HOUSE FINANCE COMMITTEE
February 6, 2007
1:36 p.m.

CALL TO ORDER

Co-Chair Meyer called the joint meeting of the House Finance Committee, the House Health and Social Services Committee, and the House Ways and Means Committee to order at 1:36:30 PM.

MEMBERS PRESENT

House Finance Committee

Representative Mike Chenault, Co-Chair
Representative Kevin Meyer, Co-Chair
Representative Bill Stoltze, Vice-Chair
Representative Harry Crawford
Representative Richard Foster
Representative Les Gara
Representative Mike Hawker
Representative Reggie Joule
Representative Mike Kelly
Representative Mary Nelson
Representative Bill Thomas, Jr.

House Health and Social Services Committee

Representative Peggy Wilson, Chair
Representative Bob Roses, Vice-Chair
Representative Anna Fairclough
Representative Mark Neuman
Representative Paul Seaton
Representative Sharon Cissna
Representative Berta Gardner

House Ways and Means Committee

Representative Mike Hawker, Chair
Representative Anna Fairclough, Vice-Chair
Representative Peggy Wilson
Representative Paul Seaton
Representative Max Gruenberg
Representative Sharon Cissna
Representative Bob Roses

MEMBERS ABSENT

None

ALSO PRESENT

Andy Cohen, Director, The Pacific Health Policy Group; Scott Wittman, Director, The Pacific Health Policy Group; Senate President Lyda Green

PRESENT VIA TELECONFERENCE

None

SUMMARY

Medicaid Program Review

1:36:34 PM

Co-Chair Meyer introduced members of the three committees.

1:37:45 PM

SENATE PRESIDENT LYDA GREEN explained that last year the Senate Finance Committee released an RFP for a program review consultant to help the committee understand Medicaid and to make suggestions on how to improve Alaska's program. A contract was awarded to the Pacific Health Policy Group RFP for a program review for the study of the Medicaid Program. Senator Green recalled a high percent of calls from Medicaid clients who are frustrated with their health care, and from health care providers who are frustrated with the growing paperwork requirements and varied reimbursement rates. She pointed out that department staff are working diligently to run the Medicaid program as efficiently as possible and are equally frustrated with juggling an overwhelming amount of details that impact every client, provider, the agency's internal organization, and the legislature.

Senator Green sympathized with how complex the Medicaid program is for clients, health care providers, and program managers, as well as for the budget staff. She noted the difficulty of finding a remedy through statute if all legislators do not fully understand the implications of their actions.

Senator Green related that the first step to better understanding of Medicaid came from the Department of Health and Social Services' fiscal forecast prepared by the Lewin Group and ECONorthwest. The key findings of this report were:

1. The Medicaid program will change fundamentally over the next 20 years from one focused on children to a program geared to caring for Alaska's growing senior and Alaska Native populations.

2. State matching funds will increase from approximately $500 million per year to more than $2 billion for a total program cost of more than $5 billion.

Senator Green reported that ECONorthwest developed a computer program by which the department can continue to update data to develop more accurate program criteria and generate funding forecasts. The establishment of baseline data and developing the forecasting model is step-one in implementing program change.

Senator Green explained step two to better understanding of Medicaid. After recovering from sticker shock of the projected costs for Medicaid, the Senate Finance Committee released an RFP for a program review consultant to help understand Medicaid and make suggestions to improve Alaska's program. In April 2006, a contract was awarded to the Pacific Health Policy Group based out of Irvine, California. Their charge was to help establish the programmatic baseline so that the legislature and the administration could make program changes to improve Alaska's Medicaid program.

Senator Green said she has heard many opinions regarding the services provided and the eligibility criteria of Medicaid, but it is very difficult to fully understand the implications of change because the program is so complicated.

Senator Green asked several questions:

> We are asked to make changes to Medicaid statutes, but how do we, as legislators, make sound recommendations when we may not fully understand the implications to the client, health care providers, agency staff, or the budget? What program changes can be made to better serve Alaska's needy population? How can we make the changes based on sound research rather than assumptions or emotions?

She explained that The Pacific Health Policy Group evaluated Medicaid eligibility and service coverage policies and provided an overview that defines the populations that Alaska is required to serve and the services it is required to cover under federal law.

1:41:33 PM

Senator Green related that legislators frequently want to know how Alaskan programs compare to those of other states. To help make this comparison, The Pacific Health Policy Group reviewed Alaska's service coverage policies and eligibility criteria and ranked Alaska with the other 49 states and Washington, DC. These rankings can be found

under Appendix A in "Report to the State of Alaska Senate Finance Committee – Medicaid Program Review" (copy on file.)

Senator Green pointed out that Alaska's Medicaid State Plan was approved in 1974. Since that time, all changes have been made by amendment and create a difficult sequence of rules to follow. She questioned:

> If the Medicaid director or key staff positions turn over, how much knowledge is lost during the transition and, therefore, how much is dropped through the cracks?
>
> How can the legislature and agency program staff create a tool to better understand the relationship of the State Plan, statutes, and regulations?

Senator Green reported that The Pacific Health Policy Group completed a crosswalk of Alaska's State Plan, statutes, and regulations to help identify where, if any, pieces did not relate well with its counterparts. This information is provided in Appendix B of the final report.

Senator Green addressed the issue of when there were optional services mandated to constrain the Medicaid program to spend within a limited budget, the restriction could not hold up to unanticipated growth in program costs and client needs. She recalled frustration to see very large supplemental requests come before the Legislature each year with relatively no option for legislators, except to pay for the cost of this important program. To answer the question of how do we create a program that is more predictable, Senator Green noted program reform options outlined in Chapters 2 through 6 of the report. Many of these options are tried and true changes that have been proved successful in other states. Although Alaska has unique obstacles when compared to other states, The Pacific Health Policy Group has identified options that may create positive changes for Alaska.

Senator Green introduced Andy Cohen and Scott Wittman. Scott Wittman is located in the Mid-West and worked most specifically on the review of program compliance and development of reform options. Andy Cohen works out of California and worked specifically on the evaluation of program policies and the comparison of Alaska's policies to those of other states.

1:44:05 PM

ANDY COHEN, DIRECTOR, THE PACIFIC HEALTH POLICY GROUP, introduced the "Alaska Medicaid Program Review" (copy on file), which was based on a 50-state analysis, a regulatory review, and an operational review. Mr. Cohen showed slides called "Presentation of Findings" and provided a handout by

the same name for the committee (copy on file). He addressed the project objectives as shown on Slide 3. The purpose of the review is to assist the legislature with the evaluation of short and long term program reform initiatives and identify strategies that enable the program to operate with the flexibility necessary to best serve Alaskans, recognizing budgetary realities. The project should also identify oversight priorities for the legislature.

1:46:51 PM

Mr. Cohen related the information on Slide 4 – potential reforms defined in the RFP. He highlighted the six reforms that were considered.

1:48:31 PM

Mr. Cohen explained Slide 5 – work steps taken. He explained the five steps of the process.

1:49:22 PM

Mr. Cohen turned to Slide 6 – topics to be covered today. He planned to address summary finding from the 50-state review, current operations and trends by service type, and recommendations for reform and oversight.

1:49:59 PM

Mr. Cohen explained the "Executive Summary" as portrayed on Slide 7. He pointed out that Alaska is expensive and mentioned cost pressures. He noted the state's aging population and reforms that can be taken.

1:51:18 PM

Mr. Cohen discussed Slide 8 – demographics and Medicaid eligibility. He gave an overview of mandatory and optional groups. He explained the "medically needy", which are termed Alaska's Chronic & Acute Medical Assistance (CAMA).

1:53:01 PM

Mr. Cohen explained the 50-State Summary table as shown on Slide 9 – Federally Defined Coverage Groups. He highlighted Slide 10 – Alaska Optional Coverage Groups (sfy '05). He explained how the money is going to be spent on these beneficiaries.

1:55:04 PM

Mr. Cohen skipped to Slide 12 to explain Coverage of Optional Populations. He further clarified that the pie charts compare Alaska to national enrollment and

expenditure. The chart on the lower right is the direction Alaska is headed due to the aging population and its impact.

1:56:17 PM

Mr. Cohen explained Slide 13 – Enrollment Growth. He made some comparison points by explaining Slide 14 – Medicaid and Uninsured Populations. Medicaid covers a large percentage of Alaskans, but the percentage without insurance is also relatively high. He discussed the tribal health factor and the way the federal government counts persons with and without insurance.

1:59:18 PM

Mr. Cohen highlighted Slide 16 – Medically Needy and CAMA. Alaska is one of 16 states without a Medically Needy program, but it has CAMA. He explained how other states have dealt with this issue. He related how "waiver eligibles" draw down federal dollars and allow for an agreed upon level of spending. He used Mississippi as an example of a state that has added a waiver program – Slide 17.

2:01:54 PM

Mr. Cohen spoke to optional and mandatory covered services, as depicted on Slide 18. Alaska is comparable to most other states in terms of the optional services covered, but is more expensive and spends more per beneficiary than other states do.

2:02:48 PM

Mr. Cohen compared Alaska to the national average per beneficiary - Slide 19. The chart on Slide 20, Expenditure Growth, shows that Alaska's expenditures grew faster than the average annual rate early in the decade, but have since fallen back to the middle range. Slide 21 shows expenditures by beneficiary type, where Alaska is ranked in the top five in every category.

2:04:37 PM

SCOTT WITTMAN, DIRECTOR, THE PACIFIC HEALTH POLICY GROUP, explained Slide 22 – Where are the Dollars Spent? He highlighted each of the five major service categories. Hospital services are depicted in Slide 23 and Physician/Clinic services are shown in Slide 24.

2:08:21 PM

Mr. Wittman discussed Pharmacy services seen on Slide 25. He related that the payment rates and dispensing fees are

among the highest in the country. He suggested strategies for bringing these costs down.

2:09:37 PM

Mr. Cohen discussed Long Term Care – Nursing Facilities/HCBS projections shown in Slide 26. He explained the low utilization load and high rates. He discussed the HCBS waiver programs shown in Slide 27. There has been a growth outside of waiver programs in personal care attendant (PCA) programs. Alaska spent $80 million on PCA, while the two waivers amounted to only $42 million. PCA would no longer be a state program if it was converted to a waiver service.

2:13:54 PM

Mr. Cohen addressed Slide 28 – Nursing Facilities/HCBS Recommendations – Long Term Care.

2:15:03 PM

Mr. Cohen spoke to the Developmentally Disabled aspect of Long Term Care, as explained on Slide 29. He stated that Alaska serves all DD beneficiaries through waivers. He explained the costs of the waiver and how they are managed. He made suggestions for how to better manage the waivers with a cost reporting tool for providers, audits, and updating of rates.

Mr. Cohen noted that 12 percent of the state's DD funding is from grants, not federal dollars. He spoke of ways to create a second waiver and to seek federal matches.

2:18:43 PM

Mr. Wittman addressed Behavioral Health – Slide 31. He spoke about insufficient community based services and discussed the "Bring the Kids Home" initiative. He suggested ways to achieve additional early intervention/community based services.

2:20:48 PM

Mr. Wittman explained Tribal Health issues – Slide 32. American Indian/Alaska Natïves (AI/AN) represents 40 percent of the state's Medicaid population; tribal health is a $740 million delivery system. The report suggests a fresh look at this issue.

2:22:34 PM

Mr. Wittman referred to a graph on Slide 33 to further explain Tribal Health – AI/AN Current Medicaid Funding. He

explained the state and federal share of Medicaid funding for both tribal providers and non-tribal providers.

2:24:06 PM

Mr. Wittman discussed Tribal Health Recommendations on Slide 34. Alaska spends about $19 million per year on nursing facility costs for AI/AN beneficiaries residing in non-tribal facilities. The report suggests that the state should consider investing in development of tribal long term care.

2:25:30 PM

Mr. Wittman discussed Slide 35 – Tribal Health Recommendation. He maintained that the state should consider a Section 1115a waiver to designate the tribal system as a managed care entity. Mr. Cohen added that the "capitation payment" would move from a state line item to a 100 percent federally funded program.

Mr. Wittman opined that the entity would be well-received. Mr. Cohen noted that it would be unique to Alaska.

2:28:38 PM

Mr. Wittman address Administration – Slide 36. He explained that DHSS was reorganized into four major divisions in 2003. He addressed administrative costs and spending.

2:29:38 PM

Mr. Wittman explained Program Integrity/Provider Payments as they relate to Administration – Slide 37. He explained that the federal government is phasing-in a new audit structure for states, known as the Payment Error Rate Measurement (PERM). He discussed the demands on the new Medicaid Management Information System (MMIS).

2:31:12 PM

Mr. Wittman spoke of Regulations – Administration, as seen in Slide 38. He maintained that the new regulations were essential, are more clearly drafted, and are already yielding results.

2:32:24 PM

Mr. Wittman spoke about Broad-Based Reform and Planning for Reform – Slide 39. Some states have undertaken major reforms. The state has more flexibility under such reform, but must commit to a level of spending.

2:34:04 PM

Mr. Wittman covered the Reform Objectives of Broad-Based Reform – Slide 40. The purpose is to ensure improved quality of care.

2:35:20 PM

Mr. Wittman listed the steps needed to achieve Broad-Based Reform - Slide 41. There are several strategies that are needed for the reform to be effective. He identified specific reforms to be undertaken.

2:37:17 PM

Representative Wilson asked about long term care and the developmentally disabled wait list. She wondered if many of those waitlisted clients are already getting some services. Mr. Cohen said they were. He suggested that the DD services could be addressed with waivers and federal dollars. Representative Wilson voiced a concern about waning federal dollars and loss of services that have already been offered. Mr. Wittman talked about the adverse results of the tightening up of services.

2:40:26 PM

Mr. Cohen thought Representative Wilson's point is well-taken. He maintained that it is harder to take existing services away.

2:41:03 PM

Representative Gardner inquired about programs needing federal approval. Mr. Wittman explained the process of a concept paper, a less formal waiver application at the state level, followed by a waiver application process. When approval is received, dependant on several factors, it usually takes about 12 to 18 months.

2:42:54 PM

Mr. Cohen added that it must be demonstrated that it has been a public process.

2:43:28 PM

Representative Gara referred to Slide 19. He wondered if the cost adjustment was based on Anchorage numbers. Mr. Cohen replied that it based on federal poverty levels, which are unique in Alaska and Hawaii. He described how the ratio was attained. He termed it a crude adjustment and explained why it was done that way. Representative Gara thought this comparison was important and should be adjusted for the reality of medical care costs around the state. Mr. Cohen

agreed, and added that there are unique transportation costs. Mr. Wittman added that the providers in other states are complaining about rates. In Alaska there is not a program with a dramatic cost shift from other payers as a result of low pay rates on the Medicaid program.

2:47:07 PM

Representative Gara referred to Denali Kid Care, known as the Childhood Health Care program nationally. He asked how the Alaska program ranks nationally with coverage at 175 percent of poverty, and if other states that provide a higher level of coverage charge a co-pay to offset costs. Mr. Cohen replied that co-pays and premiums are often charged. Mr. Wittman referred to page 23 of the report, which shows a 50-state comparison of federal poverty limits (FPL) and State Child Health Insurance Program (SCHIP) limits for children. Mr. Cohen clarified that the number is probably at 160 FPL today in Alaska due to a change in law to a fixed dollar amount.

2:49:19 PM

Representative Wilson referred to Denali Kid Care and concluded that prevention is the key. Mr. Cohen agreed and added that employers can not always take up the costs. He spoke to employer initiatives to pull in the market place and the private sector into a partnership. He referred to Oklahoma's experience in launching OFA. The federal government contributes to the cost of the program. Individuals under 200 percent of poverty working for small employers are covered at a fixed level of approximately $100 a month. The employer covers 25 percent, the worker pays up to 5 percent of their income, and the state covers the rest.

2:53:05 PM

In response to a question by Representative Wilson, Mr. Wittman explained that the intent is to lower state costs.

2:53:43 PM

Representative Kelly noticed that federal funds are shrinking. He questioned why the state would want to support a race-based health system. Mr. Wittman noted that there is a $740 million health care system, which perhaps should be expanded to cover everyone. He observed that there are federal dollars available, but emphasized that the program could be expanded. Representative Kelly concluded that the intent is to utilize federal dollars. Mr. Wittman agreed that the idea is to expand federal dollars.

2:56:57 PM

Representative Stoltze referred to certificate of need (CON) and how it affects cost. Mr. Wittman observed that there are new regulations for the CON process. He noted that the report does not address the appropriateness of the CON approach.

In response to a question by Representative Stoltze, Mr. Cohen observed that there is a difference in opinion regarding the matter and that they did not have sufficient resources to make a decision.

2:59:15 PM

Representative Thomas asked what would happen if Alaska Native Health Services were eliminated. Mr. Cohen observed that if there were no Native health care, eligible for federal funds, that the state would be responsible for 40 percent ($80 million) for Medicaid. Mr. Wittman added that INHS dollars would also add hundreds of millions to the state's percentage.

3:00:57 PM

Co-Chair Chenault referred to the uninsured population of 17.8 percent. He noted that the Native population is not considered insured if they have no other coverage, which is the same as in other states.

Mr. Cohen noted that the numbers are from a federal survey. Mr. Wittman said that many states have moved forward with additional coverage. Alaska has a high uninsured population due, in part, to the number of small employers.

Representative Nelson pointed out that there is a 42 percent cost savings for Natives being treated by a recognized provider. Mr. Cohen agreed and explained that, in many cases, the bill is higher, but the federal coverage is 100 percent.

3:04:54 PM

Representative Nelson wondered if Indian Health Service is being threatened in any way. Mr. Cohen referred to Oklahoma and concluded that the tribal system would need to be brought to the table with INHS. Representative Nelson concluded that it is a political and financial move, not a racially motivated move. Mr. Wittman interjected that it needs to be supported on the state level before it is taken to the federal level. It is more than a financial motivation; it is a means to bring service to the client groups.

3:07:56 PM

Representative Joule questioned what the result of Medicaid revision is, in terms of dollars to the state. Mr. Cohen stated that there is no end total. He stressed that it would be impossible to provide an absolute dollar amount. He could put a dollar amount on a number of items such as tribal change and CAMA. The question is whether the total investment in the system should be considered along with savings.

3:10:45 PM

Representative Gara referred to coverage by other states of higher income families with a sliding scale fee. He asked for other examples. Mr. Wittman explained that it is a cost effectiveness test. The intent is to encourage sustainability in the employer market, if insurance is less expansive for enrollment. It is a combination of programs, with sliding scale premiums. The federal government does not like to see premiums that exceed 5 percent of family income. He offered to proved examples.

3:13:34 PM

Representative Gara asked if any of the plans provide 100 percent health care coverage for children. Mr. Wittman responded that Illinois and Massachusetts do. Vermont is going to move forward to universal coverage if it does not achieve 96 percent. Washington is moving toward 300 percent of poverty level and is trying to make sure that universal coverage is achieved. Massachusetts is the only state that has already moved to 300 percent for adults.

ADJOURNMENT

The meeting was adjourned at 3:15 PM.