
21 for people with mental health or substance abuse disorders and children with severe
22 emotional disturbances. The goal of the program is to assist recipients of services
23 under the program to recover by achieving the highest level of autonomy with the least
24 dependence on state-funded services possible for each person. The program must
25 include

26 (1) a plan for providing a continuum of community-based services to
27 address housing, employment, criminal justice, and other relevant issues;

28 (2) services from a wide array of providers and disciplines, including
29 licensed or certified mental health and primary care professionals; and

30 (3) efforts to reduce operational barriers that fragment services,
31 minimize administrative burdens, and reduce the effectiveness and efficiency of the

1 program.

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

9 (d) On or before November 15 of each year, the department shall prepare a
10 report and submit the report to the senate secretary and the chief clerk of the house of
11 representatives and notify the legislature that the report is available. The report must
12 include

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

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

16 (3) a statement of whether the department has met annual targets for
17 quality and cost-effectiveness;

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

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

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

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

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

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

31 (10) the percentage decrease in the number of medical assistance

1 recipients identified as frequent users of emergency departments compared to the
2 previous fiscal year;

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

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

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

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

13 (e) In this section, "telehealth" means the practice of health care delivery,
14 evaluation, diagnosis, consultation, or treatment, using the transfer of health care data
15 through audio, visual, or data communications, performed over two or more locations
16 between providers who are physically separated from the recipient or from each other
17 or between a provider and a recipient who are physically separated from each other.

18 * Sec. 29. AS 47.07.030(d) is amended to read:

19 (d) The department shall [MAY] establish as optional services a primary care
20 case management system or a managed care organization contract in which certain
21 eligible individuals are required to enroll and seek approval from a case manager or
22 the managed care organization before receiving certain services. The purpose of a
23 primary care case management system or managed care organization contract is
24 to increase the use of appropriate primary and preventive care by medical
25 assistance recipients, while decreasing the unnecessary use of specialty care and
26 hospital emergency department services. The department shall

27 (1) establish enrollment criteria and determine eligibility for services
28 consistent with federal and state law; the department shall require recipients with
29 multiple hospitalizations to enroll in a primary care case management system or
30 with a managed care organization under this subsection, except that the
31 department may exempt recipients with chronic, acute, or terminal medical

1 **conditions from the requirement under this paragraph;**

2 **(2) define the coordinated care services and provider types eligible**
3 **to participate as primary care providers;**

4 **(3) create a performance and quality reporting system; and**

5 **(4) integrate the coordinated care demonstration projects**
6 **described under AS 47.07.039 and the demonstration projects described under**
7 **AS 47.07.036(e) with the primary care case management system or managed care**
8 **organization contract established under this subsection.**

9 * **Sec. 30.** AS 47.07.036 is amended by adding new subsections to read:

10 (d) Notwithstanding (a) - (c) of this section, the department may

11 (1) apply for a section 1915(i) option under 42 U.S.C. 1396n to
12 improve services and care through home and community-based services to obtain a 50
13 percent federal match;

14 (2) apply for a section 1915(k) option under 42 U.S.C. 1396n to
15 provide home and community-based services and support to increase the federal match
16 for these programs from 50 percent to 56 percent;

17 (3) apply for a section 1945 option under 42 U.S.C. 1396w-4 to
18 provide coordinated care through health homes for individuals with chronic conditions
19 and to increase the federal match for the services to 90 percent for the first eight
20 quarters the required state plan amendment is in effect;

21 (4) evaluate and seek permission from the United States Department of
22 Health and Human Services Centers for Medicare and Medicaid Services to participate
23 in various demonstration projects, including payment reform, care management
24 programs, workforce development and innovation, and innovative services delivery
25 models; and

26 (5) provide incentives for telehealth, including increasing the
27 capability for and reimbursement of telehealth for recipients.

28 (e) Notwithstanding (a) - (c) of this section, and in addition to the projects and
29 services described under (d) and (f) of this section, the department shall apply for a
30 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration
31 projects focused on innovative payment models for one or more groups of medical

1 assistance recipients in one or more specific geographic areas. The demonstration
2 project or projects may include

- 3 (1) managed care organizations as described under 42 U.S.C. 1396u-2;
- 4 (2) community care organizations;
- 5 (3) patient-centered medical homes as described under 42 U.S.C. 256a-
6 1; or
- 7 (4) other innovative payment models that ensure access to health care
8 without reducing the quality of care.

9 (f) Notwithstanding (a) - (c) of this section, and in addition to the projects and
10 services described under (d) and (e) of this section, the department shall apply for a
11 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration
12 projects focused on improving the state's behavioral health system for medical
13 assistance recipients. The department shall engage stakeholders and the community in
14 the development of a project or projects under this subsection. The demonstration
15 project or projects must be consistent with the comprehensive and integrated
16 behavioral health program described under AS 47.05.270(b).

17 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

18 * **Sec. 31.** AS 47.07 is amended by adding new sections to read:

19 **Sec. 47.07.038. Collaborative, hospital-based project to reduce use of**
20 **emergency department services.** (a) On or before December 1, 2016, the department
21 shall collaborate with a statewide professional hospital association to establish a
22 hospital-based project to reduce the use of emergency department services by medical
23 assistance recipients. The statewide professional hospital association shall operate the
24 project. The project may include shared savings for participating hospitals. The project
25 must include

- 26 (1) an interdisciplinary process for defining, identifying, and
27 minimizing the number of frequent users of emergency department services;
- 28 (2) to the extent consistent with federal law, a system for real-time
29 electronic exchange of patient information, including recent emergency department
30 visits, hospital care plans for frequent users of emergency departments, and data from
31 the controlled substance prescription database;

1 (3) a procedure for educating patients about the use of emergency
2 departments and appropriate alternative services and facilities for nonurgent care;

3 (4) a process for assisting users of emergency departments in making
4 appointments with primary care or behavioral health providers within 96 hours after
5 an emergency department visit;

6 (5) a collaborative process between the department and the statewide
7 professional hospital association to establish uniform statewide guidelines for
8 prescribing narcotics in an emergency department; and

9 (6) designation of health care personnel to review successes and
10 challenges regarding appropriate emergency department use.

11 (b) 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 (b) A project review committee is established in the department for the
18 purpose of reviewing proposals for demonstration projects under this section. The
19 project review committee consists of

20 (1) the commissioner of the department, or the commissioner's
21 designee;

22 (2) the commissioner of administration, or the commissioner's
23 designee;

24 (3) the chief executive officer of the Alaska Mental Health Trust
25 Authority, or the chief executive officer's designee;

26 (4) two representatives of stakeholder groups, appointed by the
27 governor for staggered three-year terms;

28 (5) a nonvoting member who is a member of the senate, appointed by
29 the president of the senate; and

30 (6) a nonvoting member who is a member of the house of
31 representatives, appointed by the speaker of the house of representatives.

1 (c) The department may contract with a managed care organization, primary
2 care case manager, accountable care organization, prepaid ambulatory health plan, or
3 provider-led entity to implement a demonstration project under this section. The fee
4 structure for a contract under this subsection may include global payments, bundled
5 payments, capitated payments, shared savings and risk, or other payment structures.
6 The department shall work with the division of insurance, Department of Commerce,
7 Community, and Economic Development, to streamline the application process for a
8 company to obtain a certificate of authority required under AS 21.09.010 as necessary
9 to participate in a demonstration project under this section.

10 (d) A proposal for a demonstration project under this section must include, in
11 addition to the elements required under (a) of this section, information demonstrating
12 how the project will implement additional cost-saving measures including innovations
13 to reduce the cost of care for medical assistance recipients through the expanded use
14 of telehealth for primary care, urgent care, and behavioral health services. The
15 department shall identify legal or cost barriers preventing the expanded use of
16 telehealth and shall recommend remedies for identified barriers.

17 (e) The department shall contract with a third-party actuary to review
18 demonstration projects established under this section. The actuary shall review each
19 demonstration project after one year of implementation and make recommendations
20 for the implementation of a similar project on a statewide basis. The actuary shall
21 evaluate each project based on cost savings for the medical assistance program, health
22 outcomes for participants in the project, and the ability to achieve similar results on a
23 statewide basis. On or before December 31 of each year starting in 2018, the actuary
24 shall submit a final report to the department regarding any demonstration project that
25 has been in operation for at least one year.

26 (f) The department shall prepare a plan regarding regional or statewide
27 implementation of a coordinated care project based on the results of the demonstration
28 projects under this section. On or before November 15, 2019, the department shall
29 submit the plan to the senate secretary and the chief clerk of the house of
30 representatives and notify the legislature that the plan is available. On or before
31 November 15 of each year thereafter, the department shall submit a report regarding

1 any changes or recommendations regarding the plan developed under this subsection
2 to the senate secretary and the chief clerk of the house of representatives and notify the
3 legislature that the report is available.

4 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

5 * **Sec. 32.** AS 47.07 is amended by adding a new section to read:

6 **Sec. 47.07.076. Report to legislature.** (a) The department and the attorney
7 general shall annually prepare a report relating to the medical assistance program
8 under AS 47.07. The report must include the following information:

9 (1) the amount and source of funds used to prevent or prosecute fraud,
10 abuse, payment errors, and errors in eligibility determinations for the previous fiscal
11 year;

12 (2) actions taken to address fraud, abuse, payment errors, and errors in
13 eligibility determinations during the previous fiscal year;

14 (3) specific examples of fraud or abuse that were prevented or
15 prosecuted;

16 (4) identification of vulnerabilities in the medical assistance program,
17 including any vulnerabilities identified by independent auditors with whom the
18 department contracts under AS 47.05.200;

19 (5) initiatives the department has taken to prevent fraud or abuse;

20 (6) recommendations to increase effectiveness in preventing and
21 prosecuting fraud and abuse;

22 (7) the return to the state for every dollar expended by the department
23 and the attorney general to prevent and prosecute fraud and abuse;

24 (8) the most recent payment error rate measurement report for the
25 medical assistance program, including fee for service programs and pilot or
26 demonstration projects; the report must also explain the reasons for the payment errors
27 and the total amount of state and federal funds paid in error during the reporting period
28 and not recovered by the department at the time of the report;

29 (9) results from the Medicaid Eligibility Quality Control program.

30 (b) On or before November 15 of each year, the department shall submit the
31 report required under this section to the senate secretary and the chief clerk of the

1 house of representatives and notify the legislature that the report is available.

2 * **Sec. 33.** AS 47.07.900(4) is amended to read:

3 (4) "clinic services" means services provided by state-approved
4 outpatient community mental health clinics [THAT RECEIVE GRANTS UNDER
5 AS 47.30.520 - 47.30.620], state-operated community mental health clinics, outpatient
6 surgical care centers, and physician clinics;

7 * **Sec. 34.** AS 47.07.900(17) is amended to read:

8 (17) "rehabilitative services" means services for substance abusers and
9 emotionally disturbed or chronically mentally ill adults provided by

10 (A) a drug or alcohol treatment center [THAT IS FUNDED
11 WITH A GRANT UNDER AS 47.30.475]; or

12 (B) an outpatient community mental health clinic [THAT HAS
13 A CONTRACT TO PROVIDE COMMUNITY MENTAL HEALTH
14 SERVICES UNDER AS 47.30.520 - 47.30.620];

15 * **Sec. 35.** AS 47.55.020(e) is amended to read:

16 (e) As a condition for receipt of payment assistance under (d) of this section,
17 the department, under regulations adopted by the department, **shall** [MAY] require a
18 person to

19 (1) apply for other state or federally sponsored programs that may
20 reduce the amount of the payment assistance; **and**

21 (2) **submit to the department a copy of the person's application for**
22 **medical assistance coverage under AS 47.07 and the decision letter the person**
23 **receives regarding the application.**

24 * **Sec. 36.** AS 09.58.020, 09.58.030, 09.58.040, 09.58.050, and 09.58.060 are repealed
25 July 1, 2019.

26 * **Sec. 37.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:

28 **INDIRECT COURT RULE AMENDMENTS.** (a) AS 09.58.020, added by sec. 10 of
29 this Act, and repealed by sec. 36 of this Act, has the effect of amending the following court
30 rules in the manner specified from the effective date of sec. 10 of this Act until July 1, 2019:

31 (1) Rules 4, 5, 7, and 12, Alaska Rules of Civil Procedure, by requiring that a

1 complaint under AS 09.58 be filed in camera and under seal and may not be served on the
2 defendant until unsealed and that a copy of the complaint be served on the attorney general;

3 (2) Rules 41 and 77, Alaska Rules of Civil Procedure, by authorizing the
4 attorney general to move for dismissal of a complaint filed by another person under
5 AS 09.58.020, added by sec. 10 of this Act and repealed by sec. 36 of this Act, and requiring
6 court approval for dismissal of the action.

7 (b) AS 09.58.025, added by sec. 10 of this Act, and amended by sec. 11 of this Act,
8 has the effect of amending Rule 27, Alaska Rules of Civil Procedure, by authorizing the
9 attorney general to issue subpoenas as part of an investigation

10 (1) under AS 09.58.015, added by sec. 10 of this Act, from the effective date
11 of sec. 10 of this Act; and

12 (2) under AS 09.58.020, added by sec. 10 of this Act, from the effective date
13 of sec. 10 of this Act until July 1, 2019.

14 (c) AS 09.58.030, added by sec. 10 of this Act, and repealed by sec. 36 of this Act,
15 has the effect of amending the following court rules in the manner specified from the effective
16 date of sec. 10 of this Act until July 1, 2019:

17 (1) Rule 24, Alaska Rules of Civil Procedure, by authorizing the attorney
18 general to intervene in a civil action filed by another person under AS 09.58.020 added by
19 sec. 10 of this Act, and repealed by sec. 36 of this Act, and limiting the participation of a party
20 to the litigation;

21 (2) Rules 26 and 27, Alaska Rules of Civil Procedure, by authorizing the
22 attorney general to request that the court issue a stay of discovery for a 90-day period, or
23 longer upon a showing by the attorney general.

24 (d) AS 09.58.040, added by sec. 10 of this Act, and repealed by sec. 36 of this Act,
25 has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, from the
26 effective date of sec. 10 of this Act until July 1, 2019, by giving a person who brings an action
27 under AS 09.58.020, added by sec. 10 of this Act, and repealed by sec. 36 of this Act, the
28 right to reasonable attorney fees and costs in an action prosecuted by the attorney general.

29 (e) AS 47.05.260, added by sec. 28 of this Act, has the effect of amending Rule 89,
30 Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure, by
31 authorizing the attorney general to apply to the court for authorization to seize property in

1 conjunction with an action filed under AS 47.05.210.

2 * **Sec. 38.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 **IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT.**

5 (a) The Department of Health and Social Services shall collaborate with Alaska tribal health
6 organizations and the United States Department of Health and Human Services to fully
7 implement changes in federal policy that authorize 100 percent federal funding for services
8 provided to American Indian and Alaska Native individuals eligible for Medicaid.

9 (b) Within 30 days after the date the Centers for Medicare and Medicaid Services
10 issues a final policy regarding the circumstances in which 100 percent federal funding is
11 available for medical assistance services received through the United States Indian Health
12 Service or tribal health facilities, the Department of Health and Social Services shall notify
13 and submit a report to the co-chairs of the house and senate finance committees of the Alaska
14 State Legislature that includes an estimate of the savings to the state resulting from the final
15 policy. Within six months after the date the Centers for Medicare and Medicaid Services
16 issues the final policy, the Department of Health and Social Services shall fully implement the
17 policy in the state.

18 (c) In this section, "Alaska tribal health organization" means an organization
19 recognized by the United States Indian Health Service to provide health-related services.

20 * **Sec. 39.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:

22 **HEALTH INFORMATION INFRASTRUCTURE PLAN.** (a) The Department of
23 Health and Social Services shall develop a health information infrastructure plan to strengthen
24 the health information infrastructure, including health data analytics capability. The purpose
25 of the health information infrastructure plan is to transform the health care system in the state
26 by providing

27 (1) data required by health care providers for care coordination and quality
28 improvement; and

29 (2) the information support required by the Department of Health and Social
30 Services and health care providers to enable development and implementation of the other
31 provisions of this Act.

1 (b) To the greatest extent practicable, the health information infrastructure plan will
2 leverage existing resources, including the health information exchange, and will identify
3 opportunities for integrating and streamlining health data systems administered by the state.

4 * **Sec. 40.** The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 FEASIBILITY STUDIES FOR THE PROVISION OF SPECIFIED STATE
7 SERVICES. (a) The Department of Health and Social Services shall procure a study
8 analyzing the feasibility of privatizing services delivered at Alaska Pioneers' Homes and
9 select facilities of the division of juvenile justice. The Department of Health and Social
10 Services shall deliver a report summarizing the conclusions of the Department of Health and
11 Social Services to the senate secretary and the chief clerk of the house of representatives and
12 notify the legislature that the report is available within 10 days after the convening of the First
13 Regular Session of the Thirtieth Alaska State Legislature.

14 (b) The Department of Health and Social Services, in conjunction with the Alaska
15 Mental Health Trust Authority, shall procure a study analyzing the feasibility of privatizing
16 services delivered at the Alaska Psychiatric Institute. The Department of Health and Social
17 Services and the Alaska Mental Health Trust Authority shall deliver a joint report
18 summarizing the conclusions of the Department of Health and Social Services and the Alaska
19 Mental Health Trust Authority to the senate secretary and the chief clerk of the house of
20 representatives and notify the legislature that the report is available within 10 days after the
21 convening of the First Regular Session of the Thirtieth Alaska State Legislature.

22 (c) The Department of Administration shall, in collaboration with the house and
23 senate finance committees, procure a study to be completed on or before June 30, 2017, to
24 determine the feasibility of creating a health care authority to coordinate health care plans and
25 consolidate purchasing effectiveness for all state employees, retired state employees, retired
26 teachers, medical assistance recipients, University of Alaska employees, employees of state
27 corporations, and school district employees and to develop appropriate benefit sets, rules,
28 cost-sharing, and payment structures for all employees and individuals whose health care
29 benefits are funded directly or indirectly by the state, with the goal of achieving the greatest
30 possible savings to the state through a coordinated approach administered by a single entity.
31 In developing the study, the Department of Administration shall seek input from the

1 Department of Health and Social Services, administrators familiar with managing government
2 employee health plans, and human resource professionals familiar with self-insured health
3 care plans. The study must

4 (1) identify cost-saving strategies that a health care authority could implement;
5 (2) analyze local government participation in the authority;
6 (3) analyze a phased approach to adding groups to the health care plans
7 coordinated by the health care authority;

8 (4) consider previous studies procured by the Department of Administration
9 and the legislature;

10 (5) assess the use of community-related health insurance risk pools and the use
11 of the private marketplace;

12 (6) identify organizational models for a health care authority, including private
13 for-profit, private nonprofit, government, and state corporations; and

14 (7) include a public review and comment opportunity for employers,
15 employees, medical assistance recipients, retirees, and health care providers.

16 (d) In this section, "school district" has the meaning given in AS 14.30.350.

17 * **Sec. 41.** The uncodified law of the State of Alaska is amended by adding a new section to
18 read:

19 MEDICAID STATE PLAN; WAIVERS; INSTRUCTIONS; NOTICE TO REVISOR
20 OF STATUTES. The Department of Health and Social Services shall amend and submit for
21 federal approval a state plan for medical assistance coverage consistent with this Act. The
22 Department of Health and Social Services shall apply to the United States Department of
23 Health and Human Services for any waivers necessary to implement this Act. The
24 commissioner of health and social services shall certify to the revisor of statutes if the
25 provisions of AS 47.05.270(a)(5), (8), and (10), added by sec. 28 of this Act, and the
26 provisions of AS 47.07.038, added by sec. 31 of this Act, are approved by the United States
27 Department of Health and Human Services.

28 * **Sec. 42.** The uncodified law of the State of Alaska is amended by adding a new section to
29 read:

30 TRANSITION: REGULATIONS. (a) The Department of Health and Social Services
31 may adopt regulations necessary to implement the changes made by this Act. The regulations

1 take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date
2 of the relevant provision of this Act implemented by the regulation.

3 (b) The Board of Pharmacy may adopt regulations necessary to implement the
4 changes made by secs. 13 - 19 of this Act. The regulations take effect under AS 44.62
5 (Administrative Procedure Act), but not before the effective date of the relevant provision of
6 secs. 13 - 19 of this Act implemented by the regulation.

7 * **Sec. 43.** The uncodified law of the State of Alaska is amended by adding a new section to
8 read:

9 **CONDITIONAL EFFECT.** (a) AS 47.05.270(a)(5), enacted by sec. 28 of this Act,
10 takes effect only if the commissioner of health and social services certifies to the revisor of
11 statutes under sec. 41 of this Act, on or before October 1, 2017, that all of the provisions
12 added by AS 47.05.270(a)(5) have been approved by the United States Department of Health
13 and Human Services.

14 (b) AS 47.05.270(a)(8), enacted by sec. 28 of this Act, takes effect only if the
15 commissioner of health and social services certifies to the revisor of statutes under sec. 41 of
16 this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.270(a)(8)
17 have been approved by the United States Department of Health and Human Services.

18 (c) AS 47.05.270(a)(10), enacted by sec. 28 of this Act, takes effect only if the
19 commissioner of health and social services certifies to the revisor of statutes under sec. 41 of
20 this Act, on or before October 1, 2017, that all of the provisions added by
21 AS 47.05.270(a)(10) have been approved by the United States Department of Health and
22 Human Services.

23 (d) AS 47.07.038, enacted by sec. 31 of this Act, takes effect only if the commissioner
24 of health and social services certifies to the revisor of statutes under sec. 41 of this Act, on or
25 before October 1, 2017, that all of the provisions added by AS 47.07.038 have been approved
26 by the United States Department of Health and Human Services.

27 (e) AS 09.58.020, added by sec. 10 of this Act, AS 09.58.025, added by sec. 10 of this
28 Act and amended by sec. 11 of this Act, AS 09.58.030, added by sec. 10 of this Act and
29 repealed by sec. 36 of this Act, AS 09.58.040, added by sec. 10 of this Act, and AS 47.05.260,
30 added by sec. 28 of this Act, take effect only if sec. 37 of this Act receives the two-thirds
31 majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

1 * **Sec. 44.** If AS 47.05.270(a)(5), enacted by sec. 28 of this Act, takes effect, it takes effect
2 on the day after the date the commissioner of health and social services makes a certification
3 to the revisor of statutes under secs. 41 and 43(a) of this Act.

4 * **Sec. 45.** If AS 47.05.270(a)(8), enacted by sec. 28 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. 41 and 43(b) of this Act.

7 * **Sec. 46.** If AS 47.05.270(a)(10), enacted by sec. 28 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. 41 and 43(c) of this Act.

10 * **Sec. 47.** If AS 47.07.038, enacted by sec. 31 of this Act, takes effect, it takes effect on the
11 day after the date the commissioner of health and social services makes a certification to the
12 revisor of statutes under secs. 41 and 43(d) of this Act.

13 * **Sec. 48.** Sections 40, 41, 42(a), and 43 of this Act take effect immediately under
14 AS 01.10.070(c).

15 * **Sec. 49.** Sections 13 - 19 of this Act take effect January 1, 2017.

16 * **Sec. 50.** Section 42(b) of this Act takes effect July 1, 2016.

17 * **Sec. 51.** Sections 11 and 12 of this Act take effect July 1, 2019.

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CS for SENATE BILL 74(FIN) (*Version U*)
SECTIONAL ANALYSIS

Section 1 (*page 2-3*)

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*)

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*)

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)

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)

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 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; 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)

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)

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.

Requests a minimum threshold damage 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.

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.

Section 13 (page 15)

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)

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)

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)

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)

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)

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)

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 updating the PDMP database at least on a weekly.

Section 20 (page 20)

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)

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)

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.

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)

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)

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 of Medicaid under the state's home and community-based services waivers;
- 6) Pharmacy initiatives;
- 7) Enhanced care management;
- 8) Redesigning the payment process by implementing fee agreements that include: premium payments for centers of excellence, penalties for hospital-acquired infections, readmission, and outcome failures, bundled payments, or global payments;
- 9) Stakeholder involvement in setting annual targets for quality and cost-effectiveness; 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 house, 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 around 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)

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)

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 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 considers 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. One 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)*

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)*

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)*

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)

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 44-51 (page 41)

Effective Dates

Provides for effective dates

DHSS Fiscal Impacts for CSSB074(FIN), version U – with amendments

GRAND TOTAL	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	\$33,869.1	\$49,181.2	\$75,376.2	\$88,958.2	\$101,419.7	\$104,417.6
GF match	(\$29,025.8)	(\$39,343.7)	(\$60,293.5)	(\$76,437.0)	(\$90,065.5)	(\$96,967.7)
GF	\$287.1	(\$1,089.7)	(\$6,514.8)	(\$6,514.8)	(\$6,514.8)	(\$6,514.8)
GF/MH	(\$2,625.0)	(\$7,154.9)	(\$11,867.8)	(\$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	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
SD/PR	\$134.9	\$177.4	\$219.8	\$219.8	\$219.8	\$219.8
TOTAL	\$3,707.0	\$2,837.0	(\$2,013.4)	(\$3,946.9)	(\$4,303.9)	(\$8,208.2)
UGF subtotal	(\$31,363.7)	(\$47,588.3)	(\$78,676.1)	(\$94,191.6)	(\$107,010.1)	(\$113,912.3)

POSITIONS

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
BHA			(2)	(4)	(4)	(4)
MAA	2	2	2	2	2	2
SDSA	1	3	3	3	3	3
CO	4	4	4	4	4	4
	7	9	7	5	5	5

CAPITAL BUDGET COSTS

<i>amount</i>	<i>fed</i>	<i>GF match</i>	<i>description</i>
\$ 1,000.0	\$ 900.0	\$ 100.0	MMIS system changes, behavioral health system reform
\$ 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
\$ 1,200.0	\$ 1,080.0	\$ 120.0	MMIS system changes, 1915(i), 1915(k), options
\$ 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
\$ 9,100.0	\$ 8,190.0	\$ 910.0	

DHSS Fiscal Impacts for CSSB074(FIN), version U – with amendments

SAVINGS MEASURES (UGF)						
	<i>FY2017</i>	<i>FY2018</i>	<i>FY2019</i>	<i>FY2020</i>	<i>FY2021</i>	<i>FY2022</i>
Federal Tribal Policy 1915(i) and (k)	(\$32,059.0)	(\$41,903.2)	(\$64,328.2)	(\$78,253.2)	(\$87,628.2)	(\$92,578.2)
Primary Care Case Mgmt	\$71.1	(\$5,118.8)	(\$10,781.6)	(\$10,866.0)	(\$10,866.0)	(\$10,866.0)
Telehealth	\$30.0	(\$722.9)	(\$2,067.1)	(\$3,361.2)	(\$4,638.1)	(\$4,638.1)
Health Homes	\$2.5	(\$650.0)	(\$1,300.0)	(\$2,900.0)	(\$4,700.0)	(\$6,650.0)
Conversion from AKPH Assistance to Medicaid Waiver	\$0.0	\$0.0	(\$1,715.0)	(\$1,723.5)	(\$1,732.0)	(\$1,741.0)
Hospital ER Use Project	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)	(\$1,066.7)
Fraud and Abuse	\$0.0	\$0.0	(\$1,120.0)	(\$1,125.6)	(\$1,131.2)	(\$1,136.9)
Coordinated Care Demo Project	(\$543.1)	(\$697.4)	(\$684.9)	(\$622.4)	(\$609.9)	(\$597.4)
Electronic Verification System, Savings	\$0.0	\$159.0	(\$1,500.0)	(\$1,500.0)	(\$1,500.0)	(\$1,500.0)
	\$611.3	(\$23.0)	(\$23.0)	(\$23.0)	(\$23.0)	(\$23.0)
	(\$32,953.9)	(\$50,023.0)	(\$84,586.5)	(\$101,441.6)	(\$113,895.1)	(\$120,797.3)



THE STATE
of **ALASKA**

GOVERNOR BILL WALKER

Department of Commerce, Community,
and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND
PROFESSIONAL LICENSING

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March 8, 2016

The Honorable Senator Anna MacKinnon
Co-Chair, Senate Finance Committee
State Capitol Room 532
Juneau, AK 99801

Dear Senator MacKinnon,

During the Senate Finance Committee hearings on March 4, I was asked to follow up on questions concerning SB74 - Medicaid Reform/PFD/HSAS/ER Use/Studies:

Below is a table of Medical Board licensing times:

During the first several months after the passage of HB281, the Department experienced a surge of applications directly from telemedicine companies. Prior to that period we were processing approximately 5-6 applications per week. After the passage of the Bill, we began processing over 20 applications per week, many coming in large batches. This 400% spike in activity is what we anticipate to experience once SB 74 is passed. The following table shows an overall 92% increase in total new applications during this period. The following year, applications increased another 30%.

	7/1/12 – 12/31/12	1/1/13 – 6/30/13	7/1/13 – 12/31/13	1/1/14 – 6/30/14	7/1/14 – 12/31/14	1/1/15 – 6/30/15	7/1/15 – 12/31/15	1/1/16 – 2/26/16
MD, DO, DPM	134	144	184	166	217	176	227	12
PA	11	0	36	38	69	66	64	2
Resident permits	10	6	15	11	43	31	34	6
MICPs	8	0	18	34	27	20	30	10
Locums	1	0	0	0	5	6	4	1
Total new applications	164	150	268	354	361	419	302	94
	314		603		780		396	
% change YOY			92%		29%		On par with FY15 volume	
Timeline				HB 281 signed into law	HB 281 effective			

Can there be an additional fee required for out-of-state licensees to help cover the additional costs associated with Telemedicine?


Both the Big Game Commercial Services and Collection Agency programs have fees that double for out-of-state licensure. Legislative authority is needed to set a different fee amount for out-of-state licensure.

Will there need to be additional travel costs for investigations out of state?

The scope and impact of telemedicine expansion is truly unknown. Currently, the Department only has subpoena powers valid within the State of Alaska, which hampers our ability to investigate outside our jurisdiction. Out of state investigations are conducted in cooperation with other licensing jurisdictions. There are tools available in-state to assist in making disciplinary decisions; one of these is the National Practitioners Data Bank, a national clearinghouse for discipline on certain healthcare licenses. It is probable that additional authority to expand licensing funds to investigate out-of-state physicians who have been the subject of a complaint will be necessary. At this point, however, it is impossible to estimate the fiscal authority needed to travel outside Alaska. Without additional authority, the tools in the Department's investigative tool box may be limited.

We hope this helps to answer some of the questions posed in committee and effectively express the Division's concerns about the bill. 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

SENATE FINANCE COMMITTEE REPORT

DATE: 4/16/15

FURTHER: Rules

DATE TURNED IN TO OFFICE: 3/7/16

Finance Committee considered SENATE BILL NO. 74

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

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

and recommends:

- be replaced with CS SB 74 (FIN) [] Same Title New Title
- [] adopt previous CS _____ (_____) [] Same Title [] New Title
- [] attached amendment(s)
- [] adopt _____ Letter of Intent
- [] further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
ADM	✓			
CED	✓	FORTHCOMING		
LAW	✓			
DHS	✓	FORTHCOMING		
DHS	✓	FORTHCOMING		
DHS	✓	FORTHCOMING		
DHS	✓	FORTHCOMING		
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DHS	✓	FORTHCOMING		
DHS	✓	FORTHCOMING		

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[] APPROPRIATION - no fiscal note * CONTINUED ON PAGE 2 →

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	Do PASS	Do NOT PASS	No REC	AMEND
<i>[Signature]</i>	MICCICHE	✓			
<i>[Signature]</i>	Bishop	✓			
<i>[Signature]</i>	DUALAN/ Hoffman	✓		✓	
CO-CHAIR: <i>[Signature]</i>	Kelly	✓			
CO-CHAIR: <i>[Signature]</i>	Mackinnon	✓			

Fiscal Note

State of Alaska
2016 Legislative Session

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

Identifier: SB074CS(FIN)-DOA-COM-03-06-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES	FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Personal Services	134.6		33.6				
Travel							
Services	700.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	834.6	0.0	33.6	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

1004 Gen Fund	834.6		33.6				
Total	834.6	0.0	33.6	0.0	0.0	0.0	0.0

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

BILL NO. CSSB 74

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: SB074CS(FIN)-DCCED-CBPL-03-07-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
Sponsor: KELLY
Requester: (S) 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
OPERATING EXPENDITURES								
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	25.0							
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	560.8	0.0	607.4	607.4	607.4	607.4	607.4	607.4

Fund Source (Operating Only)

1156 Rcpt Svcs	560.8		607.4	607.4	607.4	607.4	607.4
Total	560.8	0.0	607.4	607.4	607.4	607.4	607.4

Positions

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

Change in Revenues	560.8		607.4	607.4	607.4	607.4	607.4
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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:

CSSB074(FIN)AM added the expansion of telemedicine; updated personal services, travel, services, commodities, and analysis.

Prepared By: <u>Janey Hovenden, Director</u>	Phone: <u>(907)465-2536</u>
Division: <u>Corporations, Business and Professional Licensing</u>	Date: <u>03/07/2016 12:00 PM</u>
Approved By: <u>Catherine Reardon, Director</u>	Date: <u>03/07/16</u>
Agency: <u>Division of Administrative Services</u>	

REPORTED OUT OF
SFC 03/08/2016

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB 74(FIN)

Analysis

CSSB74 requires the pharmacist or practitioner who dispenses controlled substances, other than those administered to a patient at a health care facility, to submit to the board for inclusion in the Controlled Substance Prescription Database (PDMP) on a weekly basis. The bill allows licensed practitioners and licensed pharmacists to delegate access to the PDMP on their behalf to an agent or employee of the practitioner. It requires a pharmacist or practitioner who prescribes or dispenses controlled substances to register with the PDMP in a format established by the Board of Pharmacy, and requires the Board of Pharmacy to promptly notify the pertinent licensing board when a practitioner registers with the PDMP.

This legislation allows access to the PDMP by: the licensed pharmacist of the Department of Health and Social Services (DHSS) responsible for administering prescription drugs coverage; the licensed 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 data for the purpose of identifying and monitoring public health issues in the state.

CSSB74 allows for disciplinary action for failure to register by either the Board of Pharmacy or by another licensing board. It creates a procedure and time frame for registration with the PDMP and requires a pharmacist or practitioner to access the database to check a patient's prescription records before dispensing, prescribing, or administering a controlled substance. 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.

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.

CSSB74 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 in locations across the nation.

The division has seen a 400% increase in medical license applications since telemedicine was expanded through legislation effective November 2014. This bill would 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, and marital and family 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.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB 74(FIN)

Analysis Continued

The division shall adopt regulations for 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: \$25.0 (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: \$5.0 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. If awarded, costs of this program enhancement could be covered by federal grant funds instead of program receipts. In absence of the grant it would be paid for by Board of Pharmacy licensees.

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(STA)-LAW-CRIM-03-07-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES	316.6	0.0	316.6	316.6	316.6	316.6	316.6	316.6
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								
Total Operating	365.0	0.0	365.0	365.0	365.0	365.0	365.0	365.0

Fund Source (Operating Only)

1002 Fed Rcpts	273.7		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	91.3
Total	365.0	0.0	365.0	365.0	365.0	365.0	365.0	365.0

Positions

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

Change in Revenues	500.0		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

BILL NO. SB74

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.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. SB74

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: SB074CS(FIN)-DHSS-AKPH-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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? 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	Phone:	(907)458-2228
Division:	Alaska Pioneer Homes	Date:	03/05/2016 07:00 PM
Approved By:	Sana Efird, Assistant 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-AKPH-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES	FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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? 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 Efird, 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-BHA-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	0.0	0.0	0.0	(226.7)	(453.4)	(453.4)	(453.4)
Personal Services				(226.7)	(453.4)	(453.4)	(453.4)
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	(226.7)	(453.4)	(453.4)	(453.4)

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)
Total	0.0	0.0	0.0	(226.7)	(453.4)	(453.4)	(453.4)

Positions

Full-time				(2.0)	(4.0)	(4.0)	(4.0)
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? 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
Division: Behavioral Health
Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services
Agency: Health and Social Services

Phone: (907)269-5948
Date: 03/05/2016 06:00 PM
Date: 03/08/16

REPORTED OUT OF
SFC 03/08/2016

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-MAA-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES								
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								
Total Operating	333.9	0.0	316.2	316.2	316.2	316.2	316.2	316.2

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
Total	333.9	0.0	316.2	316.2	316.2	316.2	316.2	316.2

Positions

Full-time	2.0		2.0	2.0	2.0	2.0	2.0	2.0
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? 07/01/17

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	Phone:	(907)334-2520
Division:	Health Care Services	Date:	03/05/2016 12:00 AM
Approved By:	Sana Efird, Assistant 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-RR-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES	FY 2017	FY 2017					
Personal Services							
Travel							
Services	500.0		200.0	200.0	200.0	200.0	200.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	500.0	0.0	200.0	200.0	200.0	200.0	200.0

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
Total	500.0	0.0	200.0	200.0	200.0	200.0	200.0

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? 07/01/17

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	Phone:	(907)334-2520
Division:	Health Care Services	Date:	03/04/2016 05:00 PM
Approved By:	Sana Efird, Assistant 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-FI-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES	FY 2017	FY 2017					
Personal Services			(46.0)	(46.0)	(46.0)	(46.0)	(46.0)
Travel							
Services	680.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	680.0	0.0	(46.0)	(46.0)	(46.0)	(46.0)	(46.0)

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)
Total	680.0	0.0	(46.0)	(46.0)	(46.0)	(46.0)	(46.0)

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? 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.

Prepared By: Sean O'Brien, Director
Division: Public Assistance
Approved By: Sana Efird, 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-SDSA-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES								
Personal Services	97.3		318.3	318.3	318.3	318.3	318.3	318.3
Travel	2.3		6.9	6.9	6.9	6.9	6.9	6.9
Services	186.8		408.6	325.9	10.5	10.5	10.5	10.5
Commodities	2.5		7.5	7.5	7.5	7.5	7.5	7.5
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	288.9	0.0	741.3	658.6	343.2	343.2	343.2	343.2

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
Total	288.9	0.0	741.3	658.6	343.2	343.2	343.2

Positions

Full-time	1.0		3.0	3.0	3.0	3.0	3.0
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? 07/01/17

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	Phone:	(907)269-2083
Division:	Senior and Disabilities Services	Date:	03/05/2016 08:00 AM
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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-GRTAL-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES	FY 2017	FY 2017					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
Miscellaneous							
Total Operating	0.0	0.0	0.0	(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)

Fund Source (Operating Only)

1004 Gen Fund				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
Total	0.0	0.0	0.0	(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)

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:

Corrects the year of first anticipated UGF savings under 1915(i) option for CS SB 74 version U.

Prepared By:	Duane Mayes, Director	Phone:	(907)269-2083
Division:	Senior and Disabilities Services	Date:	02/26/2016 03:00 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-SCBG-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					(735.2)	(735.2)	(735.2)	(735.2)
Miscellaneous								
Total Operating	0.0	0.0	0.0	(735.2)	(735.2)	(735.2)	(735.2)	(735.2)

Fund Source (Operating Only)

1004 Gen Fund				(735.2)	(735.2)	(735.2)	(735.2)
Total	0.0	0.0	0.0	(735.2)	(735.2)	(735.2)	(735.2)

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:

Corrects the year of first anticipated UGF savings under 1915(i) option for CS SB 74, version U.

Prepared By: Duane Mayes, Director	Phone: (907)269-2083
Division: Senior and Disabilities Services	Date: 02/26/2016 03:00 PM
Approved By: Sana Efirid, 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-CDDG-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES	FY 2017	FY 2017					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits			(5,817.9)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous							
Total Operating	0.0	0.0	(5,817.9)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)

Fund Source (Operating Only)

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

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? 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.
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Prepared By:	Duane Mayes, Director	Phone:	(907)269-2083
Division:	Senior and Disabilities Services	Date:	03/05/2016 12:00 AM
Approved By:	Sana Efir, 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

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-CO-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES	FY 2017	FY 2017					
Personal Services	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
Services	772.6		37.6	37.6	37.6	37.6	37.6
Commodities	38.4						
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	1,317.0	0.0	543.6	543.6	543.6	543.6	543.6

Fund Source (Operating Only)

1002 Fed Rcpts	291.0		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
1004 Gen Fund	735.0						
Total	1,317.0	0.0	543.6	543.6	543.6	543.6	543.6

Positions

Full-time	4.0		4.0	4.0	4.0	4.0	4.0
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? 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 Efird, 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

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FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-BHMS-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES	FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
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							
Total Operating	250.0	0.0	4,850.0	9,900.0	14,200.0	19,000.0	19,000.0

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
Total	250.0	0.0	4,850.0	9,900.0	14,200.0	19,000.0	19,000.0

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: 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: <u>Randall P. Burns, Acting Director</u>	Phone: <u>(907)269-5948</u>
Division: <u>Behavioral Health</u>	Date: <u>03/05/2015 06:00 PM</u>
Approved By: <u>Sana Efird, Asst. Commissioner, Finance and Management Services</u>	Date: <u>03/08/16</u>
Agency: <u>Health and Social Services</u>	

REPORTED OUT OF
SFC 03/08/2016

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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				
Total Expenditures	\$ 250.0	\$ 4,850.0	\$ 9,900.0	\$ 14,200.0	\$ 19,000.0	\$ 19,000.0

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-HCMS-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES								
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								
Total Operating	337.2	0.0	(3,768.4)	(16,359.2)	(22,050.6)	(28,207.6)	(32,111.9)	(32,111.9)

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
Total	337.2	0.0	(3,768.4)	(16,359.2)	(22,050.6)	(28,207.6)	(32,111.9)

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: 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	Phone:	(907)334-2520
Division:	Health Care Services	Date:	03/06/2016 06:30 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

BILL NO. CSSB074(FIN)

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*.

AMFCA recoveries FY 2017	\$306,250
AMFCA annual recoveries FY 2018-FY2019	\$612,500
AMFCA annual recoveries FY 2020-FY2022	\$512,500

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)

Amount of Interest Penalty Recoveries FY2017	\$ 84,910
Amount of Interest Penalty Recoveries FY2018	\$127,365
Amount for FY2019-FY2022	\$169,821

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.

Amount of Self-Identified Recoveries FY2017	\$ 500,000
Amount of Self-Identified Recoveries FY2018	\$ 500,000
Amount of Self-Identified Recoveries FY2019	\$ 475,000
FY 2020	\$ 450,000
FY 2021	\$ 425,000
FY 2022	\$ 400,000

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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>
Annual recoveries for FY2017-FY2022	\$ 332,500

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 2nd 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)

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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.**

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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)
 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 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: SB 74
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB074CS(FIN)-DHSS-SDMS-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES								
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								
Total Operating	0.0	0.0	5,817.9	17,061.0	17,061.0	17,061.0	17,061.0	17,061.0

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)
Total	0.0	0.0	5,817.9	17,061.0	17,061.0	17,061.0	17,061.0

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: 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	Phone: (907)269-2083
Division: Senior and Disabilities Services	Date: 03/05/2016 10:00 AM
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

BILL NO. CSSB074(FIN)

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

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB074(FIN)

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	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)

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

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS KELLY, Giessel, Micciche, Bishop, MacKinnon, Hoffman

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 professional
3 counselor, marriage and family therapist, psychologist, psychological associate, and
4 social worker by audio, video, or data communications; relating to the duties of the State
5 Medical Board; relating to limitations of actions; establishing the Alaska Medical
6 Assistance False Claim and Reporting Act; relating to medical assistance programs
7 administered by the Department of Health and Social Services; relating to the controlled
8 substance prescription database; relating to the duties of the Board of Pharmacy;
9 relating to the duties of the Department of Commerce, Community, and Economic
10 Development; relating to accounting for program receipts; relating to public record
11 status of records related to the Alaska Medical Assistance False Claim and Reporting
12 Act; establishing a telemedicine business registry; relating to competitive bidding for

1 medical assistance products and services; relating to verification of eligibility for public
 2 assistance programs administered by the Department of Health and Social Services;
 3 relating to annual audits of state medical assistance providers; relating to reporting
 4 overpayments of medical assistance payments; establishing authority to assess civil
 5 penalties for violations of medical assistance program requirements; relating to seizure
 6 and forfeiture of property for medical assistance fraud; relating to the duties of the
 7 Department of Health and Social Services; establishing medical assistance
 8 demonstration projects; relating to Alaska Pioneers' Homes and Alaska Veterans'
 9 Homes; relating to the duties of the Department of Administration; relating to the
 10 Alaska Mental Health Trust Authority; relating to feasibility studies for the provision of
 11 specified state services; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89,
 12 Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure; and
 13 providing for an effective date."

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

15 * **Section 1.** AS 08.29.400 is amended by adding new subsections to read:

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

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

21 (2) the licensee requests that the person consent to sending a copy of
 22 all records of the encounter to a primary care provider if the licensee is not the
 23 person's primary care provider and, if the person consents, the licensee sends the
 24 records to the person's primary care provider; and

25 (3) the licensee meets the requirements established by the board in
 26 regulation.

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

5 * **Sec. 2.** AS 08.63.210 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, supervision, or treatment of a person through audio, video, or
 8 data 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. 3.** AS 08.64.101 is amended to read:

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

23 (1) examine and issue licenses to applicants;

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

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

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

31 (5) under regulations adopted by the board, contract with private

1 professional organizations to establish an impaired medical professionals program to
 2 identify, confront, evaluate, and treat persons licensed under this chapter who abuse
 3 alcohol, other drugs, or other substances or are mentally ill or cognitively impaired;

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

10 * Sec. 4. AS 08.64.364(a) is amended to read:

11 (a) The board may not impose disciplinary sanctions on a physician for
 12 rendering a diagnosis, providing treatment, or prescribing, dispensing, or
 13 administering a prescription drug that is not a controlled substance to a person
 14 without conducting a physical examination if

15 (1) [THE PRESCRIPTION DRUG IS

16 (A) NOT A CONTROLLED SUBSTANCE; OR

17 (B) A CONTROLLED SUBSTANCE AND IS PRESCRIBED,
 18 DISPENSED, OR ADMINISTERED BY A PHYSICIAN WHEN AN
 19 APPROPRIATE LICENSED HEALTH CARE PROVIDER IS PRESENT
 20 WITH THE PATIENT TO ASSIST THE PHYSICIAN WITH
 21 EXAMINATION, DIAGNOSIS, AND TREATMENT;

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

25 (2) the physician requests that [(3)] the person consent
 26 [CONSENTS] to sending a copy of all records of the encounter to the person's primary
 27 care provider if the prescribing physician is not the person's primary care provider,
 28 and, if the patient consents, the physician sends the records to the person's primary
 29 care provider.

30 * Sec. 5. AS 08.64.364 is amended by adding new subsections to read:

31 (c) The board may not impose disciplinary sanctions on a physician for

1 prescribing, dispensing, or administering a prescription drug that is a controlled
 2 substance if the requirements under (a) of this section are met and the physician
 3 prescribes, dispenses, or administers the controlled substance when an appropriate
 4 licensed health care provider is present with the patient to assist the physician with
 5 examination, diagnosis, and treatment.

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

7 (1) prescribe an abortion-inducing drug; or

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

11 * **Sec. 6.** AS 08.86.204 is amended by adding new subsections to read:

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

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

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

21 (3) the licensee meets the requirements established by the board in
 22 regulation.

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

27 * **Sec. 7.** AS 08.95.050 is amended by adding new subsections to read:

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

31 (1) the licensee or another licensed health care provider is available to

1 provide follow-up care;

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

6 (3) the licensee meets the requirements established by the board in
7 regulation.

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

12 * **Sec. 8.** AS 09.10 is amended by adding a new section to read:

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

21 * **Sec. 9.** AS 09.10.120(a) is amended to read:

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

28 * **Sec. 10.** AS 09 is amended by adding a new chapter to read:

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

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

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

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

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

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

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

16 (b) A beneficiary of an intentional or inadvertent submission of a false or
17 fraudulent claim under the medical assistance program who later discovers the claim is
18 false or fraudulent shall disclose the false or fraudulent claim to the state not later than
19 60 days after discovering the false claim.

20 (c) In addition to any criminal penalties or seizure or forfeiture of property
21 under AS 47.05, a medical assistance provider or medical assistance recipient who
22 violates (a) or (b) of this section shall be liable to the state in a civil action for

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

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

25 and

26 (3) reasonable attorney fees and costs calculated under applicable court
27 rules.

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

31 (1) furnished the attorney general or the Department of Health and

1 Social Services with all information known to the person about the violation not later
2 than 30 days after the date the information was obtained;

3 (2) fully cooperated with the investigation of the violation under
4 AS 09.58.020; and

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

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

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

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

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

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

26 (1) a copy of the complaint; and

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

29 (c) A complaint filed under this section must remain under seal for at least 60
30 days and may not be served on the defendant until the court so orders. The attorney
31 general may elect to intervene and proceed with the action within 60 days after the

1 attorney general receives both the complaint and the material evidence and the
2 information required under (b) of this section. The attorney general may, for good
3 cause shown, move the court, under seal, for an extension of the time during which the
4 complaint remains under seal under this subsection.

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

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

15 (1) intervene in the action and proceed with the action on behalf of the
16 state;

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

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

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

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

30 **Sec. 09.58.025. Subpoenas.** In conducting an investigation under
31 AS 09.58.015 or 09.58.020, the attorney general may issue subpoenas to compel the

1 production of books, papers, correspondence, memoranda, and other records in
2 connection with an investigation under or the administration of AS 09.58.010 -
3 09.58.060. If a medical assistance provider or a medical assistance recipient fails or
4 refuses, without just cause, to obey a subpoena issued under this subsection, the
5 superior court may, upon application by the attorney general, issue an order requiring
6 the medical assistance provider or medical assistance recipient to appear before the
7 attorney general to produce evidence.

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

17 (b) Notwithstanding the objections of the person who brought the action, the
18 attorney general may

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

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

27 (c) If the attorney general elects not to proceed under AS 09.58.020 with the
28 action, the person who brought the action has the right to proceed and conduct the
29 action. The attorney general may request at any time during the proceedings to be
30 served with copies of all documents related to the action, including pleadings,
31 motions, and discovery. The attorney general shall pay for the reasonable copying

1 charges for documents provided under this subsection. If the person who brought the
2 action proceeds with the action, the court, without limiting the status and rights of the
3 person who brought the action, shall allow the attorney general to intervene at any
4 time.

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

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

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

31 (c) Whether or not the attorney general participates in the action, if the court

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

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

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

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

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

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

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

22 (3) based on the public disclosure of allegations or actions in a
23 criminal or civil action or an administrative hearing, or from the news media, unless
24 the action is brought by the attorney general or the person bringing the action is an
25 original source of the information that was publicly disclosed; in this paragraph, a
26 person is an original source of the information that was publicly disclosed if the
27 person has independent knowledge, including knowledge based on personal
28 investigation of the defendant's conduct, of the information on which the allegations
29 are based, and has voluntarily provided or verified the information on which the
30 allegations are based or voluntarily provided the information to the attorney general
31 before filing an action under AS 09.58.020 that is based on the information; or

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

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

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

6 **Sec. 09.58.070. Employee protection for retaliation.** (a) An employee of a
7 medical assistance provider who is discharged, demoted, suspended, threatened,
8 harassed, or discriminated against in the terms and conditions of employment by the
9 employee's employer because of lawful acts done by the employee on behalf of the
10 employee or others in furtherance of an action under AS 09.58.010 - 09.58.060,
11 including investigation for, initiation of, testimony for or assistance in an action filed
12 or to be filed under AS 09.58.010 - 09.58.060, is entitled to the same relief authorized
13 under AS 39.90.120.

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

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

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

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

29 (b) No punitive damages may be awarded in an action brought under
30 AS 09.58.010 - 09.58.060.

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

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

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

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

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

13 (A) has actual knowledge of the information;

14 (B) acts in deliberate ignorance of the truth or falsity of the
15 information; or

16 (C) acts in reckless disregard of the truth or falsity of the
17 information;

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

21 (6) "medical assistance provider" has the meaning given under
22 AS 47.05.290;

23 (7) "medical assistance recipient" has the meaning given under
24 AS 47.05.290;

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

27 (A) an express or implied contractual grantor or grantee or
28 licensor or licensee relationship;

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

30 (C) a statute or regulation; or

31 (D) the retention of any overpayment.

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

3 * **Sec. 11.** AS 09.58.025, added by sec. 10 of this Act, is amended to read:

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

13 * **Sec. 12.** AS 09.58.070(b), added by sec. 10 of this Act, is amended to read:

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

22 * **Sec. 13.** AS 17.30.200(a) is amended to read:

23 (a) The controlled substance prescription database is established in the Board
24 of Pharmacy. The purpose of the database is to contain data as described in this
25 section regarding every prescription for a schedule [IA, IIA, IIIA, IVA, OR VA
26 CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III,
27 or IV [, OR V] controlled substance under federal law dispensed in the state to a
28 person other than those administered to a patient at a health care facility. The
29 Department of Commerce, Community, and Economic Development shall assist the
30 board and provide necessary staff and equipment to implement this section.

31

1 * **Sec. 14.** AS 17.30.200(b) is amended to read:

2 (b) The pharmacist-in-charge of each licensed or registered pharmacy,
3 regarding each schedule [IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE
4 UNDER STATE LAW OR A SCHEDULE I,] II, III, or IV [, OR V] controlled
5 substance under federal law dispensed by a pharmacist under the supervision of the
6 pharmacist-in-charge, and each practitioner who directly dispenses a schedule [IA,
7 IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE LAW OR A
8 SCHEDULE I,] II, III, or IV [, OR V] controlled substance under federal law other
9 than those administered to a patient at a health care facility, shall submit to the board,
10 by a procedure and in a format established by the board, the following information for
11 inclusion in the database on at least a weekly basis:

12 (1) the name of the prescribing practitioner and the practitioner's
13 federal Drug Enforcement Administration registration number or other appropriate
14 identifier;

15 (2) the date of the prescription;

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

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

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

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

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

24 and

25 (8) the name of the pharmacist or practitioner dispensing the controlled
26 substance and other appropriate identifying information.

27 * **Sec. 15.** AS 17.30.200(d) is amended to read:

28 (d) The database and the information contained within the database are
29 confidential, are not public records, and are not subject to public disclosure. The board
30 shall undertake to ensure the security and confidentiality of the database and the
31 information contained within the database. The board may allow access to the

1 database only to the following persons, and in accordance with the limitations
2 provided and regulations of the board:

3 (1) personnel of the board regarding inquiries concerning licensees or
4 registrants of the board or personnel of another board or agency concerning a
5 practitioner under a search warrant, subpoena, or order issued by an administrative law
6 judge or a court;

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

9 (3) a licensed practitioner having authority to prescribe controlled
10 substances or an agent or employee of the practitioner whom the practitioner has
11 authorized to access the database on the practitioner's behalf, to the extent the
12 information relates specifically to a current patient of the practitioner to whom the
13 practitioner is prescribing or considering prescribing a controlled substance;

14 (4) a licensed or registered pharmacist having authority to dispense
15 controlled substances or an agent or employee of the pharmacist whom the
16 pharmacist has authorized to access the database on the pharmacist's behalf, to
17 the extent the information relates specifically to a current patient to whom the
18 pharmacist is dispensing or considering dispensing a controlled substance;

19 (5) federal, state, and local law enforcement authorities may receive
20 printouts of information contained in the database under a search warrant, subpoena,
21 or order issued by a court establishing probable cause for the access and use of the
22 information; [AND]

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

29 (7) a licensed pharmacist employed by the Department of Health
30 and Social Services who is responsible for administering prescription drug
31 coverage for the medical assistance program under AS 47.07, to the extent that

1 the information relates specifically to prescription drug coverage under the
 2 program;

3 (8) a licensed pharmacist, licensed practitioner, or authorized
 4 employee of the Department of Health and Social Services responsible for
 5 utilization review of prescription drugs for the medical assistance program under
 6 AS 47.07, to the extent that the information relates specifically to utilization
 7 review of prescription drugs provided to recipients of medical assistance;

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

10 (10) an authorized employee of the Department of Health and
 11 Social Services may receive information from the database that does not disclose
 12 the identity of a patient, prescriber, dispenser, or dispenser location, for the
 13 purpose of identifying and monitoring public health issues in the state; however,
 14 the information provided under this paragraph may include the region of the
 15 state in which a patient, prescriber, and dispenser are located and the specialty of
 16 the prescriber.

17 * 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.

23 * Sec. 17. AS 17.30.200(h) is amended to read:

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

1 * **Sec. 18.** AS 17.30.200(k) is amended to read:

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

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

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

9 (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.

22 * **Sec. 19.** AS 17.30.200 is amended by adding new subsections to read:

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

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

30 (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

1 substances in quantities or with a frequency inconsistent with generally recognized
2 standards of safe practice.

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

5 * **Sec. 20.** AS 37.05.146(c) is amended by adding a new paragraph to read:

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

8 * **Sec. 21.** AS 40.25.120(a) is amended by adding a new paragraph to read:

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

11 * **Sec. 22.** AS 44.33 is amended by adding a new section to read:

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

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

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

19 (c) In this section,

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

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

26 * **Sec. 23.** AS 47.05.015 is amended by adding a new subsection to read:

27 (e) Notwithstanding (c) of this section, the department may enter into a
28 contract through the competitive bidding process under AS 36.30 (State Procurement
29 Code) for medical assistance products and services offered under AS 47.07.030 if the
30 contract is for durable medical equipment or specific medical services that can be
31 delivered on a statewide basis.

1 * **Sec. 24.** AS 47.05 is amended by adding a new section to article 1 to read:

2 **Sec. 47.05.105. Enhanced computerized eligibility verification system.** (a)

3 The department shall establish an enhanced computerized income, asset, and identity
4 eligibility verification system for the purposes of verifying eligibility, eliminating
5 duplication of public assistance payments, and deterring waste and fraud in public
6 assistance programs administered by the department under AS 47.05.010. Nothing in
7 this section prohibits the department from verifying eligibility for public assistance
8 through additional procedures or authorizes the department or a third-party vendor to
9 use data to verify eligibility for a federal program if the use of that data is prohibited
10 by federal law.

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

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

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

29 * **Sec. 25.** AS 47.05.200(a) is amended to read:

30 (a) The department shall annually contract for independent audits of a
31 statewide sample of all medical assistance providers in order to identify overpayments

1 and violations of criminal statutes. The audits conducted under this section may not be
 2 conducted by the department or employees of the department. The number of audits
 3 under this section may not be less than 50 each year [, AS A TOTAL FOR THE
 4 MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL
 5 BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE
 6 PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE
 7 DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS
 8 SECTION MAY NOT BE LESS THAN 75]. The audits under this section must
 9 include both on-site audits and desk audits and must be of a variety of provider types.
 10 The department may not award a contract under this subsection to an organization that
 11 does not retain persons with a significant level of expertise and recent professional
 12 practice in the general areas of standard accounting principles and financial auditing
 13 and in the specific areas of medical records review, investigative research, and Alaska
 14 health care criminal law. The contractor, in consultation with the commissioner, shall
 15 select the providers to be audited and decide the ratio of desk audits and on-site audits
 16 to the total number selected. In identifying providers who are subject to an audit
 17 under this chapter, the department shall attempt to minimize concurrent state or
 18 federal audits.

19 * Sec. 26. AS 47.05.200(b) is amended to read:

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

1 accruing from the date of the issuance of the final agency decision to recoup
 2 overpayments identified in the audit. In this subsection, the date of issuance of
 3 the final agency decision is the later of the date of

4 (1) the department's written notification of the decision and the
 5 provider's appeal rights; or

6 (2) if timely appealed by the provider, a final agency decision
 7 under AS 44.64.060.

8 * **Sec. 27.** AS 47.05 is amended by adding a new section to read:

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

10 Unless a provider is being audited under AS 47.05.200(a), an enrolled medical
 11 assistance provider shall conduct a biennial review or audit of a statistically valid
 12 sample of claims submitted to the department for reimbursement. If overpayments are
 13 identified, the medical assistance provider shall report the overpayment to the
 14 department not later than 10 business days after identification of the overpayment. The
 15 report must also identify how the medical assistance provider intends to repay the
 16 department. After the department receives the report, the medical assistance provider
 17 and the department shall enter into an agreement establishing a schedule for
 18 repayment of the identified overpayment. The agreement may authorize repayment in
 19 a lump sum, a payment plan, or by offsetting future billings as approved by the
 20 department.

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

23 * **Sec. 28.** AS 47.05 is amended by adding new sections to read:

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

27 (b) The department shall adopt regulations establishing a range of civil
 28 penalties that the department may assess against a provider under this section. In
 29 establishing the range of civil penalties, the department shall take into account
 30 appropriate factors, including the seriousness of the violation, the service provided by
 31 the provider, and the severity of the penalty. The regulations may not provide for a

1 civil penalty of less than \$100 or more than \$25,000 for each violation.

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

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

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

14 **Sec. 47.05.260. Seizure and forfeiture of real or personal property in**
15 **medical assistance fraud cases.** (a) Upon written application by the attorney general
16 establishing probable cause that a medical assistance provider has committed or is
17 committing medical assistance fraud under AS 47.05.210, the court may authorize the
18 seizure of real or personal property listed in (e) of this section to cover the cost of the
19 alleged fraud. The application may be made ex parte if the attorney general establishes
20 sufficient facts to show that notice to the owner of the property would lead to the
21 waste or dissipation of assets subject to seizure. If the attorney general does not
22 establish sufficient facts to show that notice to the owner would lead to the waste or
23 dissipation of assets subject to seizure, the application for seizure must be served on
24 the owners of the property.

25 (b) Upon issuance of the court order authorizing seizure, the owners of the
26 property may not take any action to dispose of the property through transfer of title or
27 sale of the property without written permission from the court. However, an innocent
28 purchaser may not be required to forfeit property purchased in good faith. The
29 purchaser bears the burden of proof to establish that the property was purchased
30 innocently and in good faith.

31 (c) If a medical assistance provider is convicted of medical assistance fraud

1 under AS 47.05.210 after property is seized under this section, the court may order
2 that the property be forfeited to the state and disposed of as directed by the court. If
3 the property has been sold, the proceeds of the sale shall be transmitted to the proper
4 state officer or employee for deposit into the general fund. The attorney general shall
5 return to the owner of the property any property seized under this section that the court
6 does not order to be forfeited as soon as practicable after the court issues a final
7 judgment in the medical assistance fraud proceeding under AS 47.05.210 and the
8 medical assistance provider pays any fine or restitution ordered by the court.

9 (d) An action for forfeiture under this section may be joined with a civil or
10 criminal action brought by the state to recover damages resulting from alleged medical
11 assistance fraud.

12 (e) Property that may be seized under this chapter includes bank accounts,
13 automobiles, boats, airplanes, stocks, bonds, the medical assistance provider's business
14 inventory, and other real or personal property owned and used to conduct the medical
15 assistance provider's business.

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

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

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

24 (3) expanding the use of telehealth for primary care, behavioral health,
25 and urgent care;

26 (4) enhancing fraud prevention, detection, and enforcement;

27 (5) reducing the cost of behavioral health, senior, and disabilities
28 services provided to recipients of medical assistance under the state's home and
29 community-based services waiver under AS 47.07.045;

30 (6) pharmacy initiatives;

31 (7) enhanced care management;

1 (8) redesigning the payment process by implementing fee agreements
2 that include one or more of the following:

3 (A) premium payments for centers of excellence;

4 (B) penalties for hospital-acquired infections, readmissions,
5 and outcome failures;

6 (C) bundled payments for specific episodes of care; or

7 (D) global payments for contracted payers, primary care
8 managers, and case managers for a recipient or for care related to a specific
9 diagnosis;

10 (9) stakeholder involvement in setting annual targets for quality and
11 cost-effectiveness;

12 (10) to the extent consistent with federal law, reducing travel costs by
13 requiring a recipient to obtain medical services in the recipient's home community, to
14 the extent appropriate services are available in the recipient's home community;

15 (11) guidelines for health care providers to develop health care
16 delivery models supported by evidence-based practices that encourage wellness and
17 disease prevention.

18 (b) The department shall, in coordination with the Alaska Mental Health Trust
19 Authority, efficiently manage a comprehensive and integrated behavioral health
20 program that uses evidence-based, data-driven practices to achieve positive outcomes
21 for people with mental health or substance abuse disorders and children with severe
22 emotional disturbances. The goal of the program is to assist recipients of services
23 under the program to recover by achieving the highest level of autonomy with the least
24 dependence on state-funded services possible for each person. The program must
25 include

26 (1) a plan for providing a continuum of community-based services to
27 address housing, employment, criminal justice, and other relevant issues;

28 (2) services from a wide array of providers and disciplines, including
29 licensed or certified mental health and primary care professionals; and

30 (3) efforts to reduce operational barriers that fragment services,
31 minimize administrative burdens, and reduce the effectiveness and efficiency of the

1 program.

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

9 (d) On or before November 15 of each year, the department shall prepare a
10 report and submit the report to the senate secretary and the chief clerk of the house of
11 representatives and notify the legislature that the report is available. The report must
12 include

- 13 (1) realized cost savings related to reform efforts under this section;
- 14 (2) realized cost savings related to medical assistance reform efforts
15 undertaken by the department other than the reform efforts described in this Act;
- 16 (3) a statement of whether the department has met annual targets for
17 quality and cost-effectiveness;
- 18 (4) recommendations for legislative or budgetary changes related to
19 medical assistance reforms during the next fiscal year;
- 20 (5) changes in federal laws that the department expects will result in a
21 cost or savings to the state of more than \$1,000,000;
- 22 (6) a description of any medical assistance grants, options, or waivers
23 the department applied for in the previous fiscal year;
- 24 (7) the results of demonstration projects the department has
25 implemented;
- 26 (8) legal and technological barriers to the expanded use of telehealth,
27 improvements in the use of telehealth in the state, and recommendations for changes
28 or investments that would allow cost-effective expansion of telehealth;
- 29 (9) the percentage decrease in costs of travel for medical assistance
30 recipients compared to the previous fiscal year;
- 31 (10) the percentage decrease in the number of medical assistance

1 recipients identified as frequent users of emergency departments compared to the
2 previous fiscal year;

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

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

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

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

13 (e) In this section, "telehealth" means the practice of health care delivery,
14 evaluation, diagnosis, consultation, or treatment, using the transfer of health care data
15 through audio, visual, or data communications, performed over two or more locations
16 between providers who are physically separated from the recipient or from each other
17 or between a provider and a recipient who are physically separated from each other.

18 * Sec. 29. AS 47.07.030(d) is amended to read:

19 (d) The department shall [MAY] establish as optional services a primary care
20 case management system or a managed care organization contract in which certain
21 eligible individuals are required to enroll and seek approval from a case manager or
22 the managed care organization before receiving certain services. The purpose of a
23 primary care case management system or managed care organization contract is
24 to increase the use of appropriate primary and preventive care by medical
25 assistance recipients, while decreasing the unnecessary use of specialty care and
26 hospital emergency department services. The department shall

27 (1) establish enrollment criteria and determine eligibility for services
28 consistent with federal and state law; the department shall require recipients with
29 multiple hospitalizations to enroll in a primary care case management system or
30 with a managed care organization under this subsection, except that the
31 department may exempt recipients with chronic, acute, or terminal medical

1 conditions from the requirement under this paragraph;

2 (2) define the coordinated care services and provider types eligible
3 to participate as primary care providers;

4 (3) create a performance and quality reporting system; and

5 (4) integrate the coordinated care demonstration projects
6 described under AS 47.07.039 and the demonstration projects described under
7 AS 47.07.036(e) with the primary care case management system or managed care
8 organization contract established under this subsection.

9 * Sec. 30. AS 47.07.036 is amended by adding new subsections to read:

10 (d) Notwithstanding (a) - (c) of this section, the department may

11 (1) apply for a section 1915(i) option under 42 U.S.C. 1396n to
12 improve services and care through home and community-based services to obtain a 50
13 percent federal match;

14 (2) apply for a section 1915(k) option under 42 U.S.C. 1396n to
15 provide home and community-based services and support to increase the federal match
16 for these programs from 50 percent to 56 percent;

17 (3) apply for a section 1945 option under 42 U.S.C. 1396w-4 to
18 provide coordinated care through health homes for individuals with chronic conditions
19 and to increase the federal match for the services to 90 percent for the first eight
20 quarters the required state plan amendment is in effect;

21 (4) evaluate and seek permission from the United States Department of
22 Health and Human Services Centers for Medicare and Medicaid Services to participate
23 in various demonstration projects, including payment reform, care management
24 programs, workforce development and innovation, and innovative services delivery
25 models; and

26 (5) provide incentives for telehealth, including increasing the
27 capability for and reimbursement of telehealth for recipients.

28 (e) Notwithstanding (a) - (c) of this section, and in addition to the projects and
29 services described under (d) and (f) of this section, the department shall apply for a
30 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration
31 projects focused on innovative payment models for one or more groups of medical

1 assistance recipients in one or more specific geographic areas. The demonstration
2 project or projects may include

- 3 (1) managed care organizations as described under 42 U.S.C. 1396u-2;
4 (2) community care organizations;
5 (3) patient-centered medical homes as described under 42 U.S.C. 256a-
6 1; or
7 (4) other innovative payment models that ensure access to health care
8 without reducing the quality of care.

9 (f) Notwithstanding (a) - (c) of this section, and in addition to the projects and
10 services described under (d) and (e) of this section, the department shall apply for a
11 section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration
12 projects focused on improving the state's behavioral health system for medical
13 assistance recipients. The department shall engage stakeholders and the community in
14 the development of a project or projects under this subsection. The demonstration
15 project or projects must be consistent with the comprehensive and integrated
16 behavioral health program described under AS 47.05.270(b).

17 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

18 * **Sec. 31.** AS 47.07 is amended by adding new sections to read:

19 **Sec. 47.07.038. Collaborative, hospital-based project to reduce use of**
20 **emergency department services.** (a) On or before December 1, 2016, the department
21 shall collaborate with a statewide professional hospital association to establish a
22 hospital-based project to reduce the use of emergency department services by medical
23 assistance recipients. The statewide professional hospital association shall operate the
24 project. The project may include shared savings for participating hospitals. The project
25 must include

- 26 (1) an interdisciplinary process for defining, identifying, and
27 minimizing the number of frequent users of emergency department services;
28 (2) to the extent consistent with federal law, a system for real-time
29 electronic exchange of patient information, including recent emergency department
30 visits, hospital care plans for frequent users of emergency departments, and data from
31 the controlled substance prescription database;

1 (3) a procedure for educating patients about the use of emergency
2 departments and appropriate alternative services and facilities for nonurgent care;

3 (4) a process for assisting users of emergency departments in making
4 appointments with primary care or behavioral health providers within 96 hours after
5 an emergency department visit;

6 (5) a collaborative process between the department and the statewide
7 professional hospital association to establish uniform statewide guidelines for
8 prescribing narcotics in an emergency department; and

9 (6) designation of health care personnel to review successes and
10 challenges regarding appropriate emergency department use.

11 (b) 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 (b) A project review committee is established in the department for the
18 purpose of reviewing proposals for demonstration projects under this section. The
19 project review committee consists of

20 (1) the commissioner of the department, or the commissioner's
21 designee;

22 (2) the commissioner of administration, or the commissioner's
23 designee;

24 (3) the chief executive officer of the Alaska Mental Health Trust
25 Authority, or the chief executive officer's designee;

26 (4) two representatives of stakeholder groups, appointed by the
27 governor for staggered three-year terms;

28 (5) a nonvoting member who is a member of the senate, appointed by
29 the president of the senate; and

30 (6) a nonvoting member who is a member of the house of
31 representatives, appointed by the speaker of the house of representatives.

1 (c) The department may contract with a managed care organization, primary
2 care case manager, accountable care organization, prepaid ambulatory health plan, or
3 provider-led entity to implement a demonstration project under this section. The fee
4 structure for a contract under this subsection may include global payments, bundled
5 payments, capitated payments, shared savings and risk, or other payment structures.
6 The department shall work with the division of insurance, Department of Commerce,
7 Community, and Economic Development, to streamline the application process for a
8 company to obtain a certificate of authority required under AS 21.09.010 as necessary
9 to participate in a demonstration project under this section.

10 (d) A proposal for a demonstration project under this section must include, in
11 addition to the elements required under (a) of this section, information demonstrating
12 how the project will implement additional cost-saving measures including innovations
13 to reduce the cost of care for medical assistance recipients through the expanded use
14 of telehealth for primary care, urgent care, and behavioral health services. The
15 department shall identify legal or cost barriers preventing the expanded use of
16 telehealth and shall recommend remedies for identified barriers.

17 (e) The department shall contract with a third-party actuary to review
18 demonstration projects established under this section. The actuary shall review each
19 demonstration project after one year of implementation and make recommendations
20 for the implementation of a similar project on a statewide basis. The actuary shall
21 evaluate each project based on cost savings for the medical assistance program, health
22 outcomes for participants in the project, and the ability to achieve similar results on a
23 statewide basis. On or before December 31 of each year starting in 2018, the actuary
24 shall submit a final report to the department regarding any demonstration project that
25 has been in operation for at least one year.

26 (f) The department shall prepare a plan regarding regional or statewide
27 implementation of a coordinated care project based on the results of the demonstration
28 projects under this section. On or before November 15, 2019, the department shall
29 submit the plan to the senate secretary and the chief clerk of the house of
30 representatives and notify the legislature that the plan is available. On or before
31 November 15 of each year thereafter, the department shall submit a report regarding

1 any changes or recommendations regarding the plan developed under this subsection
 2 to the senate secretary and the chief clerk of the house of representatives and notify the
 3 legislature that the report is available.

4 (g) In this section, "telehealth" has the meaning given in AS 47.05.270(e).

5 * **Sec. 32.** AS 47.07 is amended by adding a new section to read:

6 **Sec. 47.07.076. Report to legislature.** (a) The department and the attorney
 7 general shall annually prepare a report relating to the medical assistance program
 8 under AS 47.07. The report must include the following information:

9 (1) the amount and source of funds used to prevent or prosecute fraud,
 10 abuse, payment errors, and errors in eligibility determinations for the previous fiscal
 11 year;

12 (2) actions taken to address fraud, abuse, payment errors, and errors in
 13 eligibility determinations during the previous fiscal year;

14 (3) specific examples of fraud or abuse that were prevented or
 15 prosecuted;

16 (4) identification of vulnerabilities in the medical assistance program,
 17 including any vulnerabilities identified by independent auditors with whom the
 18 department contracts under AS 47.05.200;

19 (5) initiatives the department has taken to prevent fraud or abuse;

20 (6) recommendations to increase effectiveness in preventing and
 21 prosecuting fraud and abuse;

22 (7) the return to the state for every dollar expended by the department
 23 and the attorney general to prevent and prosecute fraud and abuse;

24 (8) the most recent payment error rate measurement report for the
 25 medical assistance program, including fee for service programs and pilot or
 26 demonstration projects; the report must also explain the reasons for the payment errors
 27 and the total amount of state and federal funds paid in error during the reporting period
 28 and not recovered by the department at the time of the report;

29 (9) results from the Medicaid Eligibility Quality Control program.

30 (b) On or before November 15 of each year, the department shall submit the
 31 report required under this section to the senate secretary and the chief clerk of the

1 house of representatives and notify the legislature that the report is available.

2 * **Sec. 33.** AS 47.07.900(4) is amended to read:

3 (4) "clinic services" means services provided by state-approved
4 outpatient community mental health clinics [THAT RECEIVE GRANTS UNDER
5 AS 47.30.520 - 47.30.620], state-operated community mental health clinics, outpatient
6 surgical care centers, and physician clinics;

7 * **Sec. 34.** AS 47.07.900(17) is amended to read:

8 (17) "rehabilitative services" means services for substance abusers and
9 emotionally disturbed or chronically mentally ill adults provided by

10 (A) a drug or alcohol treatment center [THAT IS FUNDED
11 WITH A GRANT UNDER AS 47.30.475]; or

12 (B) an outpatient community mental health clinic [THAT HAS
13 A CONTRACT TO PROVIDE COMMUNITY MENTAL HEALTH
14 SERVICES UNDER AS 47.30.520 - 47.30.620];

15 * **Sec. 35.** AS 47.55.020(e) is amended to read:

16 (e) As a condition for receipt of payment assistance under (d) of this section,
17 the department, under regulations adopted by the department, shall [MAY] require a
18 person to

19 (1) apply for other state or federally sponsored programs that may
20 reduce the amount of the payment assistance; and

21 (2) submit to the department a copy of the person's application for
22 medical assistance coverage under AS 47.07 and the decision letter the person
23 receives regarding the application.

24 * **Sec. 36.** AS 09.58.020, 09.58.030, 09.58.040, 09.58.050, and 09.58.060 are repealed
25 July 1, 2019.

26 * **Sec. 37.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:

28 INDIRECT COURT RULE AMENDMENTS. (a) AS 09.58.020, added by sec. 10 of
29 this Act, and repealed by sec. 36 of this Act, has the effect of amending the following court
30 rules in the manner specified from the effective date of sec. 10 of this Act until July 1, 2019:

31 (1) Rules 4, 5, 7, and 12, Alaska Rules of Civil Procedure, by requiring that a

1 complaint under AS 09.58 be filed in camera and under seal and may not be served on the
2 defendant until unsealed and that a copy of the complaint be served on the attorney general;

3 (2) Rules 41 and 77, Alaska Rules of Civil Procedure, by authorizing the
4 attorney general to move for dismissal of a complaint filed by another person under
5 AS 09.58.020, added by sec. 10 of this Act and repealed by sec. 36 of this Act, and requiring
6 court approval for dismissal of the action.

7 (b) AS 09.58.025, added by sec. 10 of this Act, and amended by sec. 11 of this Act,
8 has the effect of amending Rule 27, Alaska Rules of Civil Procedure, by authorizing the
9 attorney general to issue subpoenas as part of an investigation

10 (1) under AS 09.58.015, added by sec. 10 of this Act, from the effective date
11 of sec. 10 of this Act; and

12 (2) under AS 09.58.020, added by sec. 10 of this Act, from the effective date
13 of sec. 10 of this Act until July 1, 2019.

14 (c) AS 09.58.030, added by sec. 10 of this Act, and repealed by sec. 36 of this Act,
15 has the effect of amending the following court rules in the manner specified from the effective
16 date of sec. 10 of this Act until July 1, 2019:

17 (1) Rule 24, Alaska Rules of Civil Procedure, by authorizing the attorney
18 general to intervene in a civil action filed by another person under AS 09.58.020 added by
19 sec. 10 of this Act, and repealed by sec. 36 of this Act, and limiting the participation of a party
20 to the litigation;

21 (2) Rules 26 and 27, Alaska Rules of Civil Procedure, by authorizing the
22 attorney general to request that the court issue a stay of discovery for a 90-day period, or
23 longer upon a showing by the attorney general.

24 (d) AS 09.58.040, added by sec. 10 of this Act, and repealed by sec. 36 of this Act,
25 has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, from the
26 effective date of sec. 10 of this Act until July 1, 2019, by giving a person who brings an action
27 under AS 09.58.020, added by sec. 10 of this Act, and repealed by sec. 36 of this Act, the
28 right to reasonable attorney fees and costs in an action prosecuted by the attorney general.

29 (e) AS 47.05.260, added by sec. 28 of this Act, has the effect of amending Rule 89,
30 Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure, by
31 authorizing the attorney general to apply to the court for authorization to seize property in

1 conjunction with an action filed under AS 47.05.210.

2 * **Sec. 38.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT.

5 (a) The Department of Health and Social Services shall collaborate with Alaska tribal health
6 organizations and the United States Department of Health and Human Services to fully
7 implement changes in federal policy that authorize 100 percent federal funding for services
8 provided to American Indian and Alaska Native individuals eligible for Medicaid.

9 (b) Within 30 days after the date the Centers for Medicare and Medicaid Services
10 issues a final policy regarding the circumstances in which 100 percent federal funding is
11 available for medical assistance services received through the United States Indian Health
12 Service or tribal health facilities, the Department of Health and Social Services shall notify
13 and submit a report to the co-chairs of the house and senate finance committees of the Alaska
14 State Legislature that includes an estimate of the savings to the state resulting from the final
15 policy. Within six months after the date the Centers for Medicare and Medicaid Services
16 issues the final policy, the Department of Health and Social Services shall fully implement the
17 policy in the state.

18 (c) In this section, "Alaska tribal health organization" means an organization
19 recognized by the United States Indian Health Service to provide health-related services.

20 * **Sec. 39.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:

22 HEALTH INFORMATION INFRASTRUCTURE PLAN. (a) The Department of
23 Health and Social Services shall develop a health information infrastructure plan to strengthen
24 the health information infrastructure, including health data analytics capability. The purpose
25 of the health information infrastructure plan is to transform the health care system in the state
26 by providing

27 (1) data required by health care providers for care coordination and quality
28 improvement; and

29 (2) the information support required by the Department of Health and Social
30 Services and health care providers to enable development and implementation of the other
31 provisions of this Act.

1 (b) To the greatest extent practicable, the health information infrastructure plan will
2 leverage existing resources, including the health information exchange, and will identify
3 opportunities for integrating and streamlining health data systems administered by the state.

4 * **Sec. 40.** The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 FEASIBILITY STUDIES FOR THE PROVISION OF SPECIFIED STATE
7 SERVICES. (a) The Department of Health and Social Services shall procure a study
8 analyzing the feasibility of privatizing services delivered at Alaska Pioneers' Homes and
9 select facilities of the division of juvenile justice. The Department of Health and Social
10 Services shall deliver a report summarizing the conclusions of the Department of Health and
11 Social Services to the senate secretary and the chief clerk of the house of representatives and
12 notify the legislature that the report is available within 10 days after the convening of the First
13 Regular Session of the Thirtieth Alaska State Legislature.

14 (b) The Department of Health and Social Services, in conjunction with the Alaska
15 Mental Health Trust Authority, shall procure a study analyzing the feasibility of privatizing
16 services delivered at the Alaska Psychiatric Institute. The Department of Health and Social
17 Services and the Alaska Mental Health Trust Authority shall deliver a joint report
18 summarizing the conclusions of the Department of Health and Social Services and the Alaska
19 Mental Health Trust Authority to the senate secretary and the chief clerk of the house of
20 representatives and notify the legislature that the report is available within 10 days after the
21 convening of the First Regular Session of the Thirtieth Alaska State Legislature.

22 (c) The Department of Administration shall, in collaboration with the house and
23 senate finance committees, procure a study to be completed on or before June 30, 2017, to
24 determine the feasibility of creating a health care authority to coordinate health care plans and
25 consolidate purchasing effectiveness for all state employees, retired state employees, retired
26 teachers, medical assistance recipients, University of Alaska employees, employees of state
27 corporations, and school district employees and to develop appropriate benefit sets, rules,
28 cost-sharing, and payment structures for all employees and individuals whose health care
29 benefits are funded directly or indirectly by the state, with the goal of achieving the greatest
30 possible savings to the state through a coordinated approach administered by a single entity.
31 In developing the study, the Department of Administration shall seek input from the

1 Department of Health and Social Services, administrators familiar with managing government
 2 employee health plans, and human resource professionals familiar with self-insured health
 3 care plans. The study must

4 (1) identify cost-saving strategies that a health care authority could implement;

5 (2) analyze local government participation in the authority;

6 (3) analyze a phased approach to adding groups to the health care plans
 7 coordinated by the health care authority;

8 (4) consider previous studies procured by the Department of Administration
 9 and the legislature;

10 (5) assess the use of community-related health insurance risk pools and the use
 11 of the private marketplace;

12 (6) identify organizational models for a health care authority, including private
 13 for-profit, private nonprofit, government, and state corporations; and

14 (7) include a public review and comment opportunity for employers,
 15 employees, medical assistance recipients, retirees, and health care providers.

16 (d) In this section, "school district" has the meaning given in AS 14.30.350.

17 * **Sec. 41.** The uncodified law of the State of Alaska is amended by adding a new section to
 18 read:

19 MEDICAID STATE PLAN; WAIVERS; INSTRUCTIONS; NOTICE TO REVISOR
 20 OF STATUTES. The Department of Health and Social Services shall amend and submit for
 21 federal approval a state plan for medical assistance coverage consistent with this Act. The
 22 Department of Health and Social Services shall apply to the United States Department of
 23 Health and Human Services for any waivers necessary to implement this Act. The
 24 commissioner of health and social services shall certify to the revisor of statutes if the
 25 provisions of AS 47.05.270(a)(5), (8), and (10), added by sec. 28 of this Act, and the
 26 provisions of AS 47.07.038, added by sec. 31 of this Act, are approved by the United States
 27 Department of Health and Human Services.

28 * **Sec. 42.** The uncodified law of the State of Alaska is amended by adding a new section to
 29 read:

30 TRANSITION: REGULATIONS. (a) The Department of Health and Social Services
 31 may adopt regulations necessary to implement the changes made by this Act. The regulations

1 take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date
2 of the relevant provision of this Act implemented by the regulation.

3 (b) The Board of Pharmacy may adopt regulations necessary to implement the
4 changes made by secs. 13 - 19 of this Act. The regulations take effect under AS 44.62
5 (Administrative Procedure Act), but not before the effective date of the relevant provision of
6 secs. 13 - 19 of this Act implemented by the regulation.

7 * **Sec. 43.** The uncodified law of the State of Alaska is amended by adding a new section to
8 read:

9 **CONDITIONAL EFFECT.** (a) AS 47.05.270(a)(5), enacted by sec. 28 of this Act,
10 takes effect only if the commissioner of health and social services certifies to the revisor of
11 statutes under sec. 41 of this Act, on or before October 1, 2017, that all of the provisions
12 added by AS 47.05.270(a)(5) have been approved by the United States Department of Health
13 and Human Services.

14 (b) AS 47.05.270(a)(8), enacted by sec. 28 of this Act, takes effect only if the
15 commissioner of health and social services certifies to the revisor of statutes under sec. 41 of
16 this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.270(a)(8)
17 have been approved by the United States Department of Health and Human Services.

18 (c) AS 47.05.270(a)(10), enacted by sec. 28 of this Act, takes effect only if the
19 commissioner of health and social services certifies to the revisor of statutes under sec. 41 of
20 this Act, on or before October 1, 2017, that all of the provisions added by
21 AS 47.05.270(a)(10) have been approved by the United States Department of Health and
22 Human Services.

23 (d) AS 47.07.038, enacted by sec. 31 of this Act, takes effect only if the commissioner
24 of health and social services certifies to the revisor of statutes under sec. 41 of this Act, on or
25 before October 1, 2017, that all of the provisions added by AS 47.07.038 have been approved
26 by the United States Department of Health and Human Services.

27 (e) AS 09.58.020, added by sec. 10 of this Act, AS 09.58.025, added by sec. 10 of this
28 Act and amended by sec. 11 of this Act, AS 09.58.030, added by sec. 10 of this Act and
29 repealed by sec. 36 of this Act, AS 09.58.040, added by sec. 10 of this Act, and AS 47.05.260,
30 added by sec. 28 of this Act, take effect only if sec. 37 of this Act receives the two-thirds
31 majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

1 * **Sec. 44.** If AS 47.05.270(a)(5), enacted by sec. 28 of this Act, takes effect, it takes effect
2 on the day after the date the commissioner of health and social services makes a certification
3 to the revisor of statutes under secs. 41 and 43(a) of this Act.

4 * **Sec. 45.** If AS 47.05.270(a)(8), enacted by sec. 28 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. 41 and 43(b) of this Act.

7 * **Sec. 46.** If AS 47.05.270(a)(10), enacted by sec. 28 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. 41 and 43(c) of this Act.

10 * **Sec. 47.** If AS 47.07.038, enacted by sec. 31 of this Act, takes effect, it takes effect on the
11 day after the date the commissioner of health and social services makes a certification to the
12 revisor of statutes under secs. 41 and 43(d) of this Act.

13 * **Sec. 48.** Sections 40, 41, 42(a), and 43 of this Act take effect immediately under
14 AS 01.10.070(c).

15 * **Sec. 49.** Sections 13 - 19 of this Act take effect January 1, 2017.

16 * **Sec. 50.** Section 42(b) of this Act takes effect July 1, 2016.

17 * **Sec. 51.** Sections 11 and 12 of this Act take effect July 1, 2019.

Fiscal Note

State of Alaska
2016 Legislative Session

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

Identifier: SB074CS(FIN)-DCCED-CBPL-03-02-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
Sponsor: KELLY
Requester: (S) 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
OPERATING EXPENDITURES								
Personal Services	100.6		100.6	100.6	100.6	100.6	100.6	100.6
Travel	3.0		3.0	3.0	3.0	3.0	3.0	3.0
Services	63.1		36.1	36.1	36.1	36.1	36.1	36.1
Commodities	5.0							
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	171.7	0.0	139.7	139.7	139.7	139.7	139.7	139.7

Fund Source (Operating Only)

1156 Rcpt Svcs	171.7		139.7	139.7	139.7	139.7	139.7	139.7
Total	171.7	0.0	139.7	139.7	139.7	139.7	139.7	139.7

Positions

Full-time	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Part-time								
Temporary								

Change in Revenues	171.7		139.7	139.7	139.7	139.7	139.7	139.7
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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 estimated contractual expenses based on updated quote from current vendor and correct error in the services cost in the analysis.

Prepared By:	Janey Hovenden, Director	Phone:	(907)465-2536
Division:	Corporations, Business and Professional Licensing	Date:	03/01/2016 11:50 AM
Approved By:	Catherine Reardon, Director	Date:	03/02/16
Agency:	Division of Administrative Services, DCCED		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. CSSB 74(FIN)

Analysis

CSSB74 requires the pharmacist or practitioner who dispenses controlled substances, other than those administered to a patient at a health care facility, to submit to the board for inclusion in the Controlled Substance Prescription Database (PDMP) on a weekly basis. The bill allows licensed practitioners and licensed pharmacists to delegate access to the PDMP on their behalf to an agent or employee of the practitioner. It requires a pharmacist or practitioner who prescribes or dispenses controlled substances to register with the PDMP in a format established by the Board of Pharmacy, and requires the Board of Pharmacy to promptly notify the pertinent licensing board when a practitioner registers with the PDMP.

This legislation allows access to the PDMP by: the licensed pharmacist of the Department of Health and Social Services (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.

CSSB74 allows for disciplinary action for failure to register by either the Board of Pharmacy or by another licensing board. It creates a procedure and time frame for registration with the PDMP and requires a pharmacist or practitioner to access the database to check a patient's prescription records before dispensing, prescribing, or administering a controlled substance. 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.

Expansion of the scope and functionality of the PDMP will require a Program Coordinator 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.

If the bill passes the following expenses will be incurred:

Personal Services: \$100.6 (one full time permanent Program Coordinator I, 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: \$63.1

\$15.0 (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)

\$26.1 (contract to expand PDMP database from monthly to weekly based on current vendor)

\$10.0 (department-wide services support for one new position)

Commodities: \$5.0 in first year (computer, office panels, office furniture and other one-time needs for one new position)

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. If awarded, costs of this program enhancement could be covered by federal grant funds instead of program receipts. In absence of the grant it would be paid for by Board of Pharmacy licensees.

Fiscal Note

State of Alaska
2016 Legislative Session

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

Identifier: SB074CS(STA)-LAW-CRIM-02-26-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
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
OPERATING EXPENDITURES								
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								
Total Operating	365.0	0.0	365.0	365.0	365.0	365.0	365.0	365.0

Fund Source (Operating Only)

1002 Fed Rcpts	273.7		273.7	273.7	273.7	273.7	273.7	273.7
1005 GF/Prgm	91.3		91.3	91.3	91.3	91.3	91.3	91.3
Total	365.0	0.0	365.0	365.0	365.0	365.0	365.0	365.0

Positions

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

Change in Revenues	500.0		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:

Initial version, not applicable.

Prepared By:	Valerie Rose, Budget Analyst IV	Phone:	(907)465-3674
Division:	Administrative Services Division	Date:	02/26/2016 09:47 AM
Approved By:	Craig W. Richards, Attorney General	Date:	02/26/16
Agency:	Department of Law		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. SB74

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.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

BILL NO. SB74

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.

adopted 2/25/16

29-LS0692\V
Glover
2/23/16

CS FOR SENATE BILL NO. 74(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS KELLY, Giessel

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the controlled substance prescription database; relating to the duties
2 of the Board of Pharmacy; establishing the Alaska Medical Assistance False Claim and
3 Reporting Act; relating to medical assistance programs administered by the Department
4 of Health and Social Services; relating to public record status of records related to the
5 Alaska Medical Assistance False Claim and Reporting Act; relating to accounting for
6 program receipts; relating to annual audits of state medical assistance providers;
7 relating to seizure and forfeiture of property for medical assistance fraud; relating to
8 reporting overpayments of medical assistance payments; relating to limitations of
9 actions; establishing authority to assess civil penalties for violations of medical
10 assistance program requirements; relating to competitive bidding for medical assistance
11 products and services; relating to verification of eligibility for public assistance
12 programs administered by the Department of Health and Social Services; relating to the

1 **duties of the Department of Health and Social Services; establishing medical assistance**
2 **demonstration projects; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89,**
3 **Alaska Rules of Civil Procedure; amending Rule 37, Alaska Rules of Criminal**
4 **Procedure; and providing for an effective date."**

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

6 * **Section 1.** 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 the earlier
10 of (1) six years after the act or omission was committed, or (2) three years after the
11 date when facts material to the action were known, or reasonably should have been
12 known, by the attorney general or the Department of Health and Social Services, but
13 in no event more than 10 years after the date the violation under AS 09.58.010
14 occurred.

15 * **Sec. 2.** 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. 3.** 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

1 indirectly, a false record or statement to get a false or fraudulent claim for payment
2 paid or approved by the state under the medical assistance program;

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

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

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

12 (b) A beneficiary of an intentional or inadvertent submission of a false or
13 fraudulent claim under the medical assistance program who later discovers the claim is
14 false or fraudulent shall disclose the false or fraudulent claim to the state not later than
15 60 days after discovering the false claim.

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

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

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

21 and

22 (3) reasonable attorney fees and costs calculated under applicable court
23 rules.

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; and

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 chapter
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.

27 (c) Whether or not the attorney general participates in the action, if the court
28 finds that the action was brought by a person who planned or initiated the violation
29 alleged in the action brought under AS 09.58.020, the court may, to the extent the
30 court considers appropriate, reduce the share of the proceeds of the action that the
31 person would otherwise receive under (a) or (b) of this section, taking into account the

1 role of that person in advancing the case to litigation and any relevant circumstances
2 pertaining to the violation. If the person bringing the action is convicted of criminal
3 conduct arising from the person's role in the violation of AS 09.58.010, the court shall
4 dismiss the person from the civil action and the person may not receive any share of
5 the proceeds of the action or settlement. A dismissal under this subsection does not
6 prejudice the right of the attorney general to continue the action.

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

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

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

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

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

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

18 (3) based on the public disclosure of allegations or actions in a
19 criminal or civil action or an administrative hearing, or from the news media, unless
20 the action is brought by the attorney general or the person bringing the action is an
21 original source of the information that was publicly disclosed; in this paragraph, a
22 person is an original source of the information that was publicly disclosed if the
23 person has independent knowledge, including knowledge based on personal
24 investigation of the defendant's conduct, of the information on which the allegations
25 are based, and has voluntarily provided or verified the information on which the
26 allegations are based or voluntarily provided the information to the attorney general
27 before filing an action under AS 09.58.020 that is based on the information; or

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

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

30 The state, its agencies, current or former officers, and current or former employees, are
31 not liable for attorney fees, costs, and other expenses that a person incurs in bringing

1 an action under AS 09.58.020.

2 **Sec. 09.58.070. Employee protection for retaliation.** (a) An employee of a
3 medical assistance provider who is discharged, demoted, suspended, threatened,
4 harassed, or discriminated against in the terms and conditions of employment by the
5 employee's employer because of lawful acts done by the employee on behalf of the
6 employee or others in furtherance of an action under AS 09.58.010 - 09.58.060,
7 including investigation for, initiation of, testimony for or assistance in an action filed
8 or to be filed under AS 09.58.010 - 09.58.060, is entitled to the same relief authorized
9 under AS 39.90.120.

10 (b) Notwithstanding (a) of this section, a state employee who is discharged,
11 demoted, suspended, threatened, harassed, or discriminated against in the terms and
12 conditions of employment because of lawful acts done by the employee on behalf of
13 the employee or a person who brings an action under AS 09.58.020 or in furtherance
14 of an action under AS 09.58.010 - 09.58.060, including investigation, initiation of,
15 testimony for or assistance in an action filed or to be filed under AS 09.58.010 -
16 09.58.060, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska Whistleblower
17 Act).

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

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

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

25 (b) No punitive damages may be awarded in an action brought under
26 AS 09.58.010 - 09.58.060.

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

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

29 (2) "claim" means a request for payment of health care services or
30 equipment, whether made to a contractor, grantee, or other person, when the state
31 provides, directly or indirectly, a portion of the money, property, or services requested

1 or demanded, or when the state will, directly or indirectly, reimburse the contractor,
2 grantee, or other recipient for a portion of the money, property, or services requested
3 or demanded;

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

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

9 (A) has actual knowledge of the information;

10 (B) acts in deliberate ignorance of the truth or falsity of the
11 information; or

12 (C) acts in reckless disregard of the truth or falsity of the
13 information;

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

17 (6) "medical assistance provider" has the meaning given under
18 AS 47.05.290;

19 (7) "medical assistance recipient" has the meaning given under
20 AS 47.05.290;

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

23 (A) an express or implied contractual grantor or grantee or
24 licensor or licensee relationship;

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

26 (C) a statute or regulation; or

27 (D) the retention of any overpayment.

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

30 * **Sec. 4.** AS 17.30.200(b) is amended to read:

31 (b) The pharmacist-in-charge of each licensed or registered pharmacy,

1 regarding each schedule IA, IIA, IIIA, IVA, or VA controlled substance under state
2 law or a schedule I, II, III, IV, or V controlled substance under federal law dispensed
3 by a pharmacist under the supervision of the pharmacist-in-charge, and each
4 practitioner who directly dispenses a schedule IA, IIA, IIIA, IVA, or VA controlled
5 substance under state law or a schedule I, II, III, IV, or V controlled substance under
6 federal law other than those administered to a patient at a health care facility, shall
7 submit to the board, by a procedure and in a format established by the board, the
8 following information for inclusion in the database on a weekly basis:

9 (1) the name of the prescribing practitioner and the practitioner's
10 federal Drug Enforcement Administration registration number or other appropriate
11 identifier;

12 (2) the date of the prescription;

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

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

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

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

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

21 and

22 (8) the name of the pharmacist or practitioner dispensing the controlled
23 substance and other appropriate identifying information.

24 * **Sec. 5.** AS 17.30.200(d) is amended to read:

25 (d) The database and the information contained within the database are
26 confidential, are not public records, and are not subject to public disclosure. The board
27 shall undertake to ensure the security and confidentiality of the database and the
28 information contained within the database. The board may allow access to the
29 database only to the following persons, and in accordance with the limitations
30 provided and regulations of the board:

31 (1) personnel of the board regarding inquiries concerning licensees or

1 registrants of the board or personnel of another board or agency concerning a
2 practitioner under a search warrant, subpoena, or order issued by an administrative law
3 judge or a court;

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

6 (3) a licensed practitioner having authority to prescribe controlled
7 substances or an agent or employee of the practitioner whom the practitioner has
8 authorized to access the database on the practitioner's behalf, to the extent the
9 information relates specifically to a current patient of the practitioner to whom the
10 practitioner is prescribing or considering prescribing a controlled substance;

11 (4) a licensed or registered pharmacist having authority to dispense
12 controlled substances or an agent or employee of the pharmacist whom the
13 pharmacist has authorized to access the database on the pharmacist's behalf, to
14 the extent the information relates specifically to a current patient to whom the
15 pharmacist is dispensing or considering dispensing a controlled substance;

16 (5) federal, state, and local law enforcement authorities may receive
17 printouts of information contained in the database under a search warrant, subpoena,
18 or order issued by a court establishing probable cause for the access and use of the
19 information; [AND]

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

26 (7) a licensed pharmacist employed by the Department of Health
27 and Social Services who is responsible for administering prescription drug
28 coverage for the medical assistance program under AS 47.07, to the extent that
29 the information relates specifically to prescription drug coverage under the
30 program;

31 (8) a licensed pharmacist, licensed practitioner, or authorized

1 employee of the Department of Health and Social Services responsible for
2 utilization review of prescription drugs for the medical assistance program under
3 AS 47.07, to the extent that the information relates specifically to utilization
4 review of prescription drugs under the program;

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

7 (10) an authorized employee of the Department of Health and
8 Social Services may receive information from the database that does not disclose
9 the identity of a patient, prescriber, dispenser, or dispenser location, for the
10 purpose of identifying and monitoring public health issues in the state; however,
11 the information provided under this paragraph may include the region of the
12 state in which a patient, prescriber, and dispenser are located and the specialty of
13 the prescriber.

14 * **Sec. 6.** AS 17.30.200(e) is amended to read:

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

20 * **Sec. 7.** AS 17.30.200(h) is amended to read:

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

29 * **Sec. 8.** AS 17.30.200(k) 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 [SHALL] be purged

1 from the database after two years have elapsed from the date the prescription was
2 dispensed;

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

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

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

10 * **Sec. 9.** AS 17.30.200 is amended by adding new subsections to read:

11 (o) A pharmacist who dispenses or a practitioner who prescribes, administers,
12 or directly dispenses a schedule IA, IIA, IIIA, IVA, or VA controlled substance under
13 state law or a schedule I, II, III, IV, or V controlled substance under federal law shall
14 register with the database by a procedure and in a format established by the board.

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

18 (q) The board is authorized to provide unsolicited notification to a pharmacist
19 or practitioner if a patient has received one or more prescriptions for controlled
20 substances in quantities or with a frequency inconsistent with generally recognized
21 standards of safe practice.

22 (r) The board shall update the database on a weekly basis with the information
23 submitted to the board under (b) of this section.

24 * **Sec. 10.** AS 37.05.146(c) is amended by adding a new paragraph to read:

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

27 * **Sec. 11.** AS 40.25.120(a) is amended by adding a new paragraph to read:

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

30 * **Sec. 12.** AS 47.05.015 is amended by adding a new subsection to read:

31 (e) Notwithstanding (c) of this section, the department may enter into a

1 contract through the competitive bidding process under AS 36.30 (State Procurement
2 Code) for medical assistance products and services offered under AS 47.07.030 if the
3 contract is for durable medical equipment or specific medical services that can be
4 delivered on a statewide basis.

5 * **Sec. 13.** AS 47.05 is amended by adding a new section to article 1 to read:

6 **Sec. 47.05.105. Enhanced computerized eligibility verification system.** (a)

7 The department shall establish an enhanced computerized income, asset, and identity
8 eligibility verification system for the purposes of verifying eligibility, eliminating
9 duplication of public assistance payments, and deterring waste and fraud in public
10 assistance programs administered by the department under AS 47.05.010. Nothing in
11 this section prohibits the department from verifying eligibility for public assistance
12 through additional procedures or authorizes the department or a third-party vendor to
13 use data to verify eligibility for a federal program if the use of that data is prohibited
14 by federal law.

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

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

30 (d) To avoid a conflict of interest, the department may not award a contract to
31 provide services for the enrollment of public assistance providers or applicants under

1 this title to a vendor that is awarded a contract under this section.

2 * **Sec. 14.** AS 47.05.200(a) is amended to read:

3 (a) The department shall annually contract for independent audits of a
4 statewide sample of all medical assistance providers in order to identify overpayments
5 and violations of criminal statutes. The audits conducted under this section may not be
6 conducted by the department or employees of the department. The number of audits
7 under this section **may not be less than 50** each year [, AS A TOTAL FOR THE
8 MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL
9 BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE
10 PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE
11 DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS
12 SECTION MAY NOT BE LESS THAN 75]. The audits under this section must
13 include both on-site audits and desk audits and must be of a variety of provider types.
14 The department may not award a contract under this subsection to an organization that
15 does not retain persons with a significant level of expertise and recent professional
16 practice in the general areas of standard accounting principles and financial auditing
17 and in the specific areas of medical records review, investigative research, and Alaska
18 health care criminal law. The contractor, in consultation with the commissioner, shall
19 select the providers to be audited and decide the ratio of desk audits and on-site audits
20 to the total number selected. **In identifying providers who are subject to an audit**
21 **under this chapter, the department shall attempt to minimize concurrent state or**
22 **federal audits.**

23 * **Sec. 15.** AS 47.05.200(b) is amended to read:

24 (b) Within 90 days after receiving each audit report from an audit conducted
25 under this section, the department shall begin administrative procedures to recoup
26 overpayments identified in the audits and shall allocate the reasonable and necessary
27 financial and human resources to ensure prompt recovery of overpayments unless the
28 attorney general has advised the commissioner in writing that a criminal investigation
29 of an audited provider has been or is about to be undertaken, in which case, the
30 commissioner shall hold the administrative procedure in abeyance until a final
31 charging decision by the attorney general has been made. The commissioner shall

1 provide copies of all audit reports to the attorney general so that the reports can be
2 screened for the purpose of bringing criminal charges. The department may assess
3 interest and penalties on any identified overpayment. Interest under this
4 subsection shall be calculated using the statutory rates for postjudgment interest
5 accruing from the date of the issuance of the final agency decision to recoup
6 overpayments identified in the audit. In this subsection, the date of issuance of
7 the final agency decision is the later of the date of

8 (1) the department's written notification of the decision and the
9 provider's appeal rights; or

10 (2) if timely appealed by the provider, a final agency decision
11 under AS 44.64.060.

12 * **Sec. 16.** AS 47.05 is amended by adding a new section to read:

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

14 An enrolled medical assistance provider shall conduct at least one annual review or
15 audit of all claims submitted to the department for reimbursement and, if
16 overpayments are identified, the medical assistance provider shall report the
17 overpayment to the department not later than 10 business days after identification of
18 the overpayment. The report must also identify how the medical assistance provider
19 intends to repay the department. After the department receives the report, the medical
20 assistance provider and the department shall enter into an agreement establishing a
21 schedule for repayment of the identified overpayment. The agreement may authorize
22 repayment in a lump sum, a payment plan, or by offsetting future billings as approved
23 by the department.

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

26 * **Sec. 17.** AS 47.05 is amended by adding new sections to read:

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

30 (b) The department shall adopt regulations establishing a range of civil
31 penalties that the department may assess against a provider under this section. In

1 establishing the range of civil penalties, the department shall take into account
2 appropriate factors, including the seriousness of the violation, the service provided by
3 the provider, and the severity of the penalty. The regulations may not provide for a
4 civil penalty of less than \$100 or more than \$25,000 for each violation.

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

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

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

17 **Sec. 47.05.260. Seizure and forfeiture of real or personal property in**
18 **medical assistance fraud cases.** (a) Upon written application by the attorney general
19 establishing probable cause that a medical assistance provider has committed or is
20 committing medical assistance fraud under AS 47.05.210, the court may authorize the
21 seizure of real or personal property listed in (e) of this section to cover the cost of the
22 alleged fraud. The application may be made ex parte if the attorney general establishes
23 sufficient facts to show that notice to the owner of the property would lead to the
24 waste or dissipation of assets subject to seizure. If the attorney general does not
25 establish sufficient facts to show that notice to the owner would lead to the waste or
26 dissipation of assets subject to seizure, the application for seizure must be served on
27 the owners of the property.

28 (b) Upon issuance of the court order authorizing seizure, the owners of the
29 property may not take any action to dispose of the property through transfer of title or
30 sale of the property without written permission from the court. However, an innocent
31 purchaser may not be required to forfeit property purchased in good faith. The

1 purchaser bears the burden of proof to establish that the property was purchased
2 innocently and in good faith.

3 (c) If a medical assistance provider is convicted of medical assistance fraud
4 under AS 47.05.210 after property is seized under this section, the court may order
5 that the property be forfeited to the state and disposed of as directed by the court. If
6 the property has been sold, the proceeds of the sale shall be transmitted to the proper
7 state officer or employee for deposit into the general fund. The attorney general shall
8 return to the owner of the property any property seized under this section that the court
9 does not order to be forfeited as soon as practicable after the court issues a final
10 judgment in the medical assistance fraud proceeding under AS 47.05.210 and the
11 medical assistance provider pays any fine or restitution ordered by the court.

12 (d) An action for forfeiture under this section may be joined with a civil or
13 criminal action brought by the state to recover damages resulting from alleged medical
14 assistance fraud.

15 (e) Property that may be seized under this chapter includes bank accounts,
16 automobiles, boats, airplanes, stocks, bonds, the medical assistance provider's business
17 inventory, and other real or personal property owned and used to conduct the medical
18 assistance provider's business.

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

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

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

27 (3) expanding the use of telemedicine for primary care, behavioral
28 health, and urgent care;

29 (4) enhancing fraud prevention, detection, and enforcement;

30 (5) reducing the cost of behavioral health, senior, and disabilities
31 services provided to recipients of medical assistance under the state's home and

1 community-based services waiver under AS 47.07.045;

2 (6) pharmacy initiatives;

3 (7) enhanced care management;

4 (8) redesigning the payment process by implementing fee agreements
5 that include

6 (A) premium payments for centers of excellence;

7 (B) penalties for hospital-acquired infections, readmissions,
8 and outcome failures;

9 (C) bundled payments for specific episodes of care; or

10 (D) global payments for contracted payers, primary care
11 managers, and case managers for a recipient or for care related to a specific
12 diagnosis;

13 (9) stakeholder involvement in setting annual targets for quality and
14 cost-effectiveness;

15 (10) to the extent consistent with federal law, reducing travel costs by
16 requiring a recipient to obtain medical services in the recipient's home community, to
17 the extent appropriate services are available in the recipient's home community;

18 (11) guidelines for health care providers to develop health care
19 delivery models that encourage wellness and disease prevention.

20 (b) The department shall, in coordination with the Alaska Mental Health Trust
21 Authority, efficiently manage a comprehensive and integrated behavioral health
22 program that uses evidence-based, data-driven practices to achieve positive outcomes
23 for people with mental health or substance abuse disorders and children with severe
24 emotional disturbances. The goal of the program is to assist recipients of services
25 under the program to recover by achieving the highest level of autonomy with the least
26 dependence on state-funded services possible for each person. The program must
27 include

28 (1) a plan for providing a continuum of community-based services to
29 address housing, employment, criminal justice, and other relevant issues;

30 (2) services from a wide array of providers and disciplines, including
31 primary care providers; and

1 (3) efforts to reduce operational barriers that fragment services and
2 reduce the effectiveness and efficiency of the program.

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

10 (d) On or before October 15 of each year, the department shall prepare a
11 report and submit the report to the senate secretary and the chief clerk of the house of
12 representatives and notify the legislature that the report is available. The report must
13 include

- 14 (1) realized cost savings related to reform efforts under this section;
15 (2) realized cost savings related to medical assistance reform efforts
16 undertaken by the department other than the reform efforts described in this Act;
17 (3) a statement of whether the department has met annual targets for
18 quality and cost-effectiveness;
19 (4) recommendations for legislative or budgetary changes related to
20 medical assistance reforms during the next fiscal year;
21 (5) changes in federal laws that the department expects will result in a
22 cost or savings to the state of more than \$1,000,000;
23 (6) a description of any medical assistance grants, options, or waivers
24 the department applied for in the previous fiscal year;
25 (7) the results of demonstration projects the department has
26 implemented;
27 (8) legal and technological barriers to the expanded use of
28 telemedicine, improvements in the use of telemedicine in the state, and
29 recommendations for changes or investments that would allow cost-effective
30 expansion of telemedicine;
31 (9) the percentage decrease in costs of travel for medical assistance

1 recipients compared to the previous fiscal year;

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

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

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

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

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

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

20 * **Sec. 18.** AS 47.07.030(d) is amended to read:

21 (d) The department **shall** [MAY] establish as optional services a primary care
22 case management system or a managed care organization contract in which certain
23 eligible individuals are required to enroll and seek approval from a case manager or
24 the managed care organization before receiving certain services. **The purpose of a**
25 **primary care case management system or managed care organization contract is**
26 **to increase the use of primary and preventive care by medical assistance**
27 **recipients, while decreasing the use of specialty care and hospital emergency**
28 **department services.** The department shall

29 (1) establish enrollment criteria and determine eligibility for services
30 consistent with federal and state law; **the department shall require recipients with**
31 **multiple hospitalizations to enroll in a primary care case management system or**

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- with a managed care organization under this subsection;**
- (2) define the coordinated care services and provider types eligible to participate as primary care providers;**
- (3) create a performance and quality reporting system; and**
- (4) integrate the coordinated care demonstration projects described under AS 47.07.039 and the demonstration projects described under AS 47.07.036(e) with the primary care case management system or managed care organization contract established under this subsection.**

* Sec. 19. 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 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 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 telemedicine, including increasing the capability for and reimbursement of telemedicine for recipients.

(e) Notwithstanding (a) - (c) of this section, and in addition to the projects and services described under (d) 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

1 recipients in one or more specific geographic areas. The demonstration project or
2 projects may include

- 3 (1) managed care organizations as described under 42 U.S.C. 1396u-2;
- 4 (2) community care organizations;
- 5 (3) patient-centered medical homes as described under 42 U.S.C. 256a-
6 l; or
- 7 (4) other innovative payment models that ensure access to health care
8 without reducing the quality of care.

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

14 * **Sec. 20.** AS 47.07 is amended by adding new sections to read:

15 **Sec. 47.07.038. Collaborative, hospital-based project to reduce use of**
16 **emergency department services.** (a) On or before December 1, 2016, the department
17 shall collaborate with a statewide professional hospital association to establish a
18 hospital-based project to reduce the use of emergency department services by medical
19 assistance recipients. The statewide professional hospital association shall operate the
20 project. The project may include shared savings for participating hospitals. The project
21 must include

- 22 (1) a process for defining and identifying frequent users of emergency
23 department services;
- 24 (2) to the extent consistent with federal law,
 - 25 (A) a system for electronic exchange of patient information
26 among emergency departments;
 - 27 (B) a process to disseminate lists of frequent users to hospital
28 personnel to ensure that frequent users can be identified through the electronic
29 information exchange system;
- 30 (3) a procedure for educating patients about the use of emergency
31 departments and appropriate alternative services and facilities for nonurgent care;

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

4 (5) strict guidelines for prescribing narcotics;

5 (6) a prescription drug monitoring program; and

6 (7) designation of medical personnel to review feedback reports
7 regarding emergency department use.

8 (b) The department shall adopt regulations necessary to implement this
9 section, request technical assistance from the United States Department of Health and
10 Human Services, and apply to the United States Department of Health and Human
11 Services for waivers or amendments to the state plan as necessary to implement the
12 projects under this section.

13 **Sec. 47.07.039. Coordinated care demonstration projects.** (a) The
14 department shall contract with one or more third parties to implement one or more
15 coordinated care demonstration projects for recipients of medical assistance identified
16 by the department. The purpose of a demonstration project under this section is to
17 assess the efficacy of a proposed health care delivery model with respect to cost for,
18 access to, and quality of care for medical assistance recipients. The department may
19 contract for separate demonstration projects to coordinate care for different groups of
20 medical assistance recipients to achieve more effective care for recipients at greater
21 cost savings for the medical assistance program. The department shall request
22 proposals for projects under this section on or before December 31, 2016, and may use
23 an innovative procurement process as described under AS 36.30.308. A proposal for a
24 demonstration project under this section must be submitted to the committee
25 established under (b) of this section and must include one or more of the following
26 elements:

27 (1) comprehensive primary-care-based management for medical
28 assistance services, including behavioral health services;

29 (2) care coordination, including the assignment of a primary care
30 provider located in the local geographic area of the recipient, to the extent practical;

31 (3) health promotion;

1 (4) comprehensive transitional care and follow-up care after inpatient
2 treatment;

3 (5) referral to community and social support services, including career
4 and education training services available through the Department of Labor and
5 Workforce Development under AS 23.15, the University of Alaska, or other sources;

6 (6) sustainability and the ability to achieve similar results in other
7 regions of the state;

8 (7) integration and coordination of benefits and services;

9 (8) local accountability for health and resource allocation.

10 (b) A project review committee is established in the department for the purpose
11 of reviewing proposals for demonstration projects under this section. The project
12 review committee consists of

13 (1) the commissioner of the department, or the commissioner's
14 designee;

15 (2) the director of the division of insurance, Department of Commerce,
16 Community, and Economic Development, or the director's designee;

17 (3) the chief executive officer of the Alaska Mental Health Trust
18 Authority, or the chief executive officer's designee;

19 (4) three representatives of stakeholder groups, appointed by the
20 governor;

21 (5) a nonvoting member who is a member of the senate, appointed by
22 the president of the senate; and

23 (6) a nonvoting member who is a member of the house of
24 representatives, appointed by the speaker of the house of representatives.

25 (c) The department may contract with a managed care organization, primary
26 care case manager, accountable care organization, prepaid ambulatory health plan, or
27 provider-led entity to implement a demonstration project under this section. A
28 contract shall provide for a fee based on a per capita expense that is fair and
29 economical. The fee structure may include global payments, bundled payments,
30 shared savings and risk, or other payment structures.

31 (d) A proposal for a demonstration project under this section must include, in

1 addition to the elements required under (a) of this section, information demonstrating
2 how the project will implement additional cost-saving measures including innovations
3 to reduce the cost of care for medical assistance recipients through the expanded use
4 of telemedicine for primary care, urgent care, and behavioral health services. The
5 department shall identify legal or cost barriers preventing the expanded use of
6 telemedicine and shall recommend remedies for identified barriers.

7 (e) The department shall contract with a third-party actuary to review
8 demonstration projects established under this section. The actuary shall review each
9 demonstration project after one year of implementation and make recommendations
10 for the implementation of a similar project on a statewide basis. The actuary shall
11 evaluate each project based on cost savings for the medical assistance program, health
12 outcomes for participants in the project, and the ability to achieve similar results on a
13 statewide basis. On or before December 31 of each year starting in 2018, the actuary
14 shall submit a final report to the department regarding any demonstration project that
15 has been in operation for at least one year.

16 (f) The department shall prepare a plan regarding regional or statewide
17 implementation of a coordinated care project based on the results of the demonstration
18 projects under this section. On or before June 30, 2019, the department shall submit
19 the plan to the senate secretary and the chief clerk of the house of representatives and
20 notify the legislature that the plan is available. On or before June 30 of each year
21 thereafter, the department shall submit a report regarding any changes or
22 recommendations regarding the plan developed under this subsection to the senate
23 secretary and the chief clerk of the house of representatives and notify the legislature
24 that the report is available.

25 (g) In this section, "telemedicine" has the meaning given in AS 47.05.270(e).

26 * **Sec. 21.** AS 47.07 is amended by adding a new section to read:

27 **Sec. 47.07.076. Report to legislature.** (a) The department and the attorney
28 general shall annually prepare a report relating to the medical assistance program
29 under AS 47.07. The report must identify

30 (1) the amount and source of funds used to prevent or prosecute fraud,
31 abuse, payment errors, and errors in eligibility determinations for the previous fiscal

1 year;

2 (2) actions taken to address fraud, abuse, payment errors, and errors in
3 eligibility determinations during the previous fiscal year;

4 (3) specific examples of fraud or abuse that were prevented or
5 prosecuted;

6 (4) identification of vulnerabilities in the medical assistance program,
7 including any vulnerabilities identified by independent auditors with whom the
8 department contracts under AS 47.05.200;

9 (5) initiatives the department has taken to prevent fraud or abuse;

10 (6) recommendations to increase effectiveness in preventing and
11 prosecuting fraud and abuse;

12 (7) the return to the state for every dollar expended by the department
13 and the attorney general to prevent and prosecute fraud and abuse;

14 (8) estimated payment error rate measurement for the medical
15 assistance program;

16 (9) results from the Medicaid Eligibility Quality Control program.

17 (b) On or before October 15 of each year, the department shall submit the
18 report required under this section to the senate secretary and the chief clerk of the
19 house of representatives and notify the legislature that the report is available.

20 * **Sec. 22.** AS 47.07.900(4) is amended to read:

21 (4) "clinic services" means services provided by state-approved
22 outpatient [COMMUNITY] mental health clinics [THAT RECEIVE GRANTS
23 UNDER AS 47.30.520 - 47.30.620], state-operated community mental health clinics,
24 outpatient surgical care centers, and physician clinics;

25 * **Sec. 23.** AS 47.07.900(17) is amended to read:

26 (17) "rehabilitative services" means services for substance abusers and
27 emotionally disturbed or chronically mentally ill adults provided by

28 (A) a drug or alcohol treatment center [THAT IS FUNDED
29 WITH A GRANT UNDER AS 47.30.475]; or

30 (B) an outpatient [COMMUNITY] mental health clinic [THAT
31 HAS A CONTRACT TO PROVIDE COMMUNITY MENTAL HEALTH

1 SERVICES UNDER AS 47.30.520 - 47.30.620];

2 * **Sec. 24.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 INDIRECT COURT RULE AMENDMENTS. (a) AS 09.58.020, added by sec. 3 of
5 this Act, has the effect of amending the following court rules in the manner specified:

6 (1) Rules 4, 5, 7, and 12, Alaska Rules of Civil Procedure, by requiring that a
7 complaint under AS 09.58 be filed in camera and under seal and may not be served on the
8 defendant until unsealed and that a copy of the complaint be served on the attorney general;

9 (2) Rules 41 and 77, Alaska Rules of Civil Procedure, by authorizing the
10 attorney general to move for dismissal of a complaint filed by another person under
11 AS 09.58.020, added by sec. 3 of this Act, and requiring court approval for dismissal of the
12 action.

13 (b) AS 09.58.025, added by sec. 3 of this Act, has the effect of amending Rule 27,
14 Alaska Rules of Civil Procedure, by authorizing the attorney general to issue subpoenas as
15 part of an investigation under AS 09.58.025.

16 (c) AS 09.58.030, added by sec. 3 of this Act, has the effect of amending the
17 following court rules in the manner specified:

18 (1) Rule 24, Alaska Rules of Civil Procedure, by authorizing the attorney
19 general to intervene in a civil action filed by another person under AS 09.58.020 and limiting
20 the participation of a party to the litigation;

21 (2) Rules 26 and 27, Alaska Rules of Civil Procedure, by authorizing the
22 attorney general to request that the court issue a stay of discovery for a 90-day period, or
23 longer upon a showing by the attorney general.

24 (d) AS 09.58.040, added by sec. 3 of this Act, has the effect of amending Rules 79
25 and 82, Alaska Rules of Civil Procedure, by giving a person who brings an action under
26 AS 09.58.020 the right to reasonable attorney fees and costs in an action prosecuted by the
27 attorney general.

28 (e) AS 47.05.260, added by sec. 17 of this Act, has the effect of amending Rule 89,
29 Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure, by
30 authorizing the attorney general to apply to the court for authorization to seize property in
31 conjunction with an action filed under AS 47.05.210.

1 * **Sec. 25.** The uncodified law of the State of Alaska is amended by adding a new section to
2 read:

3 IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT.

4 (a) The Department of Health and Social Services shall collaborate with Alaska tribal health
5 organizations and the United States Department of Health and Human Services to fully
6 implement changes in federal policy that authorize 100 percent federal funding for services
7 provided to American Indian and Alaska Native individuals eligible for Medicaid.

8 (b) Within 30 days after the date the Centers for Medicare and Medicaid Services
9 adopts a final rule updating its policy regarding the circumstances in which 100 percent
10 federal funding is available for medical assistance services received through the United States
11 Indian Health Service or tribal health facilities, the Department of Health and Social Services
12 shall notify the co-chairs of the senate finance committee of the Alaska State Legislature and
13 submit a report to the co-chairs of the senate finance committee that includes an estimate of
14 the savings to the state resulting from the rule change. Within six months after the date the
15 Centers for Medicare and Medicaid Services adopts the final rule, the Department of Health
16 and Social Services shall fully implement the rule in the state.

17 (c) In this section, "Alaska tribal health organization" means an organization
18 recognized by the United States Indian Health Service to provide health-related services.

19 * **Sec. 26.** The uncodified law of the State of Alaska is amended by adding a new section to
20 read:

21 HEALTH INFORMATION INFRASTRUCTURE PLAN. (a) The Department of
22 Health and Social Services shall develop a health information infrastructure plan to strengthen
23 the health information infrastructure, including health data analytics capability. The purpose
24 of the health information infrastructure plan is to transform the health care system in the state
25 by providing

26 (1) data required by health care providers for care coordination and quality
27 improvement; and

28 (2) the information support required by the Department of Health and Social
29 Services and health care providers to enable development and implementation of the other
30 provisions of this Act.

31 (b) To the greatest extent practicable, the health information infrastructure plan will

1 leverage existing resources, including the health information exchange, and will identify
2 opportunities for integrating and streamlining health data systems administered by the state.

3 * **Sec. 27.** The uncodified law of the State of Alaska is amended by adding a new section to
4 read:

5 DEPARTMENT OF HEALTH AND SOCIAL SERVICES FEASIBILITY STUDY.

6 (a) The Department of Health and Social Services shall procure a study analyzing the
7 feasibility of privatizing services delivered at Alaska Pioneers' Homes and select facilities of
8 the division of juvenile justice. The Department of Health and Social Services shall deliver a
9 report summarizing the conclusions of the Department of Health and Social Services to the
10 senate secretary and the chief clerk of the house of representatives and notify the legislature
11 that the report is available within 10 days after the convening of the First Regular Session of
12 the Thirtieth Alaska State Legislature.

13 (b) The Alaska Mental Health Trust Authority shall procure a study analyzing the
14 feasibility of privatizing services delivered at the Alaska Psychiatric Institute. The Alaska
15 Mental Health Trust Authority shall deliver a report summarizing the conclusions of the
16 Alaska Mental Health Trust Authority to the senate secretary and the chief clerk of the house
17 of representatives and notify the legislature that the report is available within 10 days after the
18 convening of the First Regular Session of the Thirtieth Alaska State Legislature.

19 (c) The Legislative Budget and Audit Committee shall procure a study to be
20 completed on or before June 30, 2017, on the feasibility of creating a health care authority
21 that manages a single community-related risk pool for all state employees, retired state
22 employees, retired teachers, medical assistance recipients, and school district employees.

23 (d) In this section, "school district" has the meaning given in AS 14.30.350.

24 * **Sec. 28.** The uncodified law of the State of Alaska is amended by adding a new section to
25 read:

26 MEDICAID STATE PLAN; WAIVERS; INSTRUCTIONS; NOTICE TO REVISOR
27 OF STATUTES. The Department of Health and Social Services shall amend and submit for
28 federal approval a state plan for medical assistance coverage consistent with this Act. The
29 Department of Health and Social Services shall apply to the United States Department of
30 Health and Human Services for any waivers necessary to implement this Act. The
31 commissioner of health and social services shall certify to the revisor of statutes if the

1 provisions of AS 47.05.270(a)(5), (8), and (10), added by sec. 17 of this Act, and the
2 provisions of AS 47.07.038, added by sec. 20 of this Act, are approved by the United States
3 Department of Health and Human Services.

4 * **Sec. 29.** The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 TRANSITION: REGULATIONS. (a) The Department of Health and Social Services
7 may adopt regulations necessary to implement the changes made by this Act. The regulations
8 take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date
9 of the relevant provision of this Act implemented by the regulation.

10 (b) The Board of Pharmacy may adopt regulations necessary to implement the
11 changes made by secs. 4 - 9 of this Act. The regulations take effect under AS 44.62
12 (Administrative Procedure Act), but not before the effective date of the relevant provision of
13 secs. 4 - 9 of this Act implemented by the regulation.

14 * **Sec. 30.** The uncodified law of the State of Alaska is amended by adding a new section to
15 read:

16 CONDITIONAL EFFECT. (a) AS 47.05.270(a)(5), enacted by sec. 17 of this Act,
17 takes effect only if the commissioner of health and social services certifies to the revisor of
18 statutes under sec. 28 of this Act, on or before October 1, 2017, that all of the provisions
19 added by AS 47.05.270(a)(5) have been approved by the United States Department of Health
20 and Human Services.

21 (b) AS 47.05.270(a)(8), enacted by sec. 17 of this Act, takes effect only if the
22 commissioner of health and social services certifies to the revisor of statutes under sec. 28 of
23 this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.270(a)(8)
24 have been approved by the United States Department of Health and Human Services.

25 (c) AS 47.05.270(a)(10), enacted by sec. 17 of this Act, takes effect only if the
26 commissioner of health and social services certifies to the revisor of statutes under sec. 28 of
27 this Act, on or before October 1, 2017, that all of the provisions added by
28 AS 47.05.270(a)(10) have been approved by the United States Department of Health and
29 Human Services.

30 (d) AS 47.07.038, enacted by sec. 20 of this Act, takes effect only if the commissioner
31 of health and social services certifies to the revisor of statutes under sec. 32 of this Act, on or

1 before October 1, 2017, that all of the provisions added by AS 47.07.038 have been approved
2 by the United States Department of Health and Human Services.

3 (e) AS 09.58, added by sec. 3 of this Act, takes effect only if sec. 24 of this Act
4 receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution
5 of the State of Alaska.

6 * **Sec. 31.** If AS 47.05.270(a)(5), enacted by sec. 17 of this Act, takes effect, it takes effect
7 on the day after the date the commissioner of health and social services makes a certification
8 to the revisor of statutes under secs. 28 and 30(a) of this Act.

9 * **Sec. 32.** If AS 47.05.270(a)(8), enacted by sec. 17 of this Act, takes effect, it takes effect
10 on the day after the date the commissioner of health and social services makes a certification
11 to the revisor of statutes under secs. 28 and 30(b) of this Act.

12 * **Sec. 33.** If AS 47.05.270(a)(10), enacted by sec. 17 of this Act, takes effect, it takes effect
13 on the day after the date the commissioner of health and social services makes a certification
14 to the revisor of statutes under secs. 28 and 30(c) of this Act.

15 * **Sec. 34.** If AS 47.07.038, enacted by sec. 20 of this Act, takes effect, it takes effect on the
16 day after the date the commissioner of health and social services makes a certification to the
17 revisor of statutes under secs. 28 and 30(d) of this Act.

18 * **Sec. 35.** Sections 27, 28, 29(a), and 30 of this Act take effect immediately under
19 AS 01.10.070(c).

20 * **Sec. 36.** Sections 4 - 9 of this Act take effect January 1, 2017.

21 * **Sec. 37.** Section 29(b) of this Act takes effect July 1, 2016.

ALASKA STATE LEGISLATURE
SENATE FINANCE COMMITTEE

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CS for SENATE BILL 74(FIN) (Version V)
DRAFT SECTIONAL ANALYSIS

Section 1 (page 2)

Previously CS SB 75(FIN) Section 2

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 2 (page 2)

Previously CS SB 78(FIN) Section 3

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 3 (page 2-10)

Previously CS SB 78(FIN) Section 4

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 2 line 26 - page 3, lines 11*). The penalties for false claims would be civil penalties not less than \$5500 and not more than \$11,000, three times the amount of actual damages, reasonable attorneys' fees and costs as provided in court rules, possible reduction in penalties, and establishes corporate liability for false claims.

AS 09.58.015. Attorney General invitation; civil action.

Authorizes the attorney general to investigate claims brought under this statute and to work collaboratively with DHSS on such matters.

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 08.58.030. 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 08.58.050. 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 8, line 14-28*).

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 08.58.070. 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.

Requests a minimum threshold damage amount of \$5500.

AS 09.58.100. Definitions

AS 09.58.110. Short title.

Section 4 (page 10-11)

New Section

AS 17.30.200(b)

Amends to require the collection of dispensing data and to update the Prescription Database Monitoring Program (PDMP) on a weekly basis.

Section 5 (page 11-13)

New Section

AS 17.30.200(d)

- (3) Amends to authorize a licensed practitioner to delegate database access to supervised employees or clinical staff;
- (4) Amends to authorize a registered pharmacists to delegate database access to supervised employees or clinical staff;
- (7) Adds a new section to authorize PDMP database access to the State of Alaska Medicaid Pharmacy Program;
- (8) Adds a new section to authorize PDMP database access to the State of Alaska Medicaid Drug Utilization Review Committee;
- (9) Adds a new section to authorize PDMP database access to the State of Alaska Medical Examiner;
- (10) Adds a new section to authorize de-identified PDMP data access to the State of Alaska Department of Health and Social Services Division of Public Health. The Division of Public Health would not need access to identifiable data to fulfill public health objectives regarding controlled substances including prescription opiates.

Section 6 (page 13)

New Section

AS 17.30.200(e)

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

Section 7 (page 13)

New Section

AS 17.30.200(h)

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

Section 8 (page 13-14)

New Section

AS 17.30.200(k)

Amends to adopt regulations to:

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

Section 9 (page 14)

New Section

AS 17.30.200

Adding new subsections to

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

Section 10 (page 14)

Previously CS SB 78(FIN) Section 5

AS 37.05.146(c)

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

Section 11 (page 14)

Previously CS SB 78(FIN) Section 6

AS 40.25.120(a)

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

Section 12 (page 14-15)

Previously CS SB 74(STA) Section 1

AS 47.05.015

Amends by adding a new subsection to allow the Department of Health and Social Services (DHSS) to enter into a contract through the competitive bidding process under the State Procurement Code for durable medical equipment or specific medical services provided in the Medicaid program.

Section 13 (page 15-16)

Previously CS SB 74(STA) Section 2 (Amended)

AS 47.05.105 Enhanced computerized eligibility verification system.

Amends by adding a new subsection requiring the department to establish a computerized enhanced eligibility verification system to verify eligibility and to deter waste and fraud. It also requires DHSS enter into a competitively bid contract with a third-party vendor for the eligibility verification system. The annual savings must exceed the cost of implementing the system.

Section 14 (page 16)

Previously CS SB 78(FIN) Section 8

AS 47.05.200(a)

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

Section 15 (page 16-17)

Previously CS SB 78(FIN) Section 9 (Amended)

AS 47.05.200(b)

Amends so that the Department may assess interest and penalties on overpayments, identified in audits conducted under this section, by calculating interest using existing statutory rates from the date of the final agency decision.

Section 16 (page 17)

Previously CS SB 78(FIN) Section 10 (Amended)

AS 47.05.235. Duty to identify and repay self-identified overpayments.

Amends by adding a new section which requires all enrolled Medicaid providers to conduct one annual review or audit of all claims, and if overpayments are identified, to report those findings to the department within ten business days, and to establish a repayment agreement with the state.

Section 17 (page 17-22)

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

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

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

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

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

This section, upon issuance of the court order of seizure, prohibits the owners of property from disposing of the property, with a provision of good faith in the event property is sold without written permission of the court. This section further authorizes the forfeiture of any seized property if the Medicaid provider is eventually convicted of medical assistance fraud. This section provides instructions to the state to sell or return properties, and depositing funds from disposal of seized properties.

This section also allows for the action of forfeiture to be joined with another civil or criminal action for damages resulting from alleged medical assistance fraud.

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

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

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

New Subsection (b): Requires the department to efficiently manage a comprehensive and integrated behavioral health system that uses evidence based practices that are data driven with measureable outcomes. The department and the Alaska Mental Health Trust Authority must provide a plan for a continuum of community based services that includes house, employment and criminal justice issues.

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

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

Subsection (e): Provides a definition for telemedicine.

Section 18 (page 22-23)

Previously CS SB 78(FIN) Section 17 (Amended)

AS 47.07.030(d)

Amends to require DHSS to implement the primary care case management system. The purpose of this new system is to increase Medicaid enrollees' use of primary and preventive care, while decreasing the use of specialty care and hospital emergency department services.

Section 19 (page 23-24)

Previously CS SB 78(FIN) Section 12 (Amended)

AS 47.07.036

Amends by adding new subsections (d) – (f) to outline cost containment and reform measures DHSS may undertake, including seeking demonstration waivers related to innovative service delivery models, applying for other options under the Social Security Act to obtain or increase federal match, and improving telemedicine for Medicaid recipients. This section also requires DHSS to apply for an 1115 waiver for a demonstration project for one or more groups of Medicaid recipients in one or more geographic area. The demonstration project may include managed care organizations, community care organizations, patient-centered medical homes, or other innovative payment models.

Section 20 (page 24-27)

AS 47.07.038. Collaborative, hospital-based project to reduce use of emergency department services.

Previously CS SB 74(STA) Section 6 (Amended)

Requires the department to partner a statewide professional hospital organization to design and implement a demonstration project to reduce non-urgent use of emergency departments by Medicaid recipients.

AS 47.07.039(a)

New Section

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

- (1) Comprehensive primary-care-based management, including behavioral health services
- (2) Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient
- (3) Health promotion
- (4) Comprehensive transitional care and follow-up care after inpatient treatment
- (5) Referral to community and social support services, including career and education training services
- (6) Sustainability and the ability to replicate in other regions of the state
- (7) Integration and coordination of benefits and services
- (8) Local accountability for health and resource allocation

AS 47.07.039(b)

Establishes a project review committee for proposals submitted under (a) of this section. The committee is comprised of:

- 1) The DHSS commissioner or their designee
- 2) The director of the Division of Insurance, DCCED or their designee
- 3) The CEO of the Alaska Mental Health Trust Authority or their designee
- 4) Three representatives of stakeholder groups appointed by the Governor
- 5) A Non-voting member of the Senate appointed by the Senate President
- 6) A Non-voting member of the House of Representatives appointed by the Speaker of the House of Representatives

AS 47.07.039(c)

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

AS 47.07.039(d)

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

AS 47.07.039(e)

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

AS 47.07.039(f)

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

AS 47.07.039(g)

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

Section 21 (page 27-28)

Previously CS SB 74(ST-1) Section 7

AS 47.07.076 Report to legislature.

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

Section 22 (page 28)

Previously CS SB 78(FIN) Section 13 (Amended)

47.07.900(4)

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

Section 23 (page 28-29)

Previously CS SB 78(FIN) Section 14 (Amended)

AS 47.07.900(17)

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

Section 24 (page 29)

Previously CS SB 78(FIN) Section 15

Uncodified: Indirect Court Rule Amendments.

Adds a new section to outline court rule amendments as a result of the enactment of section 3 and 17.

Section 25 (page 30)

Previously CS SB 78(FIN) Section 16 (Amended)

Uncodified: Implement Federal Policy on Tribal Medicaid Reimbursement.

Requires DHSS to collaborate with Alaska Tribal health organizations and the U.S. DHHS to implement new federal policy regarding 100% federal funding for services provided to Medicaid-eligible American Indian and Alaska Native individuals within six months of the rule change being finalized. Requires DHSS to report to the co-chairs of Finance the estimated savings and calculations of savings to the state general fund within thirty days of the rule being finalized.

Section 26 (page 30-31)

Previously CS SB 78(FIN) Section 18

Uncodified: Health Information Infrastructure Plan.

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

Section 27 (page 31)

Previously CS SB 74(STA) Section 9 (Amended)

Uncodified: Department of Health and Social Services Feasibility Study.

- (a) Requires the department to conduct a study analyzing the feasibility of privatizing the Alaska Pioneers' Homes and select facilities of the division of juvenile justice.
- (b) Requires the Alaska Mental Health Trust Authority to conduct a study analyzing the feasibility of privatizing the Alaska Psychiatric Institute.
- (c) Requires the Legislative Audit and Budget Committee to conduct a study analyzing the feasibility of creating a Health Care Authority that manages a single community-related risk pool for all State of Alaska Employees, State of Alaska retirees, Teacher retirees, Medicaid Assistance recipients, and active school district employees.

Section 28 (page 31-32)

Previously CS SB 74(STA) Section 10

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 29 (page 32)

Previously CS SB 74(STA) Section 11

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 30 (page 32-33)

Uncodified: Conditional effect.
Conditional effects.

Previously CS SB 74(STA) Section 12

Previously CS SB 78(FIN) Section 23

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

Section 31-37 (page 33)

Effective Dates
Provides for effective dates

Previously CS SB 74(STA) Section 13-17

Alaska State Legislature

SENATOR PETE KELLY

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Sectional Analysis – CS for Senate Bill 74

“An Act 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 eligibility for medical assistance; relating to a medical assistance reform program; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to civil penalties for medical assistance fraud; relating to studies by the Department of Health and Social Services; relating to cost-containment measures for medical assistance; and providing for an effective date.”

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

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

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

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

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

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

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

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

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

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

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

Section 12: Conditional effects.

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

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

advised
3/3/16

29-LS0692\V.16
Bruce/Glover
2/29/16

AMENDMENT # 1

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 11, line 8, following "on":
- 2 Insert "at least"
- 3
- 4 Page 14, line 22, following "on":
- 5 Insert "at least"

adopted
3/3/16

29-LS0692\V.46
Glover
3/2/16

AMENDMENT #2

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 13, line 4:
- 2 Delete "under the program"
- 3 Insert "provided to recipients of medical assistance"

adopted
3/3/16

29-LS0692\V.17
Glover
2/29/16

AMENDMENT #3

OFFERED IN THE SENATE

BY: SEN. MACKINNON

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 17, lines 14 - 15:
- 2 Delete "An enrolled medical assistance provider shall conduct at least one annual
- 3 review or audit of all claims submitted to the department for reimbursement and, if"
- 4 Insert "Unless a provider is being audited under AS 47.05.200(a), an enrolled medical
- 5 assistance provider shall conduct a biennial review or audit of a statistically valid sample of
- 6 claims submitted to the department for reimbursement. If"

*adopted
3/3/16*

29-LS0692\V.8
Glover
2/26/16

AMENDMENT #4

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 20, line 5, following "include":
- 2 Insert "one or more of the following:"

*adopted
3/3/16*

29-LS0692\V.18
Glover
2/29/16

AMENDMENT #5

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 20, line 19, following "models":
- 2 Insert "supported by evidence-based practices"

*adopted
3/28/16*

29-LS0692\V.20
Glover
2/29/16

AMENDMENT #6

OFFERED IN THE SENATE

BY: SEN. MACKINNON

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 21, line 10:
- 2 Delete "October"
- 3 Insert "November"
- 4
- 5 Page 27, line 18:
- 6 Delete "June 30, 2019"
- 7 Insert "November 15, 2019"
- 8
- 9 Page 27, line 20:
- 10 Delete "June 30"
- 11 Insert "November 15"
- 12
- 13 Page 28, line 17:
- 14 Delete "October"
- 15 Insert "November"

*adopted
3/8/16*

29-LS0692\V.9
Nauman/Glover
2/26/16

AMENDMENT #7

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 22, line 8:
- 2 Delete "average"
- 3
- 4 Page 22, line 9:
- 5 Delete "each"
- 6 Insert "the average"

*adopted
3/3/16*

29-LS0692\V.35
Nauman/Glover
3/1/16

AMENDMENT # 8

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 22, line 26, following "of":
- 2 Insert "appropriate"

*adopted
3/3/16*

29-LS0692\V.19
Glover
2/29/16

AMENDMENT #9

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 23, line 1, following "subsection":
- 2 Insert "except that the department may exempt recipients with chronic, acute, or
- 3 terminal medical conditions from the requirement under this paragraph"

adopted 3/2/16

29-LS0692\V.11
Glover
2/26/16

AMENDMENT # 10

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MALKINNON

- 1 Page 25, line 22:
- 2 Delete "projects"
- 3 Insert "at least one project"
- 4 Following "may":
- 5 Insert "annually request proposals for additional projects under this section
- 6 thereafter. The department may"
- 7
- 8 Page 25, line 23, following "AS 36.30.308":
- 9 Insert "to award a contract for a project under this section"

*Adopted
3/3/16*

29-LS0692\V.41
Glover
3/2/16

AMENDMENT # 11

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

1 Page 27, line 29:

2 Delete "identify"

3 Insert "include the following information:"

4

5 Page 28, lines 14 - 15:

6 Delete all material and insert:

7 "(8) the most recent payment error rate measurement report for the
8 medical assistance program, including fee for service programs and pilot or
9 demonstration projects; the report must also explain the reasons for the payment errors
10 and the total amount of state and federal funds paid in error during the reporting period
11 and not recovered by the department at the time of the report;"

*adopted
3/3/16*

29-LS0692V.26
Glover
2/29/16

AMENDMENT #12

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 28, line 22:
- 2 Delete "[COMMUNITY]"
- 3 Insert "community"
- 4
- 5 Page 28, line 30:
- 6 Delete "[COMMUNITY]"
- 7 Insert "community"

*adopted
3/8/16*

29-LS0692\V.12
Nauman
2/26/16

AMENDMENT # 13

BY: SEN. MACKINNON

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 30, line 9:
- 2 Delete "adopts a final rule updating its"
- 3 Insert "issues a final"
- 4
- 5 Page 30, line 12, following "notify":
- 6 Insert "and submit a report to"
- 7
- 8 Page 30, line 12, following the second occurrence of "the":
- 9 Insert "house and"
- 10
- 11 Page 30, line 12:
- 12 Delete "committee"
- 13 Insert "committees"
- 14
- 15 Page 30, lines 12 - 13:
- 16 Delete "and submit a report to the co-chairs of the senate finance committee"
- 17
- 18 Page 30, line 14:
- 19 Delete "rule change"
- 20 Insert "final policy"
- 21
- 22 Page 30, line 15:
- 23 Delete "adopts the final rule"

- 1 Insert "issues the final policy"
- 2
- 3 Page 30, line 16:
- 4 Delete "rule"
- 5 Insert "policy"

Adopted
3/3/16

29-LS0692\V.43
Nauman/Glover
3/2/16

AMENDMENT # 24

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

1 Page 14, line 7:

2 Delete "access"

3 Insert "review the information in"

4

5 Page 14, line 9, following "patient":

6 Insert "; the regulations must provide that a pharmacist or practitioner is not
7 required to review the information in the database before dispensing, prescribing, or
8 administering a controlled substance to a person who is receiving treatment

9 (A) in an inpatient setting

10 (B) at the scene of an emergency or in an ambulance; in this
11 subparagraph, "ambulance" has the meaning given in AS 18.08.200;

12 (C) in an emergency room; or

13 (D) immediately before, during, or within the first 24 hours
14 after surgery"

*adopted
2/3/16*

29-LS0692\V.44
Bruce/Glover
3/2/16

AMENDMENT # 25

BY: SEN. MALKINNON

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

1 Page 10, following line 29:

2 Insert a new bill section to read:

3 **** Sec. 4.** AS 17.30.200(a) 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,
8 or IV [, OR V] controlled substance under federal law dispensed in the state to a
9 person other than those administered to a patient at a health care facility. The
10 Department of Commerce, Community, and Economic Development shall assist the
11 board and provide necessary staff and equipment to implement this section."
12

12

13 Renumber the following bill sections accordingly.

14

15 Page 11, lines 1 - 2:

16 Delete "IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule
17 I, II, III, IV, or V"

18 Insert "[IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE
19 LAW OR A SCHEDULE I,] II, III, or IV [, OR V]"

20

21 Page 11, lines 4 - 5:

22 Delete "IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule
23 I, II, III, IV, or V"

1 Insert "[IA, IIA, IIIA, IVA, OR VA CONTROLLED SUBSTANCE UNDER STATE
2 LAW OR A SCHEDULE I,] II, III, or IV [, OR V]"

3

4 Page 14, lines 12 - 13:

5 Delete "IA, IIA, IIIA, IV, or VA controlled substance under state law or a schedule I,
6 II, III, IV, or V"

7 Insert "II, III, or IV"

8

9 Page 29, line 28:

10 Delete "sec. 17"

11 Insert "sec. 18"

12

13 Page 32, line 1:

14 Delete "sec. 17"

15 Insert "sec. 18"

16

17 Page 32, line 2:

18 Delete "sec. 20"

19 Insert "sec. 21"

20

21 Page 32, line 11:

22 Delete "secs. 4 - 9"

23 Insert "secs. 4 - 10"

24

25 Page 32, line 13:

26 Delete "secs. 4 - 9"

27 Insert "secs. 4 - 10"

28

29 Page 32, line 16:

30 Delete "sec. 17"

31 Insert "sec. 18"

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2 Page 32, line 18:

3 Delete "sec. 28"

4 Insert "sec. 29"

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6 Page 32, line 21:

7 Delete "sec. 17"

8 Insert "sec. 18"

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10 Page 32, line 22:

11 Delete "sec. 28"

12 Insert "sec. 29"

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14 Page 32, line 25:

15 Delete "sec. 17"

16 Insert "sec. 18"

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18 Page 32, line 26:

19 Delete "sec. 28"

20 Insert "sec. 29"

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22 Page 32, line 30:

23 Delete "sec. 20"

24 Insert "sec. 21"

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26 Page 32, line 31:

27 Delete "sec. 32"

28 Insert "sec. 33"

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30 Page 33, line 3:

31 Delete "sec. 24"

1 Insert "sec. 25"

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3 Page 33, line 6:

4 Delete "sec. 17"

5 Insert "sec. 18"

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7 Page 33, line 8:

8 Delete "secs. 28 and 30(a)"

9 Insert "secs. 29 and 31(a)"

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11 Page 33, line 9:

12 Delete "sec. 17"

13 Insert "sec. 18"

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15 Page 33, line 11:

16 Delete "secs. 28 and 30(b)"

17 Insert "secs. 29 and 31(b)"

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19 Page 33, line 12:

20 Delete "sec. 17"

21 Insert "sec. 18"

22

23 Page 33, line 14:

24 Delete "secs. 28 and 30(c)"

25 Insert "secs. 29 and 31(c)"

26

27 Page 33, line 15:

28 Delete "sec. 20"

29 Insert "sec. 21"

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31 Page 33, line 17:

- 1 Delete "secs. 28 and 30(d)"
- 2 Insert "secs. 29 and 31(d)"
- 3
- 4 Page 33, line 18:
 - 5 Delete "Sections 27, 28, 29(a), and 30"
 - 6 Insert "Sections 28, 29, 30(a), and 31"
 - 7
- 8 Page 33, line 20:
 - 9 Delete "Sections 4 - 9"
 - 10 Insert "Sections 4 - 10"
 - 11
- 12 Page 33, line 21:
 - 13 Delete "Section 29(b)"
 - 14 Insert "Section 30(b)"

*adopted
3/3/16*

29-LS0692\V.34
Glover
3/1/16

AMENDMENT # 14

OFFERED IN THE SENATE

BY: SEN. MACKINNON

TO: CSSB 74(FIN), Draft Version "V"

1 Page 23, line 29, following "(d)":

2 Insert "and (f)"

3

4 Page 24, following line 8:

5 Insert a new subsection to read:

6 "(f) Notwithstanding (a) - (c) of this section, and in addition to the projects
7 and services described under (d) and (e) of this section, the department shall apply for
8 a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration
9 projects focused on improving the state's behavioral health system for medical
10 assistance recipients. The department shall engage stakeholders and the community in
11 the development of a project or projects under this subsection. The demonstration
12 project or projects must be consistent with the comprehensive and integrated
13 behavioral health program described under AS 47.05.270(b)."

14

15 Reletter the following subsection accordingly.

*adopted
3/3/16*

29-LS0692\V.36
Bruce/Glover
3/1/16

AMENDMENT #15

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 20, line 31:
- 2 Delete "primary care providers"
- 3 Insert "licensed or certified mental health and primary care professionals"
- 4
- 5 Page 21, line 1, following "services":
- 6 Insert ", minimize administrative burdens,"

*adopted
3/31/16*

29-LS0692\V.13
Glover
2/26/16

AMENDMENT # 16

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

BY: SEN. MACKINNON

- 1 Page 31, line 13:
- 2 Delete "Alaska Mental Health Trust Authority"
- 3 Insert "Department of Health and Social Services, in conjunction with the Alaska
- 4 Mental Health Trust Authority,"
- 5
- 6 Page 31, line 14, following "The":
- 7 Insert "Department of Health and Social Services and the"
- 8
- 9 Page 31, line 15, following "a":
- 10 Insert "joint"
- 11
- 12 Page 31, line 15, following the second occurrence of "the":
- 13 Insert "Department of Health and Social Services and the"

*adopted
3/3/16*

AMENDMENT #17

OFFERED IN THE SENATE

BY SENATOR KELLY

TO: CSSB 74(FIN), Draft Version "V"

1 Page 10, following line 29:

2 Insert new bill sections to read:

3 **** Sec. 4.** AS 09.58.025, added by sec. 3 of this Act, is amended to read:

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

13 *** Sec. 5.** AS 09.58.070(b), added by sec. 3 of this Act, is amended to read:

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

23 Renumber the following bill sections accordingly.

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Page 29, following line 1:

Insert a new bill section to read:

**** Sec. 26.** AS 09.58.020, 09.58.030, 09.58.040, 09.58.050, and 09.58.060 are repealed July 1, 2019."

Renumber the following bill sections accordingly.

Page 29, line 5:

Following "Act":

Insert "and repealed by sec. 26 of this Act"

Following "specified":

Insert "from the effective date of sec. 3 of this Act until July 1, 2019"

Page 29, line 11, following "Act":

Insert "and repealed by sec. 26 of this Act"

Page 29, line 13, following "Act":

Insert "and amended by sec. 4 of this Act"

Page 29, line 15:

Delete "AS 09.58.025"

Insert "AS 09.58.015 or 09.58.020 from the effective date of sec. 3 of this Act until July 1, 2019, and an investigation under AS 09.58.015 before, on, or after July 1, 2019"

Page 29, line 16, following "Act":

Insert "and repealed by sec. 26 of this Act"

Page 29, line 17, following "specified":

Insert "from the effective date of sec. 3 of this Act until July 1, 2019"

Page 29, line 19, following "AS 09.58.020":

1 Insert ", added by sec. 3 of this Act and repealed by sec. 26 of this Act,"

2

3 Page 29, line 24, following "Act":

4 Insert "and repealed by sec. 26 of this Act"

5

6 Page 29, line 25, following "Procedure,":

7 Insert "from the effective date of sec. 3 of this Act until July 1, 2019,"

8

9 Page 29, line 26, following "AS 09.58.020":

10 Insert ", added by sec. 3 of this Act and repealed by sec. 26 of this Act,"

11

12 Page 29, line 28:

13 Delete "sec. 17"

14 Insert "sec. 19"

15

16 Page 32, line 1:

17 Delete "sec. 17"

18 Insert "sec. 19"

19

20 Page 32, line 2:

21 Delete "sec. 20"

22 Insert "sec. 22"

23

24 Page 32, line 11:

25 Delete "secs. 4 - 9"

26 Insert "secs. 6 - 11"

27

28 Page 32, line 13:

29 Delete "secs. 4 - 9"

30 Insert "secs. 6 - 11"

31

1 Page 32, line 16:

2 Delete "sec. 17"

3 Insert "sec. 19"

4

5 Page 32, line 18:

6 Delete "sec. 28"

7 Insert "sec. 31"

8

9 Page 32, line 21:

10 Delete "sec. 17"

11 Insert "sec. 19"

12

13 Page 32, line 22:

14 Delete "sec. 28"

15 Insert "sec. 31"

16

17 Page 32, line 25:

18 Delete "sec. 17"

19 Insert "sec. 19"

20

21 Page 32, line 26:

22 Delete "sec. 28"

23 Insert "sec. 31"

24

25 Page 32, line 30:

26 Delete "sec. 20"

27 Insert "sec. 22"

28

29 Page 32, line 31:

30 Delete "sec. 32"

31 Insert "sec. 35"

1

2 Page 33, line 3:

3 Delete "takes effect only if sec. 24"

4 Insert "and sec. 26 of this Act take effect only if sec. 27"

5

6 Page 33, line 6:

7 Delete "sec. 17"

8 Insert "sec. 19"

9

10 Page 33, line 8:

11 Delete "secs. 28 and 30(a)"

12 Insert "secs. 31 and 33(a)"

13

14 Page 33, line 9:

15 Delete "sec. 17"

16 Insert "sec. 19"

17

18 Page 33, line 11:

19 Delete "secs. 28 and 30(b)"

20 Insert "secs. 31 and 33(b)"

21

22 Page 33, line 12:

23 Delete "sec. 17"

24 Insert "sec. 19"

25

26 Page 33, line 14:

27 Delete "secs. 28 and 30(c)"

28 Insert "secs. 31 and 33(c)"

29

30 Page 33, line 15:

31 Delete "sec. 20"

1 Insert "sec. 22"

2

3 Page 33, line 17:

4 Delete "secs. 28 and 30(d)"

5 Insert "secs. 31 and 33(d)"

6

7 Page 33, line 18:

8 Delete "Sections 27, 28, 29(a), and 30"

9 Insert "Sections 30, 31, 32(a), and 33"

10

11 Page 33, line 20:

12 Delete "Sections 4 - 9"

13 Insert "Sections 6 - 11"

14

15 Page 33, line 21:

16 Delete "Section 29(b)"

17 Insert "Section 32(b)"

18

19 Page 33, following line 21:

20 Insert a new bill section to read:

21 "* **Sec. 41.** Sections 4 and 5 of this Act take effect July 1, 2019."

*adopted
3/3/16*

29-LS0692\V.38
Glover
3/2/16

AMENDMENT #18

OFFERED IN THE SENATE

BY SENATOR KELLY

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 25, line 25:
2 Delete "one"
3 Insert "three"
4
5 Page 25, line 28, following the second occurrence of "services":
6 Insert "and coordination of long-term services and support"
7
8 Page 26, line 8:
9 Delete "benefits and services"
10 Insert "benefits, services, and utilization management"
11
12 Page 26, lines 15 - 16:
13 Delete all material and insert:
14 "(2) the commissioner of administration, or the commissioner's
15 designee;"
16
17 Page 26, line 19:
18 Delete "three"
19 Insert "two"
20
21 Page 26, line 20, following "governor":
22 Insert "for staggered three-year terms"
23

1 Page 26, lines 27 - 29:

2 Delete "A contract shall provide for a fee based on a per capita expense that is fair and
3 economical."

4

5 Page 26, line 29:

6 Following "structure":

7 Insert "for a contract under this subsection"

8 Following the second occurrence of "payments,":

9 Insert "capitated payments,"

10

11 Page 26, line 30, following "structures.":

12 Insert "The department shall work with the division of insurance, Department of
13 Commerce, Community, and Economic Development, to streamline the application process
14 for a company to obtain a certificate of authority required under AS 21.09.010 as necessary to
15 participate in a demonstration project under this section."

*adopted
3/3/16*

29-LS0692\V.25
Glover
2/29/16

AMENDMENT #19

OFFERED IN THE SENATE

BY SENATOR OLSON

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 22, line 27, following "the":
- 2 Insert "unnecessary"

*Withdrawn
3/3/16*

29-LS0692\V.32
Nauman/Glover
3/1/16

AMENDMENT #20

OFFERED IN THE SENATE

BY SENATOR BISHOP

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 31, line 22, following "employees.":
- 2 Insert "In addition, the study procured under this subsection must specifically identify
- 3 and address cost-saving strategies for the provision of health care for persons described in this
- 4 subsection that may be implemented by a private entity."

*adopted
3/3/16*

29-LS0692\V.30
Glover
3/1/16

AMENDMENT # 21

OFFERED IN THE SENATE

BY SENATOR MICCICHE

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 2, line 1, following "Services;":
2 Insert "**relating to Alaska Pioneers' Homes and Alaska Veterans' Homes;**"
3
4 Page 29, following line 1:
5 Insert a new bill section to read:
6 **** Sec. 24.** AS 47.55.020(e) is amended to read:
7 (e) As a condition for receipt of payment assistance under (d) of this section,
8 the department, under regulations adopted by the department, **shall** [MAY] require a
9 person to
10 **(1) apply for other state or federally sponsored programs that may**
11 **reduce the amount of the payment assistance; and**
12 **(2) submit to the department a copy of the person's application for**
13 **medical assistance coverage under AS 47.07 and the decision letter the person**
14 **receives regarding the application.**
15
16 Renumber the following bill sections accordingly.
17
18 Page 32, line 18:
19 Delete "sec. 28"
20 Insert "sec. 29"
21
22 Page 32, line 22:
23 Delete "sec. 28"

1 Insert "sec. 29"

2

3 Page 32, line 26:

4 Delete "sec. 28"

5 Insert "sec. 29"

6

7 Page 32, line 31:

8 Delete "sec. 32"

9 Insert "sec. 33"

10

11 Page 33, line 3:

12 Delete "sec. 24"

13 Insert "sec. 25"

14

15 Page 33, line 8:

16 Delete "secs. 28 and 30(a)"

17 Insert "secs. 29 and 31(a)"

18

19 Page 33, line 11:

20 Delete "secs. 28 and 30(b)"

21 Insert "secs. 29 and 31(b)"

22

23 Page 33, line 14:

24 Delete "secs. 28 and 30(c)"

25 Insert "secs. 29 and 31(c)"

26

27 Page 33, line 17:

28 Delete "secs. 28 and 30(d)"

29 Insert "secs. 29 and 31(d)"

30

31 Page 33, line 18:

1 Delete "Sections 27, 28, 29(a), and 30"

2 Insert "Sections 28, 29, 30(a), and 31"

3

4 Page 33, line 21:

5 Delete "Section 29(b)"

6 Insert "Section 30(b)"

*adopted
3/3/16*

29-LS0692\V.45
Glover
3/2/16

AMENDMENT #22

OFFERED IN THE SENATE

BY: SEN. MACKINNON

TO: CSSB 74(FIN), Draft Version "V"

1 Page 24, line 22, through page 25, line 7:

2 Delete all material and insert:

3 "(1) an interdisciplinary process for defining, identifying, and
4 minimizing the number of frequent users of emergency department services;

5 (2) to the extent consistent with federal law, a system for real-time
6 electronic exchange of patient information, including recent emergency department
7 visits, hospital care plans for frequent users of emergency departments, and data from
8 the controlled substance prescription database;

9 (3) a procedure for educating patients about the use of emergency
10 departments and appropriate alternative services and facilities for nonurgent care;

11 (4) a process for assisting users of emergency departments in making
12 appointments with primary care or behavioral health providers within 96 hours after
13 an emergency department visit;

14 (5) a collaborative process between the department and the statewide
15 professional hospital association to establish uniform statewide guidelines for
16 prescribing narcotics in an emergency department; and

17 (6) designation of health care personnel to review successes and
18 challenges regarding appropriate emergency department use."

*adopted
3/31/16*

29-LS0692\V.49
Glover
3/2/16

AMENDMENT # 26

OFFERED IN THE SENATE

BY SENATOR KELLY

TO: CSSB 74(FIN), Draft Version "V"

1 Page 2, line 2, following "**projects;**":

2 Insert "**relating to the duties of the Department of Administration; relating to**
3 **feasibility studies for the provision of specified state services;**"

4

5 Page 31, line 5:

6 Delete all material.

7 Insert "FEASIBILITY STUDIES FOR THE PROVISION OF SPECIFIED STATE
8 SERVICES."

9

10 Page 31, lines 19 - 22:

11 Delete all material and insert:

12 "(c) The Department of Administration shall, in collaboration with the house and
13 senate finance committees, procure a study to be completed on or before June 30, 2017, to
14 determine the feasibility of creating a health care authority to coordinate health care plans and
15 consolidate purchasing effectiveness for all state employees, retired state employees, retired
16 teachers, medical assistance recipients, University of Alaska employees, employees of state
17 corporations, and school district employees and to develop appropriate benefit sets, rules,
18 cost-sharing, and payment structures for all employees and individuals whose health care
19 benefits are funded directly or indirectly by the state, with the goal of achieving the greatest
20 possible savings to the state through a coordinated approach administered by a single entity.
21 In developing the study, the Department of Administration shall seek input from the
22 Department of Health and Social Services, administrators familiar with managing government
23 employee health plans, and human resource professionals familiar with self-insured health

- 1 care plans. The study must
- 2 (1) identify cost-saving strategies that a health care authority could implement;
- 3 (2) analyze local government participation in the authority;
- 4 (3) analyze a phased approach to adding groups to the health care plans
- 5 coordinated by the health care authority;
- 6 (4) consider previous studies procured by the Department of Administration
- 7 and the legislature;
- 8 (5) assess the use of community-related health insurance risk pools and the use
- 9 of the private marketplace;
- 10 (6) identify organizational models for a health care authority, including private
- 11 for-profit, private nonprofit, government, and state corporations; and
- 12 (7) include a public review and comment opportunity for employers,
- 13 employees, medical assistance recipients, and health care providers."

*adopted
3/3/16*

29-LS0692\V.42
Glover
3/2/16

AMENDMENT #23

OFFERED IN THE SENATE

BY: SEN. MACKINNON

TO: CSSB 74(FIN), Draft Version "V"

- 1 Page 19, line 27:
- 2 Delete "telemedicine"
- 3 Insert "telehealth"
- 4
- 5 Page 21, line 4:
- 6 Delete "telemedicine"
- 7 Insert "telehealth"
- 8
- 9 Page 21, line 6:
- 10 Delete "telemedicine"
- 11 Insert "telehealth"
- 12
- 13 Page 21, line 9:
- 14 Delete "telemedicine"
- 15 Insert "telehealth"
- 16
- 17 Page 21, line 28:
- 18 Delete "telemedicine" in both places
- 19 Insert "telehealth" in both places
- 20
- 21 Page 21, line 30:
- 22 Delete "telemedicine"
- 23 Insert "telehealth"

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Page 22, line 15:

Delete "telemedicine"
Insert "telehealth"

Page 22, line 16:

Delete "medical"
Insert "health care"

Page 22, line 19, following "other":

Insert "or between a provider and a recipient who are physically separated from each other"

Page 23, line 26:

Delete "telemedicine"
Insert "telehealth"

Page 23, line 27:

Delete "telemedicine"
Insert "telehealth"

Page 24, line 9:

Delete ""telemedicine" means the practice of health care delivery,"
Insert ""telehealth" has the meaning given in AS 47.05.270(e)."

Page 24, lines 10 - 13:

Delete all material.

Page 27, line 4:

Delete "telemedicine"
Insert "telehealth"

1

2 Page 27, line 6:

3 Delete "telemedicine"

4 Insert "telehealth"

5

6 Page 27, line 25:

7 Delete "telemedicine"

8 Insert "telehealth"

*adopted
3/3/16*

29-LS0692\V.48
Glover
3/2/16

AMENDMENT # 27

BY: SEN. MICCICHE

OFFERED IN THE SENATE

TO: CSSB 74(FIN), Draft Version "V"

1 Page 1, line 1, following "Act":

2 Insert **"relating to diagnosis, treatment, and prescription of drugs without a**
3 **physical examination by a physician; relating to the delivery of services by a licensed**
4 **professional counselor, marriage and family therapist, psychologist, psychological**
5 **associate, and social worker by audio, video, or data communications; relating to the**
6 **duties of the Department of Commerce, Community, and Economic Development;**
7 **establishing a telemedicine business registry; relating to the duties of the State Medical**
8 **Board;"**

9

10 Page 2, following line 5:

11 Insert new bill sections to read:

12 **** Section 1.** AS 08.29.400 is amended by adding a new subsection to read:

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

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

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

22 (3) the licensee meets the requirements established by the board in
23 regulation.

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

5 * **Sec. 2.** AS 08.63.210 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, supervision, or treatment of a person through audio, video, or
8 data 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. 3.** AS 08.64.101 is amended to read:

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

23 (1) examine and issue licenses to applicants;

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

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

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

31 (5) under regulations adopted by the board, contract with private

1 professional organizations to establish an impaired medical professionals program to
 2 identify, confront, evaluate, and treat persons licensed under this chapter who abuse
 3 alcohol, other drugs, or other substances or are mentally ill or cognitively impaired;

4 **(6) adopt regulations that establish guidelines for a physician who**
 5 **is rendering a diagnosis, providing treatment, or prescribing, dispensing, or**
 6 **administering a prescription drug to a person without conducting a physical**
 7 **examination under AS 08.64.364; the guidelines must include a nationally**
 8 **recognized model policy for standards of care of a patient who is at a different**
 9 **location than the physician.**

10 * **Sec. 4.** AS 08.64.364(a) is amended to read:

11 (a) The board may not impose disciplinary sanctions on a physician for
 12 **rendering a diagnosis, providing treatment, or** prescribing, dispensing, or
 13 administering a prescription drug **that is not a controlled substance** to a person
 14 without conducting a physical examination if

15 (1) [THE PRESCRIPTION DRUG IS

16 (A) NOT A CONTROLLED SUBSTANCE; OR

17 (B) A CONTROLLED SUBSTANCE AND IS PRESCRIBED,
 18 DISPENSED, OR ADMINISTERED BY A PHYSICIAN WHEN AN
 19 APPROPRIATE LICENSED HEALTH CARE PROVIDER IS PRESENT
 20 WITH THE PATIENT TO ASSIST THE PHYSICIAN WITH
 21 EXAMINATION, DIAGNOSIS, AND TREATMENT;

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

25 **(2) the physician requests that** [(3)] the person **consent**
 26 [CONSENTS] to sending a copy of all records of the encounter to the person's primary
 27 care provider if the prescribing physician is not the person's primary care provider,
 28 and, **if the patient consents,** the physician sends the records to the person's primary
 29 care provider.

30 * **Sec. 5.** AS 08.64.364 is amended by adding new subsections to read:

31 (c) The board may not impose disciplinary sanctions on a physician for

1 prescribing, dispensing, or administering a prescription drug that is a controlled
2 substance if the requirements under (a) of this section are met and the physician
3 prescribes, dispenses, or administers the controlled substance when an appropriate
4 licensed health care provider is present with the patient to assist the physician with
5 examination, diagnosis, and treatment.

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

7 (1) prescribe an abortion-inducing drug; or

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

11 * **Sec. 6.** AS 08.86.204 is amended by adding a new subsection to read:

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

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

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

21 (3) the licensee meets the requirements established by the board in
22 regulation.

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

27 * **Sec. 7.** AS 08.95.050 is amended by adding a new subsection to read:

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

31 (1) the licensee or another licensed health care provider is available to

1 provide follow-up care;

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

6 (3) the licensee meets the requirements established by the board in
7 regulation.

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

12
13 Page 2, line 6:

14 Delete "**Section 1**"

15 Insert "**Sec. 8**"

16
17 Renumber the following bill sections accordingly.

18
19 Page 14, following line 29:

20 Insert a new bill section to read:

21 **** Sec. 19.** AS 44.33 is amended by adding a new section to read:

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

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

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

29 (c) In this section,

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

1 (2) "telemedicine services" means the delivery of health care services
2 using the transfer of medical data through audio, visual, or data communications that
3 are performed over two or more locations by a provider who is physically separated
4 from the recipient of the health care services."
5

6 Renumber the following bill sections accordingly.
7

8 Page 29, line 4:

9 Delete "sec. 3"

10 Insert "sec. 10"

11
12 Page 29, line 11:

13 Delete "sec. 3"

14 Insert "sec. 10"

15
16 Page 29, line 13:

17 Delete "sec. 3"

18 Insert "sec. 10"

19
20 Page 29, line 16:

21 Delete "sec. 3"

22 Insert "sec. 10"

23
24 Page 29, line 24:

25 Delete "sec. 3"

26 Insert "sec. 10"

27
28 Page 29, line 28:

29 Delete "sec. 17"

30 Insert "sec. 25"

31

1 Page 32, line 1:

2 Delete "sec. 17"

3 Insert "sec. 25"

4

5 Page 32, line 2:

6 Delete "sec. 20"

7 Insert "sec. 28"

8

9 Page 32, line 11:

10 Delete "secs. 4 - 9"

11 Insert "secs. 11 - 16"

12

13 Page 32, line 13:

14 Delete "secs. 4 - 9"

15 Insert "secs. 11 - 16"

16

17 Page 32, line 16:

18 Delete "sec. 17"

19 Insert "sec. 25"

20

21 Page 32, line 18:

22 Delete "sec. 28"

23 Insert "sec. 36"

24

25 Page 32, line 21:

26 Delete "sec. 17"

27 Insert "sec. 25"

28

29 Page 32, line 22:

30 Delete "sec. 28"

31 Insert "sec. 36"

1

2 Page 32, line 25:

3 Delete "sec. 17"

4 Insert "sec. 25"

5

6 Page 32, line 26:

7 Delete "sec. 28"

8 Insert "sec. 36"

9

10 Page 32, line 30:

11 Delete "sec. 20"

12 Insert "sec. 28"

13

14 Page 32, line 31:

15 Delete "sec. 32"

16 Insert "sec. 40"

17

18 Page 33, line 3:

19 Delete "sec. 3"

20 Insert "sec. 10"

21 Delete "sec. 24"

22 Insert "sec. 32"

23

24 Page 33, line 6:

25 Delete "sec. 17"

26 Insert "sec. 25"

27

28 Page 33, line 8:

29 Delete "secs. 28 and 30(a)"

30 Insert "secs. 36 and 38(a)"

31

1 Page 33, line 9:

2 Delete "sec. 17"

3 Insert "sec. 25"

4

5 Page 33, line 11:

6 Delete "secs. 28 and 30(b)"

7 Insert "secs. 36 and 38(b)"

8

9 Page 33, line 12:

10 Delete "sec. 17"

11 Insert "sec. 25"

12

13 Page 33, line 14:

14 Delete "secs. 28 and 30(c)"

15 Insert "secs. 36 and 38(c)"

16

17 Page 33, line 15:

18 Delete "sec. 20"

19 Insert "sec. 28"

20

21 Page 33, line 17:

22 Delete "secs. 28 and 30(d)"

23 Insert "secs. 36 and 38(d)"

24

25 Page 33, line 18:

26 Delete "Sections 27, 28, 29(a), and 30"

27 Insert "Sections 35, 36, 37(a), and 38"

28

29 Page 33, line 20:

30 Delete "Sections 4 - 9"

31 Insert "Sections 11 - 16"

1

2 Page 33, line 21:

3 Delete "Section 29(b)"

4 Insert "Section 37(b)"



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of
Health and Social Services**

Governor's Council on Disabilities
& Special Education

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Main: 907.269.8990
Fax: 907.269.8995

March 1, 2016

Senator Pete Kelly, Co-Chair
Senator Anna MacKinnon, Co-Chair
Senate Finance Committee
Alaska State Capital Building
Juneau, AK 99801-1120

RE: Support for SB 74

Dear Senator Kelly and Senator MacKinnon,

The Governor's Council on Disabilities and Special Education (GCDSE) fills a variety of federal and state roles, including serving as the State Council on Developmental Disabilities (SCDD) under the Developmental Disabilities Assistance and Bill of Rights Act. As the state DD Council, GCDSE works with Senior and Disabilities Services and other state agencies to ensure that people with intellectual and developmental disabilities and their families receive the services and supports that they need, as well as participate in the planning and design of those services. Many of these services are paid for through Medicaid waivers in the form of Home and Community Based Services.

Recently, our Council developed a position paper (attached) specific to these waivers, and the decision to reduce the draw of families from 200 to 50 Alaskans per year off the "Developmental Disabilities Registration and Review", often called the "waitlist". This was done as a cost saving measure in the short-term. The Council believes and hopes that reform efforts such as those proposed under SB 74 will someday lead to restoring the number of draws from the "waitlist". Without such services, families are more likely to reduce their work hours or sacrifice their participation in the workforce altogether in order to care for a child or adult family member with a disability. This often leads to further dependence on government assistance programs and/or placement of the individual in out of state institutions, at a much greater cost to the state.

The Council very much appreciates your efforts develop this comprehensive reform package. In regards to fraud and audit requirements, we both support and applaud the intent of the bill to "weed out" wrongdoers and fraudulent providers. However, we do caution the committee on placing additional reporting and audit burdens on home and community based providers, especially smaller "mom and pop" organizations. We believe that self-reporting of mistakes made in billing or overpayments by providers themselves is great idea. We also believe that the Explanation of Benefits concept included in your bill is also a good idea. People and

families that receive services under Medicaid are indeed your best bet for identifying mistakes or fraudulent practices.

Again, thank your leadership in pushing Medicaid reform efforts through SB 74.

Sincerely,

A handwritten signature in black ink, appearing to read 'P. Reinhart', with a long horizontal line extending to the right.

Patrick Reinhart, Executive Director
Governor's Council on Disabilities and Special Education



Please join the Council in supporting an annual draw of 175 from the Developmental Disabilities Registration and Review DDDR ("Waitlist")

WHAT IS IT?

The Developmental Disability Registration and Review (DDRR "waitlist") is a program registry for qualified individuals with intellectual & developmental disabilities who meet "institutional level of care." The registry provides an avenue for these individuals to receive the Medicaid waiver for Home and Community-Based Services when funds become available. The DDDR is managed through the Division of Seniors & Disabilities Services (SDS), and their plan is to reduce the DDDR waitlist annual draws from 200 consumers to 50 consumers per year as a way to save money in the short-term.

WHY IS THIS AN ISSUE?

- Because of the state's commitment to draw 200 families from the DDDR for services since 2005, the number of families waiting for services has decreased from over 1200 to less than 700, currently. Reducing the draws by 75% will increase the number of consumers waiting for services and possibly triple the average wait time of 3 years.
- Families that are supporting individuals with developmental disabilities are much more likely to reduce work hours or leave the work force in order to care for their child.
- Research shows that waiver-funded supported employment services result in more job placements, higher wages, and work hours per week for individuals with disabilities. Employment ultimately has the potential to result in cost savings and better quality of life.*
- The average cost per I/DD waiver in-state is just under \$80,000 while the average cost for an out of state placement is over \$120,000.
 - Reducing the number of draws from the registry will increase pressure on state-funded grant dollars and, in some cases, result in higher-cost services if their child is placed in an out-of-state intermediate care facility.

ALTERNATIVE SAVINGS

The Council believes that we can accomplish the same level of projected savings from waiver services by implementing some of the strategies being explored now by SDS under the 1915i and 1915k state plan options beginning in 2017 as well as reviewing some current ideas, such as:

- **Streamlining the eligibility and level of care re-determination process.** Many people on the I/DD waiver have lifelong disabilities, such as Downs Syndrome, and their conditions are not going to materially improve over time. Currently, the process requires a full review and authorization every 3 years. We suggest review every 5 years and much greater use of low-cost tele-technology for reassessments vs. in-person reviews.
- **Considering implementing "soft caps" on services.** By exploring "soft caps" the division can reduce the number of hours for many services and then require justification of the need for more than a certain number of hours when needed.
- **Establishing voucher program for purchase of supplies and other personal care items.** Using a voucher card similar to the Alaska Quest card used for food stamps, allow families and/or providers to purchase some medical supplies from Walmart, Costco, or other low-cost alternatives to medical supply companies. This would also prevent continuous delivery, a common practice now, resulting in stockpiles of unneeded supplies.
- **Allowing for purchase of smart-home technology and services that reduce the need for direct staff support.** Other states and the V.A. have shown significant savings by allowing more smart-home technologies like tablets and smart phones to help a person live independently.
- **Considering a package of new services to persons who do not quite meet institutional level of care in the 1915i.** Some people and families (i.e. FASD, TBI, ADRD) need only a little bit of support, such as supervision and cuing, to help maintain community living:
 - Individuals with FASD alone cost the state nearly \$2 million over their lifetime**, through their use of the correctional system, medical treatment, residential care, and lost productivity.
 - Providing early intervention to these individuals often avoids much costlier state-funded services later in life.

Please encourage HSS/SDS to reinstate waiver draws to at least 175 individuals per year

Resources:

*Jean P. Hall, Noelle K. Kurth 2013. Employment as a Health Determinant for Working-age, Dually Eligible People with Disabilities.

<https://ku.scholarworks.ku.edu/bitstream/handle/1808/11286/Hall%20Kurth%20Hun%20202013.pdf?sequence=1>

**Lupton, Chuck. 2003. The Financial Impact of Fetal Alcohol Syndrome. Fetal Alcohol Spectrum Disorders Center for Excellence. <http://fasdcenter.samhsa.gov/Products/cost.aspx>

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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
Phone: 907.465.2550
Fax: 907.465.2974

March 2, 2016

The Honorable Senator Anna MacKinnon
Co-Chair, Senate Finance Committee
State Capitol Room 532
Juneau, AK 99801

Dear Senator MacKinnon,

The following are questions that have arisen and/or concerns with the PDMP portion of the above bill:

The effective date and authority to adopt regulations should extend to all responsible agencies.

ISSUE: The effective date of January 1, 2017, does not allow enough time for the Board of Pharmacy to adopt regulations, structure the program, notify licensees, and issue a new contract for the database expansion. July 1, 2017, is the earliest this could possibly be accomplished without harming the public or licensees. The Department and other boards must be provided with the ability to adopt regulations prior to the effective date, if needed.

SOLUTION: Change the effective date to July 1, 2017, or later. Add the Department of Commerce, Community, and Economic Development, Board of Dental Examiners, Board of Nursing, Board of Examiners in Optometry, Board of Veterinary Examiners, and the State Medical Board to Sec. 29 (b).

Funding source for PDMP expansion is inequitable.

ISSUE: The PDMP is currently funded by a five-year federal grant through DHSS. This grant is not adequate to cover the expansion of service included in this bill, and the fiscal note does not include base funding for the PDMP should grant funds cease to be available. While it is the intent of the Department to continue to seek federal grant funds to cover the costs of this program, additional sources have not yet been awarded. In order to receipt the funds required to accomplish the requirements of the bill, the Department must be authorized to charge a fee for database registration. Without this authority, the licensees of the Board of Pharmacy will be left to cover this cost.

SOLUTION: The Department will need explicit authority to charge a fee for registration so that the cost of the program does not become the sole responsibility of licensees of the Board of Pharmacy. This language will need to allow the fee to be receipted before the effective date of the law if dispensers and practitioners are to be registered on the effective date.

Veterinarians currently have prescriptive authority.

ISSUE: Veterinarians will be required to register under proposed AS 17.30.200(o). However, the bill does not specifically enumerate them in AS 17.30.200(p). Further, the requirement in AS 17.30.200(p) for the Board of Pharmacy to notify the other boards when their licensees register is an onerous and redundant requirement since the division administers all of these programs.

SOLUTION: Omit AS 17.30.200(p).

How can registration with the PDMP be easier for users?

A notarized signature page is the best means of verifying user identity and providing only those prescribers and practitioners with genuine credentials access to this sensitive data. It is done once, at the time the account is established. The personal identification verification will become even more critical if the system is opened up to delegate accounts for trusted assistants of dispensers and practitioners. Because this is HIPAA-protected information, it is critical that identity verification is acquired for access to the database.

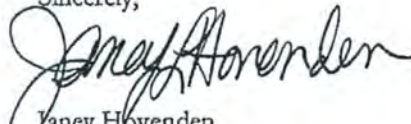
The Division continues to explore options to make it easier for PDMP users to register. One possible option includes linking data from the existing Division licensing database with the PDMP software to verify credentials. However, it is premature to confirm this as a possible solution.

Does the PDMP Software have an Application Program Interface (API) that electronic medical system providers can utilize to upload the required data to the database?

The new PDMP software vendor, APRISS, has the capability and has been providing it in some circumstances. The Gateway module is included in the current contract, however, individual entities would be required to pursue the capability with the vendor at a cost to the entity. Legislative authority is needed to permit delegate reporting in this manner.

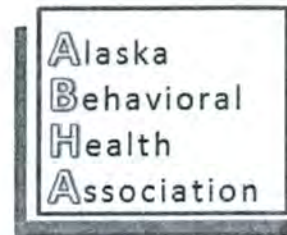
We hope this helps to answer some of the questions posed in committee and effectively express the Division's concerns about the bill. If you or any members of the committee have further questions or require additional information about anything provided here, please contact DCCED Special Assistant Micaela Fowler at 465-2503.

Sincerely,



Janey Hovenden
Director

Tom Chard
Executive Director
Alaska Behavioral Health Association (ABHA)
P.O. Box 32917 Juneau, Alaska 99803
(907/toll-free 855) 523-0376
tom.abha@gmail.com



28 February 2016

Senator Anna MacKinnon
Co-Chair, Senate Finance
Chair, Senate Medicaid Reform Committee
State Capitol Room 516
Juneau AK, 99801

Re: Eliminating the Grant Requirement for Behavioral Health Services

Senator MacKinnon,

The Alaska Behavioral Health Association (ABHA) is the trade organization representing behavioral health providers in the State of Alaska. With leadership from over 50 community mental health and substance abuse treatment providers across the state, we offer a diverse perspective with the common interest of providing access to the best quality, cost-effective behavioral health treatment available.

ABHA has advised that the decision to remove the requirement to be a grantee of the State to be able to be reimbursed by Medicaid for the provision of behavioral health treatment services would benefit from further deliberation. The requirement has been in Alaska statute for decades. The law has been fundamental in shaping our current behavioral health system of care. Reversing this longstanding statutory requirement will have unintended consequences.

Since the idea was first proposed last year, there has collectively only been a few hours of stakeholder discussions between on the decision and its potential impact the Department of Health & Social Services, Division of Behavioral Health, and current behavioral health grantees. The Alaska Behavioral Health Association has urged more thorough consideration of the proposal to remove the grant requirement since the idea was first introduced in order to help identify any unintended consequences resulting from the decision.

ABHA is not opposed to the provisions. The primary motivation attributed to the provisions to remove the grant requirement is to increase access to behavioral health treatment services. ABHA believes that if the provision is enacted carefully and with consideration, it will likely achieve that goal. We are concerned about some of the other likely impacts of eliminating the grant requirement and would like to do everything possible to avoid or mitigate any unintended negative impact. We appreciate the opportunity to raise some of the concerns that have been identified to the Committee for deliberation and guidance.

The Alaska Behavioral Health Association tried to identify some of the more likely impacts of this change on our system of care and, more importantly, on individuals' ability to access quality, cost effective behavioral health treatment services. We recognize that some of the changes that will result from this legislation will undergo additional public scrutiny through the regulatory process, that some of the detail of potential impact is most appropriately addressed in regulation, and that the reform process is iterative. We stand committed to continuing our support of this process and its goal to improve access to quality, cost-effective behavioral health treatment services.

Deliberation among providers has focused on a few key consequences. First, we believe that eliminating the grant requirement may unintentionally limit access to treatment for individuals with severe disorders that require expensive, highly-specialized treatment services. Second, acknowledging that the current behavioral health system is too heavily weighed down by administrative requirements and process management, we believe some standards need to be in place to ensure quality care and the value of public expenditures on health care for Alaskans.

The Alaska Behavioral Health Association recognizes that this discussion should have happened much earlier in this process and shares in the responsibility to have made that happen. We appreciate the Committee's indulgence to have this discussion at this stage in the process and do not want to hinder the Committee's progress on Medicaid reform or Senate Bill 74. Therefore, we respectfully propose the following. Without the benefit of more thorough deliberation among stakeholders to identify possible negative unintended consequences and potential resolutions, the Alaska Behavioral Health Association believes that simply mirroring language found in section 19 of the bill in sections 22 and 23 will help safeguard against pursuing access to treatment at the expense of quality or cost-effectiveness.

Section 19 (e)(4) of CSSB74\V recognizes the important balance between access, quality, and cost by including a requirement that the demonstration project under the 1115 waiver should "...ensure access to health care without reducing the quality of care." ABHA believes that mirroring that same requirement in sections 22 and 23 may help avoid any potentially negative unintended consequences resulting from eliminating the grant requirement.

The Alaska Behavioral Health Association sincerely appreciates all the efforts you and your committee have put into this as well as our sincere gratitude for taking the time to consider this provision in the legislation more carefully.

With respect,



Tom Chard
Alaska Behavioral Health Association (ABHA)

Tom Chard

Executive Director

Alaska Behavioral Health Association (ABHA)

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01 March 2016

Senator Anna MacKinnon
Co-Chair, Senate Finance
Chair, Senate Medicaid Reform Committee
State Capitol Room 516
Juneau AK, 99801

Re: Lifting the Grant Requirement for Behavioral Health Services

Senator MacKinnon,

The Alaska Behavioral Health Association (ABHA) is a member-driven, non-profit representing over 50 member organizations including both tribal and non-tribal publicly funded, private corporations that span the system of care from infants to the elderly, in urban and rural settings across Alaska. The Association was formed in 1996 to help improve the delivery of substance abuse and mental health treatment services in Alaska.

The behavioral health providers sincerely appreciate the Committee's ongoing efforts and the attention paid to reforming Alaska's Medicaid system. We are especially thankful for the invitations we have received to participate throughout the development of the reform recommendations.

The Alaska Behavioral Health Association (ABHA) has provided testimony to the Senate Medicaid Reform Committee on February 12th, as well as testimony to Senate Finance on February 25th and 29th. We have submitted written testimony on February 24th and 28th.

The purpose of our testimony has been to inform the decision to eliminate the grant requirement to be reimbursed by Medicaid for behavioral health services in Alaska found in sections 22 and 23 of CSSB74\V. Our latest recommendation submitted to the Committee for their consideration was to mirror language found in section 19 of the bill for sections 22 and 23 to help ensure a good balance between access, quality, and cost-effectiveness. We understand that recommendation might be problematic because those particular sections of the bill amend the definition of clinic and rehabilitative services and that the proposed consideration might be more appropriately suited for a different section of the statute.

Section 19 contemplates amending A.S. 47.07.36 by adding a new redesigned service delivery structure for behavioral health services using an 1115 waiver. There is broad agreement in the goal that increasing cost-effective access to quality treatment will benefit Alaskans. That particular section of the statute is focused on cost containment measures authorized. The expectation is that any changes considered to accessing treatment services, or changes to the quality of the treatment standards we pay for with public funds, be considered in light of their cost-effectiveness. These three are inextricably intertwined. We respectfully recommend to the Committee that they might express the pursuit of this "triple aim" in section 19 of the bill, not just for the 1115 waiver, but as an established consideration for the entire behavioral treatment system.

Specifically, we are asking that the Committee consider amending A.S. 47.07.36 to explicitly require consideration of access, quality, and cost-effectiveness in cost containment. Perhaps, the least obstructive way to include the recommendation might be to amend A.S. 47.07.36 to read:

(b) The department, in implementing this section, shall take all reasonable steps to implement cost containment measures that do consider cost-effectiveness, access to services, and quality of services, but that do not eliminate program eligibility or the scope of services required or authorized under AS 47.07.020 and 47.07.030 before implementing cost containment measures under (c) of this section that directly affect program eligibility or coverage of services.

The Alaska Behavioral Health Association (ABHA) continuously strives to improve the efficiency and effectiveness of behavioral health treatment services in Alaska. Please feel free to contact us if there is any additional information that would be helpful to you as you consider this important provision.

Sincerely,

A handwritten signature in cursive script, appearing to read "Tom Chard".

Tom Chard

Alaska Behavioral Health Association (ABHA)

Doniece Gott

From: Erin Shine
Sent: Wednesday, March 02, 2016 8:02 AM
To: Doniece Gott
Subject: FW: Comments on SSSB 74 (FIN)

From: ashleyreed@gci.net [mailto:ashleyreed@gci.net]
Sent: Tuesday, March 01, 2016 4:33 PM
To: Sen. Anna MacKinnon <Sen.Anna.MacKinnon@akleg.gov>
Subject: Fw: Comments on SSSB 74 (FIN)

Senator -

Please find below a few constructive comments from Geneva Woods Medical on SB 74. My apologies for not getting them to you sooner.

Regards,

Ashley Reed
907. 229. 4049
Sent via BlackBerry by AT&T

From: Dan Afrasiabi <dan.afraziabi@genevawoods.com>
Date: Wed, 2 Mar 2016 00:59:07 +0000
To: ashleyreed@gci.net<ashleyreed@gci.net>
Cc: Tom Gimple<tom.gimple@gmail.com>; Gabriel Kompkoff<Gabriel.Kompkoff@chugach.com>; Jonathon B Rubini<jrubini@jlproperties.com>
Subject: Comments on Proposed Bill

Ashley,

As you know, Geneva Woods employs over 250 Alaskans and is a critical component of community-based care thought the state. We have reviewed the proposed bill and agree with the vast majority of the **themes** presented and the potential to improve health care results for Alaskans while reducing costs. However, as they say, "the devil is in the details". Upon review of the details with from an objective perspective, a few very serious problems become manifest. Below, I have outlined 3 of these issues, and have proposed reasonable language that achieves the State's objectives, without creating an unreasonable and untenable burden on the industry in Alaska.

- Section 8 proposes that AS 17.30.200(k) be amended. The requirement that a pharmacist check the database prior to dispensing any class of controlled substance is not realistic. While the intention here is good, we do not believe anyone truly appreciates the burden this puts on pharmacies, when all

classes of Scheduled medication (including Class V) are included. For example, many prescription sleeping tablets that are routinely prescribed by any provider fall in the Class V category. As such, the regulatory burden that such a heavy requirement places on the pharmacist is truly not necessary in order to achieve the policy goals of the State (with which we completely agree). As such, we propose that the requirement be limited to Class IIA drugs, which are the subject of the concern.

Proposed language: “(4) that a pharmacist or practitioner shall access the database to check a patient’s prescription records before dispensing, prescribing, or administering *a Schedule IIA* controlled substance to the patient.”

- Section 12 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, 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 language: “(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...”

- Section 16 proposes to amend AS 47.05 by adding a new section, AS 47.05.235. For a company of any size and complexity, let alone a company of our size, the requirement to annually review every claim is onerous and frankly beyond the scope of reasonableness. We understand and appreciate what the state wants to accomplish. We already get hit with audits on virtually a weekly basis and are forced to have a full compliance department just for that purpose. If the State now wants to place an additional burden that requires us to audit every single claim, it simply becomes an untenable situation.

Proposed language: “(a) An enrolled medical assistance provider shall conduct a *reasonable review of claims* submitted to the department...”

- 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 language: “(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”

There are a number of other punitive, and frankly on the face of it, potentially unconstitutional provisions. For example, the state is requesting to be given the right to freeze assets on the mere suspicion of overpayment or fraudulent activity. To us, this seems like a very heavy-handed power that has the potential for abuse in the future. Furthermore, the state wants to request penalties, in addition to standard costs and recoveries of audits, in cases of overpayment. Again, it seems to us that this provision has the potential for future problems.

Having said that, our main focus remains on the four items listed above. Please let me know if I can further explain any of these issues.

Thanks,

Dan

Dan Afrasiabi | CEO | Geneva Woods Pharmacy, Inc.

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THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

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Health and Social Services

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February 26, 2016

Senator Anna MacKinnon, Co-Chair
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Sen.Ann.MacKinnon@akleg.gov

Senator Pete Kelly, Co-Chair
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Phone: (907) 465-3709
Sen.Pete.Kelly@akleg.gov

Senator MacKinnon and Senator Kelly:

Thank you for the opportunity to provide written recommendations and feedback for consideration by the Senate Finance Committee for CSSB74.

1. Prescription Drug Monitoring Program
 - Two spots reference "on a weekly basis"
 - Section 4, Page 11, Line 8
 - Section 9, Page 14, Line 22
 - For the committee's consideration: The Department recommends "on **at least** a weekly basis"
2. Duty to identify and repay self-identified overpayments
 - Section 16, Page 17, Lines 14 – 15
"An enrolled medical assistance provider shall conduct at least one annual review or audit of all claims submitted to the department..."
 - For the committee's consideration: "**Unless a provider is being audited under 47.05.200(a)**, an enrolled medical assistance provider shall conduct **a biennial** review or audit of **a statistically valid sample of** claims submitted to the department..."
3. Language Clarification
 - Section 17, Page 20, Lines 18 - 19
 - For the committee's consideration: The Department recommends adding "based on evidence based practice."
 - Guidelines for health care providers to develop health care delivery models **based on evidence based practice** that encourage wellness and disease prevention.

4. Report to the Legislature
 - Section 17, Page 22, Lines 8 - 9
“the percentage increase or decrease in average state general fund spending for each medical assistance recipient compared to the previous fiscal year
 - For the committee’s consideration: The department recommends deleting the word “each.”

5. Case management for recipients with multiple hospitalizations
 - Section 18, Page 22, Line 29 through Page 23, Line 1
 - For the committee’s consideration: “the department shall require recipients with multiple hospitalizations to enroll in a primary care case management system or with a managed care organization **except for recipients with conditions that may necessitate multiple hospitalizations** under this subsection”

6. Coordinated Care Demonstration Projects
 - Section 20, Page 25, Lines 21 - 23
 - For the committee’s consideration: The department recommends adding, “**and annually thereafter,**”
“The department shall request proposals for projects under this section on or before December 31, 2016, **and annually thereafter,** and may use an innovative procurement process as described under AS 36.30.308.”

7. Language Suggestion
 - Section 22, Page 28, Lines 20 - 24
 - For the committee’s consideration: The department recommends using the language from CSSB78 in Section 13, Page 17, Lines 19 – 23

8. Language Suggestion
 - Section 23, Page 28, Lines 25 through Page 29, Line 1
 - For the committee’s consideration: The department recommends using the language from CSSB78 in Section 13, Page 17, Lines 24 - 31

9. Implement Federal Policy on Tribal Medicaid Reimbursement
 - Section 25, Page 30, Lines 1 - 16
 - To more accurately describe the process, the department recommends the following:
 - Section 25, Page 30, Line 9: states “adopts a final rule updating its policy”
For the committee’s consideration: The Department recommends “**issues a final policy**”
 - Section 25, Page 30, Line 16: states “fully implement the rule in the state”
For the committee’s consideration: The department recommends “fully implement the **policy** in the state”

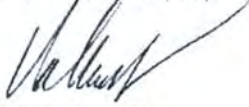
- For the committee's consideration: The Centers for Medicare and Medicaid Services (CMS) issued the final policy on February 26, 2016. Implementation may need to be addressed through the effective date clause.

10. Dates in the bill

- Section 17, Page 21, Line 10: "On or before October 15"
 - For the committee's consideration: The department recommends, "On or before **November 15**"
- Section 20, Page 27, Lines 18 & 20: "June 30"
 - For the committee's consideration: The department recommends, "**November 15**"
- Section 21, Page 28, Line 17: "On or before October 15"
 - The department recommends, "On or before **November 15**"

Thank you for the opportunity to provide comments.

Quyana (thank you).



Valerie Davidson
Commissioner
Department of Health & Social Services



SHO #16-002

Re: Federal Funding for Services “Received Through” an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

February 26, 2016

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities¹ may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.²

¹ For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

² As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

AI/ANs who meet the eligibility requirements for the Medicaid program in the state in which they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,³ Departmental Appeals Board decisions,⁴ and federal court decisions,⁵ has been that 100 percent FMAP is available for amounts expended for services under the following circumstances:

- (1) The service must be furnished to a Medicaid-eligible AI/AN;
- (2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
- (3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility's services; and
- (4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly

³ Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).

⁴ *North Dakota Dept. of Human Services*, DAB No. 1854 (2002); *South Dakota Dept. of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services*, DAB No. 1919 (2004).

⁵ *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v. Centers for Medicare & Medicaid Services*, 424 F. 3rd 931 (9th Cir. 2005); *Arizona Health Care Cost Containment System v. McClellan*, 508 F.3rd 1243 (9th Cir. 2007).

for services. CMS received 182 comments from 91 commenters including Tribes, Tribal organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

In this letter, we are re-interpreting the scope of services considered to be “received through” an IHS/Tribal facility. Under our previous interpretation, in order to be “received through” an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a “facility service.” By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be “received through” an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Request for Services In Accordance With a Written Care Coordination Agreement

In this letter, CMS also revises its interpretation to provide that a service may be considered “received through” an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable IHS/Tribal facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.

A covered service will be considered to be “received through” an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner’s care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state’s Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient’s care and the IHS/Tribal facility retains control of the patient’s medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity⁶.

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient’s care, the state expenditure for the service would not qualify for 100 percent FMAP.

At a minimum, care coordination will involve:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;

⁶ Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement Act.

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

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and, to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Medicaid Billing and Payments to Non-IHS/Tribal Providers

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was "received through" an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state's payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal

providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has “received [services] through” the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services “received through” an IHS/Tribal facility if the following conditions are met:

- (1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;
- (2) The service meets the same requirements to be considered “received through” an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;
- (3) The non-IHS/Tribal provider is a network provider of the enrollee’s managed care plan;
- (4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider’s contractual agreement with the managed care plan; and
- (5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services “received through” an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Compliance and Documentation

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services “received through” an

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

Applicability to Section 1115 Demonstrations

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being "received through" an IHS or Tribal facility that are described in this SHO are present.

Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates

The 100 percent FMAP for services "received through" an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services "received through" an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,

/s/

Vikki Wachino

Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials



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.

February 26, 2016

Senator Anna MacKinnon
State Capital
Juneau, AK 99801

Re: Comments on CSSB74 Version V Medicaid False Claims and Reporting Act 2/25/16

Dear Senator MacKinnon,

Thank you for the opportunity for our Vice President, Michael Bailey to offer a verbal presentation to your committee during the public comment session yesterday. On behalf of AADD, I am submitting a written version of the following points we wished to present.

1. Protections for self-reporting.

Sec. 16. AS 47.05.235 (b) (p17)

AADD appreciates the added protection against interest or penalties for self-identified overpayments following a specific audit that are currently in Sec 16., specifically "The department may not assess interest or penalties on an overpayment identified and repaid by a medical assistance provider under this section."

Providers are 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.

AADD requests that this same language is added to Sec 3. AS 09.58.010 (b) (p3) 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 may not assess interest or penalties on an

overpayment self- identified and repaid by a medical assistance provider under this section.”

2. Reasonable audit size requirements.

Sec 16. AS 47.05.235 (a) (p17)

States that the “medical assistance provider shall conduct at least one annual review or audit of all claims submitted to the department for reimbursement”.

This requirement will create an onerous administrative burden on providers which is not currently paid for in the Medicaid rates. AADD recommends an adjustment of language to “at least one annual review or audit of a statistically valid sample of all claims submitted”.

3. Reasonable statute of limitations.

Sec 1 AS.09.010.075 (p2)

AADD expresses concern with the reporting time frames (6 years for person to bring action, or 3 years for State of Alaska). Extended litigation processes will be expensive for providers, and presents significant risk of the loss of provider options for recipients. Smaller providers will be driven out of business because they cannot withstand this level of exposure.

Most organizations have experienced disgruntled employees who have been disciplined or discharged for their wrongful actions. An employee with criminal intent may manipulate this section (as a “whistleblower”) to retaliate against an organization, or to conceal their own wrongful acts, so the organization may not be the first to identify the issue. AADD recommends removal of this section or the reduction of the time limits to avoid unintended consequences of eliminating choice of providers for recipients.

4. More precise definition of agent.

Sec 3 AS 09.58.010 (e) (p4)

AADD expresses concern with lack of definition of “agent” who “acted with apparent authority.” The remoteness of Alaska does not allow for every fieldworker to be micro-managed, so many providers have established Standard Operating Procedures and Policies (also required for accreditation compliance) that indicate expected behavior of employees. These include fraud and false claims prevention. An employee who acts outside of established company policies should not be considered an agent.

AADD recommends modification of this section (and clearly defining “agent”) to exclude organizations from actions by rogue employees who acted outside of established company policies. Suggested language may be:

“An agent with apparent authority is defined as a paid representative of the principal, who holds a position with decision-making authority to influence or change established Standard Operating Procedures or Policies”.

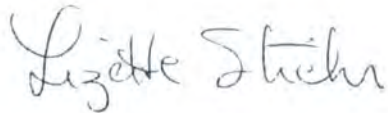
5. Additional qualification for auditors.

Sec 14. AS 47.05.200 (a) (p16)

AADD requests the addition of "expertise in the health care industry" to the qualifications of an audit contractor. It is the experience of providers that auditors without an understanding of health care will incorrectly assess overpayments, resulting in inefficiencies and waste related to clarifying and defending accurate claims.

Please feel free to contact me if you have any questions or seek additional clarification of these points.

Sincerely,

A handwritten signature in cursive script that reads "Lizette Stiehr".

Lizette Stiehr
Executive Director



ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION

February 26, 2016

Senator Anna MacKinnon, co-chair
Senate Finance Committee
State Capitol, Room 516
Juneau, AK 99801

Dear Senator MacKinnon,

Thank you for the opportunity to testify at the Senate Finance Committee hearing on SB 74 on February 25. ASHNHA greatly appreciates the work of the Senate Finance Medicaid Reform Subcommittee on this bill and for allowing our association the opportunity to provide input. I wanted to expand on some of my comments at the hearing and to provide you with additional information and feedback on this important legislation.

This bill represents a significant step forward in Alaska's health care reform journey. States that have successfully managed health care costs have a long history of engaging in reform, so we view this bill as the start of a process that will lead us to a more sustainable health care system. We encourage the Legislature to continue the dialogue into future legislative sessions.

This bill articulates a reform vision for the Medicaid program, including payment reform, enhanced care management, telemedicine, public-private partnerships and short-term cost reduction. We support the broad vision for the health care system outlined in the legislation.

The bill establishes a framework for payment reform, beginning with demonstration projects. Changing the health care system takes time and we fully support the use of demonstration projects to test new payment and delivery models. We appreciate the flexibility given to the Department of Health & Social Services to solicit innovative demonstration proposals and we remain committed to the idea that innovation can come from within Alaska's provider community. One size does not always fit all in our diverse state and we appreciate that this bill recognizes the need to develop local and regional solutions to managing health care.

We support the efforts in the fraud and abuse sections of the bill to limit redundant audits. It is important for the state to have the tools to address fraud and abuse, but to ensure that in doing so we do not burden low-risk providers with unnecessary administrative work that will only drive additional cost into the system.

We concur with the focus on primary care, through developing a primary care case management system. We support strengthening primary care as a building block for system change.

Finally, I want to note that we are enthusiastic and willing partners with the State and the Alaska Chapter of the American College of Emergency Physicians in a project to reduce the



unnecessary use of emergency departments (EDs), not just for the Medicaid population, but for all ED users. ASHNHA and ACEP have advocated for this project for more than a year because we believe it will have a significant and positive impact on reducing unnecessary ED utilization, while improving care. Major components of the project include an electronic data interchange to better share information between EDs, enhanced case management, opioid prescribing guidelines and patient education. A similar project in Washington State resulted in an overall reduction in Medicaid ED visits of nearly 10% and a reduction of 25% in prescriptions of controlled substances from EDs. This kind of provider engagement and public-private partnership will be critical to ongoing success in managing health care costs.

The ability to negotiate shared savings on this project is an important step forward in payment reform. As providers look at moving from a volume-based system to one based on value, the ability to engage in shared savings and other forms of risk is important learning for us and for the state moving forward.

I'd like to highlight a few areas of concern. We appreciate the committee's effort to address fraud and abuse. As low-risk providers, hospitals and nursing homes have a significant stake in ensuring the integrity of the Medicaid program. We support giving the Departments of Law and Health & Social Services the necessary tools to combat fraud and abuse. However, every dollar spent in compliance or in litigation is a dollar added to health care costs. As you ask providers to reduce costs, we ask that you consider the administrative burden you are placing on them. This bill contemplates a significant structural change to our fraud and abuse statutes. Some of the provisions included in the committee substitute were introduced in SB 78 in late January, including the overpayment section and the private right of action section. We are concerned that many providers are not yet aware of these changes and have not had an opportunity to understand their impact.

The bill creates a new private right of action where private persons or entities can bring an action on behalf of the government and share in the monetary judgment. This has the potential of incentivizing frivolous lawsuits, costing providers time and resources as they defend themselves against unwarranted assertions. Even if a lawsuit is ultimately thrown out, providers will have spent time and attorney's fees in defending themselves.

The only place SB 74 clearly states that the new enforcement "action" (referenced in Sec. 09.10.075, page 2, Section 1) is limited to Medicaid (those involving medical assistance payment fraud) is in the header. This creates ambiguity.

In addition, the bill expands existing AS 09.10.120 to be more clearly linked to Medicaid-related claims. This statute was previously focused more on natural resource and property-related frauds, and raises a question -- why treat Medicaid fraud more harshly than other frauds under AS 09.10.120 (e.g., longer statute of limitations)? (Page 2, Section 2)

The proposed Section 3 (AS 09.58.010) contains a number of fairly onerous provisions unrelated to actions that result in a false payment. If the state were to adopt this approach we suggest an amendment to subsection (a)(5) (in bold): ***“(5) knowingly enter into an agreement, contract, or understanding with an officer or employee of the state for approval or payment of a claim under the medical assistance program knowing that the information in the agreement, contract, or understanding is false or fraudulent [and is material to receipt of payment for medical assistance].”***

Much of AS 09.58.010 and AS 09.58.020 through .040 appears to be based on the federal False Claims Act. The Federal FCA doesn't define "proceeds of the action" with the overly-broad definition in this Alaska proposal. As noted previously, duplicate or conflicting compliance obligations between state and federal statutes can be problematic, both for the state and for providers.

Sec. 09.58.090 creates a very low threshold (\$5,500) for this new enforcement mechanism and penalties. We suggest a more material threshold of damage to the state before this type of enforcement kicks in.

The new statutory audit provision [Sec. 14 AS 47.05.200(a)] is extremely onerous and one-sided. It does not require the state to evaluate for over- and under-payments, and it is inconsistent with existing Alaska Medicaid approaches to audits. More specifically, the following language is problematic:

- The new obligation in Sec. 16 (AS 47.05.235) that each provider must do an annual self-audit "of all claims submitted" and report the overpayment within 10 days. This obligation is a substantial burden when providers have effectively attested to the accuracy of each claim when submitted. In addition, there is no mention of reporting or recovering underpayments, and no provision for the state to audit for or pay interest on underpayments.
- While we appreciate the inclusion of language that the department may not assess interest and penalties on overpayments identified by providers, this section does not appreciate the full complexity of identifying or repaying overpayments. The MMIS system does not always make it easy to "refund" payments, since adjusting line items can be problematic and Xerox has to accept adjustments. Some providers have old credit balances dating back many years that Xerox will not accept. Until the State and Xerox agree to accept all refunds initiated by providers, regardless of whether they are self-identified or identified through external audits, it is unfair to invoke a penalty.
- The term "overpayment" needs to be better defined. Overpayments can be relatively simple (e.g. a duplicate payment made by Medicaid or another payer is determined to be primary) or more complex. Payments for non-covered services are difficult for providers to identify and should not be the provider's responsibility to self-report. An example would be if the patient was authorized for a four day inpatient stay, stayed for five days



- and the state paid the full five days. This should be the state's responsibility to identify, but under this legislation if an audit identified the overpayment, providers would be subject to interest and penalties. Fee schedule or rate payment errors are also very difficult for providers to identify and should be the state's responsibility. Finally, system defects should be excluded from penalties. The MMIS system currently has known defects that are resulting in consistent overpayments for certain claims. Until the system is paying claims accurately, it is not just to consider penalizing providers for overpayments.
- We also suggest that if this approach to enforcement is adopted it must include standards for uniform/fair audits, and limitations on audit contractors using extrapolations that create assumptions of additional overpayment.

Regarding other areas of the bill, in Section 18 on page 22, we suggest a wording change. Lines 24 – 27 of the bill say that a primary care case management system or managed care organization should “increase the use of primary and preventive care.... While decreasing the use of specialty care and hospital emergency department services.” We suggest amending that section to read “...decreasing the use of **unnecessary** specialty care and hospital emergency room services.” This reflects the intent of decreasing unnecessary care, rather than decreasing necessary care.

We fully support enhanced use of the prescription drug database and we support efforts to increase participation in the program. We are concerned that in some hospital-based contexts, it is not always possible for physicians, pharmacists or their agents to check the patient's prescription record before dispensing, prescribing or administering a controlled substance. A specific example would be emergent trauma care.

We suggest eliminating Sec. 19 (e) (page 23) as duplicative. Section 20 (47.07.039, page 25) addresses the projects contemplated in Sec. 19 (e) in much more detail. We appreciate the work that went into crafting the language in Section 20 and we fully support moving forward under this framework.

Again, I want to express our appreciation for the significant work done in crafting this legislation. We look forward to working further with the committee to continue the difficult, yet important work of health care reform.

Thank you for your time. I would be happy to answer any further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Becky Hultberg", written in a cursive style.

Becky Hultberg, President/CEO



Alaska Psychological Association

Advancing psychology as a science, a profession, and a means of promoting health and welfare

February 25, 2016

Senator Pete Kelly, Co-Chair
Senator Anna MacKinnon, Co-Chair
Senate Finance Committee
Alaska State Capitol Building
Juneau, AK 99801-1120

RE: Proposed Medicaid Reform Legislation- Revising Sec. 22. AS 47.07.900(4)

Dear Senate Finance Co-Chairs and Members of the Committee:

The Alaska Psychological Association (AK-PA) was formed, as a member based entity to advance psychology as science, profession and as a means for promoting human welfare in Alaska. As part of our larger charge to the people of Alaska we have been heavily invested in the process of Medicaid reform and implementing truly comprehensive and integrated healthcare that promotes the health and welfare of citizens and also reduces costs.

We believe that the intent of the proposed legislation is to provide for needed access to both primary care as well as behavioral health services, with the goal of making services available to those with lower levels of need, so that more expensive, "deep-end" services (e.g., inpatient hospitalization, ER visits) can be avoided. In addition, there is research that demonstrates that providing access to behavioral health services is effective in reducing the overall costs of healthcare, as the majority of patient visits to primary care settings have an emotional component, patients struggle with making the needed lifestyle changes that will allow them to manage chronic diseases and illnesses, and much mental illness goes untreated in the current system.

Medicaid programs should recognize and consistently cover basic, medically necessary mental health services provided by licensed mental health professionals, allowing them to practice within the scope of their respective licenses. This will promote patient choice of provider, and allow Medicaid patients to access the range of mental health services available to patients in the private sector.

If it is the intent of the Legislature to allow for the provision of clinical services by independently licensed mental health providers (i.e., psychologists, licensed psychological associates, LCSWs, LPCs, LMFTs), we recommend that Sec. 22. AS 47.07.900(4) be amended to read: *"4) 'clinic services' means services provided by state-approved outpatient mental health clinics, state-operated community mental health clinics, outpatient surgical care centers, physician clinics, medical clinics/primary care settings, and mental health services provided by licensed mental health professionals that fall under their scope of practice as defined by relevant Alaska statute."*

We strongly believe that eliminating unnecessary restrictions on the practice of mental health professionals by allowing them to provide and be reimbursed for their full scope of services is vital to the success of health reform in Alaska.

Our association hopes that you consider this revision. Please consider us as a resource.

Respectfully,

A handwritten signature in blue ink, appearing to read "Michael Sobocinski", written over a horizontal line.

Michael Sobocinski, PhD
President, Alaska Psychological Association

cc: Members of Senate Finance Committee
Valerie Davidson, Commissioner, DHSS
Randall Burns, Division of Behavior Health, DHSS
Jeff Jessee, Mental Health Trust



Alaska Psychological Association

Advancing psychology as a science, a profession, and a means of promoting health and welfare

February 25, 2016

Senator Pete Kelly, Co-Chair
Senator Anna MacKinnon, Co-Chair
Senate Finance Committee
Alaska State Capitol Building
Juneau, AK 99801-1120

RE: Proposed Medicaid Reform Legislation- Sec. 17. AS 47.05, Defining Sec. 47.05.270. (e)

Dear Senate Finance Co-Chairs and Members of the Committee:

The Alaska Psychological Association (AK-PA) was formed, as a member based entity to advance psychology as science, profession and as a means for promoting human welfare in Alaska. Psychology as a profession recognizes and welcomes the expanding role of technology in the provision of needed psychological services and the continuous development of new technologies that may be useful in the practice of psychology. These practices represent both new opportunities as well as very real challenges to the provision of services that recognize the geographical and cultural richness in a state such as Alaska.

Telemedicine practice is a highly complex service, and guidance to professionals is in a continual state of change. As is the case with other professional healthcare disciplines, the American Psychological Association has published a set of practice guidelines for the practice of telepsychological services, the Guidelines for the Practice of Telepsychology. These highlight the complexity inherent in telehealth: "The practice of telepsychology involves consideration of legal requirements, ethical standards, telecommunication technologies, intra- and interagency policies, and other external constraints, as well as the demands of the particular professional context."

Issues related to the provision of psychological services across jurisdictional boundaries have not been resolved. Again, as noted by the American Psychological Association, "Psychological service delivery systems within such institutions as the U.S. Department of Defense and the Department of Veterans Affairs have already established internal policies and procedures for providing services within their systems that cross jurisdictional and international borders. However, the laws and regulations that govern service delivery by psychologists outside of those systems vary by state, province, territory, and country (APAPO, 2010)." AK-PA believes that these issues will require additional deliberate review so that telehealth services are provided in a competent and ethical manner that is responsive to the unique needs of the individuals being served. Protecting the welfare of the consumers of these services is a critical aspect of the implementation of telemedicine services.

Therefore, as the State of Alaska and the Alaska Legislature undertakes Medicaid Reform, we would like to take this opportunity to advocate for a specific statute change. The statute, **AS 47.05**, defines the practice of "telemedicine." Because of the inherent complexity of the issues relate to the ethical and competent delivery of telemedicine services and the need to ensure that Alaskans are provided high-quality care that is responsive to

the unique needs of Alaskans, and to protect the welfare of Alaskans being served through telemedicine services, **our association recommends adding the following requirement (in bold):**

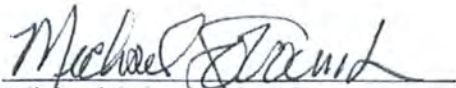
Sec. 47.05.270. Medical assistance reform program.

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

We believe that adequate regulatory oversight of telemedicine services in Alaska requires that the respective licensing boards be authorized to ensure that services provided meet the standard for professional practice established in Alaska, until such time as national guidelines and standards are in place that can guide the practice of this mode of service delivery.

Our association hopes that you strongly consider this revision. Please consider us as a resource.

Respectfully submitted,



Michael Sobocinski, PhD
President, Alaska Psychological Association

cc: Members of Senate Finance Committee
Valerie Davidson, Commissioner, DHSS
Randall Burns, Division of Behavior Health, DHSS
Jeff Jessee, Mental Health Trust



Quality Community Behavioral Health Services Since 1985

"We help adults with mental illness live their own best lives"

**Public Testimony on CS for SB 74
February 25, 2016**

Senators Kelly and MacKinnon, Co-Chairs and
Committee Members
Senate Finance Committee
Alaska Legislature
State Capitol
Juneau, Alaska

As a provider of both mental health and substance use disorder treatment services for over 30 years, I have a long-term commitment to ensuring that the organizations I lead are efficient, effective, innovative, provide the highest quality care, and achieve targeted outcomes, to serve those who need our services.

As you make decisions about Medicaid Expansion, reform bills, and the budget closeout process please keep in mind 3 points:

1. Changes aimed at increasing access to services, including the possibility of eliminating the current requirement that providers have a behavioral health grant as a condition of eligibility to bill Medicaid will decrease oversight and accountability of providers. This will broaden the potential for intentional or unintentional Medicaid fraud, waste, and abuse. Where would the monitoring control of all these new providers come from and what might be the costs involved?
2. As much as I would like a streamlined grant system, another concern is that the current system ensures that state designated Community Behavioral Health Centers have to serve everyone who is in need of treatment, regardless of ability to pay. We are required to have sliding fee scales for self-pay clients and we can't just accept persons for whom we might think provide us the greatest ability to bill for the most lucrative services.
3. If everyone can bill Medicaid, there will be an increased vulnerability to the system of care for "cherry picking" those persons whose needs will produce the greatest revenue, and declining to serve those who have no payor source or very limited resources and who need services that have reimbursement rates that don't reflect the true cost of providing those services. Often, the latter are some who are in the greatest need of mental health services.

Please consider these points as you move forward in your decision making process. Again, thank you for the hard work you are doing for all Alaskans.

Pamela Watts
Executive Director
Juneau Alliance for Mental Health, Inc.

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Juneau, Alaska 99801

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Quality Community Behavioral Health Services Since 1985

*"We help adults with mental illness
live their own best lives"*

February 24, 2016

Senators Pete Kelly and Anna MacKinnon
Co-Chairs, Senate Finance Committee
State Capitol
Juneau AK, 99801

Subj: Medicaid Expansion and Reform Bills (SB78, SB74, HB148, HB227)

Dear Senators Kelly and MacKinnon:

As a provider of both mental health and substance use disorder treatment services for over 30 years, I have a long-term commitment to ensuring that the organizations I lead are innovative, accountable, and provide the highest quality of care while operating efficiently and effectively. We strive toward excellence using Best Practices and innovation. We measure our outcomes to achieve the best possible results with available resources.

As Medicaid Expansion and reform bills and the budget closeout process moves forward, and decisions are made about systems of care and allocations of resources, please keep in mind the following important considerations:

1. Changes aimed at increasing access to services, including eliminating the requirement that providers have a behavioral health grant as a condition of being eligible to bill Medicaid, will decrease oversight and accountability of providers. This will broaden the potential for intentional or unintentional Medicaid fraud, waste, and abuse. Where would the monitoring control of all these new providers come from?
2. Removing the grant requirement so that anyone could provide behavioral health services will allow new providers to "cherry pick" who they see and what services they provide. Comprehensive community behavioral health centers serve a predominantly low or no-income clientele and those who are un-resourced (most of whom are charged on a sliding fee scale with less than 5% of actual cost of care recovered). They provide care for the most high-acuity, seriously mentally ill, chronic alcoholics/addicts, and severely emotionally disturbed youth – Alaskans often requiring community based case management services and requiring services from the Psychiatric Emergency Services programs. They are able to provide this level of comprehensive care with the limited resources available, in part, because they are currently able to balance higher cost services with more profitable services. If the grant requirement is lifted and competition grows for the more profitable services, a tipping point will seriously threaten the comprehensive behavioral health provider's ability to maintain high-acuity, high cost care.
3. How will the state ensure that a system of care remains available for those who most need it as grant funding is reduced and there is no longer a sufficient economy of scale for non-profit providers to offer a continuum of care, services that no one else wants to take on?

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4. The services that are provided by Community Behavioral Health Centers and substance abuse treatment programs are essential to providing a safety net to keep people from defaulting to the Correctional system, Public Safety, Office of Children's Services, Emergency Departments, homeless shelters (if they exist), or other entities/systems where the true cost of caring for them would far exceed the investment in these behavioral health services.
5. Finally, innovative practices have been or are being implemented across the state that have already shown results or show significant promise to address multiple problems and reduce overall costs. Some of these include:
 - Housing First – provides housing and support services to chronic, late-stage alcoholics who have cycled through emergency rooms, hospitals, and jails. Reduces burden on Public Safety, hospitals, courts, and Corrections.
 - Integrated Primary Care Behavioral Health Clinics – persons with serious mental illness, co-occurring disorders, histories of trauma, and chronic health/medical conditions receive one-stop shop services designed to improve overall wellness, reduce expensive medical care and psychiatric hospitalizations, and increase independence in community.
 - Partnerships with the Court System to reduce costs – Community Behavioral Health Centers, substance abuse treatment providers, and others are diligently working with the Court System to mitigate correctional costs by offering specialty courts as an alternative to incarceration. Persons with mental illness or substance use disorders can choose treatment over incarceration, helping keep people out of our overcrowded prisons and reducing the likelihood of recidivism. Community Behavioral Health Centers also partner with Corrections to provide pre-and post-release behavioral health services to incarcerated seriously mentally ill adults to help make their transition back into the community successful to reduce recidivism.

These and other programs provided by state grantees could be lost if funding is cut too drastically and/or there is no grant requirement or other stringent oversight required for behavioral health Medicaid providers. I realize that you have a difficult task and deeply appreciate your diligence and hard work. If you have any questions or require more information, please don't hesitate to contact me.

Respectfully,



Pamela Watts

Executive Director

Juneau Alliance for Mental Health, Inc.

Doniece Gott

From: Erin Shine
Sent: Thursday, February 25, 2016 2:04 PM
To: Doniece Gott
Subject: Fwd: SB 74 and the AK PDMP

From: anne <annezink@gmail.com>
Date: February 25, 2016 at 1:50:59 PM AKST
To: <senate.finance@akleg.gov>, Erin Shine <Erin.Shine@akleg.gov>
Cc: Carl Heine <heine.carl@gmail.com>, Becky Hultberg <becky@ashnha.com>, Andy Elsberg <elsberga@gmail.com>, Regan and Ben Brooks / Shelton <benjamin.shelton@me.com>, Pauline Proulx <plp@wsma.org>
Subject: Fwd: SB 74 and the AK PDMP

Esteemed Members of the Senate Finance Committee,

Thank you for including ACEP (Alaska College of Emergency Physicians) in the review of Medicaid structure and all of your work and effort on this important bill. In general we are very supportive of the bill as you wrote it. We appreciate all of the support regarding mental health, substance abuse, access to primary care and improved care management as well as support of the Prescription Drug Base.

If we may suggest some amendment to the legislation that might accomplish the goal of having increased use of the data base, but also may prevent the legislation for unintended risk (like not stabilizing a trauma patient who needs an emergent CT but can not hold still because of pain). By saying "reviewing information" it would allow a practitioner to review what was pushed to us, or pulled by a delegate rather than personally accessing the data base. We also fear that if you leave it the way it is, it may also affect EMS as they may not be able to give a narcotic to a patient with a broken leg as part of a long transport. The other area the inpatient setting, if you have a series of providers (like hospilist) administering medication, it is unclear if the data base would have to be accessed every time by the provider, or anesthesiologist before giving meds before every case. We would also mention, that there are varying views from the ED physicians regarding any mandate regarding accessing the data base all together. Some feel it makes sense for prescribing, others feel like this is very limiting. Regardless, making it mandator for administering controlled substance is very problematic. Dr. Heine was also able to testify regarding this topic to this today.

We would suggest either taking out the mandate all together or changing it to something like this:

Page 14 Lines 6 - 9

(4) that a pharmacist or practitioner shall [access the database] **review the information in the data base** to check a patient's prescription records before dispensing or prescribing [or administering] a controlled substance to the patient. **It is recommend that the data base be accessed prior starting administration of controlled substances, but recognizes that emergent patient care must come first.**

Regarding the rest of the ED bill here are some other changes that we would suggest to clarify the language to really see the benefits that Washington State found.

Page 25 / 25 lines 15 -31 / 1-12

Sec. 47.07.038. Collaborative, hospital-based project to reduce use of emergency department services. (a) On or before December 1, 2016, the department shall collaborate with a statewide professional hospital association to establish a hospital-based project to reduce the use of emergency department services by medical assistance recipients. The statewide professional hospital association shall operate the project. The project may include shared savings for participating hospitals. The project must include

(1) an **interdisciplinary** process for defining, [and] identifying and **minimizing** frequent users of emergency department services,

(2) to the extent consistent with federal law,

(A) a system for **real time** electronic exchange of patient information, **including but not limited to recent emergency department visits, hospital care plans for frequent utilizers and data from the Prescription Drug Data Base** [among emergency departments];

[(B) a process to disseminate lists of frequent users to hospital personnel to ensure that frequent users can be identified through the electronic information exchange system] ; - (I would remove all of B if included in A)

(3) a procedure for educating patients about the use of emergency departments and appropriate alternative services and facilities for nonurgent care;

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

(5) [strict] guidelines **that are uniform throughout the state** for prescribing narcotics **from the emergency department**;

[(6) a prescription drug monitoring program; and] - (it seems as though this should come out as it is covered elsewhere)

(7) designation of medical personnel to review (feedback reports) **success and challenges** regarding **appropriate** emergency department use.

(b) The department shall adopt regulations necessary to implement this

section, request technical assistance from the United States Department of Health and Human Services, and apply to the United States Department of Health and Human Services for waivers or amendments to the state plan as necessary to implement the projects under this section.

Thank you all for you time and including us as part of this discussion, I can't explain how excited I am to help implement these changes and make our system more efficient, save the state money and improve care for our patients.

Anne

Anne Zink, MD, FACEP
Emergency Medicine Medical Director Mat-Su Regional Hospital, Palmer Alaska
Alaska ACEP President
annezink@me.com
907-315-5991

Tom Chard

Executive Director

Alaska Behavioral Health Association (ABHA)

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24 February 2016

Senator Anna MacKinnon
Chair, Senate Medicaid Reform Committee
State Capitol Room 516
Juneau AK, 99801

Re: Lifting the Grant Requirement for Behavioral Health Services

Senator MacKinnon,

The Alaska Behavioral Health Association (ABHA) is a member-driven, non-profit with leadership representing over 50 member organizations including both tribal and non-tribal publicly funded, private corporations that span the system of care from infants to the elderly, in urban and rural settings across Alaska. The Association was formed in 1996 to help improve the delivery of substance abuse and mental health treatment services in Alaska.

The behavioral health providers sincerely appreciate the committee's ongoing efforts and the attention paid to reforming Alaska's Medicaid system. We are especially thankful for the invitations we have received to participate throughout the development of the reform recommendations.

The Governor's Medicaid Expansion and Reform Bills ([HB148](#) and [SB78](#)), Representative Seaton's Reform Bill ([HB227](#)), and the Agnew Beck Report ([Recommended Medicaid Redesign + Expansion Strategies for Alaska](#)) all make the recommendation to lift the grant requirement to be able to be reimbursed by Medicaid for behavioral health services. It has been stated that the main motivation behind the recommendation is to increase access to available behavioral health services. This provision will essentially allow anyone (not just "a nonprofit corporation, a city or borough government, or other political subdivision of the state") to be reimbursed by Medicaid for behavioral health services.

The Alaska Behavioral Health Association has some questions and concerns about the potential unintended consequences of lifting the grant requirement to be able to be reimbursed by Medicaid for behavioral health services.

In short, this law has been in statute for decades and has fundamentally shaped our system of care. When asked, it does not appear that those wishing to remove the requirement have a good understanding of why the law was in place to begin with or what the potential unintended consequences might be should the requirement be removed. The Alaska Behavioral Health Association suggests that the decision to reverse this long-standing statutory requirement might be considered separately from the rest of the reform recommendations.

We are neither for nor against the provision, but simply suggest more thorough discussion.

Some likely impacts (with consideration) follow based on discussion to date that the behavioral health providers have held on potentially removing the grant requirement.

- Lifting the grant requirement may improve access to treatment for clinical services in more urban areas. Beneficiaries enrolled in the Medicaid program based on income, rather than disability, would most likely be accessing clinical behavioral health services. The potential impact on rehabilitative behavioral health services, particularly in more remote settings, is less certain.
- Smaller, remote communities have raised concerns about private, for profit, niche providers taking the more profitable service lines and leaving comprehensive community providers with the loss leaders (who typically require more intensive and costly services). This may result in either a limitation on the services available to the community, closed treatment programs, or worse – providers closing. Ideally, there would be agreements between providers in these communities to safeguard against this and help ensure that the clients get the services they need, but there is no requirement or guarantee that this happen.
- It is unclear what impact this will have on the State's overall Medicaid behavioral health services budget.
- We are not certain what impact this will have on the comprehensive community provider's ability to recruit and retain necessary workforce. Right now teams of providers work under the authority of a Community Behavioral Health Centers (CBHC). These providers already struggle to recruit and retain the workforce necessary to meet their community's behavioral health needs.
- The grant program is the only quality assurance control on behavioral health treatment services. The MMIS billing and payment system does not have the capability to track clinical quality outcomes. In part, this may lead to a race to the least costly provider (regardless of treatment efficacy). There will not likely be a level playing field when it comes to different providers.
- The grant requirements involve an enormous amount of reporting to a system focused on managing processes (instead of outcomes). Several providers have mentioned that lifting the grant requirement will allow them the opportunity to weigh the amount of grant funding they receive from the state against the relative effort and expense involved in order to make the decision of whether or not to forego the grant (this is especially true as we are refinancing our system of care to one more reliant on Medicaid).

Proponents of lifting the grant requirement have suggested that the Centers for Medicaid and Medicare (CMS) view the requirement as an impediment to access to behavioral health care. It is unclear how an Alaskan law that has been in statute for so long all of the sudden became an urgent concern. Given some of the potential unintentional impact, some of which is stated above, ABHA is not certain that simply lifting the grant requirement would not cause more harm than good – even to access.

Certainly more discussion would help uncover the far-reaching impact of the decision of whether or not to remove the grant requirement and would help avoid or mitigate any unintended consequences.

The Alaska Behavioral Health Association (ABHA) continuously strives to improve the efficiency and effectiveness of behavioral health treatment services in Alaska. Please feel free to contact us if there is any additional information that would be helpful to you as you consider this important provision.

Sincerely,



Tom Chard

Alaska Behavioral Health Association (ABHA)

Alaska State Legislature

SENATOR PETE KELLY

SESSION:

Alaska State Capitol
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Sponsor Statement – CS Senate Bill 74 (STA)

“An Act 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 eligibility for medical assistance; relating to a medical assistance reform program; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to civil penalties for medical assistance fraud; relating to studies by the Department of Health and Social Services; relating to cost-containment measures for medical assistance; and providing for an effective date.”

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 4). This program requires the Department of Health and Social Services to expand the use of telemedicine, significantly 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, and more. Reforms and costs containment to the Medicaid program will also be accomplished through two new demonstration projects through the Centers for Medicaid and Medicare Services (Sections 6 and 8).

Fraud prevention is further enhanced by adding civil penalties and damages for knowingly submitting false Medicaid payment claims (Section 3). The new damages and penalties set out in CSSB 74 are in addition to other legal remedies the State of Alaska and DHSS has available to utilize. The legislature would now receive an annual report relating to Medicaid fraud, abuse, errors, and vulnerabilities from DHSS and the attorney general (Section 7).

CSSB 74 directs DHSS to initiate one or more managed care or case management demonstration project for individuals enrolled in the Medicaid program (Section 8). Managed care is frequently maligned as dis-incentivizing proper or appropriate care. Rather, health plan management has shown that it actually improves care outcomes, grants better, appropriate access and saves money. Most states employ some form of managed care in their Medicaid programs. It works much like traditional health insurance where a Medicaid member becomes a subscriber in the health plan and the plan is paid by the state Medicaid office via a capitated rate, a global rate or a pass through on fee for service billings. The state then invoices the federal government and is paid at the prevailing Medicaid rate. This is relatively simple to implement and there are many examples of successful implementations across the nation. According to the Kaiser Family Foundation, thirty-nine states now contract with comprehensive managed care organizations (MCOs) to serve at least some Medicaid beneficiaries, and nationally, over half of all Medicaid beneficiaries get their care through these plans. Alaska can no longer afford to be one of the outliers.

The new reform program will also look at payment redesign (Section 4). 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, the other and largest government payer. These innovations frequently streamline the payment process, eliminate billing and payment irregularities and eliminate payment errors. In addition to Medicare, many insurance carriers and 47 of 50 states employ the Diagnosis Related Group (DRG) Medicaid payment mechanism and two others were in stages of implementation by July 2015. There are several other payment blueprints in place in other states that can be employed.

The use of telemedicine for primary care and urgent care will also be expanded under CSSB 74 (Sections 4 and 8). A study by Alaska Native Tribal Health Consortium (ANTHC) found telemedicine averted the need for travel in 40% of cases reviewed using telemedicine. ANTHC is leading the state's charge on telemedicine, and should be built on for even greater access statewide.

CSSB 74 begins the process to explore privatization (Section 9). 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 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. SB 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

SENATOR PETE KELLY

SESSION:
Alaska State Capitol
Juneau, AK 99801
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Explanations of Changes – CSSB 74(STA)

“An Act 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 eligibility for medical assistance; relating to a medical assistance reform program; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to civil penalties for medical assistance fraud; relating to studies by the Department of Health and Social Services; relating to cost-containment measures for medical assistance; and providing for an effective date.”

Version H to Version S (SHSS)

- Removed sections regarding health savings accounts (HSAs) for Medicaid beneficiaries and contributions to HSAs from the Permanent Fund Dividend.
- New Section 1 regarding false Medicaid claims and establishing civil penalties for fraud.
- Section 2
 - Added behavioral health for the expanded use of telemedicine (Page 3, line 14)
 - Changed the report due date to October 15 in subsection (c) (Page 4, line 7)
 - Expanded the report scope under subsection (c) regarding Medicaid reforms, savings, and costs (Page 4, line 11 through Page 5, line 9)
 - Added in a definition of “telemedicine” (Page5, lines 10-14)
- New Section 4 requiring an annual report to the legislature regarding DHSS efforts to reduce Medicaid fraud.
- Section 5
 - Allows the demonstration project to be focused on Medicaid managed care or case management
 - Changes the one or more demonstration projects from individuals enrolled in the Denali KidCare program to the entire Medicaid program.
 - Changed the start date to January 31, 2016
 - Requires the department to enter into contracts with one or more third-party for the demonstration projects.

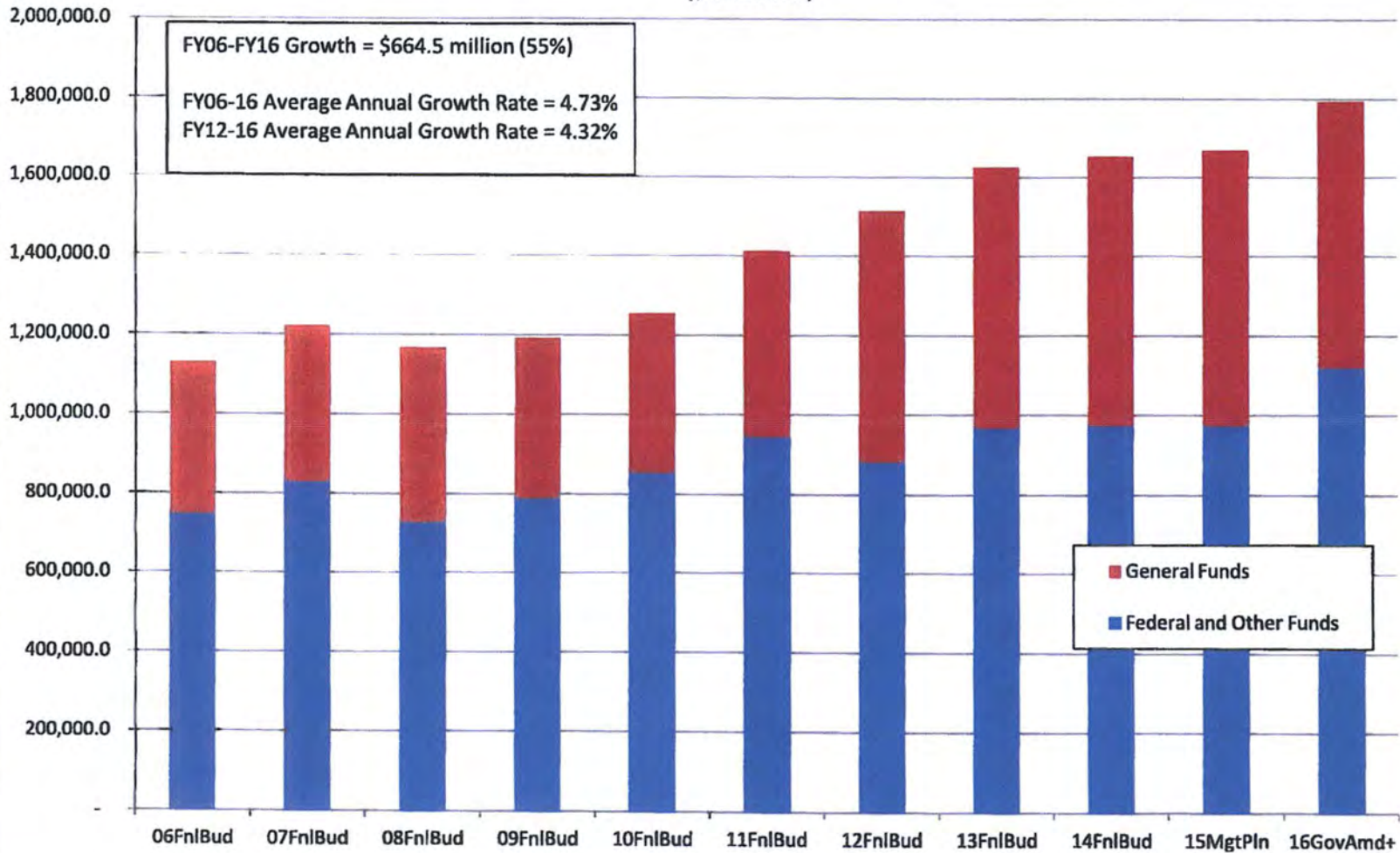
Version S to Version F (SSTA)

- Expanded the title of the bill on Page 1, lines 1 – 8 to include “An Act 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 eligibility for medical assistance”
- New Section 1 – Page 1, line 10 through Page 2, line 3
 - This sections allows 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.
- New Section 2 – Page 2, lines 4 through 16
 - Subsection (a) directs the department to establish a computerized income, asset, and identity eligibility verification system for the purpose of verifying eligibility, eliminating duplication of public assistance payments, and deterring waste and fraud in public assistance programs.
 - Subsection (b) directs the department to enter into a competitively bid contract with a third-party vendor for the eligibility verification system. The department may also contract with a third-party vendor to provide information to facilitate reviews of recipient eligibility conducted by the department.
- Section 4 (Section 2 in Version S)
 - Page 4, line 14 through 22 – (8) redesigning the payment process - Changes specifically list payment reforms that should be included:
 - (A) premium payments for centers of excellence;
 - (B) penalties for hospital-acquired infections, readmissions, and outcome failures;
 - (C) bundled payments for specific episodes of care; and
 - (D) global payments for contracted payer, primary care managers, and case managers for a recipient or for care related to a specific diagnosis
 - Page 6, Lines 7 & 8 – adds new (14) to the annual report related to Medicaid reform. DHSS will also report on the cost, in state and federal funds, for providing optional services under AS 47.07.030(b), the Medicaid program
- New Section 5 – Page 6, lines 14 through 19
 - Requires the legislature to approve any new additional groups added to the Medicaid program on or after March 23, 2010
- Section 12 – (Section 9 in Version S)
 - At the request of Legislative Legal, made technical fixes to the conditional effect language in Subsections (a) through (e) by replacing “that section” with the specific provision reference of the bill
- Made conforming changes to renumber sections and references to specific sections

MEDICAID APPROPRIATIONS

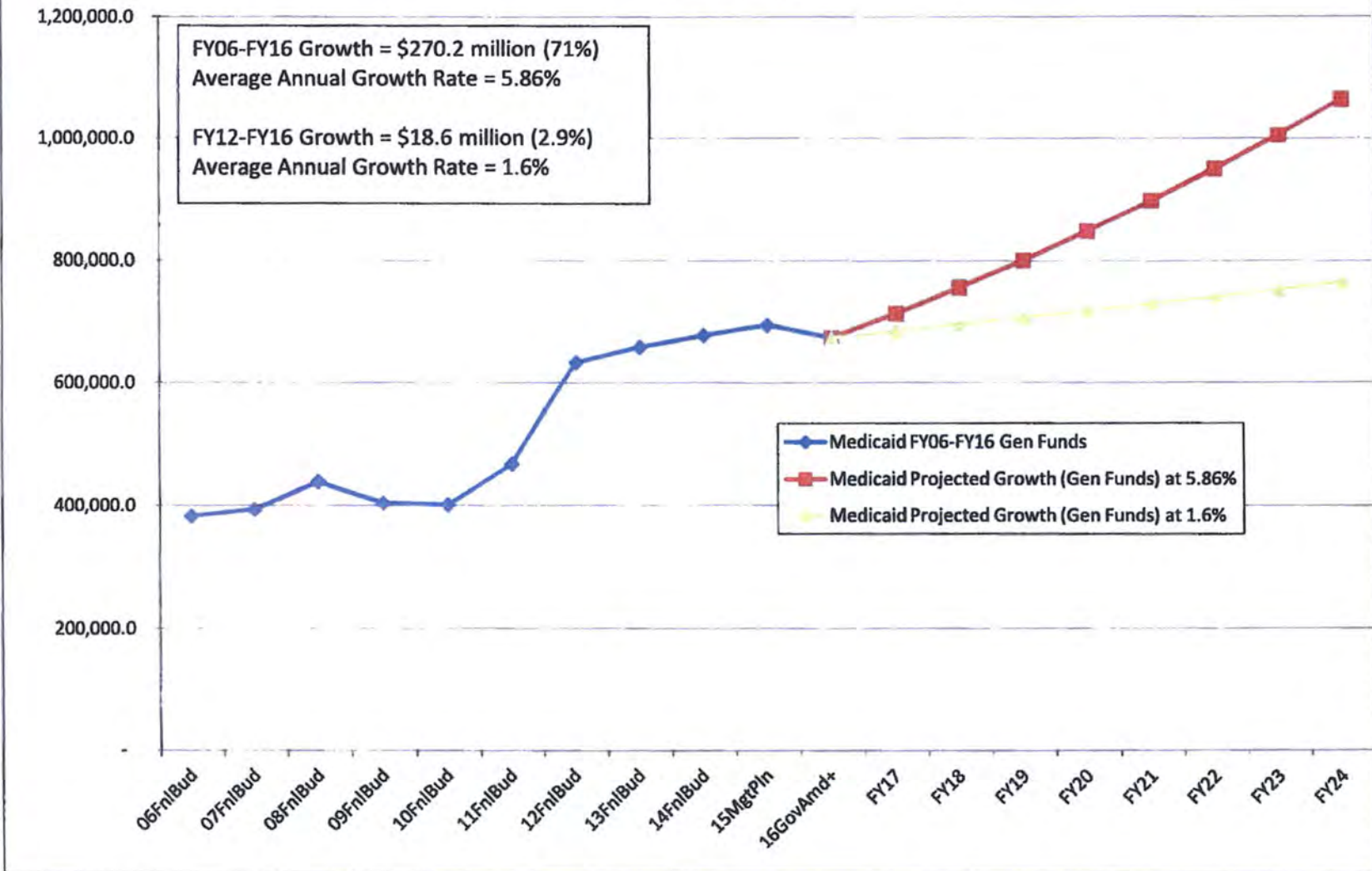
(All Funds)

(\$Thousands)

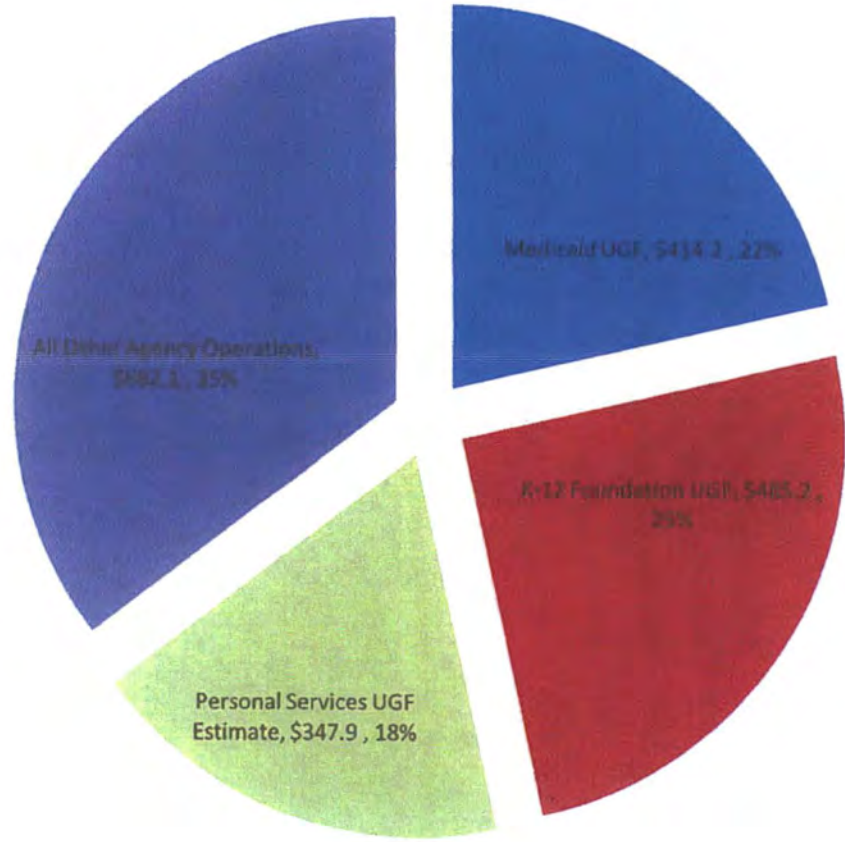


Historical and Projected Medicaid Growth

(GF Only)
(\$Thousands)



**Cost Drivers--Agency Operations
Contribution to Budget Increases FY06-FY15 (\$ millions)
\$1.9 Billion Total UGF Increase**





March 27, 2015

Senator Pete Kelly
State of Alaska Legislature
120 4th Street
State Capitol Room 156
Juneau, Alaska 99801

RE: Value of Medicaid Managed Care

Dear Senator Kelly,

Aetna Medicaid applauds the Alaska State Legislature for taking the time to consider the value of a Managed Medicaid program for the State. Aetna has been a leader in Medicaid managed care since 1986 and currently serves nearly three million members across 16 states. We have more than 28 years of experience in managing the care of the most medically fragile and vulnerable populations, using innovative approaches to achieve successful health care results and favorable cost outcomes.

Medicaid Managed Care is a proven vehicle to achieve the reform mandates that the State of Alaska is trying to achieve. The purpose of this letter is to share the value of managed care. We recognize that the State of Alaska is unique in geography, population, and healthcare needs, and so we offer our experience from other unique states across our nation that have shown Medicaid managed care to be a consistent pathway to achieve high quality integrated healthcare while controlling costs.

National Trends and Medicaid Managed Care Overview

Medicaid is the single largest source of health coverage in the U.S., with over 60 million beneficiaries and \$450 billion in annual spending.¹ A staggering one-fifth of the total US population is enrolled in Medicaid today, consuming 15% of all national health expenditures. Within the next 10 years enrollment will reach 80 million enrollees with an \$850 billion annual price tag.²

States are not exempt from these tremendous growths in enrollment and costs. Here in Alaska, total Medicaid spending is approximately \$1.6 billion annually and is projected to double in the next 10 years.³ Uncontrolled growth in Medicaid diverts dollars that otherwise could be invested in education, infrastructure, and other priority initiatives. States across the country facing extreme budget pressure are increasingly turning to capitated managed care for a solution to achieve budget predictability, quality assurance, access to care, ease of navigation, and integrated whole-person healthcare - the goals this Group is charged with.

Currently, thirty-eight states and Washington, D.C. contract with Medicaid Managed Care Organizations (MCO) to deliver care to beneficiaries in their states. Today roughly two thirds of all Medicaid

¹ <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf#page=9>

² <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf#page=10>

³ http://dhss.alaska.gov/fms/Documents/MESA/MESA_2012-32.pdf#page=28

beneficiaries receive some form of care through an MCO.⁴ This figure will grow to 75% by 2015.⁵ Over 70% of Children's Health Insurance Plan beneficiaries are receiving their services through Medicaid health plans.⁶ The clear nationwide trend of moving to Medicaid managed care models signals the value states are receiving from MCOs. Alaska should weigh the potential benefits as they relate to the Reform Advisory Group's goals.

2/3 of all Medicaid beneficiaries receive care through an MCO

Benefits of Managed Care

Matching the benefits of managed care to Alaska's reform goals

1. Stability and Predictability in Budgeting

Risk-based managed care transfers financial risk away from the state budget and places it directly on MCOs. As a result, state funds are not subject to the variability and overruns that arise under a fee-for-service (FFS) model, creating a more stable and predictable budget.

Additionally, states have reported cost savings under Medicaid managed care models. A 2010 industry report found that over an eight-year period states could save up to 5% of FFS costs by enrolling children and low-income families in Medicaid managed care, and could realize up to 8% in savings over current costs by expanding managed care to seniors and people with disabilities.⁷ This study also found that Alaska could save \$260 million over the same period.⁸ A separate well known survey of 24 states, completed by The Lewin Group, found that each state saved from half of one percent up to twenty percent through managed care.⁹ Medicaid health plans saved Pennsylvania \$5.0-\$5.9 billion over a 10-year period, and Kentucky is on track to see \$1.3 billion in savings after moving over 500,000 beneficiaries from FFS to managed care.^{10,11} A 2012 report by the Robert Wood Johnson Foundation indicated that states which find most value from managed care are those with the highest Medicaid FFS reimbursement rates, and the rates here in Alaska are the highest in the nation.¹²

Cost savings can also be achieved through significant reduction in fraud, waste, and abuse. CMS reports show that payment error rates for Medicaid FFS are significantly higher than those in Managed Care.¹³ For example, the FY2013 payment error rate for Medicaid FFS was 3.6% compared to Managed Care's 0.3% - a \$6.6 billion difference.¹⁴

2. Increasing the ease and efficiency of navigating the system

Managed care models help both providers and beneficiaries navigate a traditionally complex and fragmented health care system. MCOs, for example, specialize in provider relations. Most state Medicaid managed care contracts require MCOs to have dedicated staff to liaison with providers for educational purposes and the resolution of issues. Direct face-to-face partnership with the provider community increases the ease and efficiency with which providers navigate the system.

⁴ <http://www.gao.gov/assets/670/663306.pdf#page=13>

⁵ <http://avalara.com/expertise/managed-care/insights/analysis-medicaid-plans-expected-to-grow-20-this-year-under-aca-expansion>

⁶ http://www.mhpa.org/_upload/Medicaid%20Managed%20Care%20Primer%20February%202013.pdf#page=2

⁷ <http://www.unitedhealthgroup.com/~media/UHG/PDF/2010/UNH-Working-Paper-3.ashx#page=59>

⁸ <http://www.unitedhealthgroup.com/~media/UHG/PDF/2010/UNH-Working-Paper-3.ashx#page=30>

⁹ Lewin Group, "Medicaid Managed Care - A Synthesis of 24 Studies," July 2004, Updated March 2009, accessed at <http://www.lewin.com/publications/Publication/395/>

¹⁰ Lewin Group, "An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program," May 2011

¹¹ Gov. Beshear, "Aggressive Action Plan for Managed Care Paying Off", accessed at <http://migration.kentucky.gov/newsroom/governor/20131024managedcare.htm>

¹² http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106/subassets/rwjf401106_1#page=2

¹³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/PERM-MedicaidErrorRates.pdf>

¹⁴ <http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf#page=175>

Under a managed care model, MCOs are further able to eliminate fragmentation by investing in and implementing provider information systems where health care professionals can easily and quickly file claims, receive payments, and access necessary information. Most MCOs have the advantage of bringing years of national experience in managing provider concerns and needs through their information systems' platforms to provide a seamless system that enables providers to focus their time on what they do best - caring for their patients.

Managed care also improves navigation of the healthcare system for beneficiaries by increasing access to quality healthcare.^{15,16} A core competency and requirement of an MCO is to contract with the provider community to form a network of healthcare professionals that members can access. In a FFS delivery system, Medicaid beneficiaries often have difficulty finding providers willing to treat them. Estimates suggest that only about half of primary care providers nationally are accepting new Medicaid patients.¹⁷ Under a risk-based managed care model, states can address this access problem by requiring MCOs to meet specified network adequacy standards for primary and specialty care that can include requirements such as state-determined minimum provider-to-population ratios, distance travel time maximums, and limits on appointment wait times. Compared to FFS models, MCOs have greater flexibility to structure provider contracts to incentivize provider participation in areas where access to care is a particular concern. MCOs have provider directories and toll-free phone lines to assist enrollees in finding a provider. If an enrollee needs to see a specialist, a MCO will facilitate access to that service and provide transportation if necessary. A Kaiser Commission study found that improved access to care was one of the biggest benefits states cited in their use of managed care over FFS.¹⁸

3. Providing whole care for the patient by uniting physical and behavioral health treatment

Aetna Medicaid agrees with the Reform Group's goal of achieving integrated, whole-person care. Most healthcare providers and MCOs would agree that a successful delivery system model must consider a beneficiary's physical, behavioral and psychosocial needs to be effective. Aetna Medicaid, for example, has developed the Integrated Care Management (ICM) model that looks at the totality of each member's needs to determine both root cause and proximate cause of health care issues. The goal of our ICM model, regardless of the member's physical or behavioral health needs, is to provide them with the right care, in the right place, at the right time.

Managed care organizations also create a "medical home" by coordinating care with beneficiaries, their families, and their physicians. They support physician practice management systems that emphasize prevention, early diagnosis, treatment, and coordinated management of whole-person care. This integrated approach to providing care isn't feasible under a disjointed FFS model.

Improved Outcomes through Accountability

Quality assurance and quality improvement is one of the most significant benefits of Medicaid Managed Care. According to the Medicaid Health Plans of America, an industry trade association, 25% of Medicaid health plans have achieved accreditation through the National Committee for Quality Assurance (NCQA).¹⁹ Federal regulations require annual quality reviews of Medicaid health plans and specify state oversight expectations. Most states conduct additional reviews of Medicaid health plans to ensure that they meet state rules and regulations in areas such as utilization review and grievances and appeals. Medicaid health plans are required to report performance measures, such as HEDIS, to the state. These performance measures provide valuable data to health plans, states, researchers, and policymakers for

¹⁵ <http://dss.mo.gov/mhd/oversight/pdf/ffs-mgdcare10feb18.pdf#page=39>

¹⁶ <http://www.ncbi.nlm.nih.gov/pubmed/16679438>

¹⁷ Peter Cunningham and Ann O'Malley, "Do Reimbursement Delays Discourage Participation by Physicians? Data Watch," Health Affairs, November 18, 2008.

¹⁸ <http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=12745&page=9>

¹⁹ <http://www.mhpa.org/upload/Medicaid%20Managed%20Care%20Primer%20February%202013.pdf#page=4>

assessing the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects.

Holding providers and managed care plans accountable through HEDIS quality data provides the state with a tool that has been shown to consistently improve quality metrics in challenging environments. Many of the 25 Leading Health Indicators listed in the Healthy Alaskans 2020 plan are HEDIS requirements for NCQA accredited plans. Several of the indicators that are proving a challenge to the State – such as decreasing preventable hospitalizations, increasing prenatal care in the 1st trimester, and reducing the number of children not receiving ACIP recommended vaccinations – are areas where managed Medicaid plans excel.^{20,21,22} Using managed care would provide the State with an accountable and nationally-recognized system to track and improve outcomes for all Alaskans.

MCO Quality Snapshot

- Increased prenatal care rates
- Decreased preventable hospitalizations
- Increased number of children receiving ACIP vaccinations

Considerations for Implementing Medicaid Managed Care

Several issues must be considered as Alaska evaluates Medicaid reform and managed care. The following areas should be discussed to determine the best solution for Alaska’s unique needs:

Risk Model

The Medicaid Reform Group must determine the optimal point for Alaska on the managed care continuum considering state goals and population.

Primary Care Case Management (PCCM)	Built on the FFS delivery system where the state typically pays providers a small fee per member per month (PMPM) for case management
Prepaid Health Plans (PHPs)	Plans at financial risk for a limited set of benefits such as dental or mental health services
Risk-based managed care	The most common form of managed care. States contract with MCOs on a capitated basis for a comprehensive benefit package

Risk-based managed care is the only alternative that will yield budget predictability/stability, administrative efficiency for providers, and holistic physical and behavioral health treatment for members.

Program design: Benefits, enrollment, and populations

Implementation of a successful program is dependent on the planning and design of several key areas including:

²⁰ <http://www.masonbay.com/clients/dev2/cahp-html-3/pdfs/MC-ManagedCareValueRptsF5012009.pdf>
²¹ <http://www.hrsa.gov/quality/toolbox/508/pdfs/prenatalmoduleaccess.pdf>
²² http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf

Benefits	Determining covered benefits is a critical decision point. Integrated whole-person care cannot be achieved if, for example, behavioral health or dental benefits are provided outside of the managed care contract.
Enrollment	Enrollment rules are another critical program design area. Deciding if enrollment is mandatory, voluntary, or has an opt-out will determine a program's success. Mandatory enrollment with lock-in periods will yield the most cost savings and quality outcomes.
Populations	Populations that will be enrolled in managed care must be carefully weighed. Extending managed care to populations with challenging medical needs, such as the aged and disabled, is encouraged to maximize savings but must be balanced with rate-setting practices to properly adjust for health status and risk.

Special Financing Programs and Supplemental FFS Payments

The existence of special financing programs and supplemental FFS payments such as Upper Payment Limits (UPL), which are relied upon by hospitals and safety net providers, may appear to be a complicating factor standing in the way of states considering implementation of a capitated managed care model. There are, however, a number of methods for resolving this issue and increasing the amount providers receive through these supplemental payments while still implementing managed care. Some states have used federal waivers as well as the inclusion of provider tax and intergovernmental transfer funding in managed care rates to solve this funding issue.²³ We encourage Alaska to look at how other states have handled this issue if this is of concern to the State.

Timeline and Critical Planning Steps

Medicaid reform and implementation of managed care must be conducted in a responsible and methodical manner. It is common to see states take 18 months to move to managed care. This allows time to:

- Receive stakeholder and advocacy input into program design
 - Proactively engage with community based organizations, member advocate groups, and providers to ensure all parties participate in the process to make program implementation successful
 - Customize the program to drive cultural competency-tailored solutions to health disparity gaps found across unique Alaskan populations
- Design the program: populations included, benefits offered, enrollment mechanisms, etc.
- Write and receive approval of CMS waiver and prepare state plan amendment documentation
- Prepare the provider community for transition to a managed care model
- Draft and release a competitive procurement that will ensure transparent MCO selection and foster free market competition
- Select plans and implement program

In Closing

Aetna Medicaid would like to thank you for the opportunity to contribute to the Medicaid reform dialogue in Alaska. We believe Medicaid managed care is a viable option for Alaska and we offer support and encouragement as Alaska navigates the complexities of Medicaid Reform.

²³ http://hcr.amerigroupcorp.com/wp-content/uploads/2013/04/Achieving_the_Benefits_of_Managed_Care_While_Preserving_Funds_From_Upper_Payment_Limit_Programs.pdf



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Research Brief

TO: Senator Pete Kelly
FROM: Chuck Burnham, Legislative Analyst
DATE: March 2, 2015
RE: Medicaid: Status of State Expansion under the Affordable Care Act and Selected Information on the Use of Managed Care Organizations
LRS Report 15.284

You asked about the status of Medicaid expansion under the Affordable Care Act (ACA) among the states. You also wished to know about the use of managed care organizations (MCOs) in state Medicaid programs. Specifically, you wanted to know whether states that expanded Medicaid under the ACA implemented use of MCOs as part of the expansion, and if that administrative structure was delineated in legislation authorizing the expansion.

The federal Patient Protection and Affordable Care Act (P.L. 111-148), or ACA, includes a requirement that states expand Medicaid programs to cover individuals with incomes of up to 138 percent of the federal poverty level.¹ However, the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*, made Medicaid expansion under the ACA optional for the states. According to the Kaiser Family Foundation (KFF), to date 28 states have expanded their Medicaid programs under the provisions of the ACA. Governors and/or legislative leadership in seven of the 22 states that have thus far rejected expansion, including Alaska, are currently considering expansion.²

Use of Private Managed Care Organizations in Medicaid³

“Managed care organization” (MCO) is a term covering an array of health insurance delivery models. Typically MCOs contract with health care providers and medical facilities to provide services at reduced costs for members covered by the organization. According to the federal Centers for Medicare and Medicaid Services (CMS), managed care is intended to provide a

health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of health benefits and additional services through contracted arrangements between state agencies and managed care organizations that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce program costs and better manage utilization of health services.

¹ Text of the ACA can be accessed at <http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html>. Portions of the federal healthcare overhaul are also contained in the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), <http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf>.

² The KFF tracks state actions on expansion of Medicaid under the ACA at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#>. The Foundation is a not-for-profit research organization with the goal of being “a trusted source of information in a health care world dominated by vested interests.” The KFF generally supports the ideal that all people have access to health insurance, but takes no position on the ACA or any other law.

³ The efficacy of managed care as a means to reduce costs and improve quality is a question outside the scope of your request. It is important to note, however, that research on the topic has reached mixed conclusions. Nonetheless, recent studies have shown that well-designed and implemented managed care strategies can transfer risk away from government payers (see, for example, <http://www.columbia.edu/~jnv2106/jvanparys jmp.pdf>).

Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.⁴

According to the federal Centers for Medicaid and Medicare Services (CMS), pursuant to regulations at 42 CFR 438, four types of managed care entities are recognized for Medicaid programs as follows:

- Managed Care Organizations (MCOs)
 - Comprehensive benefit package
 - Payment is risk-based/capitation
- Primary Care Case Management (PCCM)
 - Primary care case managers contract with the state to furnish case management (location, coordination, and monitoring) services
 - Generally, paid fee for service for medical services rendered plus a monthly case management fee
- Prepaid Inpatient Health Plan (PIHP)
 - Limited benefit package that includes inpatient hospital or institutional services (example: mental health)
 - Payment may be risk or non-risk
- Prepaid Ambulatory Health Plan (PAHP)
 - Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation)
 - Payment may be risk or non-risk

States can implement managed care delivery systems for Medicaid recipients under three separate authorizations within the federal Social Security Act (P.L. 74-271): state plans (Section 1932[a]), plan waivers under Section 1915(a-b), and plan waivers under Section 1115.⁵ The KFF provides a useful overview of states' use of waivers in expanding Medicaid under the ACA at <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

Recent Medicaid MCO Activity in the States

Research by the KFF and others has illustrated that Medicaid enrollment in MCOs has increased substantially in recent years. This growth has been driven, in part, by expansion of Medicaid under the ACA; however, the use of MCOs has also increased in non-expansion states as policymakers and others continue to seek ways to control the growth of costs. According to data compiled by the consultancy PricewaterhouseCoopers (PwC), enrollment in private MCOs by Medicaid recipients increased by roughly 9.3 million individuals in the year beginning third-quarter 2013. Over the same time period, total Medicaid enrollment increased by approximately 9 million enrollees. That is to say, net growth in the number of Medicaid enrollees covered by a private MCO has been somewhat greater than overall Medicaid expansion.

According to PwC, the share of Medicaid recipients nationwide receiving comprehensive medical coverage through a private MCO increased from about 59 percent to 66 percent over the year studied.⁶ These recipients are spread among the 39 states with Medicaid MCOs in place, wherein enrollment ranges from 11 percent in Iowa to 100 percent in Tennessee—one of the states that has rejected expansion under the ACA. According to the KFF, 90 percent of all Medicaid recipients live within the 39 states with Medicaid MCOs.

⁴ <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

⁵ Waivers exempt states from certain requirements of federal law in order to allow flexibility to design programs to most effectively deliver and fund services. Relevant sections of federal law and regulation, state managed care profiles, details on the parameters of waivers, and technical assistance for states regarding managed care are all available at <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

⁶ Ari Gottlieb, "The Expanded State of Medicaid in the United States: Private Medicaid Health Plans Crossing the Tipping Point," PricewaterhouseCooper, January 2015, http://www.mhpa.org/_upload/201501StateofMedicaid2014.pdf.

As the increases in enrollment figures referenced above suggest, a great deal of activity has occurred with regard to Medicaid managed care in recent years.⁷ Among the changes states have variously implemented over fiscal years 2014 and 2015 is the addition of geographic areas covered by MCOs (9 states), creation or expansion of eligibility groups (34 states), and enactment of policies making enrollment in managed care mandatory for some segment of Medicaid recipients (13 states).⁸ The attached table shows for each state the status of Medicaid expansion under the ACA, level of enrollment in private MCOs for Medicaid recipients, and an account of the states where selected expansions to MCO coverage have been implemented.

Implementation of Medicaid MCOs in Legislation Expanding Medicaid under the ACA

We located no instance in which legislation to expand Medicaid under the ACA created an associated MCO program, or directed state agencies to do so, where no such program previously existed. There are likely a number of reasons this approach has not widely been undertaken. First, of course, is the fact that Medicaid MCOs were already operating in many states when ACA expansion was undertaken. Further, where those programs do not exist at the time of expansion, an amendment to the state plan or approval of a waiver as mentioned above is required prior to the implementation of a Medicaid managed care program.

In a number of states where expansion under the ACA has taken place, it was not accomplished through stand-alone legislation. For example, Delaware, New Jersey, Rhode Island, and Washington expanded Medicaid through line items in budget bills—a legislative vehicle that is not necessarily well suited for detailed programmatic directives. In other states—prominently Kentucky and Ohio—expansion under the ACA was directed by their respective governor absent enabling legislation.

Although we located no legislation directing creation of Medicaid MCOs, a number of states' enabling measures provided some degree of direction regarding managed care. For example, California's voluminous ACA legislation includes a requirement that Medicaid recipients enroll in Medi-Cal managed care in counties where such plans are or become available [Cal. Welfare and Institutions Code § 14005.60(c)(1-2)].⁹ Enabling legislation in Michigan is more broadly prescriptive regarding the use of MCOs, directing an aggressive move toward the use of waivers to mandate Medicaid managed care as follows:

By September 30, 2015, the department of community health shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees [in Medicaid under the ACA]. The department of community health shall include contracted health plans as the mandatory delivery system in its waiver request. The department of community health also shall pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the 4 integrated care demonstration regions beginning July 1, 2014. By September 30, 2015, the department of community health shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans.¹⁰

The legislation authorizing Medicaid expansion under the ACA in New Hampshire seeks to control costs, in part, by making premium assistance for certain adults newly eligible for Medicaid contingent upon those enrollees choosing either a qualified health plan from a federally-facilitated health exchange or one of the state-contracted MCOs.¹¹

⁷ Legislative Research calculations based on data provided by Gottlieb, PwC, pp. 13-14.

⁸ The KFF publishes a great deal of data and analysis through its Medicaid Managed Care Market Tracker at <http://kff.org/state-category/medicaid-chip/medicaid-managed-care-market-tracker/>.

⁹ See § 9 of the enabling legislation in California is available at http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0001-0050/abx1_1_bill_20130614_amended_sen_v97.htm.

¹⁰ Act No. 107, 2013, Section 105d(i)(4), <http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA-0107.pdf>.

¹¹ New Hampshire SB 413-FN-A, § XXIV(a), <http://www.gencourt.state.nh.us/legislation/2014/SB0413.html>.

These examples are by no means exhaustive of legislative directives regarding MCOs and ACA expansion, and as we indicated above, policymakers across the country are aggressively seeking changes to and increased use of managed care for Medicaid enrollees. Ultimately, should Alaska pursue such policies, their specific design and implementation would necessarily be driven by the state's unique geography, demographics, medical markets, and the needs of Medicaid recipients.

We hope this is helpful. If you have questions or need additional information, please let us know.

Medicaid: Status of State Expansion under the Affordable Care Act (ACA) and Selected Information on the use of Private Managed Care Organizations (MCO)

Location	Status of Medicaid Expansion Under the Affordable Care Act ¹	Private MCO Enrollment ² (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015 ³		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
United States	Adopted: 28 states Reconsidering: 7 states Rejected: 15 states	43,331	65%	9 States	34 States	13 States
Alabama	Rejected	0	0%			
Alaska	Reconsidering	0	0%			
Arizona	Adopted	1,316	83%		X	
Arkansas	Adopted	166	19%			
California	Adopted	7,931	77%	X	X	X
Colorado	Adopted	780	72%	X	X	
Connecticut	Adopted	0	0%			
Delaware	Adopted	181	78%		X	
Florida	Rejected	2,685	74%	X	X	X
Georgia	Rejected	1,177	68%		X	
Hawaii	Adopted	326	100%		X	
Idaho	Rejected	0	0%			
Illinois	Adopted	378	12%	X	X	X
Indiana	Adopted	760	68%		X	X
Iowa	Adopted	59	11%	X	X	
Kansas	Rejected	399	93%			
Kentucky	Adopted	1,050	90%		X	
Louisiana	Rejected	907	71%		X	X
Maine	Rejected	0	0%			
Maryland	Adopted	1,077	84%			
Massachusetts	Adopted	773	42%		X	X
Michigan	Adopted	1,459	76%		X	
Minnesota	Adopted	801	75%		X	
Mississippi	Rejected	160	21%		X	
Missouri	Reconsidering	389	47%			
Montana	Reconsidering	0	0%			
Nebraska	Rejected	188	81%		X	
Nevada	Adopted	403	67%		X	
New Hampshire	Adopted	127	86%	X	X	X
New Jersey	Adopted	1,476	92%		X	
New Mexico	Adopted	578	89%		X	X
New York	Adopted	4,389	76%	X	X	X

Medicaid: Status of State Expansion under the Affordable Care Act (ACA) and Selected Information on the use of Private Managed Care Organizations (MCO) (continued)

Location	Status of Medicaid Expansion Under the Affordable Care Act ¹	Private MCO Enrollment ² (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015 ³		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
North Carolina	Rejected	0	0%			
North Dakota	Adopted	13	Unavailable	X	X	X
Ohio	Adopted	2,133	84%		X	
Oklahoma	Rejected	0	0%			
Oregon	Adopted	850	86%		X	
Pennsylvania	Adopted	1,668	74%		X	
Rhode Island	Adopted	223	86%		X	
South Carolina	Rejected	737	64%		X	X
South Dakota	Rejected	0	0%			
Tennessee	Reconsidering	1,241	100%			
Texas	Rejected	3,539	89%		X	
Utah	Reconsidering	195	78%		X	X
Vermont	Adopted	0	0%			
Virginia	Reconsidering	707	78%		X	
Washington	Adopted	1,186	73%		X	X
West Virginia	Adopted	202	40%		X	
Wisconsin	Rejected	702	62%	X	X	
Wyoming	Reconsidering	0	0%			

Notes: 1) Expansion status as of January 27, 2015. "Reconsidering" indicates that following the state's initial rejection of expansion, the governor and/or legislature in the states listed have indicated that serious consideration is being given to pursuing Medicaid expansion under the ACA.

2) This column shows the number of Medicaid enrollees covered by a comprehensive Managed Care Organization plan for medical services offered by private-sector insurance providers or public organizations that are not state agencies. Figures include only medical coverage; behavioral, dental, and pharmaceutical managed care plans are not considered.

3) These three columns indicate whether states have expanded the geographical scope and eligibility of Medicaid MCO plans, and if mandatory enrollment in an MCO has been implemented, during fiscal years 2014 and 2015.

Sources: Status of Medicaid expansion and MCO geographic / eligibility expansion and mandatory enrollment: Kaiser Family Foundation, State Health Facts, Medicaid and CHIP, <http://kff.org/state-category/medicaid-chip/>. Private MCO enrollment by state data: Ari Gottlieb, "The Expanded State of Medicaid in the United States: Private Medicaid Health Plans Crossing the Tipping Point," PricewaterhouseCooper, January 2015, http://www.mhpa.org/_upload/201501StateofMedicaid2014.pdf.



Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies

Prepared for:
America's Health Insurance Plans

July 2004

Updated March 2009

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EXECUTIVE SUMMARY

In 2004, America's Health Insurance Plans engaged The Lewin Group to synthesize existing research on the savings achieved when states have implemented Medicaid managed care programs. This report is an update of the 2004 report, and includes both studies from the previous report and studies that have been released since 2004. In all, The Lewin Group reviewed 24 studies.¹ The studies reviewed were identified and selected by America's Health Insurance Plans and Lewin and include federally required independent assessments, studies commissioned by the federal and state governments, private foundations, and researchers, and one health plan-funded study. Studies are grouped into three categories:

1. State studies, which examine states' cost savings in their overall Medicaid managed care programs
2. Targeted Medicaid managed care studies, which assess savings in Medicaid managed care programs targeted to specific populations
3. Specific service studies, which analyze Medicaid managed care program savings for specific services.

Appendix A lists the studies reviewed.

It is worth noting that, although not a focal point of this engagement, many of the studies reviewed addressed the impact of managed care on access and continuity of care as well as on costs. In the overwhelming majority of cases, the state Medicaid managed care programs were found to have improved Medicaid beneficiaries' access to services, and both the programs and individual managed care organizations (MCOs) have earned high satisfaction ratings from enrollees.

The studies present compelling evidence that Medicaid managed care programs can yield savings. The studies also suggest that certain populations or services are especially likely to generate savings in a managed care delivery system. We summarize these findings below.

- **First, the studies strongly suggest that the Medicaid managed care model typically yields cost savings.** While percentage savings varied widely (from half of 1 percent to 20 percent), nearly all the studies demonstrated a savings from the managed care setting
- **Second, the studies provide some evidence that Medicaid managed care savings are significant for the Supplemental Security Income (SSI) and SSI-related population.** In Arizona, 60 percent of the \$102.8 million savings achieved from 1983 to 1991 is from the SSI population. In the Kentucky Region 3 Partnership, the SSI population made up 25 to 34 percent of total enrollment and accounted for 53 to 61 percent of the savings achieved from 1999 to 2003. An analysis of a subset of the entire Oklahoma aged, blind, and disabled (ABD) population who were enrolled in a particular Medicaid health plan

¹ This total includes two reports on Michigan Medicaid, two reports on Maryland's HealthChoice's program, two on Ohio's program, and two reports on the Texas STAR+PLUS program.

and who were among the highest 10 percent of service users found that overall costs per member per month (PMPM) were four percent lower in managed care than in fee-for-service (FFS). The Texas STAR+PLUS program, which focuses on SSI enrollees, achieved PMPM savings of \$4 in the first waiver period and \$92 in the second waiver period. In addition, Pennsylvania HealthChoices, which relies heavily on capitation for its disabled population, experienced average annual per capita costs that were \$6,800 lower for its beneficiaries with disabilities than the average of surrounding states. These savings are notable even if they can not be solely attributed to managed care.

- **Third, various studies demonstrated that states' Medicaid managed care cost savings are largely attributable to decreases in inpatient utilization.** A study of preventable hospitalizations in California found that the rates of preventable hospitalization were 38 and 25 percent lower in managed care than in FFS for the Temporary Assistance for Needy Families (TANF) and SSI populations, respectively. In Ohio's PremierCare program, inpatient costs decreased 27 percent under capitated Medicaid managed care, from \$76 PMPM to \$55 PMPM. Furthermore, a study of inpatient utilization for alcohol-related treatment in Pennsylvania found that costs per person decreased by approximately 26 percent at the managed care site in Philadelphia County, while costs per person increased by approximately 32 percent at the FFS site in Allegheny County
- **Finally, pharmacy was also an area where Medicaid managed care programs yielded noteworthy savings.** A comparison of drug costs under FFS vs. Medicaid managed care, using FFS and MCO drug cost and utilization data for the TANF population from multiple states, found that the PMPM cost of drugs in the managed care setting was 10 to 15 percent lower than in the FFS setting. Arizona's PMPM for prescription drugs for the ABD Medicaid population, which are delivered and paid for within Arizona's Medicaid managed care model, were found to be far lower than the PMPM drug costs for the ABD population under any state Medicaid FFS. Pennsylvania's annual PMPM prescription cost increase of 14.4 percent under its FFS system fell to 9.1 percent during the 3 years following implementation of the HealthChoices program, the Commonwealth's Medicaid managed care program

The reports summarize the cost savings experience of just some of the states that have implemented managed care for their Medicaid populations. Since the early 1990s, state Medicaid programs have turned increasingly to managed care to improve access to care and contain costs. Many states have enrolled sizable portions of their Medicaid beneficiary populations in some form of managed care – most often in managed care plans that provide comprehensive services to their members on a coordinated, prepaid basis.² However, there is still substantial opportunity for states to expand Medicaid enrollment in managed care plans.

² This report deals exclusively with savings from the comprehensive, prepaid managed care plan model in which health plans are paid a capitation rate and are responsible for providing and/or arranging for the provision of all or a majority of Medicaid covered services for their enrollees. The primary care case management (PCCM) model is also used by a large number of states, often in conjunction with the prepaid, comprehensive managed care plan model. Under the PCCM model, each Medicaid recipient is linked with a primary care physician who receives a per capita management fee to coordinate a patient's care. However, all medical services provided to the recipient are paid on a fee-for-service basis. References in this report to "Medicaid managed care," "managed care model," and "Medicaid managed care model" are references to the comprehensive prepaid managed care model only and are not inclusive of the PCCM model. The PCCM model is not the subject of this report.

According to the Centers for Medicare and Medicaid Services (CMS), 45.6percent of the Medicaid population was enrolled in comprehensive prepaid managed care as of June 2007. A number of states, though, have “carved out” some of the highest-cost services from their managed care programs, and most states have excluded entire eligibility categories – generally the high-cost disabled populations – from their managed care initiatives. As a result, while more than half of all Medicaid beneficiaries are enrolled in some form of managed care, more than 80 percent of national Medicaid spending remains in the FFS setting.³

Given the adverse budget pressures currently confronting states, policymakers are understandably interested in assessing whether such Medicaid managed care expansion might ease these fiscal pressures. Within the Medicaid budget, the alternative paths to fiscal savings seem much more troublesome – cutting eligibility, eliminating benefits, or reducing already-low provider payment levels.

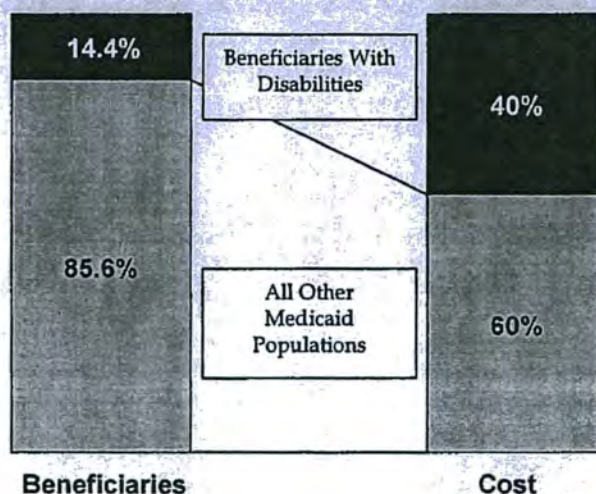
The findings from this study demonstrate that the managed care model achieves access and quality improvements while at the same time yielding Medicaid program savings. Further, it is clear that – through carefully crafted managed care program design that is tailored to the state’s Medicaid populations and geographic landscape – real opportunities exist for states to benefit from expanding the Medicaid managed care model to eligibility categories and services heretofore largely excluded from managed care.

³ 2005 Medicaid Quarterly Statement, Centers for Medicare and Medicaid Services, <http://msis.cms.hhs.gov/>.

I. INTRODUCTION AND CONCEPTUAL OVERVIEW

Since the early 1990s, state Medicaid programs have turned increasingly to the managed care model⁴ because of its potential to contain rapidly rising Medicaid program costs, while improving access to care and bringing more mainstream providers into play. However, although a substantial proportion of Medicaid beneficiaries nationwide are enrolled in managed care, a large proportion of Medicaid expenditures – indeed 80 percent⁵ – remain in the FFS system. This is largely because most states have not yet embraced the managed care model for people with disabilities enrolled in Medicaid. These subgroups, though comprising a relatively small percentage of Medicaid beneficiaries overall, represent the highest-need, highest-cost categories of eligibility, and thus a disproportionate share of total Medicaid expenditures.⁶

Exhibit 1. Distribution of Population and Costs, FY2004



In addition, a number of states “carve out” certain services, such as prescription drugs and mental health, from their existing managed care programs and pay for these services on a FFS basis.

⁴ This report deals exclusively with savings from the comprehensive, prepaid managed care plan model in which health plans are paid a capitation rate and are responsible for providing and/or arranging for the provision of all or a majority of Medicaid covered services for their enrollees. The Primary Care Case Management (PCCM) model is also used by a large number of states, often in conjunction with the prepaid, comprehensive managed care plan model. Under the PCCM model, each Medicaid recipient is linked with a primary care physician who receives a per capita management fee to coordinate a patient’s care. However, all medical services provided to the recipient are paid on a fee-for-service basis. References in this report to “Medicaid managed care,” “managed care model,” “Medicaid managed care model,” and “capitated managed care” are references to prepaid managed care model only and are not inclusive of the PCCM model.

⁵ 2005 Medicaid Quarterly Statement, Centers for Medicare and Medicaid Services, <http://msis.cms.hhs.gov/>.

⁶ Kaiser Family Foundation State Health Facts, Distribution of Medicaid Enrollees by Enrollment Group and Distribution of Medicaid Payments by Enrollment Group, FY2004, <http://www.statehealthfacts.org>.

Thus, for state policymakers dealing with Medicaid budget woes, Medicaid managed care expansion emerges as a particularly attractive alternative to the other primary options available, including reductions in eligibility, benefits, or still deeper cuts in already low provider payment rates that further undermine Medicaid's ability to avoid being perceived as a "second class" system of coverage.

As states consider expansion of Medicaid managed care, it is useful to understand both the reasons the comprehensive, prepaid managed care model would be expected to save money and the challenges to such programs in yielding savings. This knowledge can help guide states not only in their broad decisions regarding implementation or expansion of Medicaid managed care, but perhaps more importantly in designing the specifics of managed care initiatives – including eligible populations to target, geographic areas to include, and whether enrollment is voluntary versus mandatory. Below we briefly outline some of the theoretical cost-savings opportunities and challenges associated with the managed care model in Medicaid, and then set the stage for the body of our report, which summarizes the research on Medicaid managed care.

A. Savings Potential of the Managed Care Model

Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the FFS setting. The FFS model is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively. Managed care organizations (MCOs), on the other hand, combine within one entity the responsibility for both the financing and delivery of health care and thus have strong incentives – and means – to coordinate care and, in turn, reduce the costs of inpatient and other expensive categories of health care services, where Medicaid spending is concentrated.

Initiatives to generate savings in the Medicaid FFS setting have predominantly focused on price controls, whereby states cut their payments to providers. While this approach may result in savings, it is not without risks. Low payments drive mainstream physicians out of the Medicaid program, impeding Medicaid beneficiaries' access to primary, preventive and specialty care services and funneling Medicaid care toward more expensive institutional-based services.

Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms, including but not limited to the following:

- Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients
- Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors
- Providing a "medical home" to an individual and utilizing a physician's expertise to refer patients to the appropriate place in the system (as opposed to relying on the patient's ability to self-refer appropriately)
- Providing individualized case management services and disease management services

- Channeling care to providers who practice in a cost-effective manner
- Using lower cost services and products where such services and products are available and clinically appropriate (in lieu of higher-cost alternatives)
- Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness

B. Challenges Faced by the Medicaid Managed Care Model

Collectively, the above mechanisms create strong savings opportunities for the Medicaid managed care model. At the same time, there are also some factors working against the model's ability to achieve savings in Medicaid. These challenges are outlined below.

Transitory Enrollment. A unique challenge in the Medicaid managed care arena is the volatile eligibility in the Transitional Assistance to Needy Families (TANF) population. Most Medicaid MCO enrollees are TANF beneficiaries, and by definition these persons have short-term enrollment duration. This poses a substantial administrative burden in continually processing a large volume of enrollments and disenrollments, including new member orientation activities and materials. The volatile nature of TANF enrollment also obviously inhibits the MCOs' ability to influence these persons' longer-term health status and cost trajectory.

Poverty-Related Enrollee Characteristics. Medicaid beneficiaries often face a number of barriers to health care that are related to their impoverished status. These include low educational attainment, language and literacy barriers, homelessness, lack of reliable transportation, and inadequate child care options, to name a few. Such barriers may challenge MCOs' efforts to manage and coordinate enrollee care and often require them to make additional investments to accomplish those goals.

Prescription Drug Rebates. The Omnibus Budget Reconciliation Act of 1990 established the Medicaid Drug Rebate Program, designed to ensure that Medicaid did not pay "list" prices for prescription drugs, but was able to take advantage of discounts that were available to manufacturers' most favored purchasers (the "best price"). Drug manufacturers participating in the drug rebate program provide quarterly rebates to states for drugs dispensed to state Medicaid beneficiaries. These rebates result in "best price" to Medicaid, i.e., Medicaid pays the lowest price paid for a prescription product by any purchaser, other than federal discount programs and state pharmaceutical assistance programs. However, the law excludes drugs paid for by Medicaid MCOs (on behalf of their Medicaid enrollees) from being counted toward manufacturers' rebate requirement. As private purchasers, Medicaid managed care plans are not entitled to the rebates mandated by the Medicaid Drug Rebate Program. Medicaid MCOs must enter into separate negotiations with drug manufacturers, either directly or through their contracting pharmacy benefits managers. Because MCOs do not have the same most favored status as Medicaid, they are not able to negotiate discounts as large as those realized by the state Medicaid agencies through the rebate program.

Rural Barriers. Rural settings pose daunting challenges to the managed care model in Medicaid (as well as for other payers). The limited number of providers can make development

of a network problematic, and the market may be unable to provide the economies of scale that are achievable in more metropolitan areas.

Limited Price Discount Strategies. One avenue for savings that exists for MCOs outside of Medicaid, price discounts, generally is not available in the Medicaid managed care arena. Outside the Medicaid arena, MCOs are often able to negotiate "discount for volume" arrangements with participating providers, whereby patients are channeled to providers who are willing to accept an MCO's payment terms. Given the low level of Medicaid unit prices versus other payers, and the corresponding low levels of Medicaid participation among physicians, it is not realistic or appropriate from a network development perspective – to drive down Medicaid prices. Savings instead must occur predominantly through truly "managing care" as opposed to managing price.

Capitation Rate-Setting. An overarching issue that determines the level of Medicaid savings that will be achieved through the capitated model is the capitation rates themselves. It is by no means an automatic process for states to pay a capitation rate that builds in savings and is also sufficient to cover MCOs' medical costs, administrative costs, and profit/operating margin needs. A delicate balance often exists. Capitation rates set unnecessarily high can obviously result in states having greater expenditures under their managed care program than in their FFS programs. Rates set too low will make it difficult to attract or retain health plans and could violate the federal requirement that rates must be actuarially sound.

C. Objectives of This Report

Given both the potential of and challenges for managed care to yield savings to state Medicaid programs, as well as federal requirements that states report on the savings their Medicaid managed care programs have achieved, state and federal governments, private foundations, and health plans have commissioned numerous studies on the fiscal impacts of capitated Medicaid managed care initiatives. To better understand the findings of the research to date, America's Health Insurance Plans has asked The Lewin Group (Lewin) to objectively summarize a sample of the body of research.

In total, Lewin reviewed 24 studies⁷, including federally-required independent assessments of state Section 1915(b) waiver programs targeting specific types of services or populations, and general reports on the impact of Medicaid managed care. Some of the studies were conducted by states, while others such as the independent assessments were conducted by entities such as academic research institutions or consulting or actuarial firms. Other studies were conducted under contract with the federal government or private foundations. One study was health plan funded. Studies were identified and selected by America's Health Insurance Plans and Lewin with the goal of providing a balanced overview of cost savings that have been achieved under Medicaid managed care.

Section II of this report presents findings from the research, including an overview of each of the 24 studies that were reviewed followed by a summary of findings by topic area. The

⁷ This total includes two reports on Michigan Medicaid, two reports on Maryland's HealthChoice's program, and two reports on the Texas STAR+PLUS program.

assessment summarizes the basic structure of programs (e.g., eligibility, benefits, and enrollment), as well as cost savings. Cost savings generally are presented as a percent of estimated FFS costs or difference in per member per month (PMPM) costs between the FFS and prepaid Medicaid managed care settings. The second portion of Section II groups the study findings into selected areas (TANF/Supplemental Security Income [SSI], medical service category, etc.) and discusses the specific areas where savings appear to have been most substantial.

Section III summarizes the key findings from our syntheses and describes some potential policy implications.

II. FINDINGS FROM THE RESEARCH

This section summarizes each of the 24 studies reviewed. Studies are grouped into those that examined states' overall capitated Medicaid managed care programs, those that looked at state capitated Medicaid managed care programs targeted to specific populations, and those that analyzed specific aspects of Medicaid managed care, such as the model's impact on pharmacy services. A summary of savings achieved under Medicaid managed care as reported in the studies is provided in Appendix B and detailed summaries of the studies are included in Appendix C. The section below also provides brief summaries of quality and access to health care outcomes of the capitated managed care programs, if the information was provided in the studies.

In considering the savings associated with Medicaid managed care reported in the studies reviewed, a few caveats are necessary. The savings data from the studies cannot be compared directly to one another because of differences in state programs and study methodologies for which no adjustments were made. The assessment of savings from Medicaid managed care programs is predicated on what Medicaid program costs would have been under FFS. As states expand their Medicaid managed care programs and gain more experience with managed care, they also erode the FFS baseline data used to determine cost-effectiveness.

It is also important to point out that assessments of savings from Medicaid managed care generally are comparing what *claims* costs would have been under FFS to the state's payments to MCOs within the managed care program for the health care and administrative services they are required to provide. That is, cost effectiveness is measured by *net* savings, after taking into account:

- Claims savings under managed care
- The administrative expenses MCOs incur as a result of their efforts to coordinate care and achieve savings
- Allowance for an operating surplus

MCO administrative activities typically include health care-related services such as case management, quality management, disease management, and utilization management. Payments to MCOs also incorporate a profit/operating margin. Health plans must have a realistic opportunity to achieve a favorable operating margin, particularly considering the downside financial risk that these organizations bear.

A. Summary of Key Studies

1. *Cost Effectiveness Studies of Specific State Programs*

This section describes general studies of states' overall Medicaid managed care programs. This analysis included a review of 11 studies conducted in 9 states along with 2 independent assessments. Of these, Arizona, Kentucky, Michigan, New Mexico, Ohio, Washington, Pennsylvania, and Wisconsin all enroll both TANF and SSI beneficiaries into their capitated managed care initiatives. Only Kentucky, New Mexico, and Pennsylvania include children in foster care in their Medicaid managed care programs. Common state carve-outs include long-term care, pharmacy, mental health and substance abuse services, and school-based health services. MCO enrollment is mandatory in Arizona, Kentucky, Michigan, New Mexico, and Wisconsin, while Ohio, Pennsylvania, and Washington operate mixed mandatory/voluntary programs. Exhibit 2 summarizes selected components of states' Medicaid managed care programs.

Exhibit 2. Summary of Select Medicaid Managed Care Programs

State	TANF children	TANF adults	Foster Care	Pregnant Women	SSI, SSI-Related	Mandatory/Voluntary	Carve-Outs (As Of Year Evaluation Was Conducted)
AZ	✓	✓		✓	✓	M	Arizona capitates all services. Mental health services and long-term care services are provided through specialized capitated MCO programs, separate from the "acute" capitated program. Select drug classes or specific drugs.
KY	✓	✓	✓	✓	✓	M	Long-term care, mental health, and school-based services
MD	✓	✓	✓	✓	✓	M	Specialty mental health services, nursing facility services after the first 30 continuous days of care, LTC HCBS, physical therapy, speech therapy, occupational therapy, audiology services, and select drug classes or specific drugs
MI	✓	✓		✓	✓	M/V	Long-term care, dental, behavioral, school-based health services, select classes or specific drugs
NM	✓	✓	✓	✓	✓	M	Behavioral Health, select classes or specific drugs, long-term care
OH	✓	✓		✓	✓	M	Long-term care, mental health, substance abuse services, non-emergency transportation
PA	✓	✓	✓	✓	✓	M/V	Behavioral health, long-term care
WA	✓	✓		✓	✓	M/V	Vision (glasses only), long-term care
WI	✓	✓		✓	✓	M	Long-term care, transportation, family planning, prenatal care coordination, targeted case management, dental, chiropractic, school-based services, TB-related services, employer sponsored coverage wrap-around services, pharmacy

Notes: In Michigan's Medicaid program, managed care enrollment is mandatory for AFDC, SSI, and Aged, Blind and Disabled (ABD) populations in all but 19 counties where it is voluntary. In Wisconsin, most Medicaid beneficiaries are served in a mandatory enrollment model, which has been implemented in 47 counties; voluntary enrollment is used in 21 more rural counties. In Pennsylvania, HealthChoices is mandatory in the Southeast, Southwest, and Lehigh/Capital Zones, while the remainder of the Commonwealth is FFS or voluntary capitated managed care. Washington State's Medicaid program is mandatory for its' TANF beneficiaries. The State currently operates a voluntary program, the Washington Cost Offset Pilot Project, for its' SSI/SSI-related beneficiaries.

a. Arizona

The level of cost savings achieved by states' Medicaid managed care programs is presented primarily on a percentage or PMPM basis, given that the states all have different enrollment

levels. The Arizona study yielded the largest percentage costs savings among the states evaluated. In FY1991, total savings in the Arizona Health Care Cost Containment System (AHCCCS) were \$52 million, representing a 19 percent savings versus what FFS costs were estimated to have been absent Medicaid managed care. To calculate the FFS equivalent, researchers used cost data from states with similar programs.

Throughout the period of 1983 to 1993, AHCCCS achieved cost savings of 11 percent for medical services and seven percent in total cost savings once the MCOs' allocations for administrative costs and operating margins were factored in. AHCCCS slowed the growth rate in Medicaid expenditures between 1983 and 1991 to 6.8 percent under Medicaid managed care from an estimated 9.9 percent under FFS.⁸ In March 1997, more than 450,000 AHCCCS beneficiaries were mandatorily enrolled in capitated MCOs. Enrollment as of February 2004 is above 750,000, resulting from coverage expansions. It can be inferred that the cost-effectiveness of the Medicaid managed care program has been at least partially responsible for enabling Arizona to finance such-large scale enrollment growth in the AHCCCS program.

b. Wisconsin

In Wisconsin, AFDC children and adults, pregnant women, children, and families are enrolled in the capitated managed care program on a mandatory basis in all regions where a sufficient MCO presence exists. In 2001 and 2002, it was estimated that Wisconsin's managed care programs achieved cost savings of 7.9 and 10.7 percent of what costs would have been under FFS.⁹ These savings were driven in part by reductions in emergency room visits through use of a 24-hour nurse line that is available to all MCO members; decreased annual hospital admissions and days through utilization management techniques such as concurrent review, coordination of long-term care services, chronic disease management, prior authorization for certain services, discharge planning, and prescription drug management. During the study period, 283,207 individuals were enrolled in MCOs. Per member per month savings are shown in Exhibit 3.

Exhibit 3. Wisconsin MCO Per Member Per Month Savings

Coverage Category	2001 PMPM Savings	2002 PMPM Savings
BadgerCare	\$3.87	\$23.57
AFDC-Related/Healthy Start Children	\$11.37	\$11.26
Pregnant Women	\$111.83	\$152.39

The study also reports that Wisconsin Medicaid MCOs outperform FFS Medicaid on quality measures. MCO enrollees were more likely to have at least one primary care visit and were more likely to receive mental health/substance abuse evaluations. Inpatient admission rates were lower among MCO enrollees than those in FFS.

⁸ U.S. General Accounting Office, *Arizona Medicaid - Competition Among Managed Care Plans Lowers Program Costs*, October 1995.

⁹ Milliman USA, *Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality*, February 2002.

c. *Kentucky*

The prepaid Medicaid managed care program in Kentucky operates in the Commonwealth's largest urban area, which includes Jefferson County (Louisville) and 15 neighboring counties. About 20 percent of the Commonwealth's Medicaid population lives in this area, known as Region 3. Enrollment in an MCO is mandatory in the Region 3 Partnership and one MCO, Passport Health Plan, a provider-run Medicaid health plan, currently operates in the region. In FY2000, total Region 3 enrollment in Passport Health Plan was 97,255 individuals, and in CY2003, enrollment was about 126,524.¹⁰

From 1999 to 2003, the largest program cost savings have occurred in the SSI population. From year to year the SSI population accounted for 25 to 34 percent of Region 3 Medicaid managed care enrollment, but 53 to 61 percent of program savings were attributable to this subgroup.¹¹ The savings calculations account for start-up costs and costs related to Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. Since 1999, program savings have grown as shown in Exhibits 3 and 4.

Exhibit 4. Savings in the Kentucky Partnership Program

Fiscal Year	Total Dollar Savings (millions)	Savings as a Percent of Estimated FFS Costs
1999	\$7.9	2.8%
2000	\$16.1	5.4%
2001	\$32.6	9.5%
2002	\$35.8	9.5%
2003*	\$17.7	4.1%

* Calendar Year

Exhibit 5. Per Member Per Month Savings by Population in the Kentucky Partnership

Population	FY2000	FY2001	FY2002	CY2003*
TANF	\$8.25	\$15.08	\$15.09	\$6.69
Foster Care	\$7.72	\$14.27	\$14.39	\$15.17
Pregnant Women	\$11.58	\$18.47	\$15.59	\$4.60
SSI/Medicare	\$11.09	\$28.25	\$38.00	\$19.41
SSI/No Medicare	\$27.92	\$54.79	\$59.79	\$31.91
Composite	\$13.75	\$25.74	\$26.53	\$11.67

*Calendar Year

The Kentucky Partnership has demonstrated favorable performance with respect to quality of care and access to services. Since 1997, Passport Health Plan has made improvements in several key performance indicators, including adolescent immunizations, well child visits in the first 15

¹⁰ Milliman USA, Kentucky Region 3 Partnership Program, December 2003.

¹¹ Lewin analysis of data contained in Milliman 2003, Kentucky Region 3 Partnership Program, December 2003.

months of life, prenatal care in the first trimester or within 42 days of enrollment, well-child (i.e., EPSDT), and enrollee satisfaction. Additionally, the Passport Health Plan scored above the National Commission of Quality Assurance Quality (NCQA) Compass mean.^{12,13}

d. Ohio

Multiple cost-effectiveness studies have been performed on Ohio's Medicaid managed care program. These evaluations have been conducted by Mercer Government Human Services Consulting, with whom the State of Ohio has contracted to perform Independent Assessments of the capitated model's financial performance relative to the State's fee-for-service (FFS) coverage setting.

The most recent Mercer study, completed in 2006 and evaluating FY2004 outcomes, found that Ohio's capitated programs created \$72.4 million in FY2004 savings, a percentage savings of 4.2% relative to expected FFS costs in the absence of the capitation initiative.¹⁴ As shown in Table 6, savings were found to occur relative to FFS in the medical services arena as well as for administrative costs.

Exhibit 6. Savings From Ohio's Capitated Medicaid Program, July 2003 - June 2004

Expenditures	Upper Payment Limit (estimated FFS costs in absence of capitated program)	Costs Under the Capitated Managed Care Program	Savings
Medical Services	\$1,551,922,277	\$1,497,108,886	\$54,813,391
Administrative	\$54,456,231	\$36,902,780	\$17,553,451
Total Program	\$1,606,378,508	\$1,534,011,666	\$72,366,842

In an earlier assessment completed in August 2004, Mercer estimated that Ohio's capitation programs achieved Medicaid savings of \$26.4 million (4.2%) in FY2002 and \$55.1 million (7.0%) in FY2003. Ohio's FY2002 savings were derived by medical service category and are primarily attributed to a 27 percent decrease in PMPM costs for inpatient hospital services.¹⁵

Ohio's capitation programs at the time of these assessments predominantly included TANF populations. In several counties (primarily the State's largest urban areas), the TANF population was mandatorily enrolled into MCOs; whereas in several other counties enrollment into MCOs occurred on a voluntary basis. More recently, Ohio has begun mandatorily

¹² Passport Health Plan presentation, transmitted to Lewin on February 27, 2004 from AmeriHealth Mercy staff.

¹³ Quality Compass is a database of health plan quality performance and enrollee satisfaction, as measured using HEDIS and CAHPS.

¹⁴ Independent Assessment of Cost-Effectiveness for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2006.

¹⁵ Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, August 2004.

enrolling its ABD population (with the exception of certain sub-populations)¹⁶ into the 8-region system.

e. Michigan

Michigan's Medicaid managed care program is implemented statewide and is a mix of mandatory and voluntary enrollment. The State has implemented the State plan option to require Medicaid enrollees in rural areas to enroll in a single MCO. As of 2007, there were 937,815 individuals enrolled in a Michigan Medicaid MCO.¹⁷

A Michigan Department of Community Health presentation included data demonstrating historic savings in the Medicaid managed care program in terms of PMPM costs. From FY2001 to FY2004, the Medicaid PMPM costs have been lower in the managed care program than in FFS. Each year the savings surpassed the savings achieved in the preceding year.¹⁸ Exhibit 7 below summarizes the savings achieved in the Medicaid managed care program.

Exhibit 7. Michigan Medicaid Per Member Per Month Costs - FFS versus MCO

Fiscal Year	FFS	Medicaid MCO	Percent Difference*
2001	\$177	\$161	-9%
2002	\$188	\$162	-14%
2003	\$199	\$167	-16%
2004	\$210	\$170	-19%

* Lewin calculation

The presentation provided little detail about the source of savings, however it is reasonable to assume that some of the savings comes from the enrollment of the SSI and SSI-related population. While the presentation did not provide total program savings data, it demonstrates that the Medicaid managed care program is experiencing growing annual savings by virtue of the annual MCO payment rate increases being lower than what FFS PMPM cost increases were estimated to be.

A 2005 Center for Health Program Development and Management (University of Maryland, Baltimore County [UMBC]) report found that although total spending increased in the Michigan Medicaid program by almost \$550 million for FY2004 (primarily due to caseload growth), the state would continue to save between \$28 million and \$129 million in state funds in FY2006 if the state used a capitated managed care model (the model currently in place under Michigan's Medicaid program) over a FFS model.¹⁹

¹⁶ Individuals are first classified as ABD by the SSA, then must meet certain criteria (e.g. income level) to be classified by the state.

¹⁷ Michigan Department of Consumer and Industry Services, Michigan HMO Enrollment Information, http://www.michigan.gov/documents/hmo_enr1_25290_7.html.

¹⁸ Michigan Department of Community Health, Presentation - Michigan Medicaid: New Direction, July 23, 2003.

¹⁹ University of Maryland, Baltimore County, Center for Health Program Development and Management, Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, April 2005.

Michigan operates the Quality Assurance Assessment Program (QAAP), a unique program that assesses a fee of 6 percent on all non-Medicare premiums. All contracted MCOs pay the assessed fee to the State, which then becomes additional revenue to the State. Note that QAAP is not assessed on the State's FFS program; and therefore, results in higher costs to MCOs.

Exhibit 8 compares estimated State costs for MCOs and FFS. UMBC modeled 4 scenarios to find the impacts that different delivery systems would have on State funds. The baseline model included:

- A 6 percent premium assessment fee under QAAP
- A 12.4 percent MCO rate increase for FY2006 (to achieve actuarial soundness)²⁰

The modeling included assessments with and without the 12.4 percent MCO rate increase for FY2006 because, at the time of the report, funding for the FY2006 rate increase was uncertain. If the rate increase did not occur, the State's program would encounter two problems:

- Operating the program below actuarial sound rates, thereby the State would have to seek a federal waiver
- The quality of care the MCOs provide, in addition to the MCOs financial solvency could suffer

**Exhibit 8. Comparison of Estimated State Costs - MCO vs. FFS
Cumulative Data (FY2004-2006)²¹**

	MCO	FFS	Difference*
Without FY2006 MCO Rate Increase/QAAP	\$1,952	\$2,281	-16%
Without FY2006 MCO Rate Increase/Without QAAP	\$2,129	\$2,281	-7%
With FY2006 MCO Rate Increase/With QAAP	\$2,035	\$2,281	-12%
With FY2006 Rate Increase/Without QAAP	\$2,219	\$2,281	-2%

*Lewin calculation

As noted above, a Medicaid managed care model without the QAAP produces lower savings for managed care. For example, although the State will still see a savings of \$152 million over a 3-year period without a 12.4 percent increase in capitation rates and without the use of QAAP, this savings is still half of what would be realized if QAAP were in place. Additionally, savings will still be met when the State implements an increase of capitation rates by 12.4 percent for FY2006 (for the State to meet actuarial soundness).

²⁰ This 12.4% rate increase was not implemented by the State.

²¹ The State of Michigan operates a premium assessment fee, otherwise known as the Quality Assurance Assessment Program (QAAP). At the time of the evaluation, all operating MCOs were required to pay an assessed fee of six percent on all non-Medicare premiums. The fee is paid to the state and therefore becomes incoming revenue. QAAP is not applied to FFS and therefore results in higher costs to managed care.

f. Maryland

Maryland's Medicaid managed care program, HealthChoice, was implemented in 1997 under an 1115 demonstration waiver, which requires state demonstrations to be budget neutral over the five year waiver period.²² Maryland has used savings from its prepaid Medicaid managed care initiative to finance an expansion in Medicaid eligibility and coverage. The Maryland Department of Health and Mental Hygiene projects individual Medicaid eligibility group costs on a PMPM basis; therefore, the State is at-risk if costs exceed the approved amount. The primary expenditures for the program include capitation payments made to participating MCOs in addition to FFS payments for carved-out services.²³

The Maryland Department of Health and Mental Hygiene published an evaluation of HealthChoice in January 2002, which found the program to be budget neutral over the course of the evaluation period.^{24,25} The report states that during the first two years of the waiver, the State exceeded its budget neutrality cap.²⁶ Budget neutrality means that any expansion programs or services funded through the HealthChoice waiver are financed through savings achieved as a direct result of the HealthChoice program. However, in the third year, waiver spending fell to about two percent under the cap and fourth year spending also was on target to stay under the cap. HealthChoice is a mandatory program. Enrollment has grown from 381,000 in CY2000 to almost 491,800 in CY2006.²⁷

According to the evaluation, the HealthChoice program has improved access to health care services. The evaluation reports that the percentages of children who had a well-child visit, individuals who had accessed an ambulatory service, and children's access to dental services increased from 1997 to 2002.²⁸

Beginning in FY2005, HealthChoice implemented expansion programs (e.g., family planning, primary adult care, and therapeutic rehabilitation services) to the existing program. Expenditures for these expansion programs have increased annually, and expenditures have also increased annually as a percent of total expenditures for each fiscal year beginning in 2005.

A December 2007 report on the budget neutrality of the HealthChoice program found that budget neutrality was met for FY2000 through FY2007. By the end of FY2000, HealthChoice was finally operating on a positive cumulative margin between the program's actual and maximum allowable expenditures, at approximately 1.2 percent under the budget cap. On a

²² To be budget neutral, the state must demonstrate over a five-year period that it did not spend more than it would have in the absence of the waiver.

²³ University of Maryland, Baltimore County, Center for Health Program Development and Management, Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, December 2007.

²⁴ Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation Final Report & Recommendations, January 2002.

²⁵ The HealthChoice evaluation began in January 2001, during its fourth waiver year.

²⁶ Initially, Maryland experienced a problem in setting appropriate capitation payment rates, effectively overpaying MCOs for SSI recipients and driving up total program costs.

²⁷ Maryland HealthChoice Program Factsheet, January 2007, <http://www.dhnh.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf>.

²⁸ Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation Final Report & Recommendations, January 2002 and HealthChoice Evaluation Update, January 2004.

cumulative basis, HealthChoice was 10 percentage points under the budget cap as of FY2007, or about \$2 billion under the cap. Even with the existence of the aforementioned expansion programs, HealthChoice's budget neutrality has remained between 12.2 and 15.1 percentage points under the budget cap for each Fiscal Year (2005-2007).²⁹

g. Mathematica Study of Savings Experience In Five States

A 2001 Mathematica Policy Research, Inc. study examined the research on the early experiences of Medicaid managed care programs implemented through 1115 waivers in Hawaii, Maryland, Oklahoma, Rhode Island, and Tennessee.³⁰ Researchers targeted these states because they were among the first states to turn to statewide Medicaid managed care programs to curtail growing program costs, among other program goals. Prior to implementing the demonstration programs, the states had varying levels of experience with managed care in their Medicaid programs; some had implemented capitated programs, Primary Care Case Management (PCCM) programs, or had no Medicaid managed care. All states covered the poverty-related eligibility groups (AFDC and AFDC-related) in their capitated Medicaid managed care programs, but differed in their coverage of the SSI and SSI-related population. The 1115 waiver programs in Hawaii, Oklahoma, and Rhode Island did not include the SSI populations or the medically needy aged and disabled populations. Maryland, Oklahoma, and Rhode Island excluded the medically needy children and adult populations.

To measure the impact of Medicaid managed care on total program costs, the States' annual growth rate of Medicaid medical costs were compared to the national average. The researchers hypothesized that the rate of growth of program costs would be reduced under managed care. The study authors concluded that the waiver programs had little impact on State expenditures. Maryland's Medicaid managed care program experienced a slight decrease in growth of Medicaid medical costs. Oklahoma, Rhode Island, and Hawaii had growth rates that were slightly higher than the national average. State expenditure growth rates generally were close to the national average (Exhibit 9).

**Exhibit 9. Growth Rate in Medicaid Medical Costs per Enrollee
(includes all Medicaid beneficiaries)**

State	Average Annual Growth Rate (%)	National Average Growth Rate (%)	Years
HI	3.0	2.9	1993 – 1998
MD	- 0.2	2.6	1996 – 1998
OK	2.8	2.4	1995 – 1998
RI	3.4	2.9	1993 – 1998
TN	2.8	2.9	1993 – 1998

This study included a health outcomes analysis of shifting from FFS to managed care for the

²⁹ University of Maryland, Baltimore County, Center for Health Program Development and Management, Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, December 2007.

³⁰ Mathematica Policy Research, Inc., Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansion, April 2001.

TennCare program. The analysis was not conducted for the other State programs because of data quality issues. The study reports that perinatal outcomes and the number of physician visits per beneficiary remained steady in the shift from FFS to managed care. The study analyzed the experience of SSI beneficiaries who were enrolled in TennCare and found that they had relatively high levels of access to care and satisfaction. The report states that most of these individuals had a usual source of care and received preventive care services.

h. Pennsylvania

In 1997, Pennsylvania implemented HealthChoices, a capitated Medicaid managed care program. At the time, enrollment into the program was mandatory in the more urban counties of the Commonwealth, while the remaining counties remained FFS or participated in a voluntary enrollment capitated managed care program. In 2003, the Commonwealth terminated planned expansion of the mandatory managed care program in the FFS counties in favor of an enhanced primary care case management (EPCCM) program. In response to this policy change, a coalition of the seven MCOs administering HealthChoices commissioned The Lewin Group to conduct a comparative evaluation of HealthChoices and FFS. One area of assessment was cost-effectiveness.³¹

HealthChoices has performed exceedingly well financially, serving as a national model. The HealthChoices MCOs have consistently controlled rates of medical cost escalation, collectively holding average annual medical cost escalation to 7.4 percent, compared to an average annual cost escalation of 10.4 percent under FFS. Based on data analysis, it appears that HealthChoices has saved Pennsylvania more than \$2.7 billion from 1999-2004.

Exhibit 11. Pennsylvania's Comparisons of Annual Rates of Cost Escalation

Medicaid Population Group	Years Assessed	Dept. Annual PMPM Cost Escalation*	MCO Annual PMPM Medical Cost
Pennsylvania FFS Medicaid**	1999 – 2002	10.4%	n/a
MCO Average***	2001 - 2004	7.4%	7.9%

* Reflects Department of Public Welfare's increase in cost of health plan premiums.

** 2002 was the most recent available for FFS data.

*** Averages are first calculated for each health plan by assessing PMPM cost escalation in each rate cell across a fixed set of enrollment numbers (to ensure that the cost trend is not being driven by changes in enrollment mix). The average rates of increase for each health plan are then averaged together weighted by each plan's 2003 enrollment level.

Year after year, the financial status of HealthChoices has remained in balance.

A number of states have seen health plans exit the Medicaid market due to inadequate rates. In Pennsylvania, the collective medical loss ratio of the HealthChoices health plans is approaching 90 percent, and while there is some variability in operating margins across plans, in the aggregate the MCOs are holding administrative costs to approximately 8 percent of revenue and achieving an operating margin of about 3 percent.

³¹ The Lewin Group, Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program, May 2005.

Furthermore, the cost-effectiveness that is occurring under HealthChoices is predominantly attributable to coordination of care. The HealthChoices program has served as a vehicle for propping up – rather than ratcheting down or discounting – unit prices paid to safety net providers vis-à-vis FFS rates.

i. New Mexico

The New Mexico Medical Review Association retained Lewin to conduct an independent assessment of the quality, access, and cost-effectiveness of health care services delivered under New Mexico's Managed Care program, Salud!³² The Salud! Program was implemented on July 1, 1997. Prior to that, the State used a FFS program coupled with a PCCM called Primary Care Network (PCN). Though PCN managed to improve access and contain costs, the need for a more rigorous risk-based managed care model was evident.

To determine the cost-effectiveness of Salud!, Lewin estimated the FY2006 savings achieved relative to FFS costs. The savings fell between three and five percent. This percentage range was based on the following information:

- The initial 5 percent savings built into the program's capitation rates
- An earlier Lewin study estimating savings to be between 1 and 2 percent during FY2000 and FY2001, but growing between these two years
- The fact that Salud! capitation rates have increased, on average, 8.6 percent per year between 2003-2006, a trend line that closely parallels national Medicaid per capita cost norms
- The CY2005 program-wide medical loss ratio of 85.3 percent, which is well-matched with industry-wide Medicaid managed care norms, but is 2 to 3 percentage points below the average medical loss ratio typically occurring in other states with mandatory enrollment for both TANF and SSI subgroups

This savings range is translated into a total dollar savings estimate in Exhibit 12. In situations where a single savings estimate is needed, it is recommended that the midpoint range is used, or a four percent savings. During FY2006 Lewin estimated that Salud! created savings of \$33 million to \$56 million with the midpoint estimate being a savings of \$44 million. These figures include both the State and federal share of Medicaid expenditures.

³² The Lewin Group, Independent Assessment of New Mexico's Medicaid Managed Care Program – Salud!, February, 2007.

Exhibit 12. Estimated Salud! Savings

Salud PMPM Weighted Average Capitation Rate, FY2006	\$359.51
Approximate Average Enrollment	245,000
Approximate member months, FY2006	2,940,000
Estimated Salud! Costs, Total Dollars, FY2006	\$1,056,959,400
Savings Percentage Versus FFS	
Low Estimate	3%
Midpoint Estimate	4%
High Estimate	5%
Estimated FFS Costs in Absence of Salud!	
Low Estimate	\$1,089,648,866
Midpoint Estimate	\$1,100,999,375
High Estimate	\$1,112,588,842
Estimated Salud! Savings, FY2006	
Low Estimate	\$32,689,466
Midpoint Estimate	\$44,039,975
High Estimate	\$55,629,442

Note: Figures assume percent savings accrue to both physical and behavioral health cost components. All figures represent both State and federal share of Medicaid expenditures.

j. Washington

The State of Washington retained The Lewin Group to provide an analysis of possible new cost containment and revenue enhancement strategies for the State.³³ Washington's Medicaid program has already been successful in reducing and containing costs by working "smarter" and more efficiently than virtually all other states. As one of its efforts to contain costs, Washington established the Medicaid Utilization and Cost Containment Initiative (UCCI), which is designed to find efficiencies and lower expenditures in the State's Medicaid program, without reducing benefits or eligibility. In addition to UCCI, the State is also exploring other avenues for potential savings in its Medicaid program. It has also been estimated that between \$25.4 million and \$30.2 million in cost avoidance and recovery is attributable to UCCI (exclusive of additional administrative expenses associated with UCCI). The UCCI program savings were generated as a result of increasing coordination of benefits as well as provider audits and quality reviews.

³³ The Lewin Group, Medicaid Cost Containment: Report No. 3, January 2003.

2. *Studies of Medicaid Managed Care Programs Involving Population Subgroups*

The studies previously mentioned describe state experiences with Medicaid managed care programs that cover broad populations typically the TANF and TANF-related³⁴ children and adults, and in some cases the SSI and SSI-related children and adults, and pregnant women; and provide comprehensive Medicaid services, with noted carve-outs. Several states have also implemented targeted Medicaid managed care programs available only to specific Medicaid populations. This review of research included studies of the Texas STAR+PLUS program, a study of the impact of Medicaid managed care on the urban ABD population in Oklahoma, a prospective analysis of estimated savings achievable under Medicaid managed care for Hennepin County in Minnesota, and an evaluation of New Mexico's behavioral health program.

a. *An Independent Assessment of the STAR+PLUS Program*

The State of Texas also conducted independent assessments of its 1915(b) waiver program, known as STAR+PLUS. STAR+PLUS provides integrated primary, acute, and long-term care services to the SSI and SSI-related³⁵ population residing in Harris County (Houston), including those who are dually eligible for Medicaid and Medicare.³⁶ Medicaid managed care enrollment is mandatory for the large majority of the SSI and SSI-related population; most STAR+PLUS eligible individuals choose between enrolling in one of two MCOs, while a smaller number (SSI clients under age 21) may choose between the HMOs and the PCCM program. Prescription drugs are carved-out of the capitated program. As of February 2004, there were 62,782 individuals enrolled in STAR+PLUS. During the period of the first independent assessment (February 1998 to January 2000), 55,000 were enrolled. During the second independent assessment period (September 1999 to August 2002), 57,000 were enrolled.³⁷ (This represents the large majority of the SSI and SSI-related population in Harris County, as enrollment is mandatory for all except approximately 5,000 who are allowed to participate voluntarily.)

Savings achieved in each year of the STAR+PLUS program have grown annually, suggesting that a ramp-up phenomenon exists as the health plans, enrollees, and provider community become increasingly accustomed to the managed care setting over time. During the first waiver period, Texas experienced additional costs of \$1.97 million or \$2.68 PMPM in Year 1 due to

³⁴ TANF-related beneficiaries may include those individuals who do not qualify for cash payments under TANF but who are medically needy, pregnant women and children for whom the state's financial criteria for Medicaid eligibility may not be as strict, etc.

³⁵ Many Medicaid programs do not require receipt of cash assistance for eligibility under the Aged, Blind, and Disabled (ABD) program. A person may qualify even if his or her income and resources are too high for SSI. Thus, the SSI-related category includes those aged, blind, and disabled individuals who are medically needy but do not qualify for cash payments under SSI.

³⁶ Not all SSI and SSI-related beneficiaries are eligible for Medicare. SSI-related Medicaid beneficiaries are not eligible for Medicare because their income and resources are too high to qualify for SSI and, in turn, for Medicare. In addition, SSI beneficiaries are not eligible for Medicare until after 24 months of continuous disability benefits.

³⁷ Texas A&M Public Policy Research Institute, STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, October 1999. Of the 57,000 Medicaid beneficiaries participating in STAR+PLUS in the second independent assessment period, 44 percent received Medicaid benefits only and 56 percent were dually eligible. Dually eligible enrollees continued to receive acute care services from the Medicare provider of their choice and received only Medicaid long-term care services from their STAR+PLUS HMO.

implementation costs, and savings of \$7.57 million or \$10.22 PMPM in Year 2. Combined savings in Years 1 and 2 were \$6.05 million or \$4.11 PMPM.³⁸

Waiver period one savings were less than one percent of the program cost for the entire waiver period. In the second waiver period, total savings were \$66 million or \$100.95 PMPM in Year 1 (February 2000 to January 2001), and \$56 million or \$82.71 PMPM in Year 2 (February 2001 to January 2002).

Combined savings in waiver period two were \$123 million or \$91.67 PMPM.³⁹ Waiver period two savings represent an almost 17 percent reduction in State Medicaid costs as compared to projected FFS costs for this population. In addition, it is worth noting that in the first waiver period, three MCOs participated in STAR+PLUS, while in the second waiver period, two participated.

The first assessment evaluated enrollee satisfaction and found that STAR+PLUS enrollees had satisfaction levels that were about the same as FFS enrollees. The STAR+PLUS evaluation indicated that the program had an inpatient discharge rate and average length of stay that was similar to the FFS baseline and decreased the number of emergency room visits. STAR+PLUS MCOs also assigned care coordinators to enrollees in an appropriate manner. The second assessment found that STAR+PLUS continued to reduce the number of inpatient discharges and average length of stay.

The State has sought to expand STAR+PLUS to several new market areas. A State slide presentation⁴⁰ explaining the State's approach contained some additional performance-related information. Member satisfaction ratings are consistently high across a series of specific access issues, inpatient stays have been lowered by 28 percent, the number of members accessing community-based adult day care services has increased 38 percent and the number of members accessing personal assistant services has increased 32 percent.

³⁸ Ibid.

³⁹ Texas A&M Public Policy Research Institute, Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program, June 2002.

⁴⁰ "Medicaid Managed Care Expansion" slide presentation, which state staff are currently using to describe the state's intended broadening of STAR+PLUS.

b. Serving the Aged, Blind, and Disabled in Oklahoma Medicaid Managed Care

Until the end of 2003, the aged, blind, and disabled (ABD) population in Oklahoma was mandatorily enrolled in the State's Medicaid managed care program known as SoonerCare.⁴¹ In more urban areas of the State, Medicaid beneficiaries, including the ABD population, were enrolled in fully prepaid MCOs, while in more rural parts Medicaid beneficiaries received health care services through a partially prepaid PCCM delivery system. The Center for Health Care Strategies commissioned a study of Oklahoma's experience in providing prepaid health care services to the ABD population in the State's urban managed care service areas, i.e., Oklahoma City, Tulsa, and Lawton. The study focused on the 583 beneficiaries enrolled in the Heartland Health Plan of Oklahoma (HHPO) who also were among the top 10 percent of service users from among this urban ABD population.⁴² The study analyzed enrollment and medical claims data from the 12 months before and following each member's enrollment into managed care, during the time period from February 1998 to December 2000.

The study found that average managed care claims PMPM were 15 percent lower than the cost of caring for those individuals in FFS in the 12 months prior to their enrollment in the MCO, even though the MCO benefit package was more comprehensive. When the study assessed the full managed care payment cost in relation to the FFS claims costs, overall PMPM costs were 4 percent lower under managed care.⁴³ In considering these savings estimates, it is important to remember that this study only looked at the subgroup of the Oklahoma Medicaid ABD population living in the State's urban Medicaid managed care region and that enrolled in a single MCO.

The study also summarized findings from a focus group and surveys related to access to care, continuity of care, and satisfaction. The focus group was conducted in October 2001 and surveys were fielded from September to December 2001. Focus group participants noted that HHPO provided access to a fuller range of services than were previously provided and that care coordination had improved in comparison to FFS Medicaid. They also felt that the overall quality of services for individuals with disabilities enrolled in HHPO had improved. Satisfaction survey results indicated that enrollees had a high level of satisfaction with managed care - 80 percent of respondents described their satisfaction as "very good" or "good," the two highest ratings.

c. Medicaid Managed Care in Hennepin County, Minnesota

A third study attempted to prospectively estimate the level of savings that could be achieved under Medicaid managed care for a study population of adult women in Hennepin County,

⁴¹ This report provides information regarding Oklahoma's experience enrolling the aged, blind, and disabled individuals into capitated Medicaid managed care, although effective January 2004, Oklahoma discontinued its capitated Medicaid managed care program. Following the November 2003 decision of one of the state's three MCOs to not renew its contract, the state decided to end its capitated program. Individuals who were enrolled in a Medicaid MCO are being transitioned into the PCCM program. Oklahoma Health Care Authority Press Releases on November 6 and 12, 2003, <http://www.ohca.state.ok.us/general/media/newpress/>.

⁴² Center for Health Care Strategies, *Serving the Special Program/ Aged, Blind, and Disabled Population*, April 2002.

⁴³ *Ibid.*

Minnesota.⁴⁴ Hennepin County includes Minneapolis and is the State's largest county. Researchers used 1987 ambulatory care cost data from Maryland's AFDC Medicaid program to approximate cost of care because when the Minnesota data was originally collected as part of a related study, cost data were not collected. Researchers also assessed Minnesota's inpatient hospital payment rates (using data for 1985). The study estimated savings associated with moving to Medicaid managed care from FFS to be about 10 percent, taking into account the initial effects of switching to managed care.

d. Assessment of HUSKY, Connecticut's Medicaid Managed Care Program

Connecticut's mandatory capitated Medicaid managed care program began in 1995 as a 1915(b) waiver, and became known as Healthcare for Uninsured Kids and Youth (HUSKY) in 1997. HUSKY is mandatory for the TANF population (HUSKY A) and SCHIP (HUSKY B) throughout the entire State. As of December 2006, over 309,000 beneficiaries were enrolled in either HUSKY A or B through one of four MCOs. The Lewin Group studied the HUSKY program to assess the program's cost performance.⁴⁵ Lewin looked at the following Medicaid managed care models:

- Managed Care Organizations (MCOs)
- Primary Care Case Management (PCCM)
- Disease Management (DM)
- Complex Case Management (CCM)

Lewin found that the HUSKY population's per capita cost escalation has been below both the national rate of TANF cost escalation as well as the rate of inflation in selected non-HUSKY Medicaid subgroups (i.e., disabled eligibles, adults). Under the capitated HMO/MCO model that HUSKY operates, MCOs have held their medical loss ratios (between 90 and 91 percent) and administrative cost ratios (below 10 percent) at favorable levels when compared to their respective national averages.

Expenditures under HUSKY are at least 5 percent below what any newly implemented non-capitated Medicaid managed care model would be able to deliver, translating to an annual Medicaid spending differential of at least \$37 million (5 percent of the 4 MCOs' collective CY2005 Medicaid premium revenues of \$740 million).

⁴⁴ Freund, D., Kniesner, T., LoSasso, A., How Managed Care Affects Medicaid Utilization A Synthetic Difference-in-Difference Zero-Inflated Model, April 1996.

⁴⁵ The Lewin Group, Assessment of HUSKY, Connecticut's Medicaid Managed Care Program, January 2007.

Exhibit 15. Estimated Overall Percentage Savings by Model, TANF Population

Medicaid Managed Care Model	Overall Savings (Loss) Percentage Versus FFS
HMO/MCO	6.7%
PCCM/DM	2.0%
CCM	4.0%
PCCM/DM/CCM	4.2%

Source: Percentage savings estimates of each model prepared as part of Lewin Group report, "Assessment of Medicaid Managed Care Expansion Options in Illinois," May 2005. Savings percentages shown depict the region that is deemed most comparable to Connecticut, and represent percentage savings during the first implementation year.

Note also that the figures shown in Exhibit 15 depicted savings during the initial implementation year. The capitated HMO/MCO model is expected to yield growing savings over time, and as shown above, yields rough one and a half times more savings than the next closest model (PCCM/DM/CCC).

e. *New Mexico's Behavioral Health Program*

The Lewin Group conducted an independent assessment of the access, quality, and cost effectiveness of health care services delivered under New Mexico's Behavioral Health Collaborative (the Collaborative).⁴⁶ The Collaborative chose a capitated behavioral health plan to implement a new behavioral health system after a 2002 report found the previous behavioral health system to be fragmented, and saw costs for psychiatric inpatient services double from \$17 to \$38 million between FY1997-2001.

The cost-effectiveness of New Mexico's behavioral health initiative is extremely difficult to assess for several reasons. First, by many accounts there was an under-utilization of services under Salud! which prompted the switch to a behavioral health carve-out model. Against this baseline, Medicaid behavioral health care costs were presumed to need to increase. Second, additional services were added in the behavioral health plan's contract that were not covered under Salud!, which creates commensurate cost increases. Third, the program is in its first year of implementation. It is far too early to obtain sound data on the impacts of the newly redesigned system, and the carve-out approach requires years to evolve (rather than months) before its true impacts can be discerned.

Exhibit 16 presents the State's estimated Medicaid behavioral health costs during State FY2005 (under Salud!) and during State FY2006 under the carve-out initiative implemented by the capitated behavioral health plan. These figures estimate that behavioral health costs increased by 26 percent in total dollars, and by 33.6 percent on a PMPM basis from FY2005 - FY2006. This is clearly a large-scale, intentional increase designed to strengthen the behavioral health services delivery system and improve patient outcomes, yet it is not possible to make a determination as to whether these investments will prove to be cost-effective.

⁴⁶ The Lewin Group, Independent Assessment of New Mexico's Behavioral Health Program. March 2007

Exhibit 16. Behavioral Health Cost Comparisons, FY2005 versus FY2006

	Member months	MCO Behavioral Health Expenditures	Costs Including 15% Administration Allocation
State FY2005			
Total Dollars, MCOs, FY2005	3,139,978	\$131,693,246	\$151,447,233
PMPM, MCOs, FY2006		\$41.94	\$48.23
State FY2006			
Total Dollars, Value Options, FY2006	2,967,182	\$166,312,611	\$191,259,502
PMPM, Value Options, FY2006		\$56.05	\$64.46

3. Studies of Medicaid Managed Care Program Impacts On Specific Services

Several studies examine the impact of state Medicaid managed care programs on certain types of services. The following section describes the findings of studies of prescription drug use, preventable hospitalizations in California, and alcohol treatment and cost in Medicaid FFS versus Medicaid managed care.

a. Comparison of Medicaid FFS and Capitated Pharmacy Costs and Usage

The Center for Health Care Strategies funded 2 studies related to the impact of Medicaid managed care on prescription drug cost and utilization. Both of these studies were conducted by The Lewin Group. The first study examined FFS drug spending and usage data from 5 states compared to similar data from 13 Medicaid health plans in ten states,⁴⁷ specifically for the TANF population.⁴⁸ The study examined the key factors influencing prescription drug costs: prices, mix of drugs prescribed, and utilization. The study concluded that for the TANF population, PMPM prescription drug costs were 10 to 15 percent lower in capitated Medicaid managed than in the FFS setting, although MCOs initially started at a 15 percent price disadvantage largely due to Medicaid drug rebates rules. Once factors such as MCOs' lower dispensing fees, their ability to influence the mix of lower cost drugs used (including generics), and the lower number of prescriptions due to greater management of the pharmacy benefit are considered, drug expenditures in Medicaid MCOs become lower than in FFS.⁴⁹ According to Lewin's calculations, post-rebate average drug costs were \$20.46 PMPM in the FFS programs and \$17.36 PMPM in Medicaid managed care.

The second CHCS/Lewin study analyzed the option of carving-out prescription drugs from the prepaid managed care setting of Arizona's AHCCCS program, using a simulation based on

⁴⁷ States were requested to provide data from CY2001.

⁴⁸ Center for Health Care Strategies, Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Settings, prepared by The Lewin Group, January 2003.

⁴⁹ Lewin has documented in a series of studies, including the CHCS-funded studies referenced herein and additional studies that can be downloaded at no charge from Lewin's website (www.lewin.com) that the generic fill rate in the capitated setting is roughly ten percentage points higher than in the Medicaid FFS environment. Prescriptions filled per member per month are also considerably lower in the capitated setting.

Federal FY2002 cost data. Currently, prescription drugs are included in the AHCCCS MCO payment rate. Lewin assessed the effectiveness of the AHCCCS pharmacy benefit by comparing prescription drug cost and utilization data from AHCCCS to the data from other Medicaid programs, and prepared cost estimates of carving-out prescription drugs from AHCCCS.⁵⁰

The study found the AHCCCS program to be exceptionally cost-effective in providing prescription drugs. The PMPM cost of providing pharmaceuticals to the ABD population in the AHCCCS program in Federal FY2002 was \$112.21, the lowest figure in the nation and 38 percent below the national average PMPM cost of \$181.01. The next nearest State was Michigan, whose PMPM costs were 11 percent higher than Arizona's. The difference in PMPM cost is particularly compelling because Arizona fully capitates prescription drugs costs, while nearly all other states pay for ABD persons' pharmacy claims under FFS.

Another important study finding is that carving out prescription drugs from the Medicaid managed care setting and paying for drugs on a FFS basis would result in a net cost to the state, not generate savings. The estimated net additional cost to the state of providing prescription drugs under FFS would be \$3.7 million. While Arizona would gain \$40 million in rebate savings, the administrative costs associated with carving out prescription drugs, such as developing and maintaining a preferred drug list and claims processing and changes in the drug mix and volume, would negate any savings and ultimately result in added costs.

b. Preventing Unnecessary Hospitalization in Medi-Cal

A study conducted by the Primary Care Research Center at the University of California and funded by the California HealthCare Foundation, compared Medi-Cal (California's Medicaid program) preventable hospitalization rates between 1994 and 1999 under managed care to FFS.⁵¹ The study found that TANF and TANF-related enrollees in Medi-Cal managed care had 38 percent lower rates of preventable hospital admissions (7.1 per thousand) than in FFS (11.4 per thousand). Between 1994 and 1999, the Medi-Cal program experienced an average decrease in preventable admissions of 7,000 per year, resulting in a \$66 million reduction in inpatient hospital costs as compared to what would have been incurred in FFS.

The SSI-population enrolled in Medi-Cal managed care experienced a decrease of 25 percent in the rate of preventable hospitalizations. SSI-eligible Medi-Cal enrollees were required to enroll in managed care plans in 8 counties. The preventable hospitalization rates were 57.5 per thousand in managed care and 76.4 per thousand in FFS. While the actual rates of hospitalization were understandably higher among the SSI population, the difference in admission rates between managed care and FFS were similar between the TANF and SSI groups. This finding would seem to support the argument that the higher need SSI population would benefit, both in terms of care management and cost savings, from broader enrollment in managed care.

⁵⁰ Center for Health Care Strategies, Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared by The Lewin Group, November 2003.

⁵¹ California HealthCare Foundation, Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care, prepared by Primary Care Research Center, University of California, San Francisco, February 2004.

c. *Comparison of Alcohol Treatment and Costs between FFS and Medicaid Managed Care*

The National Institute on Alcohol Abuse and Alcoholism⁵² funded a study on the two most populated counties in Pennsylvania, Allegheny and Philadelphia, to examine the differences between utilizing managed care with a behavioral health carve-out (Philadelphia) and serving persons entirely in the FFS setting (Allegheny) on the utilization and cost of alcohol-related treatments for high-risk beneficiaries being treated for alcohol abuse or other dependency problems. The study looked at the two populations between 1995 (before managed care-implementation) and 1998 (after managed care-implementation).

Over the study period, per person costs for those treated decreased from \$7,662 to \$5,664 at the managed care site in Philadelphia. Included in this decline was a \$1,200 reduction for alcohol abuse treatment, and a decrease of \$900 for drug abuse treatment per person. Length of stay and daily bed costs were also reduced at the managed care site in Philadelphia County. In contrast, the costs at the Allegheny County FFS site increased from \$4,871 to \$6,449 throughout the study period. The FFS site did, however, show a decline of \$400 in alcohol costs and \$250 for drug costs per person, although there was a significant increase of \$2,000 per person in psychiatric inpatient costs due to longer lengths of stay and more psychiatric co-morbidities.

A regression analysis of both sites showed that managed care did not significantly lower treatment costs, but the difference in costs were impacted by other variables. The FFS site in Allegheny County had increased costs due to psychiatric hospital inpatient stays in addition to increased psychiatric co-morbidities. The managed care site in Philadelphia County also showed a marked increase in co-morbid psychiatric problems, but managed care programs like the one in Philadelphia County are able to keep costs to a minimum by contracting with inpatient facilities and negotiating lower per diem rates. The managed care site was also able to lower costs by treating alcohol and drug dependencies at non-hospital facilities.

B. Findings by Topic Area

Earlier, this report described some assumptions that could be made about savings under a prepaid Medicaid managed care program. It was expected that savings under managed care for the Medicaid population would be greater in urban settings, among the SSI and SSI-related populations, and that certain services would be more amenable to savings. Based on the studies reviewed, it is generally difficult to isolate the specific sources of Medicaid managed care savings because the studies do not provide sufficient detail or did not include such an analysis. However, some observations about source of savings can be made.

1. The SSI and SSI-Related Population

The studies provided some evidence that Medicaid managed care savings could be significant for the SSI and SSI-related population because they typically are high users of services and are the most costly group to cover. In some states, most of overall Medicaid managed care savings

⁵² Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, Rothbard, A. and Kuno, E., *The American Journal of Managed Care*, May 2006.

achieved is attributable to this population. In Arizona, 60 percent of the \$102.8 million achieved from 1983 to 1991 was from the SSI population. In the Kentucky Region 3 Partnership, the SSI population made up 25 to 34 percent of total enrollment and accounted for 53 to 61 percent of the savings achieved from 1999 to 2003. Oklahoma also provided Medicaid services to the ABD population through MCOs. An analysis of a subset of the entire ABD population who were enrolled in a particular health plan and who were among the highest 10 percent of service users found that average claims PMPM were lower in managed care than in FFS based on data from February 1998 to December 2000.

The STAR+PLUS program in Texas is targeted to the urban SSI population of Harris County. The independent assessments reviewed indicate that the enrollment of this Medicaid population into managed care has yielded savings and that the level of savings has grown over time. Savings during the first waiver period (February 1998 to January 2000) was \$6.05 million or \$4.11 PMPM, and \$123 million or \$91.67 PMPM in the second waiver period (September 1999 to August 2002). In addition, Pennsylvania HealthChoices, which relies heavily on capitation for its population with disabilities, experienced average per capita costs that were \$6,800 lower for its beneficiaries with disabilities than the average of surrounding states. These savings are notable even if they can not be solely attributed to managed care.

2. Inpatient Services

The studies demonstrated that cost savings are largely attributable to decreases in inpatient utilization. The study of preventable hospitalizations in California found that the TANF and TANF-related populations had 38 percent lower rates of preventable hospitalizations, saving the state an estimated \$66 million between 1994 and 1999. The SSI and SSI-related population had 25 percent lower rates of preventable hospitalizations.

Hospital care was also a key factor in the savings attained by Ohio's PremierCare. Inpatient costs decreased 27 percent under Ohio's Medicaid managed care program, from \$76 PMPM before implementation of the program (in CY2000) to \$55 PMPM once the program was implemented (in State FY2002). Furthermore, a study of inpatient utilization for alcohol-related treatment in Pennsylvania found that costs per person decreased by approximately 26 percent at the managed care site in Philadelphia County, while costs per person increased by approximately 32 percent at the FFS site in Allegheny County.

3. Prescription Drugs

Pharmacy was also an area where Medicaid managed care programs yielded noteworthy savings. The Center for Health Care Strategies' comparison of FFS and Medicaid managed care drug costs (CY2001), using FFS and MCO drug cost and utilization data for the TANF population from multiple states, found that the PMPM cost of drugs in a capitated setting was 10 to 15 percent lower than in the FFS setting (even after taking into consideration the larger rebates state agencies receive under FFS).

In a related study of prescription drug costs in Arizona's AHCCCS program, which currently carves in prescription drugs, it was determined (based on Federal FY2002 data) that retaining the benefit in the prepaid MCO model was more cost-effective when compared to carving it out.

This study also found that Arizona's PMPM pharmacy costs are well below those of any other state's Medicaid program - an important finding given that Arizona is the only State that fully capitates the Medicaid pharmacy benefit. For example, Arizona's PMPM pharmacy costs for the aged/blind/disabled population were found to be 38 percent below the national average. Additionally, Pennsylvania Medicaid's annual PMPM prescription annual cost increase of 14.4 percent under its FFS system dropped to 9.1 percent during the 3 years following the implementation of HealthChoices.

4. Quality Impacts

Access to care and quality under Medicaid managed care were not the main focal points of this review of the research but the reviews of the studies yielded information on some access and quality data. Some studies⁵³ reported on analysis of utilization data and findings from consumer surveys. In most cases, state Medicaid managed care programs have improved Medicaid beneficiaries' access to services, and both the programs and individual MCOs have earned high satisfaction ratings from enrollees. We provide examples below.

In Wisconsin, HMOs members are more likely to have at least one primary care physician (PCP) visit than those in FFS. In 1997, 56.6 percent of HMO members had a PCP visit compared to 44.7 percent of those in FFS; in 1998, 57.3 percent of HMO members had a PCP visit compared to 42.3 percent of those in FFS.⁵⁴

Connecticut's HUSKY population has been found to obtain a large volume of office visit services. Aggregating each MCO's utilization reports for CY2005 shows that more than 1.7 million visits occurred, split 54 percent between primary care and 46 percent specialist care. On average, HUSKY enrollees obtained 2.9 primary care visits during 2005 and 2.5 specialist visits.⁵⁵

In the Pennsylvania HealthChoices program, the MCOs have significant experience monitoring and improving quality for their members. The Commonwealth plays a strong role in requiring a broad array of quality assurance and quality improvement components of all the HealthChoices MCOs. In addition to the required monitoring, the MCOs and their staff have a strong commitment to quality care, quality service, to monitoring themselves, and planning improvement initiatives, across every aspect of their business.

New Mexico's Salud! program has been successful providing and improving quality care to Medicaid members across the State. Although quality improvement is a continuous process, New Mexico and the MCOs are actively striving to provide quality services to members. In areas that score below national benchmarks, each MCO has internal procedures in place to ensure that these areas are addressed. Each MCO also performed well on HEDIS® and CAHPS® measures.

⁵³ Wisconsin, Kentucky, Maryland, Tennessee, Texas, New Mexico, Connecticut, Pennsylvania, and Oklahoma.

⁵⁴ Milliman USA, Inc. Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, February 2002.

⁵⁵ As a comparison, low risk children in Colorado's Medicaid program utilized primary care services at a rate of 1.2 visits per year and high risk children in Colorado's Medicaid program utilized services at a rate of 3.7 visits per year in 2002.

These types of findings are important because they demonstrate that Medicaid managed care can maintain or increase enrollees' ability to obtain necessary health care services while generating program savings.

III. CONCLUSION

Studies indicate that Medicaid managed care has been successful in achieving cost savings in a variety of states for a variety of populations, although the level of savings varies. Savings in the states included in the studies reviewed ranged from half of 1 percent to 20 percent of what costs would have been under FFS and the research indicates that the level of savings grows over time as states gain more experience with their programs. According to the studies reviewed, Medicaid managed care enrollees have provided high ratings of the programs and their MCOs.

Based on the review of cost effectiveness studies of Medicaid managed care programs, there are several policy implications to be considered. First, states may want to consider including the SSI and SSI-related population in a Medicaid managed care program. While many Medicaid managed care initiatives have generated savings when focused on the TANF population, the savings that can be achieved in the SSI subgroup appear to exceed those available through serving TANF. The population of Medicaid beneficiaries with disabilities makes up 14.4 percent of total Medicaid enrollment, but accounts for 40 percent of total Medicaid expenditures.⁵⁶ The studies reviewed demonstrated very strong savings can be achieved by capitated health plans in SSI beneficiaries' inpatient and pharmacy costs.

Second, some states with Medicaid managed care programs are revisiting their carve-in/carve-out decisions. Pharmacy carve-outs enable states to obtain higher rebates through the federal rebate program, whereas capitating (or "carving in") the pharmacy benefit offers superior benefits management with regard to the mix and volume of medications.

In summary, while it is difficult to accurately predict the level of cost savings that will be achieved in any given Medicaid managed care program, our synthesis of findings from a large body of research on the topic clearly illustrates that Medicaid managed care typically saves money and represents a highly attractive alternative to reductions in eligibility and benefits and/or provider payment cuts. There have been instances where states have not achieved savings from their Medicaid managed care program in a given year, and other instances where health plans have exited the program. There is obviously always going to be a point below which the state's managed care payment rates are no longer viable for MCOs. However, the preponderance of the research evidence is that prepaid managed care partnerships between state Medicaid agencies and MCOs can produce substantial program cost savings without forcing the health plans to operate at a financial loss. The federal requirement for actuarially sound rates is a critical building block for successful program. As states consider expanding their Medicaid managed care programs and as other states implement new Medicaid managed care programs, they may wish to include certain populations (e.g., SSI) and services (e.g., pharmacy and mental health services) that have often been excluded from Medicaid managed care due to quality and access to care concerns. Some of the studies included in this report addressed quality and access to care and their findings demonstrated positive results from Medicaid managed care.

⁵⁶ Kaiser Family Foundation State Health Facts, Distribution of Medicaid Enrollees by Enrollment Group and Distribution of Medicaid Payments by Enrollment Group, FY2004, <http://www.statehealthfacts.org>

Appendix A. Bibliography of Studies Reviewed

Cost Effectiveness Studies of Specific State Programs

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- Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, Milliman USA, Feb. 2002
- Kentucky Region 3 Partnership Program, Milliman USA, December 2003
- Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2003
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- Michigan Medicaid: New Directions Presentation by the Michigan Department of Community Health, July 23, 2003; and Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, April 2005
- HealthChoice Evaluation, Maryland Department of Health and Mental Hygiene, January 2002; and Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, December 1, 2007
- Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansions, Mathematica Policy Research, for the Centers for Medicare and Medicaid Services, April 2001
- Comparative Evaluation of Pennsylvania's Health Choices Program and Fee-for-Service Program, The Lewin Group, May 2005, <http://www.lewin.com/NR/rdonlyres/49FBE34A-23DC-479E-A227-D464EECBDA6/0/3178.pdf>
- Independent Assessment of New Mexico's Medicaid Managed Care Program - Salud!, The Lewin Group, February 2007, <http://www.lewin.com/NR/rdonlyres/14A9B20B-FEC1-432E-A0D45BE461C305EA/0/NMPhysicalHealthMedicaidMCOAssessment421863.pdf>
- Medicaid Cost Containment: Report No. 3 (Washington State), The Lewin Group, January 2003.

Studies of Medicaid Managed Care Programs Involving High-Need Population Subgroups

- STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, Texas A&M University, Public Policy Research Institute, October 1999 and June 2002
- Serving the Special Program/Aged, Blind and Disabled Population (in Oklahoma's Medicaid managed care) by Schaller Anderson, April 2002

- How Managed Care Affects Medicaid Utilization A Synthetic Differences Zero-Inflated Count Model, Freund, D., Kriesner, T., LoSasso, A., April 1996
- Assessment of HUSKY, Connecticut's Medicaid Managed Care Program, The Lewin Group, January 22, 2007, <http://www.lewin.com/NR/rdonlyres/BA89A732-061C-4396-BB7D-A2CD49021A25/0/CTMedicaidMCFinalRpt.pdf>
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- Comparisons of Medicaid Pharmacy Costs of Usage between the Fee-for-Service and Capitated Setting, prepared for CHCS by The Lewin Group, January 2003. http://www.chcs.org/publications3960/publications_show.htm?doc_id=213037
- Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared for CHCS by The Lewin Group, November 2003. <http://www.lewin.com/NR/rdonlyres/B37D9B2E-D750-4CFD-AE09-ACC061E57033/0/PharmacyCarveOutAHCCCS.pdf>
- Preventing Unnecessary Hospitalization in Medi-Cal: Comparing Fee-for-Service with Managed Care, CHCF, February 2004
- Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, Rothbard, A. and Kuno, E., The American Journal of Managed Care, May 2006

Appendix B. Summary of Reported Savings

State/Study	Estimated Savings Under Capitated Managed Care	Year
State Programs		
Arizona	19% of FFS costs	1991
	7% of FFS costs	1983 - 1993
Kentucky	2.8% of FFS costs	FY1999
	5.4% of FFS costs	FY2000
	9.5% of FFS costs	FY2001
	9.5% of FFS costs	FY2002
	4.1% of FFS costs	FY2003
Ohio	2.2% of FFS costs	State FY2002
	7.0% of FFS costs	State FY2003
	4.5% of FFS costs	State FY2004
Wisconsin	7.9% of FFS costs	2001
	10.2% of FFS costs	2002
Michigan	9% of FFS costs	FY2001
	14% of FFS costs	FY2002
	16% of FFS costs	FY2003
	19% of FFS costs	FY2004
	16% of FFS costs (without FY2006 MCO rate increase/with QAAP)	FY2006
	7% of FFS costs (without FY2006 MCO rate increase/without QAAP)	FY2006
	12% of FFS costs (with FY2006 MCO rate increase/with QAAP)	FY2006
	2% of FFS costs (with FY2006 MCO rate increase/without QAAP)	FY2006
Maryland	Over budget neutrality cap	7/97 - 6/99
	2% under its budget neutrality cap	7/97 - 6/00
	10% under its budget neutrality cap	FY1998 - FY2007
Pennsylvania	10 - 20% of FFS costs	2000 - 2004
New Mexico	3 - 5% of FFS costs	FY2006
Washington

State/Study	Estimated Savings Under Capitated Managed Care	Year
Targeted Medicaid Managed Care Programs		
Texas STAR+PLUS	\$4.11 PMPM	4/98 - 3/00
	\$91.67 PMPM, 17% of FFS costs	4/00 - 3/02
Oklahoma - Special Populations/ABD	4%	1998 - 2000
Minnesota Hennepin County	10% of FFS costs	--
Connecticut HUSKY	6.7% of FFS costs	CY2005
New Mexico Behavioral Health	Intentional increase w/ implementation	2005
Service Specific Studies		
CHCS - Prescription Drugs	Drug costs were 18% higher in FFS	--
Arizona - Prescription Drug Carve-Out Option	\$3.7M cost to carve-out Rx from capitation	--
California - Preventable Hospitalization	\$66M reduction in preventable hospital costs	1994 - 1999
Pennsylvania - Alcohol Treatment	Cost of treatment for alcohol-related conditions decreased by almost \$2K per member at the managed care site	1995 - 1998

Appendix C. Side by Side Summary of Studies

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
State Studies				
<p>Arizona Medicaid - Competition Among Managed Care Plans Lowers Program Costs, U.S. General Accounting Office, October 1995</p>	<p>1115 Waiver</p> <p>AHCCCS is Arizona's statewide Medicaid managed care program implemented in 1982. Prior to AHCCCS, Arizona did not operate a Medicaid program.</p> <p>Nine private or county health plans health plans cover the AHCCCS population. Five of the health plans are not-for-profit entities.</p>	<p>AHCCCS includes family planning, behavioral health, and LTC.</p>	<p>As of February 2004, 767,857 individuals were enrolled in the acute care program.</p> <p>(Enrollment data from Acute Care Enrollment, By County By Health Plan, http://www.ahcccs.state.az.us/Statistics/Enrollment/Acute/2004/enrollmnt.asp)</p>	<p>In FY1991, federal savings were \$37 M and state savings were \$15M in acute care costs.</p> <p>Arizona's capitation rate for Medicaid declined by 11% in 1994 even while other states' per capita costs grew.</p> <p>Arizona's administrative costs are higher than in other states.</p> <p>AHCCCS slowed the growth rate in Medicaid expenditure compared with the state might have experienced in a traditional FFS program. For the AFDC and SSI populations, the per capita growth rate from 1983 to 1991 was 6.8% versus an estimated 9.9% for a traditional Medicaid program.</p> <p>The biggest slow-down in AHCCCS growth rate was for SSI beneficiaries after 1987.</p> <p>Overall, AHCCCS spend 81% of what a traditional Medicaid program would have spent.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<p>Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, Milliman USA, Feb. 2002</p> <p>Study funding not specified</p>	<p>1115 waiver</p> <p>HMOs are present in nearly every WI county, and mandatory managed care enrollment has been implemented completely or partially in 47 counties. Voluntary managed care enrollment occurs in 21 counties. Enrollment is voluntary in counties where only 1 HMO is present.</p> <p>Eligibility: AFDC-children - Children who meet the requirements for the former AFDC program.</p> <p>BadgerCare - Parents and children under age 19 with incomes less than 185% FPL. Families income above 150% pay a premium of 3% of family income.</p> <p>Healthy Start - children and pregnant women with incomes up to 185% FPL, no asset limit.</p> <p>Dual eligibles are not enrolled.</p>	<p>Comprehensive benefits.</p> <p>BadgerCare Carve-outs include: LTC, transportation, family planning, prenatal care coordination, targeted case management, dental, chiropractic, school-based services, and TB-related services. Families with employer sponsored coverage, receive Medicaid wrap around services for those services excluded from the employer's benefits package.</p>	<p>Enrollment: AFDC/Healthy Start Children and Pregnant Women: 216,185 (as of report publication)</p> <p>BadgerCare: 64,036 (as of report publication)</p>	<p>2001: \$14M in state savings, \$21M in federal savings.</p> <p>2002: \$22M in state savings, \$34M in federal savings.</p> <p>The study attributes savings to MCO efforts such as a 24-hour nurse line, utilization management activities, and disease management programs. The 24-hour nurse line focused on reducing unnecessary emergency room visits, and the utilization efforts helped to reduce hospital inpatient admissions and number of inpatient days; which lead to reduced costs.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
KY Region 3 Partnership Program, Milliman USA, December 2003	1115 Waiver	Standard Medicaid benefits are covered. Carve-outs include LTC, MH, and school-based services.	2003: 132,579	Total Savings: FY1999: \$7.9M (2.8%) FY2000: \$16.1M (5.4%) FY2001: \$32.6M (9.5%) FY2002: \$35.8 M (9.5%) FY2003: \$17.7M (4.1%) - including savings from PCCM
	Mandatory for TANF, foster care, SOBRA, SSI, KCHIP.	Non-emergency transportation services are covered only for enrollees who need transport by stretcher only.	32% Sobra 29% TANF 17% SSI, no Medicare 10% Duals 9% KCHIP 4% Foster Care	
Health plan-funded study	All non-institutionalized Medicaid beneficiaries are enrolled, including dual eligibles. Dual eligibles receive the Medicaid only benefits (Rx and transportation) under the Partnership, dba Passport Health Plan.	There are no cost-sharing requirements.	(Enrollment data provided by University Health Care Inc, dba Passport Health Plan presentation, provided to The Lewin Group on 2/27/04.)	PMPM Savings: FY2000 TANF: \$6.69 Foster Care: \$15.17 Preg. Women: \$4.60 SSI/Medicare: \$19.41 SSI/No Medicare: \$31.91 Composite: \$11.67
	Passport Health Plan is a non-profit, provider-run, Medicaid health plan. AmeriHealth Mercy Health Plan administers Passport Health Plan.			
	Region 3 represents the state's largest urban area, including Louisville in Jefferson County and 15 surrounding counties. This area makes up 20% of the state's Medicaid population.			Sources of savings are not identified, but Passport attributes its savings to disease and utilization management (personal communication with Jill Bell of Passport Health Plan on 2/27/04).

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2003	1915(b) waiver Healthy Families (parents and kids up to 100% FPL) and Healthy Start (kids up to age 19 up to 200% FPL and pregnant women up to 150% FPL).	Standard Medicaid benefits are covered. The majority of mental health and substance abuse, and non-emergency transportation are paid under FFS. LTC is carved-out.	Enrollment (as of February 2004): Total managed care: 495,555 (2004) Mandatory: 297,166 (2004) Voluntary: 2107 (2004) "Preferred Option": 196,292 (2004) (Enrollment data from Ohio Department of Job and Family Services, Fact Sheet 2.4, Medicaid Managed Care, http://jfs.ohio.gov/ohp/bcps/FactSheets/MedicaidManagedCare.pdf)	\$26.4M in State FY2002 (2.2% of FFS) Cost effectiveness analysis compared projected FFS costs of the OH Medicaid program in managed care counties (w/o waiver) with the actual costs under the waiver. The main source of savings is from decreased use of inpatient hospital services.
State-funded study	6 health plans participate in 15 counties (as of July 03). MCO enrollment is mandatory in 4 counties, and voluntary in 5 counties. 6 counties are "Preferred Option" where only 1 MCO operates. In "Preferred Option" counties, beneficiaries choose either the MCO or FFS.			

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Michigan Medicaid: New Directions Presentation by MIDCH, July 23, 2003	1915(b) Waiver The Michigan capitated Medicaid program is statewide, in all but 19 counties. Managed care enrollment is mandatory in counties where the state can guarantee that 2 health plans will accept auto-assignment. Michigan has implemented the single plan rural option authorized under 42 C.F.R. 438.52.	Carved-out services include dental, behavioral health, school based services provided to special education students, and long term care.	As of August 2003, 836,387 individuals were enrolled in a Michigan Medicaid MCO. As of June 30, 2006, 1.3 million individuals were enrolled in a Michigan Medicaid MCO (http://www.statehealthfacts.org/profileInd.jsp?ind=216&cat=4&gn=24).	Medicaid Health Plans have lower costs and a slower rate of increase in PMPM costs. The difference in FFS and MCO PMPM costs as calculated by Lewin using data from the presentation are: 2001: -9% 2002: -14% 2003: -16% 2004: -19%
Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, prepared for the Michigan Department of Community Health, April 2005	Beneficiaries choose between at least 2 full-risk health MCOs in 54 of 83 counties; enrollment in a single MCO is voluntary in 7 counties; automatic enrollment into an MCO occurs in 4 counties; the single plan rural option occurs in 15 counties; MCO enrollment is not available in 3 counties. The voluntary population also includes: migrant individuals, Native Americans, individuals with TB, pregnant women in their third trimester or who became Medicaid eligible because of their pregnancy.			MCO PMPM costs were 9% lower than FFS PMPM costs and so forth. When capitated managed care is compared to alternative delivery systems, Michigan would save between \$28 million and \$129 million in State funds for FY2006. Comparison of Estimated State costs - MCO vs. FFS (cumulative 2004-2006): Without FY2006 MCO rate Increase/With QAAP: FFS costs \$330 million more than MCO Without FY2006 MCO rate Increase/Without QAAP: FFS costs \$152 million more than MCO With FY2006 MCO rate Increase/With QAAP: FFS costs \$247 million more than MCO With FY2006 MCO rate Increase/Without QAAP: FFS costs \$62 million more than MCO
Center for Health Program Development and Management at the University of Maryland, Baltimore County	Beneficiaries choose between at least 2 full-risk health MCOs in 54 of 83 counties; enrollment in a single MCO is voluntary in 7 counties; automatic enrollment into an MCO occurs in 4 counties; the single plan rural option occurs in 15 counties; MCO enrollment is not available in 3 counties. The voluntary population also includes: migrant individuals, Native Americans, individuals with TB, pregnant women in their third trimester or who became Medicaid eligible because of their pregnancy. Eligible populations include: TANF and related, SSI and related, and ABD.			

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
HealthChoice Evaluation, MD Dept. of Health and Mental Hygiene, January 2002	1115 Waiver Enrollment is mandatory for children, pregnant and postpartum women, families receiving Temporary Cash Assistance (TCA), Individuals receiving SSI, and foster children.	Carve-outs: specialty mental health, rare and expensive case management, long-term nursing facility benefit, health-related special education services under an IEP or IFSP, substance abuse treatment services in ICF-Additions for children under age 21, OT/PT, and speech therapy and audiology.	In CY2002, 455,000 were enrolled. Nearly 80% of MD Medicaid beneficiaries were enrolled in an MCO.	The 1115 waiver was found to be budget neutral. The state exceeded the BN cap in the 1 st 2 years of the waiver, but spending has been below the cap since. By the end of the third year, spending was about 2% below the cap.
State-funded study and Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, prepared for the Maryland Department of Health and Mental Hygiene, December 2007	Seven for-profit MCOs serve HealthChoice enrollees, of which 5 MCOs serve Medicaid enrollees only. The 4 largest MCOs are statewide.		By June 2003, 487,073 Individuals were enrolled in HealthChoice (Maryland HealthChoice Factsheet, January 2004, http://www.dhmh.state.md.us/mma/pdf/MdHC-fact-2004.pdf .) By 2006, 491,800 Individuals were enrolled in HealthChoice (Maryland HealthChoice Factsheet, January 2007, http://www.dhmh.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf .)	HealthChoice met the budget neutrality test each year for FY2000 through FY2007. By the end of FY2007, the State was about \$2 billion, or about 10 percentage points of margin under the budget cap.
Center for Health Program Development and Management at the University of Maryland, Baltimore County				Neither study identifies specific sources of savings.

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<p>Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansions, Mathematica Policy Research, for CMS, April 2001</p> <p>Study funding from the federal government</p>	<p>MPR and Urban Institute conducted a 6 year evaluation of 5 Medicaid 1115 waiver programs - HI, MD, OK, RI, TN - the were implemented between 1994-1997.</p>	<p>Comprehensive Medicaid benefits, with some state by state variation.</p>	<p>Varied by state.</p>	<p>Demonstrations had little impact on state expenditures and states did not achieve a high level of savings. 1 of the 5 states had average annual growth rates close to the national average for the same years.</p> <p>HI: 3.0%, US: 2.9%, years: 1993 - 1998</p> <p>MD: -0.2%, US: 2.6%, years: 1996 - 1998</p> <p>OK: 2.8%, US 2.4%, years: 1995 - 1998</p> <p>RI: 3.4%, US: 2.9%, years: 1993 - 1998</p> <p>TN: 2.8%, US: 2.9%, years: 1993 - 1998</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program, by The Lewin Group, May 2005	HealthChoices is Pennsylvania's managed care program for Medical Assistance beneficiaries. This program was implemented in 1997 as mandatory in Pennsylvania's urban zones.	Comprehensive Medicaid benefit package.	As of December 2007: Southeast: 495,333 Southwest: 271,769 Lehigh/Capital: 243,920	Despite being implemented in urban settings with higher cost platforms, HealthChoices average annual medical cost increase was 7.4% between 2001-2004, while FFS medical costs increased 10.4% between 1999-2002.
Coalition of Medical Assistance Managed Care Organizations	In 2003, the Pennsylvania Department of Public Welfare terminated statewide expansion of HealthChoices in favor of the ACCESS Plus program, an enhanced primary care case management and FFS program.			While other states' managed care programs are unable to balance profits with saving the state money, HealthChoice has found the balance with approximate revenue ratios of 90% medical cost, 8% administrative, and 3% profit. A conservative estimate has HealthChoices saving approximately \$2.7 billion between 2000 and 2004.
Independent Assessment of New Mexico's Medicaid Managed Care Program - Salud!, by The Lewin Group February, 2007	1915(b) waiver Salud! is administered by 3 MCOs.	Comprehensive Medicaid benefit package.	Lovelace MCO Members: 66,450	Higher costs per eligible due to quality of coverage, provider gross receipt tax of 7% and a premium tax assessment.
New Mexico Medical Review Association	All 3 MCOs were rated "excellent" by the National Committee for Quality Assurance. Physician fee schedules are high relative to other states.	Disease management, childhood immunization, adolescent outreach, and prenatal care programs. Addresses cultural and linguistic barriers.	Molina MCO Members: 59,159 Presbyterian MCO Members: 1,237	Annual cost trends are aligned with national averages. Estimated savings for FY2006 are between 3-5%, or \$33-\$56 million.

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<p>Medicaid Cost Containment Report No. 3, by The Lewin Group, January 2003</p> <p>The Washington State Legislature</p>	<p>Washington's Medicaid Utilization and Cost Containment Initiative (UCCI) is designed to find efficiencies and lower expenditures in Medicaid without reducing benefits or eligibility. One approach to cost containment has been the administering of care to the Medicaid population by 6 HMO's. The Lewin Group looked at the relationship between the HMO's and the State to find further opportunities for the State's cost saving efforts.</p>	<p>Comprehensive Medicaid benefit package.</p>	<p>In 2003, 403,162 Medicaid beneficiaries were enrolled in 1 of the 6 HMO's.</p> <p>The top 3 HMOs in terms of percentage of total enrollment were:</p> <p>Molina Healthcare - 38% Community Health Plan - 28% Premera Blue Cross - 11%</p>	<p>Washington had been increasing managed care rates at a pace higher than inflation. As a result, the HMOs had gained a surplus of \$30M, or 2.8% of Medicaid premiums from their Medicaid business from 1999-2001. If the State had limited just the 3 most Medicaid-focused HMOs to the State average hospital operating margin of 1.5% during CY2002, the State would have saved about \$30.5M.</p> <p>With an expected increase of capitation payments from \$600M to \$700M in 2004, the State could save \$7M for each percentage point reduction in payments.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Targeted Medicaid Managed Care Program Studies				
STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, Texas A&M University, PPRJ, October 1999	1915(b) Waiver for SSI and SSI-related populations in Harris County (Houston). These individuals are required to enroll in Medicaid managed care.	All Medicaid primary care, acute and long-term care services are covered. Medicaid only enrollees also receive specialty, home health, medical equipment, lab, x-ray, and hospital services through MCOs.	About 55,000 were enrolled mandatorily during the first waiver period. During the second waiver period, 57,000 individuals were enrolled.	Cost savings in the first waiver period: Waiver year 1: -\$1.97M, -\$2.68 PMPM Waiver year 2: \$7.57 M, \$10.22 PMPM
and	STAR+PLUS enrollees can choose between 2 MCOs or the PCCM, if the individual is not dually eligible.	Dually eligible enrollees receive acute care services from Medicare providers and LTC services through managed care, including personal care services, adult day care, and 1915(c) services.	As of February 2004, 62,782 individuals were enrollee. (STAR+PLUS website, http://www.hhsc.state.tx.us/starplus/enrollmen_numbers/confirm ed/confirm.htm .)	Waiver years 1&2: \$6.05M, \$4.11 PMPM Savings were less than 1% of the cost for the two years combined.
Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program, Public Policy Research Institute, June 2002 (Second waiver period)	94% of the population is over the age of 20, and 43% are age 65 or older.	Prescription drugs are carved out of managed care, but an enhanced benefit is available to managed care enrollees who choose the same MCO for Medicare and Medicaid services.		Cost savings in the second waiver period: Waiver year 1: \$66M, \$100.95 per member month Waiver year 2: \$56M, \$82.71 per member month Waiver years 1 & 2: \$123M, \$91.67 per member month.
State-funded studies				This represents a nearly 17% reduction in state Medicaid expenditure for this population from what would have been spent absent the waiver.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<p>Serving the Special Program/Aged, Blind and Disabled Population (In OK Medicaid managed care) by Schaller Anderson, April 2002</p> <p>Center for Health Care Strategies funded study</p>	<p>1115 Waiver</p> <p>Managed care enrollment became mandatory for the ABD Medicaid population in 1999. Managed care was implemented in 17 counties surrounding the urban centers of Oklahoma City, Tulsa, and Lawton. In other counties, the PCCM model was implemented.</p> <p>The study covered the SP/ABD population, i.e., the 583 individuals who were the top 10% of ABD service utilizers who were also enrolled in the Heartland Health Plan of Oklahoma.</p> <p>Individuals who are disabled and have incomes up to 100% FPL are eligible for Medicaid.</p> <p>**Effective Jan. 2004, the capitated managed care program was discontinued. In Nov. 2003, 1 of the 3 MCOs decided not to renew its contract with OHCA, prompting OHCA to terminate the MCO program. Individuals enrolled in an MCO are being transitioned into the PCCM program.</p>	<p>Behavioral health services are included in the MCOs benefits package with a \$10,000 per beneficiary limit. Beyond the limit the state pays 70% of additional claims. Carved out services include non-emergency transportation, services ordered through an IEP or IFSP, court-ordered treatment, non-state plan services ordered as a result of an EPSDT visit.</p>	<p>Claims savings were 15% of FFS. In assessing the full managed care payment costs in relation to FFS claims cost, overall PMPM costs were 4% lower in managed care. After removing the 10 most expensive enrollees, savings under managed care were 31%.</p>	
<p>How Managed Care Affects Medicaid Utilization A Synthetic Differences Zero-Inflated Count Model, Freund, D., Knlesner, T., LoSasso, A., April 1996</p> <p>AHRQ-funded study</p>	<p>The study analyzed the effects of managed care on doctor office visits, hospital outpatient dept. visits, ER visits, and hospital inpatient days.</p> <p>The study population included adult women.</p>	<p>Comprehensive Medicaid benefits were modeled.</p>	<p>Based on Hennepin County data used for the study.</p>	<p>Estimated economic savings totaled about 10%, which the authors state is lower than estimated savings reported in states' waiver applications.</p> <p>The 10% savings figure accounts for the initial effect of switching to managed care.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Assessment of HUSKY, Connecticut's Medicaid Managed Care Program, prepared for the four participating HUSKY managed care companies by The Lewin Group, January 2007	1915(b) waiver Connecticut's mandatory capitated managed care program for the State's TANF (HUSKY A) and SCHIP (HUSKY B) populations. HUSKY is statewide and is served by four different HMOs.	Comprehensive Medicaid benefits package. Carve-out: behavioral health (January 2006), essentially creating a disease management initiative for behavioral health services.	Over 309,000 (HUSKY A - 292,852; HUSKY B - 16,579) enrolled as of December 2006 Anthem Blue Cross Blue Shield - 132,852 Community Health Network - 57,703 HealthNet - 82,678 (only HUSKY A) WellCare - 36,198	HUSKY's per capita cost escalation is below the national rate for TANF cost escalation and the rate of inflation for selected non-HUSKY Medicaid subgroups. HUSKY medical loss ratio is 90-91% compared to 84.5% nationally. HUSKY administrative costs were between 6.8% and 10.2% between 2003 and 2005, low when compared to the national average of 12.2%. Expenditures under HUSKY are at least 5% less than any new non-capitated Medicaid managed care model (annual Medicaid savings of at least \$37 million).
Anthem Blue Cross Blue Shield Community Health Network of Connecticut HealthNet of the Northeast WellCare of Connecticut	Over 80% of the State's TANF spending occurs through capitation payments to health plans.			

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Independent Assessment of New Mexico's Behavioral Health Program, by The Lewin Group, March 2007	Prior to establishing a single, comprehensive mental health system for Medicaid beneficiaries in 2006, New Mexico had a fragmented system.	Comprehensive behavioral health services for the New Mexico Medicaid population.	As of July 2006, 69,380 individuals were enrolled in New Mexico's ValueOptions behavioral health carve-out.	It is not yet possible to determine the cost effectiveness of the new program for two reasons. First, the program has only been in place a year, therefore a comparison of trends cannot be made. More importantly, the program was replacing an inadequate predecessor and thus had many additional costs in an attempt to strengthen the behavioral health delivery system and improve patient outcomes. As a result, behavioral health costs increased by 26.3% in total dollars and by 34.5% on a PMPM basis. Despite the inability to determine true cost effectiveness, there is evidence of improved service delivery under the new program.
New Mexico Medical Review Association	Under the new program, behavioral health was carved out from the services provided by the 3 Medicaid MCOs. ValueOptions administered the program. The transitioning phase of the program was completed in 2006.			

Report	Program Description and Enrollment	Benefits	Savings
Service Specific Studies			
<p>Comparison of Medicaid Pharmacy Costs of Usage between the Fee-for-Service and Capitated Setting, prepared for CHCS by The Lewin Group, January 2003</p> <p>Center for Health Care Strategies funded study</p>	<p>Reported data focus on TANF enrollees.</p>	<p>Prescription drugs only.</p>	<p>Lewin calculated average PMPM pharmacy costs using data provided by states. The average cost in FFS was \$20.46 PMPM and in managed care \$17.36 PMPM. Both figures are post rebate and take into the average rebates received. Pharmacy costs are 18% higher in FFS than in managed care.</p> <p>This difference in average pharmacy costs exists even though health plans initially have a 15% price disadvantage compared to states, largely due to the Medicaid drug rebate rules. However, once lower dispensing fees, high rate of substitution of lower cost drugs, and reduced number of prescriptions is factored in, health plans achieve better drug prices than stated do for FFS.</p>
<p>Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared for CHCS by The Lewin Group, November 2003</p> <p>Center for Health Care Strategies funded study</p>	<p>AHCCCS is Arizona's Medicaid 1115 waiver program. Currently prescription drugs are included in the managed care benefit.</p>	<p>The study looked at prescription drugs only.</p>	<p>The AHCCCS system operates a cost-effective prescription drug benefit currently. The analysis demonstrates that the AHCCCS system is more cost-effective than other Medicaid programs, including in FFS. The study concludes that carving-out pharmacy from the capitation would increase program costs by \$3.5M.</p>

Report	Program Description and Enrollment	Benefits	Savings
<p>Preventing Unnecessary Hospitalization In Medi-Cal: Comparing Fee-for-Service with Managed Care, CHCF, February 2004</p> <p>California HealthCare Foundation funded study</p>	<p>Medi-Cal managed care was implemented on a county by county basis and included both voluntary and involuntary enrollment.</p> <p>During the study period, most of the large urban counties moved to mandatory managed care for CalWORKS (TANF) eligible Medi-Cal beneficiaries, if they hadn't already done so. The county operated health system (COHS) counties also moved to mandatory managed care for SSI-eligible beneficiaries.</p>	<p>Looked at preventable hospitalizations only.</p>	<p>The preventable hospitalization rate for Cal-WORKS eligible Medi-Cal beneficiaries was 7.2/1000 per year versus 11.4/1000 in FFS. The managed care rate was more than a third lower. Based on the average charge per preventable hospitalization, the cost to Medi-Cal was more than \$66M less in managed care than it would have been in FFS.</p> <p>The average annual rate of preventable hospitalization for SSI-eligible Medi-Cal beneficiaries was 57.5/1000 versus 76.4/1000 in FFS, about a third lower. The difference between FFS and managed care rates was about the same as for the CalWORKS population.</p>
<p>Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, May 2006.</p> <p>The American Journal of Managed Care</p>	<p>Philadelphia County: 400,000 enrolled (as of January 1998).</p> <p>The MCO is a carve-out agency that receives PMPM capitation fee for providing behavioral health services to the enrolled population.</p> <p>Allegheny County (Pittsburgh): 140,000 enrolled (as of January 1998) in the FFS program.</p> <p>During the study period, both sites were funded equally for public substance abuse treatment systems.</p>	<p>The study looked at behavioral health services for high-risk public-sector clients between 1995 and 1998 who were being treated for alcohol abuse or dependence problems.</p>	<p>The study looked at the pre- (1995) and the post-managed care period (1998) in both the managed care and FFS sites.</p> <p>Per person behavioral health costs decreased from \$7,662 to \$5,664 at the MC site per person, while they increased from \$4,871 to \$6,449 at the FFS site per person.</p> <p>Managed care site (Philadelphia County): \$1,200 reduction for alcohol abuse treatment; \$900 reduction for drug abuse treatment per person.</p> <p>FFS site (Allegheny County): \$400 reduction for alcohol costs; \$250 reduction for drug costs per person; increase of \$2000 per person for psychiatric inpatient costs.</p>