

# 2014 Record of Public Comments Received by the Alaska Health Care Commission

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Updated: 12-4-14

## Comments Received During Public Comment Period on Draft Report

Subject(s)	Commenter	Summary of Contents	Form and Date
2015 Priorities & Activities (Evidence-Based Medicine)	David Driscoll, PhD, MPH, Director, Institute for Circumpolar Health Studies, UAA	Pleased University faculty is included as a local resource for evidence-based guideline transmission through curricula. University staff and faculty can play additional roles in promotion of evidence-based practice in Alaska, such as developing evidence reports related to significant health outcomes in Alaska; and compiling, synthesizing, and translating evidence-based research findings on topics of concern to Alaska for health care stakeholders. Dr. Driscoll provided a similar service for the U.S. Agency for Healthcare Research and Quality while with the University of N. Carolina at Chapel Hill Evidence-based Practice Center.	Email; 11/17/2014
General; Fraud & Abuse; 2015 Priorities & Activities	Lizette Stiehr, Executive Director, Alaska Association on Developmental Disabilities (AADD)	<ul style="list-style-type: none"> <li>• 2015 Priorities &amp; Activities:               <ul style="list-style-type: none"> <li>○ AADD supports the policies selected for further action in 2015.</li> <li>○ Agrees with increased use of and support for Telehealth systems</li> <li>○ Agrees with the focus on wellness</li> </ul> </li> <li>• Regarding Fraud &amp; Abuse Recommendation I. a (enroll all rendering provider types): AADD does not support this approach for preventing fraud and abuse within the Home &amp; Community-Based Waiver System. Service delivery is more diverse than the PCA (personal care assistant) model and this requirement would not enhance effectiveness and quality. Individual enrollment of large group of part-time direct service workers would exacerbate existing workforce shortages and impact access to care.</li> </ul>	Letter; 11/19/2014

		<ul style="list-style-type: none"> <li>• Regarding Fraud &amp; Abuse Recommendation I.d (provide EOBs to Medicaid recipients): AADD agrees – providers recently advocated for this (transparency in billing for Medicaid patients) at MRAG meeting.</li> <li>• Regarding Fraud &amp; Abuse Recommendation V.g (electronic verification of PCA and Waiver services): AADD does not support this recommendation. Direct service providers are already required to document their work in electronic records, and requiring verification of contact with each recipient is particularly problematic for single providers serving groups (e.g. group day habilitation). It also assumes technology is available across the state, and adds work time when it fails. Creates another layer of administrative burden, is duplicative, creates a new unfunded mandate, and detracts from the core mission.</li> </ul>	
Fraud & Abuse; 2015 Priorities & Activities	Jeannie Monk, Senior Program Officer, Alaska State Hospital & Nursing Home Association (ASHNHA)	<ul style="list-style-type: none"> <li>• Appreciates focus on reducing fraud and abuse, but it is not a systemic problem — important to target resources to areas where it is more likely to occur.</li> <li>• Regarding Fraud &amp; Abuse Recommendations: <ul style="list-style-type: none"> <li>○ I.b (repurpose discretionary Myers &amp; Stauffer audits to target high-risk providers): Agree — Alaska hospitals and nursing homes have demonstrated compliance and the health care system is well-served by reducing unnecessary costs.</li> <li>○ I.c (improve communication with providers) and I.e (seek waiver from CMS from Medicaid Recovery Audit Contract program requirement): Agree — These are common sense approaches to the objective.</li> <li>○ V.d (care coordination for emergency room over-utilizers): Agree — suggest looking at WA State’s successful “ER is for Emergencies” program as a potential model; ASHNHA can help the State with this.</li> </ul> </li> <li>• 2015 Activities — Evidence-Based Medicine: Supports the concept in general, but success will depend on implementation — done poorly it will limit access, but done well it can improve</li> </ul>	Letter; 11/20/2014

		<p>quality. Stakeholder education is a good use of Commission resources.</p> <ul style="list-style-type: none"> <li>• 2015 Activities — Transparency: ASHNHA supports transparency; many hospitals are proactively posting quality data. More work needs to be done. Utility of data versus administrative costs of providing it is a key consideration, as facilities are under increasing regulatory and administrative burden, but supportive and willing to participate with the Commission as an engaged stakeholder.</li> <li>• 2015 Activities — Payment Reform: <ul style="list-style-type: none"> <li>○ Activity A: There are barriers to implementing enterprise-wide purchasing policies, such as public procurement rules. All proposed activities reference purchasing policies and strategies, implying rate negotiation rather than system transformation. Recommend changing the wording in this section from “purchasing policies and strategies,” to “payment methodologies.”</li> <li>○ Activity B: Recognize need to shift from pay-for-volume to pay-for-value. That shift in Alaska will be incremental. Demonstration and pilot projects to test new payment methods are important, and State must be willing to partner with providers.</li> </ul> </li> <li>• 2015 Activities — Workers’ Comp Reform: ASHNHA members, as large employers, supported 2014 legislation, and generally support this area of focus for the Commission’s work.</li> <li>• 2015 Activities — Healthy Lifestyles: ASHNHA supports this focus.</li> <li>• 2015 Activities — Opioid Control: Deeply concerned about this epidemic; supports Commission’s plans to facilitate learning, and can assist with finding experts in this field.</li> <li>• 2015 Activities — Foster Telehealth: Supports the recommendations and proposed activities. Telemedicine is underutilized due to multiple</li> </ul>	
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		<p>barriers. Include licensing regulatory barriers in the to-do list for stakeholders', and consider use of interstate medical licensure compact. Consider telemedicine as an opportunity in payment reform for improving access and quality of care through innovative delivery models. ASHNHA Telemedicine briefing papers are included as attachments for reference.</p>	
All-Payer Claims Database	Meg Jones, Associate General Counsel, United Healthcare Insurance Company	<p>Consider the APCD Core Standards which are available from the APCD Council, and which have been adopted successfully by many states and address most of the goals for health and price transparency and quality reporting. The Standards have proven effective in CO, UT, ME, NH, and VA, as have variations implemented in VT, MN and OR. They will most likely become the common standard nationally.</p> <p>UnitedHealthcare is an industry leader with national APCD experience, and would like to participate in Alaska stakeholder meetings and help Alaska avoid some of the issues experienced by other states that have developed overly complex data reporting requirements resulting in delays and poor data quality.</p>	Letter; 11/28/2014
Fraud & Abuse	Josh Steffes – <i>affiliation unknown</i>	<ul style="list-style-type: none"> <li>• Regarding Fraud &amp; Abuse Recommendations IV.c (remove statutory barrier to DHSS and Dept of Law access to prescription drug database) and IV.d (create robust prescription drug control program): Strongly opposed to these two recommendations. They would reduce medical privacy and harm doctor-patient confidentiality. Medicaid patients would be flagged as doctor-shoppers for seeking second opinions. Extensive program expansion will place bureaucrats in the middle of patients and their doctors resulting in poor health outcomes.</li> <li>• Regarding Fraud &amp; Abuse Recommendation V.f (investigating beneficiaries who pay cash for prescriptions): Most strongly opposed to this recommendation, because: <ul style="list-style-type: none"> <li>○ Nothing inherently suspicious about making purchases with cash – reduces fees for businesses and reduces risk of credit card breach.</li> </ul> </li> </ul>	Email; 11/28/2014

		<ul style="list-style-type: none"> <li>○ Bureaucrats shouldn't investigate people for everyday transactions unless there is evidence of abuse.</li> <li>○ Purchase still requires signature and valid photo id.</li> <li>○ Others receiving publicly funded insurance (eg, state workers) are not subject to this level of scrutiny.</li> <li>○ Investigation is not defined, raising numerous concerns.</li> <li>○ Government investigations into purchase decisions of Medicaid recipients may be unconstitutional and violate the first and fourth amendments.</li> <li>○ Casts too wide a net and will engulf many innocent Medicaid beneficiaries.</li> </ul>	
General; 2015 Priorities & Activities	J. Kate Burkhart, Executive Director, Alaska Mental Health Board & Advisory Board on Alcoholism and Drug Abuse	<ul style="list-style-type: none"> <li>● General Comments: Applaud Commission's increased efforts to include behavioral health in consideration of the entire health care system.</li> <li>● 2015 Activities – Evidence-based Medicine: A 2014 Streamlining Initiative identified recommendations for improving behavioral health prior authorization processes (Report attached). Please review, and include the behavioral health boards and AK Behavioral Health Association in streamlining efforts.</li> <li>● 2015 Activities – Transparency: Concur with need for pricing info for consumers and providers, but concerned about Department's ability to provide this information due to lack of administrative resources and discretionary staff. Also concerned about burden on providers to provide this data. Encourage further discussion on cost benefit of this recommendation.</li> <li>● 2015 Activities – Prevention/Healthy Lifestyles: Important, but concerned that Healthy Alaskans 2020 excluded key health issues due to data limitations. Research on issues driving poor health outcomes must be implemented in structured way to support a more informed process in identifying health priorities for each decade.</li> </ul>	Letter; 11/28/2014

		<ul style="list-style-type: none"> <li>• 2015 Activities – Prevention/Opioid Control: Support this recommendation, but consider adding continuing education related to illicit drug abuse impact of reduced access to prescription opiates. Incidence of heroin abuse and addiction has increased as prescription opioid controls have been implemented. Recommend that Medical and Pharmacy Boards work together on regulations regarding Naloxone for patients in treatment for opiate addiction. Prevention and safety policies must include treatment of opiate addiction or costs will just shift to other sectors.</li> <li>• 2015 Activities – Telehealth: Strongly endorse this as a priority and encourage the Commission to examine how state laws and regulations support and hinder effective use of telemedicine, which is essential to behavioral health providers across the state.</li> </ul>	
General; Fraud & Abuse; 2015 Priorities & Activities	Nancy Shima, CEO, Northland Audiology & Hearing Services	<ul style="list-style-type: none"> <li>• General Comments: <ul style="list-style-type: none"> <li>○ 3 key components of access, quality and affordability are intertwined and it may be difficult to achieve and maintain all three. Alaska’s delivery challenges result in lack of economies of scale and higher overhead costs. Public payers (Medicare, Medicaid, TRICARE) underpay – rates are lower than the cost of providing services – and private pay patients subsidize publicly funded patients. Reduced private fee levels may result in loss of ability to see publicly funded patients and lack of access for those vulnerable citizens.</li> <li>○ Most providers already subscribe to evidence-based practice – Commission should incorporate evidence-based practices in health care reform strategies – look at lessons learned re: effectiveness of provider incentives and understand roles of intrinsic and extrinsic rewards in reshaping healthcare practices.</li> <li>○ Quit portraying providers as greedy.</li> <li>○ Use evidence-based practices to understand the degree and picture of success.</li> </ul> </li> <li>• Regarding Fraud &amp; Abuse Recommendation I.d (Providing Medicaid Patients with EOBs): Providing Explanation of Benefits to Medicaid Patients not likely to bear fruit given the</li> </ul>	Email; 12/01/2014

		<p>challenges with Xerox; and lacking meaningful negative impact tied to overspending.</p> <ul style="list-style-type: none"> <li>• Regarding Fraud &amp; Abuse Recommendations IV.A (require bonding), and V.c (Service Utilization Review): Requiring some provider types to be bonded, or looking for and auditing unusual use patterns may help uncover fraud and abuse.</li> <li>• 2015 Priorities &amp; Activities — Workers’ Comp Reform: Reducing Worker Comp fees to Medicaid levels may decrease access, value and quality for Workers’ Comp patients.</li> <li>• 2015 Priorities &amp; Activities — Payment Reform: Payment reform initiatives would benefit by bringing providers into the discussion early.</li> <li>• 2015 Priorities &amp; Activities — Prevention/Healthy Lifestyles: Likely the most cost effective measure in the long run and should be a major campaign initiative.</li> </ul>	
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## Erickson, Deborah L (HSS)

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**From:** David Driscoll <ddriscoll@uaa.alaska.edu>  
**Sent:** Monday, November 17, 2014 12:01 PM  
**To:** Erickson, Deborah L (HSS)  
**Subject:** RE: a comment on Recommendations of the Alaska Health Care Commission

Good morning Deb,

Thank you for this gracious response.

Allow me to provide more background on my note below:

I am pleased that the members of the Commission included University faculty as a local resource for the transmission of evidence-based guidelines through curricula. With this email, I would like to highlight an additional role that University faculty and staff might play in the promotion of evidence-based practice in Alaska. University personnel can develop evidence reports for local health stakeholders related to common, expensive, and/or significant health outcomes in Alaska. We are a state with unusual challenges and needs, which are often insufficiently described in national evidence-based reports. I propose that, with the necessary resources, University health and medical researchers can collect and synthesize literature, and facilitate the translation of evidence-based research findings to stakeholders, related to topics of concern to Alaska.

Prior to coming to UAA, I had the pleasure of working with the Evidence-based Practice Center (EPC) at RTI International and UNC Chapel Hill to provide such a service to the Agency for Healthcare Research and Quality. The EPC reviewed relevant scientific literature to produce evidence reports based on rigorous, comprehensive syntheses and analyses of the scientific literature on topics relevant to clinical, social science/behavioral, economic, and other health care organization and delivery issues. The resulting evidence reports were used by Federal and State agencies, private sector professional societies, health delivery systems, providers, payers, and others committed to evidence-based health care.

Please let me know if I can provide additional information.

Best,

*David*

phone - 907/786-6581

fax - 907/786-6576

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**From:** Erickson, Deborah L (HSS) [<mailto:deborah.erickson@alaska.gov>]  
**Sent:** Friday, November 14, 2014 3:51 PM  
**To:** David Driscoll  
**Subject:** RE: a comment on Recommendations of the Alaska Health Care Commission

Hi Dr. Driscoll,

Thanks so much for taking the time to review our draft. And thanks for the offer to participate in future work with university stakeholders on evidence-based medicine – we have you on our list and will make sure you're invited!

I'm sure the Commission will be interested to hear your suggestion to have the university partners participate in disseminating Alaska-specific evidence to clinicians. They will consider your suggestion at their meeting on December 9 when they review all of the comments we'll receive this month and then make final changes for their 2014 report.

I can and will share this e-mail message from you below as your official comments and suggestion with them if you'd like — Or was this just a preliminary inquiry and would you prefer to provide a little more background to explain your request?

I'll plan to share your message below with them, unless I hear otherwise from you. Please feel free to give me a call (334-2474) if you want to discuss our process.

Best,  
Deb

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**From:** David Driscoll [<mailto:ddriscoll@uaa.alaska.edu>]  
**Sent:** Monday, November 10, 2014 10:01 AM  
**To:** Erickson, Deborah L (HSS)  
**Subject:** a comment on Recommendations of the Alaska Health Care Commission

Hello Deb,

I wanted to thank you for all your hard work on draft report of the Health Care Commission. I'd like to specifically speak to the item below...

1. The Commission recommends that Commissioners of State agencies responsible for purchase of medical services (Health & Social Services, Administration, Labor & Workforce Development, and Corrections) and the President of the State University System:

a. Incorporate high grade evidence-based medicine when making determinations relative to provider payment methods and health plan benefit design (such as covered services, prior authorization requirements, and patient cost-sharing differentials); and in so doing:

- Coordinate development and application of evidence-based medicine policies across programs and departments to create a consistent approach supporting improved quality and efficiency in Alaska's health care system.

- Support a transparent policy development process.

- Develop policies that do not restrict access to appropriate treatment, but foster informed discussions between patients and clinicians to support individualized, evidence-based choices to improve the quality of health care.

- Ensure prior authorization processes are efficient, prompt, and user-friendly for providers and patients.

d. Provide patient decision-support tools to assist State health insurance plan members and public program clients to make effective care choices in consultation with their clinicians.

e. Promote provider-patient relationships through payment structures and benefit designs that support providers in monitoring patient compliance, and support patients to comply with best practices for managing chronic conditions such as asthma, diabetes, hypertension, and hyperlipidemia.

**Recommendation:** Convene University of Alaska and Alaska Pacific University health program leaders and stakeholders to discuss current strategies and opportunities for strengthening integration of evidence-based medicine skill development in curricula for clinician and health care administrator training programs such as nursing, medicine, and health care management.

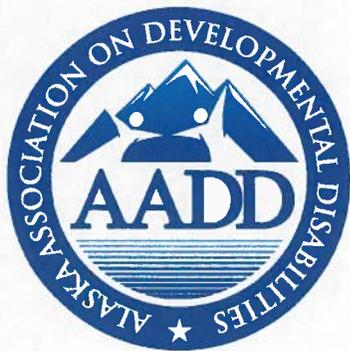
First, this is an exciting and important concept, and I'd be pleased to participate in these discussions.

Second, I wonder if you might be willing to augment this recommendation to include having University partners also coordinate the collection and dissemination to current clinicians evidence-based recommendations that are of particular relevance for Alaskans?

Best,

*David*

David L. Driscoll, PhD, MPH  
Associate Professor and Director, Institute for Circumpolar Health Studies  
Associate Dean for Research, College of Health  
University of Alaska Anchorage  
3211 Providence Drive, DPL 404  
Anchorage, Alaska 99508  
[DDriscoll@uaa.alaska.edu](mailto:DDriscoll@uaa.alaska.edu)  
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**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.*

November 19, 2014

Debra Erickson, Executive Director  
Alaska Health Care Commission  
3601 C Street, Ste. 902  
Anchorage, AK 99503-5923

Dear Debra ,

The Alaska Association on Developmental Disabilities (AADD) is the voice of 40 providers offering developmental disability services through the Home and Community Based waiver system statewide. The members of the association offer services to individuals of all ages under the Medicaid waiver program.

Our Association has reviewed the Transforming Health Care in Alaska, 2014 Report, 2010 – 2014 Strategic Plan. We support the prioritization selected by the Commission for work in 2015 particularly: Increasing Transparency, Engage and Support Employees, Strengthen Front End Care and Improve Care for Seriously Ill Patients.

During public comment the Medicaid Reform Advisory Group, recipients and parents asked for transparency of the billing to Medicaid for their costs and services pointing out their interest and willingness to help detect potential fraud and abuse. AADD made recommendations to the same group concerning increased use of telehealth which is reflected under prioritized goal VI: Improving Care for Seriously Ill patients. Any support of the telehealth system state wide will be a cost savings opening other opportunities for such services. Additionally, the ACES study supports the wisdom of the focus on wellness, supported strongly in your Health Care Plan.

AADD does want to provide some caution in Core Strategy III, Pay for Value. We agree that the proposed activities for 2015 for the Commission should include convening leaders of the impacted Departments and starting with demonstration projects. Under the previous work in the Plan, Core Strategy III, on page 10 includes a recommendation: " a) requiring the enrollment of all rendering provider types."

AADD does not support this approach to preventing fraud and abuse within the Home and Community Based waiver system. The nature of service delivery is more diverse than the PCA model and this enrollment requirement would not enhance the effectiveness and quality services.

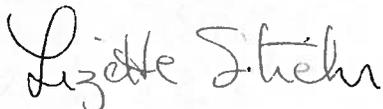
The individual enrollment of a large population of part time direct service workers would increase high turnover and exacerbate an existing shortage in the workforce. If it were required this would add to the hiring burden of programs and slow the process of getting direct service providers into homes and community for services.

AADD does not support Core Strategy III, in section V, on page 11 which is a recommendation to increase medical management to address waste in the Medicaid program by: g) "Implementing electronic verification of PCA and waiver services."

Currently direct service providers document their work in electronic records the provider agencies have implemented. Requiring contact with the agency at each pick up and dropping off of each recipient of a service is complicated by a single direct service provider giving services to more than one recipient (group day habilitation), assumes the technology available across the State of Alaska and adds working and time constraints when technology fails. It creates yet another layer that the agency is required to develop, maintain and check. Families or individuals with responsibility for consumers know if services were provided and do contact agencies when there is a delay or a no-show. This additional layer of technological oversight is duplicative and detracts from the core mission of providing services.

These strategies also represent new "unfunded mandates" that are added to provider agencies. Thank you for allowing the field an opportunity to comment on all of your hard work on behalf of the health of all Alaskans.

Sincerely,

A handwritten signature in cursive script that reads "Lizette Stiehr".

Lizette Stiehr  
Executive Director, AADD  
907-854-0322  
director@aaddalaska.org



November 20, 2014

Deborah Erickson, Executive Director  
Alaska Health Care Commission  
3601 C Street, Suite 902  
Anchorage, Alaska 99503-5924

Dear Deb,

Thank you for the opportunity to provide comments on the Alaska Health Care Commission's 2014 Report/2010-2014 Strategic Plan.

Regarding the 2014 Findings and Recommendations, we appreciate the focus on reducing fraud and abuse in the Medicaid program. As we have seen in the news, fraud and abuse does exist within the program, but such fraud and abuse is not systemic. Thus, it is important to target resources toward areas where fraud and abuse are more likely to occur.

Given the significant number of recommendations in the document, we will not comment on each individually, but rather reserve our comments for those we feel most valuable. Specifically, we support recommendation I(b) which recommends repurposing discretionary Myers and Stauffer audits under AS 47.05.200 to target provider types that pose the greatest risk of overpayment, relieving the administrative burden on providers demonstrating compliance. We believe that Alaska hospitals and nursing homes have demonstrated compliance and the health care system is well-served by reducing unnecessary state expenses and administrative costs.

We also appreciate the recognition of the need to improve communication with providers through the audit process and the recommendation that the state seek a waiver from CMS for the Medicaid Recovery Audit Contractor program. These common sense steps will help to accomplish the state's objective of reducing fraud and abuse by enabling the state to focus effort where it is most needed.

Finally, we agree with and support the need for care coordination and case management for Medicaid recipients who overutilize the emergency rooms. We would like to highlight a program in Washington State, the "ER is for Emergencies" program, which has reduced overall fee-for-service emergency room visits by 9.9% and reduced the rate of ER utilization by frequent visitors (defined as five or more visits annually) by 10.7%. Scheduled drug prescription also dropped by 24 percent. Our members remain willing to have conversations with the state about implementation of this program in Alaska.

Regarding the proposed Commission activities for 2015, we provide the following comments:

***Incorporate Evidence-based Medicine in Payment & Benefit Design and Provide Decision-Support:*** Many of these recommendations relate to specific actions by health plans, so we will

not provide specific comment on those recommendations. In general, however, we support the concept of evidence-based medicine. As with any policy recommendation, however, the success or failure of the initiative will depend upon implementation. If done poorly, evidence-based medicine could limit access to necessary treatment. If implemented well, however, evidence-based medicine can improve the quality of care. Providing additional education to stakeholders and the public about evidence-based medicine is a productive use of the Commission's resources.

***Investigate Transparency Legislation:*** ASHNHA members support the concept of transparency. Through the Hospital Engagement Network project, many our facilities have become more transparent with respect to quality data, posting their data publicly in their facilities. We recognize that more work remains to be done and that our members are at different points with respect to price and quality transparency. A key consideration for both price and quality transparency is the utility of the data versus the administrative cost of collecting, posting and maintaining it. We are mindful of these considerations and the increasing regulatory, administrative and fiscal burdens our facilities face. Nevertheless, we support the concept and will be working through the process with the Health Care Commission as an engaged stakeholder, with the hope that through the process, we can reach consensus on appropriate and useful information for the public.

***Implement Payment Reform:*** Providers will respond to what the market is willing to pay for. The current system pays for volume, but a better system would pay for value (defined by the triple aim of cost, quality and patient experience). While many in the health care field recognize the misalignment between what is optimal and what the system currently pays for, system transformation in Alaska will likely be incremental. Thus, we believe it is important to facilitate demonstration projects and pilot projects to test new ways of paying for care (Recommendation III.1.B). For these to be successful, the state must be willing to partner with providers to explore concepts like shared savings.

We note that there are significant barriers to enterprise-wide purchasing efforts (Recommendation III.1.A), such as the state procurement code, which this document does not address. Further, we recommend a language change in this section. All three of the sub-bullets (i, ii, and iii) refer to purchasing policies and strategies, which imply negotiation on rates rather than system transformation. We believe that the state should focus on working collaboratively with payers to explore payment reform rather than implementing "purchasing policies and strategies." The concept of payment methodology should be more integrated into these sections and should replace the purchasing policies language.

***Reform Workers' Compensation Laws:*** ASHNHA supported Workers' Compensation Reform legislation in the 2014 Legislative Session. Hospitals are typically the largest private sector employers in their communities. As such, workers' compensation costs are a significant issue. While we have not yet taken positions on the specific reform activities identified (with the exception of the fee-for-service fee schedule, which was addressed last session), we provide our general support for this area of focus of the Commission's work.

***Encourage and Support Healthy Lifestyles:*** We support this as a policy focus of the Commission.



**Adopt Opioid Control Policies and Programs:** Alaska's hospitals and nursing homes are deeply concerned about the opioid epidemic. One of the successes of the "ER is for Emergencies" project is the reduction in opioid prescriptions for the Medicaid populations. Emergency Rooms play a role in helping to address this issue. We support the efforts of the Commission to facilitate additional learning in this area and we can assist by providing the names of experts in the field.

**Foster Telehealth:** We support the recommendations and activities under telehealth. We believe that telemedicine and telehealth are underutilized assets in Alaska because of challenges in policy, payment, equipment and broadband capacity, licensure, training resources, and actual implementation.

We see value in the Commission convening stakeholders to identify barriers to implementation, develop strategies to overcome the challenges, and support increased utilization of telehealth in Alaska. We would add to the list of activities for the stakeholders to work to overcome regulatory barriers such as licensure and to consider Alaska participation in an interstate medical licensure compact.

During 2014, ASHNHA invested resources to investigate telehealth opportunities and challenges with a special emphasis on small/rural hospitals. We have identified specific barriers that create obstacles to implementing telehealth services and believe the Commission could take an active role in advocating for solutions to the obstacles. ASHNHA also completed an assessment of the current state of telehealth among small/rural hospitals and identified issues that need to be addressed to increase adoption of telehealth.

As part of the effort to support and advocate for telemedicine in Alaska, it would be beneficial to consider telemedicine an opportunity in payment reform rather than in the existing fee for service model. As part of larger reform, telemedicine could be a way to increase access to care, and to improve care coordination and home care monitoring if reimbursement is not focused solely on office-based encounters.

Included with this letter are two of the briefing papers developed as part of our telehealth investigation that outline existing telehealth services and needs/issues identified. A third paper focused on telehealth legislation, payment and regulations will be released soon. We hope this information will add to the Commission's effort.

Thank you for the opportunity to comment on the 2014 Report.

Sincerely,

A handwritten signature in black ink that reads "Jeannie Monk". The signature is written in a cursive, flowing style.

Jeannie Monk  
Senior Program Officer

Attachments: Telehealth Issues and Needs and Telehealth Promise and Practice in Alaska



**Meg Jones**  
Associate General Counsel  
7525 SE 24<sup>th</sup> Street, Mercer Island, WA 98040  
Tel 206-230-7117 | [meg.l.jones@uhc.com](mailto:meg.l.jones@uhc.com)

Sent Via Electronic Mail

November 28, 2014

Deborah Erickson, Executive Director  
Alaska Health Care Commission  
3601 C Street, Ste. 902  
Anchorage, AK 99503-5923

via e-mail: [deborah.erickson@alaska.gov](mailto:deborah.erickson@alaska.gov)

Re: UnitedHealthcare Insurance Co. comments – Alaska Health Care Commission

Dear Ms. Erickson:

Thank you for making the Alaska Health Care Commission 2014 draft report available for comment. United Healthcare Insurance Co (UnitedHealthcare) respectfully submits the following comments.

UnitedHealthcare would urge Alaska to consider the APCD Core Standards which are available from the APCD Council at [http://www.apcdouncil.org/sites/apcdouncil.org/files/APCD%20Council%20CORE%20Data%20Elements\\_5-10-12.pdf](http://www.apcdouncil.org/sites/apcdouncil.org/files/APCD%20Council%20CORE%20Data%20Elements_5-10-12.pdf) which have been adopted successfully by many states, and address most of the goals for health transparency, price transparency, and quality reporting. This flat file format has been proven effective in CO, UT, ME, NH, and VA, with variations of the same implemented in VT and MN and OR, and most likely to become the common standard.

As an industry leader with national APCD experience, UnitedHealthcare would like to participate in stakeholder meetings and assist Alaska in meeting their health care data goals, as well as share our vast APCD experience with Alaska, as you embark on this work. We would appreciate the opportunity to participate in ongoing dialogue to help Alaska avoid some of the issues experienced by other states with overly complex data reporting, which may lead to delays and disappointing data quality.

Sincerely,  
*Meg L. Jones*

Meg L. Jones  
Associate General Counsel  
UnitedHealthcare Insurance Company

## **Erickson, Deborah L (HSS)**

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**From:** Josh Steffes <joshsteffes@gmail.com>  
**Sent:** Friday, November 28, 2014 4:10 PM  
**To:** Erickson, Deborah L (HSS)  
**Subject:** Transforming Health Care in Alaska 2014 Draft - Public Comment

Hello Deborah Erickson:

I am writing in strong opposition to three recommendations by the Alaska Health Care Commission in Part III of its *Transforming Health Care in Alaska 2014 Public Comment Draft*.

### **Part III: Section IV. c) and d)**

The first two recommendations I am opposed to read, respectively:

*"Remove statutory barriers to Department of Health & Social Services and Department of Law access to and use of the Prescription Drug Database for fraud identification and statewide drug abuse prevention efforts."*

*"Create a more robust prescription drug control program by ensuring financial support to continue the program, and supporting upgrade of the database to real-time functionality to identify and prevent doctor-shopping practices."*

These recommendations would reduce medical privacy and harm doctor-patient confidentiality. Medicaid recipients will potentially be discouraged from seeking second opinions for fear of being flagged as doctor-shoppers. Access to electronic protected health information should only be expanded in a carefully-crafted manner under necessary circumstances.

An extensive program expansion, removal of apparent statutory protections or limitations, and addition of real-time functionality, taken together, will place bureaucrats in the middle of patients and their doctors, ultimately leading to poor health outcomes.

I am in strongest opposition to the third recommendation.

### **Part III: Section V. f)**

*"Investigating beneficiaries who pay cash for prescriptions for controlled substances, potentially with the intent of making the purchase more difficult to track, to ensure the drugs were not diverted for improper or illegal use."*

This recommendation is severely misguided on a number of grounds.

1. There is nothing inherently suspicious about making purchases with cash. Cash allows local businesses to keep more of the purchase price by avoiding transaction fees. It also reduces the risk of credit or debit card theft by limiting the number of businesses that have such information. Rampant credit card and data breaches, as occurred at Target, Home Depot,

Kmart, Michaels, Dairy Queen, AT&T, JP Morgan Chase and now apparently Staples – among many others – highlight the increasing importance of this practice.

2. Bureaucrats should not be "investigating" people for everyday transactions that don't meet any credible measure of suspicion, let alone reasonable suspicion. Even if such standards aren't required to be applied under law, we should respect the medical privacy of Medicaid recipients unless clear evidence of abuse is present.
3. The doctor-prescribed medicine that is being referred to is kept behind the counter. To purchase this medicine, a signature and valid photo identification is required. Anyone looking to make "the purchase more difficult to track" would be overlooking these factors. Of course, if false identification was presented, that would constitute reasonable suspicion.
4. The potentially-cited defense that Medicaid recipients receive public money and therefore should be subject to this additional level of scrutiny is dubious given its extraordinary nature. State workers, judges, and politicians receive public money as well and will not be subject to an "investigation" for purchasing their doctor-prescribed controlled-medicine with cash (if not on Medicaid, as most likely are not). Any recommendation of this magnitude should – if not simply apply across the board – then first and foremost include the most powerful in society, not the least.
5. "Investigation" is not defined and could be construed to mean any number of things, which itself raises a number of concerns.
  - o How invasive would the investigation be?
  - o Would there be any limits, checks, or balances on those conducting the investigation?
  - o What rights and resources would Medicaid beneficiaries have to protect themselves?
  - o Would law enforcement be involved at the initial stage? At what point would they be?
  - o When would recipients be informed they were under investigation? If the investigation goes nowhere, would they ever be?
  - o Would data be made public regarding how many innocent people were investigated versus those that were attempting to abuse the system?
  - o Would the cost of investigating these innocent people be made public?
  - o Would Medicaid recipients be informed before making their purchase that they will be subject to an investigation if they do so with cash?
6. Arguments can reasonably be made that government investigations into the purchase decisions of Medicaid recipients in this manner are unconstitutional and violate the first and fourth amendments. For instance, if an individual did utilize cash to purchase doctor-prescribed medicine in an effort to avoid being tracked, that could be construed as a politically-motivated, constitutionally-protected protest against overwhelming government surveillance. Meeting that legal, peaceful protest with further government surveillance and unchecked investigations is not only deeply ironic, but radical and dangerous to a free society.
7. This extreme recommendation casts too wide a net and will engulf many innocent Medicaid beneficiaries in illegitimate investigations. Targeting a population based upon their low income and health care needs with investigations lacking reasonable suspicion of wrongdoing is beneath privacy-conscious Alaska and should be scrapped from the final draft.

Fraud is an extremely important topic in all respects and must be taken seriously, especially given the public resources involved here. However, I feel the commission has erred in the three recommendations outlined above.

Thank you for your time and consideration of this lengthy comment on this important matter.

~Josh Steffes



THE STATE  
of **ALASKA**  
GOVERNOR SEAN PARNELL

**Department of  
Health and Social Services**

ALASKA MENTAL HEALTH BOARD  
ADVISORY BOARD ON ALCOHOLISM  
AND DRUG ABUSE

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Deborah Erickson, Executive Director  
Alaska Health Care Commission  
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Re: Comment on *Transforming Health Care in Alaska, 2014 Findings and Recommendations*

Ms. Erickson,

The Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse (Boards) appreciate the opportunity to comment on the Alaska Health Care Commission's *Transforming Health Care in Alaska, 2014 Findings and Recommendations*. We applaud the Commission's increased efforts to include behavioral health in its considerations of Alaska's entire health care system, and the opportunities we have had to inform the Commission's processes. The Boards provide the following comments about specific findings and recommendations. For clarity, the sections of the Commission's recommendation are in bold, followed by comments from the Boards.

**Policy Recommendation I.**

**Proposed Commission Facilitation Activity C: Prepare a white paper on options and opportunities for improving prior authorization procedures in State of Alaska health plans (AlaskaCare and Medicaid) to make them more user-friendly for health care providers.**

The Boards, in partnership with the Alaska Behavioral Health Association, have specifically identified prior (or "service") authorizations as an area in need of streamlining. The results of the 2014 Streamlining Initiative are attached. We urge the Commission to review these findings and recommendations and to include the Boards and Alaska Behavioral Health Association in any deliberations regarding how best to streamline behavioral health system prior authorization processes.

**Policy Recommendation II.1: Investigate Transparency Legislation (from 2013 Annual Report)**

**The Alaska Health Care Commission recommends the Commissioner of the Department of Health and Social Services investigate, and the Alaska Legislature support implementation of, a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices as engaged consumers.**

While the Boards concur in the need for and value of accurate pricing information for consumers and providers, we have serious concerns about the Department's ability to provide quality information as contemplated by this recommendation. There is neither an excess of administrative resources within the Department nor an excess in funds available for contracting out the planning, research, and analysis required to offer Alaskans this kind of pricing transparency. There is also a lack of discretionary staff or financial resources to support implementation of the system by which this information would be made available to consumers. This is of particular concern to our constituency, many of whom experience chronic mental health and co-morbid conditions. Inaccurate or superficial information related to price/cost of care for chronic conditions will result in poorly informed consumers and policymakers. We also have significant concerns as to the financial burden to providers of gathering and reporting these data. We encourage the Commission to have further discussion and consideration of the costs and benefits of this effort in our current financial climate.

#### **Policy Recommendation VII.1**

**Proposed Commission Facilitation Activity A: Convene leaders of the Healthy Alaskans 2020 initiative from the Department of Health and Social Services and the Alaska Native Tribal Health Consortium (Commissioner, CEO and Division Directors) with the Healthy Alaskans 2020 Advisory Team to identify and discuss challenges to ongoing implementation of this collaborative statewide population health improvement initiative. Work together to identify options for long term sustainability.**

The Boards emphasize the value of this activity. At present, Healthy Alaskans 2020 relies on indicators and strategies chosen for their ability to be measured as well as their potential to improve health outcomes. This process has had the unintended consequence of excluding key health issues. Research of issues driving poor health outcomes in Alaska needs to be implemented and monitored in a structured way in between development of Healthy Alaskans initiatives. This intentional coordination of effort would allow for study of baseline data for important indicators – allowing for a more informed process in identifying focus areas each decade.

#### **Policy Recommendation VII.6: Adopt Opioid Control Policies & Programs (from 2013 Annual Report)**

**The Alaska Health Care Commission recommends the State of Alaska adopt aggressive prescription opioid control policies and programs. . .**

The Boards concur with this recommendation, and see value in all four recommended strategies for reducing over-prescribing of opiates and prescription diversion. We would encourage the Commission to add specific continuing education related to the incidence of illicit drug abuse (i.e. heroin) as a result of reduced access to prescription opiates to its recommendations. Over the past decade, as tribal health organizations, physicians, and pharmacists have tightened prescribing practices and instituted no-narcotics lists for patients suspected of prescription misuse or diversion, the incidence of heroin abuse and addiction has increased. Acknowledgement of this likely switch to street drugs by Alaskans with opiate must be considered. We also encourage the Commission to recommend that the State Medical Board and

Board of Pharmacy work together to promulgate regulations to govern the prescribing and dispensing of Naloxone to patients in treatment for opiate addictions. Any public health and safety policy related to opiates in health care must include the treatment of opiate addiction, and this is an area in which physicians have specifically asked for guidance from the State Medical Board. Without this additional considerations, money saved in the medical area will just be shifted to public safety, behavioral health, and/or other agencies.

**Policy Recommendation VIII.A.3: Foster Telehealth (a & b from 2009 and c & d from 2012 Annual Report)**

The Boards strongly endorse this as a priority, and encourage the Commission to undertake an examination of how Alaska's laws and regulations support – and hinder – the effective use of telemedicine. Telemedicine is essential to behavioral health providers in small communities, as well as large ones. For example, Fairbanks relies on this provision of health care delivery for Alaskans who require services from a psychiatrist. Telemedicine supports discharge and aftercare planning for patients returning to rural communities, and can ensure consistent care from physicians and providers with whom patients have an established and ongoing relationship. This not only results in a higher quality of care for patients/clients, but also reduces costs incurred for *locum tenens* providers.

Thank you for the opportunity to participate in the Commission's work over the past year, and the to share our comments on the 2014 report.

Sincerely,



J. Kate Burkhart  
Executive Director

## **Erickson, Deborah L (HSS)**

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**From:** Nancy Shima <rongstad@gci.net>  
**Sent:** Monday, December 01, 2014 6:01 AM  
**To:** Erickson, Deborah L (HSS)  
**Subject:** Alaska Health Commission public comments

### **Public Comments for the Alaska Healthcare Commission, whose charge is to find pathways that result in the highest overall health status of all Alaskans.**

3 key healthcare components (access, quality & affordability) identified by the Commission as pivotal indicators in Alaska's transformative optimization strategies and assessments, are intertwined such that changes in one facet stand to affect status/performance levels in the others. It is reasonable to expect to simultaneously hit 2 optimization goals of this triad, but a far greater challenge (and perhaps an unattainable goal) to achieve and to sustain concurrent optimization of all three.

Given Alaska's unique population patterns coupled by healthcare provider shortages, it is easy to surmise that our state's private medical providers hold a monopoly that affords them to too much fee-setting clout. As a means to support the best health of all Alaskans and help avert the state's looming healthcare spending crisis, Commission recommendations encourage provider assistance via measures that may include lowering fees and seeing more patients, taking (more) responsibility for patient compliance and health outcomes, counselling/educating patients about healthy/preventative/risk-lowering measures, etc. Major third party administrators stand ready to cast their insurance networks all across this final, elusive healthcare frontier.

When private healthcare providers set their fee rates, they must necessarily assess their practice's particular sustainability challenges (i.e. will patient numbers, medical services types and payment rates generate adequate revenue to meet expected overhead expenses?) Specialty providers practicing in low population areas can be particularly sensitive to the notion that they lack efficiency advantages afforded by *economy of scale*, and thus may seek creative ways to adapt their practice patterns in an effort to reach a sustainability equilibrium. Some common Alaskan provider supplementary measures might include flying to outlying communities in order to offer periodic services, but this also incurs tradeoffs that contribute to increased practice overhead costs (travel/lodging expenses, clinic staff and expensive equipment duplications, additional clinic rental fees etc.) as well as potential quality-of-life issues that can affect the provider and/or their family.

Most local providers tend to try to find ways to see all patients needing their services. Alaska's "typical" population mix has relatively high percentages of "underpaying" patients (such as those covered by Medicare/Medicaid/TriCare-type insurances) where reimbursement rates are lower than the costs of providing services. (This, despite, as the Milliman report indicates,

such federally funded “allowable” rates range being much higher than in the study’s comparator states.) From a business perspective, seeing these patients is only possible only as long as there are sufficient subsidizing funds collected from private pay patients to offset the losses. (Assuming all patients receive the same highest quality of care, this is a scenario that reflects high healthcare access rates, lower rating in “affordability” (for private pay patients) and an “affordable” rating for the federally sponsored/funded ‘underpaying’ patients.) No private practice can stay in business relying solely on the reimbursement rates paid for services to Medicare/Medicaid/TriCare patients. Given Alaska’s high proportion of Medicaid recipients, and the fact that the state’s fastest growing population segment is the Medicare-aged bloc, such measures as private pay fee reduction (which would thereby score a higher Transformative Healthcare measure for “value”), *unless accompanied by concurrent sufficiently-rising reimbursement rates for the large ‘underpayer’ population*, would likely fail as a sustainable business model (thus scoring 0 on the “access” prong.) An alternate lifesaving measure the provider might be forced to enact is to cease accepting Medicare/Medicaid/TriCare patients. Thus some of the state’s most vulnerable citizens could rate the provider ok on features of “quality” and “value” but poorly on access.

Comments regarding the Commission’s proposed measures **(Part 111) Medicaid fraud reduction**: Based on my experiences with many Medicaid patients who were advised about the costs for their services (and our occasionally being instructed by Medicaid to “re-council,”) I have scant basis to believe that that this *cost-counselling information approach* will result in significant cost-savings. As well, I have little faith that sending Medicaid patients all their EOBs will reduce fraud. For starters, considerable time may have lapsed between the date of service and the recipient receiving the final EOB, or the patient may not remember or recognize the rendering provider’s name or service. Acknowledging that Xerox EOBs can be difficult to decipher, even for medical billing staff, I expect that it will likely be even more ‘unmeaningful’ to Medicaid recipients. Given the multiple re-processings needed with Xerox still, there would be just a lot of meaningless-looking EOBs for the Medicaid recipient to try to decipher. Unless there is some meaningful negative impact tied to individual overspending, I suspect most Medicaid patients would become ‘immune’ to the piles of EOBs that may flood their mailboxes. I believe in the mission of uncovering and thwarting attempts at Medicaid fraud, but for the majority of Medicaid recipients and their families, I don’t believe notifying them via EOB will bear fruit. Requiring some groups of provider types to be bonded, or looking for unusual use patterns and auditing for those may help uncover fraud and abuse.

**Regarding the 7 identified Alaska Healthcare Transformation Strategies, proposed Priorities and Related actions:**

Policy Recommendation activities pertinent to IV.4. Regarding measures to **reduce Workers Compensation fees** (i.e. to match Medicaid reimbursement levels.) With reduced compensation, some providers will no longer agree to see these patients. Given this commenter’s given background perspective (provided above) regarding the provider services

for “underpayers”, consider that if reductions are made in the Workers Compensation fee schedule (to Medicaid reimbursement levels) more WC claimants may find it difficult to find a local provider willing to provide their healthcare services, so additional travel funds will be required. From a provider practice perspective, handling some Workers Compensation claims is already be overly burdensome and often requires considerable extra effort in order to receive payment, (despite having obtained prior approvals.) As well, some WC patients may have more in-depth healthcare needs than many Medicaid patients and may seem overly demanding in requesting items that Medicaid rates don’t cover, etc. **What seems like a good idea in cost savings, may decrease access, value and quality.**

**Proposed Facilitation Activities for Policy Recommendation III.1 A** In most Healthcare Committee meetings thus far, it seem that in general, the voice of the healthcare provider has not been offered or heard. Some payment reform initiatives would benefit by bringing providers into the discussion much sooner than the Commission proposes. What could look like a great idea in terms of group purchasing schemes may not be workable overall for providers, so it is better to have provider input early and understand their concerns and what is feasible from their perspective.

**V11.1 Focus on prevention** is likely the most cost effective measure in the long run and **should be a major campaign initiative.**

**Other misc:**

**Most healthcare providers already understand and subscribe to “best practices” and “evidence based practices.” The Commission should aim to incorporate evidence-based practices in designing Alaska’s HealthCare Reform strategies. Look at lessons ie. regarding the effectiveness of provider incentives for providing Quality Medicine. Understand the roles of provider intrinsic and extrinsic rewards in reshaping healthcare practices.**

**Quit portraying all providers as greedy.**

**Use evidence-based practices to understand the degree and picture of “success” portrayed by other states you plan include in your presentations to employers etc.**

**I hope these comments have been helpful to the Commission.**

**Best regards,**

**Nancy Shima**

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**From:** Erickson, Deborah L (HSS) [mailto:deborah.erickson@alaska.gov]

**Sent:** Friday, November 28, 2014 12:40 PM