**MINUTES**
**SENATE FINANCE COMMITTEE**
**SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE**
**February 6, 2007**
**9:01 a.m.**

## CALL TO ORDER

Co-Chair Lyman Hoffman convened the meeting at approximately 9:01:28 AM.

## PRESENT

**Senate Finance Committee:**
Senator Lyman Hoffman, Co-Chair
Senator Bert Stedman, Co-Chair
Senator Charlie Huggins, Vice Chair
Senator Kim Elton
Senator Donny Olson
Senator Joe Thomas
Senator Fred Dyson

**Senate Health, Education & Social Services Committee**:
Senator Bettye Davis, Chair
Senator John Cowdery
Senator Joe Thomas
Senator Kim Elton
Senator Fred Dyson

**Also Attending:** SENATOR LYDA GREEN; SENATOR JOHN COWDERY; SENATOR GARY STEVENS; ANDY COHEN, Director, Pacific Health Policy Group; SCOTT WITTMAN, Director, Pacific Health Policy Group

**Attending via Teleconference:** There were no teleconference participants

## SUMMARY INFORMATION

Medicaid Program Review Presentation
Pacific Health Policy Group

The Committee heard a report regarding the State's Medicaid program from Pacific Health Policy Group, a consulting firm secured by the Legislature. No Committee action was taken.

9:01:37 AM

^Alaska Medicaid Program Review Presentation

Alaska Medicaid Program
Review Presentation
by Pacific Health Policy Group

9:02:11 AM

Co-Chair Hoffman advised that the Pacific Health Policy Group's (PHPG) presentation would align with the information included in the handout titled "Alaska Medicaid Program Review" [copy on file] dated February 2007. The Review is a synopsis of PHPG's comprehensive "Medicaid Program Review" report [copy on file] dated January 2007. A document titled "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025", dated February 15, 2006 [copy on file], which had been prepared at the request of the Alaska Department of Health and Social Services (DHSS) by the Lewis Group and ECONorthwest, was also distributed.

Co-Chair Hoffman recognized Senator Lyda Green for "spearheading" the effort to address the challenges presented to the State by the Medicaid program. Senator Green was also instrumental in selecting PHPG as the consulting firm charged with compiling the January 2007 Medicaid report.

9:03:36 AM

SENATOR LYDA GREEN acknowledged Legislative Staffer, Ginger Blaisdell, for developing the strategy utilized in this effort.

9:04:04 AM

Senator Green informed the Committee that she and other legislators often receive calls from Medicaid beneficiaries and providers "who are frustrated with the growing paperwork" accompanying Medicaid programs. Even though State personnel are

"working diligently to make the Medicaid program work as efficiently as possible" they, like members of the Legislature and program beneficiaries, are frustrated by the complexity of the program. Legislative "fixes" to Medicaid program's problems have been evasive.

9:04:47 AM

Senator Green communicated that the Lewin Group and ECONorthwest report was the initial step toward understanding the Medicaid issue. She cited the key findings of that report as follows.

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.

9:05:25 AM

Senator Green characterized Medicaid program funding increases as "sobering".

Senator Green advised that ECONorthwest developed a computer program which allows DHSS to continually update data and forecast future funding needs. The baseline data provided by ECONorthwest's report and their forecasting model were instrumental in the effort to implement program change.

Senator Green stated that following the release of the Lewin Group and ECONorthwest report, the Senate Finance Committee released a Request for Proposals (RFP) for the development of "a programmatic baseline so that the Legislature and the Administration could make program changes to improve Alaska's Medicaid program". That contract was awarded to PHPG.

Senator Green explained that any changes to the State's Medicaid program, which was developed in 1974, are made via the amendment process. This has resulted in "a difficult sequence of rules to follow".

9:06:31 AM

Senator Green also warned of the potential for institutional knowledge to be lost as State Medicaid management team transitions occur.

Senator Green communicated that the purpose of securing a firm to review the State's Medicaid plan, Statutes, and regulations was to provide information upon which the Legislature and the Medicaid program management "could identify where, if any, pieces did not relate well with its counterparts". This information is provided in Appendix B of PHPG's comprehensive report.

Senator Green declared that many opinions exist about program services and eligibility requirements. The issue is complex, as are "the implications of change" on stakeholders. While the Legislature is responsible for recommending program Statute changes, they are challenged "to make sound recommendations when we may not fully understand the implications to the client, providers, agency staff or the budget".

Senator Green proclaimed that program changes "to better serve Alaska's needy population … should be based on sound research rather than on assumptions".

Senator Green informed the Committee that the report also ranked Alaska's Medicaid "services and eligibility criteria" against other states and the District of Columbia. This information is reflected in Appendix A of PHPG's comprehensive report.

9:08:37 AM

Senator Green cited another concern as follows.

> 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 needs and client needs. It was frustrating 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.
>
> How do we create a program that is more predictable? Program reform options are outlined in Chapters 2 through

Chapter 6. Many of these options are tried and true changes that have been 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 reported that PHPG has a history of Medicaid program reform success in other states including Arizona, Oklahoma, Vermont, and West Virginia. PHPG has also worked extensively with the federal Indian Health Service (IHS) and tribal providers to address problems unique to those services. Some of the reforms resulting from those efforts could benefit Alaska.

Senator Green informed the Committee that Andy Cohen, a policy analyst with PHPG, would be leading today's presentation. His expertise included evaluating "managed care strategic planning; fee for service; home and community service; base services; and service providers".

9:10:08 AM

Alaska Medicaid Program Review
Presentation of Findings
The Pacific Health Policy Group
February 2007

ANDY COHEN, Director, Pacific Health Policy Group, appreciated the opportunity to discuss the findings of the work PHPG conducted over the past six months. A power point presentation accompanied the "Presentation of Findings" handout.

[NOTE: For reference purposes, the Senate Finance Committee Secretary made a notation on each page of the corresponding timestamp in which that page in the presentation was addressed. A copy of the handout can be obtained by contacting the Legislative Research Library at (907)465-3808.]

Page 2

Medicaid Review
Introduction
Pacific Health Policy Group

- PHPG is a health care consulting firm, founded in 1994

- Offices in California and Illinois]
- Our focus is Medicaid/SCHIP and other government-funded health care programs
- Have provided assistance to 20+ states
- We also have worked with counties, providers, foundations and private health insurers

Mr. Cohen reviewed the information. PHPG has worked with numerous state legislatures and state Medicaid agencies to "assess their programs and identify areas for reform".

Mr. Cohen expressed that today's discussion will address "unique features" and challenges being experienced in administering the Alaska Medicaid program. Every state's Medicaid program has "faced growing challenges with regard to meeting the service needs of their beneficiaries while at the same time keeping the program fiscally sustainable", and PHPG drew on the experience of "the best practices" of other states in its recommendations for Alaska.

9:12:37 AM

Page 3

Medicaid Review
Introduction

Project objectives

- Evaluate the Alaska Medicaid program relative to other states ("50-state analysis")
- Ensure that program operations reflect current statutes, rules and policies ("regulatory review")
- Assess current program operations and identify best practices from other states ("operational review")
- Assist the legislature with the evaluation of short and long term program reform initiatives - identify strategies that enable the program to operate with the flexibility necessary to best serve Alaskans, recognizing budgetary realties
- Identify oversight priorities for the legislature

Mr. Cohen reviewed the study's objectives. PHPG compared Alaska's Medicaid program to those of other states in order to view it in "a broader context for how the program looks". PHPG's

review also drew on the findings of the aforementioned Lewin/ECONorthwest report.

Mr. Cohen stressed that PHPG conducted "an assessment" of the current program rather than "an audit". The intent was to determine "how the program worked today, the issues and challenges for funding it, and take those findings" and compare them to operations that have been successful in other states. The ultimate goal was to develop "both short and long term program reform initiatives" for the Legislature and DHSS to consider.

Mr. Cohen assured the Committee that Alaska is not alone in having to cope with Medicaid program fiscal challenges. While having to address "short term priorities" within annual fiscal constraints is an on-going dilemma, the effort must consider the "major systemic changes" the Medicaid program is undergoing at both the federal and state level to make it sustainable over the long term.

Mr. Cohen communicated that during today's discussion, PHPG would be offering strategies the State might consider in order to provide "the needed flexibility to act quickly, but also with a long term perspective in mind, as challenges present themselves". PHPG also considered the cumbersome affect of the amendment process in its program review.

9:16:11 AM

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Medicaid Review
Introduction

Potential reforms defined in RFP

- Developing public/private partnerships between Medicaid and employers - adopting market-based reforms
- Introducing managed care, to the extent feasible
- Enacting cost sharing - premiums/co-pays, perhaps tied to benefits
- Containing costs through program caps
- Increasing federal financial participation by obtaining matching dollars for services funded with state dollars only

- Strengthening the tribal health system

Mr. Cohen praised the reform criteria specified in the Legislative RFP and noted that each criterion was addressed in the report. PHPG was not restricted to the Legislative list and was able to draw on other states' reform experiences such as the public/private partnership approach. These partnerships have allowed employers and state and federal Medicaid programs to link up and provide private health care coverage to uninsured, working, low-income individuals and their families.

Mr. Cohen noted that managed health care is limited in Alaska. This is also true in many rural areas of the country. A number of other states with high rural areas have implemented alternative types of managed health care systems.

Mr. Cohen communicated that recent federal Medicaid revisions have improved states' cost sharing opportunities. To that point, care should be given to insure that shifting costs such as premiums and co-payments to individuals not discourage people "from availing themselves of preventive services", primary care, and other services.

Mr. Cohen reviewed reform measures being pursued in other states. For example, Vermont transitioned "its entire Medicaid program out of the traditional Medicaid system" through a federal waiver process. While the waiver process would provide a state more flexibility, the waiver process requires a state to operate within a specified federal funding level for a period of time. Florida has implemented a defined contribution program rather than the traditional defined benefit package.

Mr. Cohen divulged that "the federal government has looked to the states as the laboratories for creativity" in addressing Medicaid program costs.

Mr. Cohen had been surprised to learn that the federal Tribal Health System (THS) Medicaid component for Alaska is the largest in the nation "in terms of the number of Native Alaskans and American Indians who are served and the dollars that are spent on the program". South Dakota is a distant second. Thus, strengthening the THS in Alaska is paramount.

9:21:49 AM

Page 5

Medicaid Review
Introduction

Work Steps:

- Interviewed provider representatives and beneficiary stakeholders
- Consulted with DHSS and other state agency staff
- Reviewed recently-issued reports examining Medicaid's long term growth; long term care system; and behavioral health system
- Compared Alaska enrollment and expenditure data to comparable data for the other fifty states
- Evaluated best practices and innovative approaches in other states for applicability to Alaska
- Note: DHSS has not had the opportunity to review figures/assumptions

Mr. Cohen reviewed the work steps taken to date by PHPG, and acknowledged the assistance provided by DHSS employees, the Alaska Mental Health Trust Authority (AMHTA), and Senator Green and her staff in this endeavor.

Mr. Cohen complimented the State's efforts to date toward addressing the issues identified in the work steps. For instance, the Lewin report provided important information about long term enrollment and spending forecasts and AMHTA has commissioned behavioral health system studies. Rather than duplicating those efforts, PHPG "built on" the information provided by those efforts. National and other states' studies were also utilized.

Mr. Cohen noted that DHSS has not had an opportunity to review PHPG's comprehensive report since it was just recently delivered to them.

9:23:38 AM

Page 6

Medicaid Review
Introduction

Topics to be Covered Today

1. Summary findings from 50-state review
   - Demographics and Medicaid eligibility
   - Covered services & aggregate expenditures
2. Current operations & trends, by service type
   - Acute care
   - Long term care - elderly/physically disabled & MR/DD
   - Behavioral health
   - Tribal health (all services)
   - Administration
3. Recommendations for reform and oversight

Mr. Cohen overviewed the topics and noted that an effort would be made to avoid acronyms. To that point, he defined MR/DD as Mental Retardation/Developmental Disabilities.

9:24:30 AM

Page 7

Medicaid Review
Introduction

Executive Summary:

- Alaska is expensive, on a per beneficiary basis
- However, the state falls into the middle range in most areas, in terms of the populations and services covered
- The aging of the state's population is going to place significant pressures on the delivery system and Medicaid's budget
- There are a number of reforms within the existing Medicaid structure that can be taken to improve services and better control costs
- There also are structural reforms that the state should consider to ensure the program's long term sustainability

Mr. Cohen reviewed the information. The aging and disabled population of the State would place the most monetary pressure on the Medicaid system over the long term. "That's the future that we confront."

9:26:25 AM

Page 8

50-State Summary
Demographics & Medicaid Eligibility

Overview
- Medicaid eligibility is segmented into mandatory and optional populations
- Mandatory groups have a "categorical" linkage to eligibility - e.g., children, pregnant women, disabled
- Optional groups typically are persons who meet mandatory/categorical criteria but whose income is too high
- Every state covers some optional groups, although the extent of the coverage varies widely
- Some states also cover "medically needy" persons through Medicaid - similar to Alaska's Chronic & Acute Medical Assistance (CAMA) eligibles

Mr. Cohen noted that the Medicaid eligibility issue is addressed in Chapter 2 of the PHPG report. The structure of the Medicaid program is quite complicated and consists of five eligibility groupings: kids; pregnant women; parents of eligible children; low-income; and aged and disabled persons. Some Medicaid coverage for individuals is mandatory and some is optional. Certain programs are mandatory as a condition of a state's entering into the federal Medicaid program. Federal regulations specify and describe in detail the income level requirements pertinent to each grouping within a mandatory program covered by the State.

Mr. Cohen specified that optional programs are those to which a state agrees to provide coverage beyond federal Medicaid eligible standards for the five beneficiary categories. There is no limit on the amount above the mandatory eligibility income standards a state could provide.

Mr. Cohen noted that while each state in the nation has opted to provide beyond the federal minimums, there is "a great deal of variation between states as to which groups are covered beyond that minimum and to what extent".

Mr. Cohen also noted that several states have incorporated a sixth group of beneficiaries, "the medical needy", into their Medicaid program. Alaska does not. While the medical needy program resembles an optional program, it is not considered as such because the incomes of the group exceed federal qualifications. However, the states' medical needy programs allow people "to count" the medical expenses incurred by their medical condition toward their income maximums, thereby "spending down" their income to a level that would qualify them for coverage.

Mr. Cohen noted that while Alaska does not have the medical needy program, it does have a program called the Chronic & Acute Medical Assistance (CAMA) program "that serves the same kinds of people in the similar way…". The CAMA program is solely funded with State dollars.

9:29:36 AM

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50-State Summary
Federally Defined Coverage Groups

Mandatory Group

1) Children under age 6 in households with income below 133 percent of FPL ($21,945 for a family of two in Alaska)
2) Children ages 6 and older in households with income below 100 percent of FPL ($16,500 for a family of two)
3) Parents at or below a state's AFDC cutoffs from July 1996, when welfare reform was enacted (75 percent of FPL for non-working parents; 81 percent for working parents)
4. Pregnant women at or below 133 percent of FPL
5) Aged, blind or disabled SSI beneficiaries with income below 75 percent of FPL ($9,188 for a household of one)
6) Working disabled persons at or below SSI limits
7) Medicare eligibles above SSI limits qualifying for limited benefits (QMB, SLMD and AI groups)

Optional Group
1) Children under age 6 in households at or above 133 percent of FPL
2) Children ages 6 and older in households at or above 100 percent of FPL

3) Low-income parents above the state's AFDC cutoff
4) Pregnant women above 133 percent of FPL
5) Aged, blind and disabled beneficiaries between 75 and 100 percent of FPL
6) Working disabled above SSI limits
7) Nursing home residents above SSI limits but below 300 percent of SSI
8) Individuals at risk of needing nursing facility or ICF/MR placement but served through an HCBS waiver
9) Women with breast or cervical cancer
10) Medically needy individuals

Mr. Cohen cited this information as being a summary of the federal Mandatory Groups and the Optional Groups through which states can expand their Medicaid program beyond the income levels mandated by the federal Medicaid poverty level (FPL).

Mr. Cohen noted that individuals in categories 7 and 8 of the Optional program are nursing home residents who are served through a Home and Community Based Waiver Program (HCBS). He noted that every state in the nation offers assistance to such nursing home residents. Assistance to women with breast and cervical cancer is a fairly new Optional program.

9:30:44 AM

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50-State Summary
Alaska Optional Coverage Groups (sfy '05)

[A table developed by the DHSS depicting the different categories comprising the Optional Programs in Alaska. The information is presented by category based on the five federal groupings. Such things as enrollment and expenditures per enrollee are depicted.]

Mr. Cohen pointed out that while children comprise the largest component of the State's optional Medicaid program, only $2,114 is spent per child on an annual basis. The most expensive group, at $53,518 per beneficiary, is the Aged, Blind & Disabled group, which includes those served in nursing homes or by waivers. This group receives approximately 20 percent of the total annual State spending on Medicaid. This is also the group whose numbers are anticipated to increase in the future.

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50-State Summary
Coverage of Optional Populations

Alaska is middle-range in coverage of major optional categories, such as children and pregnant women

[Chart comparing Alaska's coverage relative to federal mandatory income levels to the highest and lowest state coverage's in the nation.]

This page was not addressed in the presentation.

9:33:00 AM

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50-State Summary
Coverage of Optional Populations

Overall, Alaska's optional groups account for a smaller than average portion of enrollment and spending

[Four pie charts were depicted: one pair indicating that the enrollment in Alaska's Optional programs (27 percent) in the year 2005 was lower than the national average (29 percent) and the other pair indicating that Alaska's Optional program expenditures that year accounted for 30 percent of the budget compared to a national optional program expenditure of 43 percent.]

Mr. Cohen noted that the higher national expenditure was due to the fact that the numbers of elderly and disabled populations in the nation exceed that of Alaska.

9:33:32 AM

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50-State Summary
Enrollment Growth

Total Medicaid enrollment until 2005 exceeded state population growth, but trailed the national rate

[Graph comparing Alaska's population and Medicaid enrollment growth to the national Medicaid enrollment growth during the years 2000 and 2005.]

Mr. Cohen noted that Alaska's population and Medicaid growth percentages "converged" in the year 2005 due to actions taken by DHSS to control Medicaid program costs.

9:34:13 AM

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50-State Summary
Medicaid & Uninsured Populations

Medicaid covers a large percentage of Alaskans, but the percentage without insurance is also relatively high

[Two sets of state rankings were depicted: one ranking the top ten states according to citizens utilizing Medicaid, and one ranking the top ten states according to the percent of its citizens who are uninsured. Alaska is ranked fourth in terms of its populace utilizing Medicaid and tenth in the number of uninsured.]

Mr. Cohen communicated that approximately one of five people in Alaska are covered by Medicaid. Alaska differs from the other states ranked in the top ten, as they are "generally comprised of low income states or states like Vermont" which have reformed their programs and are covering people "who would otherwise" be uninsured.

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50-State Summary
Distribution by Payor Mix

Relatively fewer Alaskans have employer-sponsored coverage, not surprising given the prevalence of small employers in the state.

[Graph comparing the number of Alaskans to other United States' citizens receiving medical coverage from Medicaid, Medicare, Employer-based, Direct Purchase, Military, or Uninsured coverage.]

Mr. Cohen reviewed the information and noted that Native Alaskans in the State, who only have access to health care through the federal Tribal Health System," are classified by the federal government as uninsured".

9:35:12 AM

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50-State Summary
Medically Needy & CAMA

Overview

- Medically Needy programs serve persons whose incomes exceed categorical limits, but who incur medical expenses sufficient to qualify on that basis
- Alaska is one of the 16 states without a Medically Needy program
- The state's CAMA program is similar to a Medically Needy program, but is funded with state dollars only ($2.2 million in 2004)
- Some states have added CAMA-like populations to Medicaid through waivers, thereby capping the state's financial liability, while drawing down additional federal matching dollars.

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50-State Summary
Medically Needy & CAMA

Overview

- Example: Mississippi added a program in 2005 through a Section 1115a waiver covering most of the same groups as CAMA (cancer, diabetes, etc.)
- Mississippi projected the program would be "budget neutral" by forestalling onset of disabling conditions requiring long term care

- Converting the CAMA program would likely not require legislation, unless the eligibility standards for the program were altered

Mr. Cohen reviewed the information and stated that while CAMA is solely funded by State dollars, it differs from similar Medically Needy programs adopted by other states, in that it is not an entitlement program. Optional programs such as the Medically Needy program which operate under traditional federal Medicaid rules are "obligated to spend to whatever [level] is required by law in terms of the folks who present for the program".

Mr. Cohen noted that some states have addressed this issue by conducting a federal waiver process. This has allowed them to provide coverage to individuals, receive federal dollars, "but cap their obligation at whatever level is established and negotiated out with the feds".

9:36:06 AM

Page 18

50-State Summary
Covered Services

Overview

- Medicaid-covered services are also segmented into mandatory and optional groups (children are entitled to a wider range of mandatory services than adults)
- Alaska is comparable to most other states in terms of the optional services offered
- Alaska spends more per beneficiary than other states and costs grew rapidly in the first part of the decade
- DHSS has taken a number of steps to contain costs, consistent with actions in other states
- Demographic trends are going to impose serious cost pressures in the next decade

Mr. Cohen addressed the information. While the DHSS has endeavored to contain program expenses, the projected increase in the State's aging and disabled population will continue to present challenges. The State must also address the tribal

health challenge which is "more structural and infrastructural in nature".

9:37:06 AM

Page 19

50-State Summary
Expenditures per Beneficiary

Alaska spent more than the national average per beneficiary in 2003, even after adjusting for cost-of-living.

[Bar graph comparing Alaska's unadjusted and an estimated adjusted average cost per beneficiary, approximately $6,400 and $5,200 respectfully, to the national average of $4,000.]

Mr. Cohen noted that these figures are dated and do not reflect changes undertaken by DHSS to contain costs. The figures were also adjusted by federal standards to account for the high cost of living experienced in the State. The cost of living adjustment accounted for approximately half of the difference between Alaska's average cost and the national cost. Transportation costs for Medicaid delivery in Alaska also exceed those of other states.

9:38:04 AM

Page 20

50-State Summary
Expenditure Growth

Alaska's Medicaid expenditures grew faster than the average annual rate early in the decade, but have since fallen back to the middle-range.

[Line graph comparing Alaska's expenditures to those of the United States for three time periods: 1991-2001, 2001-2004, and 2004-2005.]

Mr. Cohen noted that both the State and the nation's Medicaid programs rapidly expanded between 1991 and 2001. Alaska outpaced the federal Medicaid program growth rate from 2001 to 2004. As

reflected on the chart, DHSS cost containment efforts such as provider payment freezes, up-front service authorization controls, and pharmacy controls began to curb Alaska's cost growth in 2004 and 2005 and Alaska's growth rate began to track with the national rate during this period.

9:39:01 AM

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50-State Summary
Expenditures by Beneficiary Type

Alaska ranked in the top 5 in every category (unadjusted dollars)

[Chart depicting Alaska's ranking against the highest and lowest amounts paid by other states in terms of unadjusted 2003 dollars spent on Children, Adults, Elderly, Blind & Disabled, and in Total.]

Mr. Cohen noted that Alaska ranked near the top in each of the listed categories. Alaska's ranking would fare better today as a result of DHSS cost containment measures.

9:39:31 AM

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Alaska Medicaid
Where Are the Dollars Spent?

Most spending falls into five major service categories

[Pie chart depicting Alaska's major Medicaid service areas and the percent of funding attributed to each: Long Term Care, 27 percent; Hospital care, 24 percent; Behavioral Health, 14 percent; Pharmacy, 14 percent; Physician/Clinic care, 11 percent; and Other expenditures, 10 percent.]

SCOTT WITTMAN, Director, Pacific Health Policy Group, clarified that in Alaska, services for individuals who have developmental disabilities are a component of long-term care.

9:40:25 AM

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Alaska Medicaid
Acute Care

Hospital Services

- In 2003, Alaska spent $1,200 per beneficiary for inpatient services, fourth highest in the country
- Alaska spent $168 per beneficiary for outpatient services, second highest in the country
- The higher costs occurred despite lower than average utilization

Mr. Wittman reviewed the data and noted that, while Alaska ranks high in amounts spend per beneficiary for inpatient and outpatient service, it is not ranked high in "utilization" which is the actual number of days of service or visits per beneficiary. The lower utilization numbers however are countered by the higher provider costs per visit resulting from such things as higher salaries and costs of supplies and utilities.

Mr. Wittman advised that disease management programs and increased primary care physician opportunities could further reduce utilization, particularly in terms of emergency room visits and other preventable admissions.

9:42:26 AM

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Alaska Medicaid
Acute Care

Physician/Clinic

- Alaska's physician payment rates are the highest in the country, partly because of the prevalence of tribal and cost-based providers
- Physicians perceive the fee schedule to be essential for supporting their practices - the reverse of what normally occurs
- The state faces a worsening physician supply shortage - one that could be exacerbated by cutting fees

- Telemedicine is a promising concept for stretching provider capacity. The state implemented payment regulations in 2002, but utilization remains low

Mr. Wittman discussed the findings. Alaska's physician care costs are double the national average. Furthermore, people served by both Medicaid and Medicare programs have difficulty accessing physicians and services. This is exacerbated by the current deployment of military physicians.

Mr. Wittman noted that efforts to attract physicians and provide adequate access to medical care have added to already high physician rates.

9:43:51 AM

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Alaska Medicaid
Acute Care

Pharmacy

- In 2003, prescription drug expenditures per beneficiary (before rebates) were $788, 13th highest in the country
- The state has taken a number of cost containment actions, including joining a purchasing pool and introducing a preferred drug list
- Alaska pays among the highest rates for drugs and dispensing fees - which to some extent supports critical access pharmacies
- The state should consider differential pricing strategies, targeting urban chains for discounts. This likely could be enacted through regulation, without the need for a statutory change.

Mr. Wittman discussed the information and disclosed that Alaska's dispensing fee is the highest amongst states. DHSS is furthering several cost containment efforts to lower costs.

9:44:54 AM

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Alaska Medicaid

Long Term Care

Nursing Facilities/HCBS
- LTC accounted for one-quarter of Medicaid expenditures in 2005, but is projected to grow significantly as the state's elderly population grows in size (from 55,000 seniors in 2005 to 80,000 in 2015)
- Under current trend lines, Medicaid LTC spending is projected to increase from $273 million in 2005 to $877 million in 2015
- Nursing home rates are highest in the country, but utilization is the lowest, partly due to a lack of beds
- Pioneer Homes, which are licensed as Assisted Living Facilities, are becoming de facto Alzheimer's providers, though in a relatively costly setting

Mr. Wittman read the information and noted that the elderly population in the State is projected to triple over the next ten years. This would change the utilization of nursing homes, which is currently low.

9:45:49 AM

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Alaska Medicaid
Long Term Care\

Nursing Facilities/HCBS
- The state has two HCBS waiver programs for elderly and physically disabled persons (OA and OPD), but neither are designed to serve persons with Alzheimer's/dementia.
- The waivers also offer limited in-home support services, encouraging many to seek Personal Care Attendant (PCA) services outside the waiver.
- In 2005, PCA costs reached $80 million, while the two waivers amounted to only $42 million
- The state has introduced prior authorization rules for PCA, but a comprehensive pre-admission screen encompassing all community services (with PCA converted to a waiver service) would allow the state to operate a more holistic system

Mr. Wittman shared that while the State has federal waivers for in-home support services, those services are limited. Thus, costs are increasing as people seek in-home Personal Care Attendants (PCA) services outside of the waiver. A tightening of the rules pertaining to accessing PCA services, specifically a new pre-admissions screening, has been implemented to address "the growth curve" being experienced.

9:46:47 AM

Mr. Cohen warned that while the cost of Alaska's Optional Group services is currently lower than the national average, it is anticipated to approach national levels.

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Alaska Medicaid
Long Term Care

Nursing Facilities/HCBS Recommendations

- Institute up-front, comprehensive pre-admission screening and care planning
- Convert PCA to a waiver service
- Add waiver services targeted to Alzheimer's/Dementia as less costly alternatives to Pioneer Homes (e.g., AFC) and/or establish case-mix adjusted payments for Pioneer Homes
- Also consider a provider tax on Nursing Facilities as a revenue source (also recommended by PCG in its report). Federal law permits up to a six percent tax
- The tax would require legislative action. The other recommendations would require federal approval

Mr. Cohen stated that efforts to contain the costs of large programs such as PCA services outside of the waiver should be addressed. A waiver process has built-in controls on spending and a comprehensive pre-admission screening which considers each individuals needs. Having a large PCA component outside of the waiver defeats the effort to provide comprehensive service.

Mr. Cohen reviewed PHPG's recommendation to move PCA services entirely into a waiver program. Additional waiver services should be developed to address other challenges such as Alzheimer's. A comprehensive effort should be made to keep the

elderly and physically disabled in the community where they live rather than in more costly environments such as Pioneer Homes. The waiver process could assist in meeting individual needs as well as containing costs.

Mr. Cohen communicated that federal regulations allow states to impose up to a six percent tax on institutional providers like nursing facilities. The money generated by the tax is subject to a federal match. DHSS is considering whether the federal regulations accompanying this tax would offset its benefits.

9:49:45 AM

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Alaska Medicaid
Long Term Care

Developmentally Disabled

- Alaska serves all DD beneficiaries through waivers, outside of institutional settings - one of only a handful of states to do so (making it a leader)
- In 2004, expenditures per waiver beneficiary were sixth highest in the country ($63,000 verses $37,000 average)
- DHSS should develop and introduce a mandatory, uniform cost reporting tool for providers (and audit requirements)
- Rates should be updated through application of a reasonable annual inflator and rebased periodically (e.g., every four or five years)
- This likely could be implemented at the regulatory level through changes to the principles of reimbursement

Mr. Wittman discussed the Developmentally Disabled (DD) waiver services provided in the State and disclosed the need for DHSS to develop a uniform rate setting system for these services.

9:50:56 AM

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Alaska Medicaid
Long Term Care

Developmentally Disabled

- About 12 percent of the state's DD spending is through state-funded grants ($18 million in 2005) - average for the fifty states, but below states that have achieved close to 100 percent federally-matched programs
- Unmatched DD dollars are being spent, in part, on persons on the DD waiver waiting list and persons deemed not eligible under current screening criteria - the reverse of the elderly/physically disabled program
- The state could create a second waiver, with distinct eligibility criteria. Enrollment could be capped at the numbers served today with state dollars - and the dollars matched
- The new waiver would require federal approval and possibly legislative action, if the waivers are authorized in statute

Mr. Wittman reviewed PHPG's findings and recommendations. The effort should be to garner additional federal match dollars.

9:51:43 AM

Page 31

Alaska Medicaid
Behavioral Health

Overview

- Over 80 percent of behavioral health dollars in 2005 went toward treating children, with 90 percent of all spending split between Residential Psychiatric Treatment Centers (RPTCs) and general mental health
- The state spends very little on early intervention activities, to prevent or treat behavioral health conditions at an initial stage
- CMHC rates have been flat for over a decade - with most additional funding going to serve persons in crisis
- The "Bring the Kids Home" initiative is an important effort, though it will bring Alaska only to the stage many states reached years ago and will leave Alaska dependent on inpatient care

- Savings achieved through Bring the Kids Home should at least partly invested in early intervention/community-based services, in line with trends in other states

Mr. Wittman declared that the State is challenged by an insufficient level of community behavioral health services. The State is spending significant money for children in out-of-state services. Increasing these services would lower costs and recognize the social implications of keeping families together.

9:52:50 AM

Page 32

Alaska Medicaid
Tribal Health

Overview

- American Indian/Alaska Natives (AI/AN) represent 40 percent of the state's Medicaid population; tribal health is a $740 million delivery system
- The tribal system faces significant fiscal challenges, as HIS funding has been increasing at 1 -2 percent per year
- The health status of Alaska Natives is significantly worse than that of the general population on many key measures, such as tuberculosis and diabetes
- The AI/AN population is younger than average, but its elderly segment is growing significantly and will require a tribal LTC provider infrastructure that does not exist today
- The state may have an opportunity to dramatically alter the fiscal landscape - and provider system - for AI/AN beneficiaries

Mr. Wittman stated that the discussion regarding AI/AN tribal health programs included the consideration of program reforms that would strengthen the program and garner additional financial investment. The effort should also contemplate transitioning the tribal health system into a complete delivery system offering acute care service, long-term service, and behavioral health service. A managed care system approach would allow the tribal health program to further develop

infrastructure and garner additional federal funds as opposed to a combination of federal and State dollars.

Mr. Wittman advised that while the State Medicaid funding levels have increased, the Indian Health Service (IHS) program funding has been "relatively flat".

9:54:24 AM

Page 33

Alaska Medicaid
Tribal Health

AI/AN Current Medicaid Funding

[Two pie charts comparing the State/Federal Fiscal Year 2005 (FFY 05) AI/AN Medicaid expenditures to non-tribal provider expenditures.]

Mr. Wittman re-emphasized the fact that the State is required to share in the cost of services provided to Alaska Natives by non-tribal providers. Currently the State spends approximately $93 million in this regard. Strengthening the IHS service infrastructure could increase federal funding to 100 percent. The State could then utilize its money to further "develop the health system".

9:55:18 AM

Page 34

Alaska Medicaid
Tribal Health

Tribal Health Recommendation

- Alaska spends about $19 million per year on nursing facility costs for AI/AN beneficiaries residing in non-tribal facilities ($8 million state dollars)
- The state should consider investing in development of tribal long term care capacity, to allow beneficiaries to be served closer to family/friends, while garnering 100 percent federal matching dollars. For example:

| | State | Federal | Total |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Nursing Facility Expenditures: | | | |
| Non-Tribal Provider | | | |
| *Cost per nursing facility day | $170 | $230 | $400 |
| *Total annual Medicaid expenditures to serve 50 clients | $3,096,660 | $4,203,340 | $7,300,000 |
| *Ten-year Medicaid Expenditures (8% annual growth) | $44,859,959 | $60,891,947 | $105,751,906 |
| Investment in Tribal Provider Infrastructure | | | |
| *State investment | $8,000,000 | | |
| (equal to estimated construction cost of 60-day bed facility) | | $7,300,000 | $7,300,000 |
| *Ten-year Medicaid expenditures (census = 50) | | $105,751,906 | $105,751,906 |
| *Total Expenditures | $ 8,000,000 | $105,751,906 | $105,751,906 |
| Potential State Savings Over Ten Years: | | | |
| Single Facility | $36,859,959 | | |

Mr. Wittman spoke to the potential savings that could be achieved by moving nursing facilities into the tribal health provider system. A State investment of $8 million into a 60-bed long term care facility operating under a tribal health provider system could be 100 percent federally funded. The State would spend in excess of $44 million on non-provider nursing facility services over a ten year period under current conditions.

9:56:18 AM

Page 35

Alaska Medicaid
Tribal Health

Tribal Health Recommendation

- Medicaid expenditures within the tribal health system receive 100 percent federal funding; services provided to AI/AN beneficiaries by non-tribal providers are matched at the regular rate
- Under a Section 1115a waiver, the state, in collaboration with tribal providers, could designate the tribal system as a managed care entity
- The entity would be funded for all care - including services furnished by non-tribal providers. However, the "capitation payment" would be submitted for 100 percent federal match
- The new entity would have flexibility to invest savings into areas of greatest need for AI/AN beneficiaries
- This initiative would require federal approval, which is not assured

Mr. Wittman explained PHPG's tribal health program recommendations. After obtaining a Section 1115a waiver, a tribal health system with tribal or contracted providers would be capitalized with 100 percent federal funds.

9:57:48 AM

Page 36

Alaska Medicaid
Administration

Overview

- DHSS was reorganized into four major divisions in 2003 - the department overall falls into the "super agency" structure adopted by many states to consolidate "public health/behavioral health/Medicaid
- In 2003 (pre-organization), Medicaid's administrative costs were $504 per beneficiary (or $403, adjusting for cost-of-living), versus a national average of $224
- Administrative costs represented a 6.8 percent of total expenditures, closer to the national average of five percent
- Administrative spending also grew more slowly in Alaska from 1997 to 2004 than it did nationally

Mr. Cohen noted that all states find the Medicaid program expensive to administer. This is particularly true in Alaska as its high fixed costs "are spread over a small beneficiary population" in a large geographic area. He reiterated that actions taken by the DHSS assisted in containing costs.

9:58:13 AM

Page 37

Alaska Medicaid
Administration

Program Integrity/Provider Payments

- The federal government is phasing-in a new audit structure for states, known as the Payment Error Rate Measurement (PERM) process; Alaska's first audit is scheduled for 2008
- States that have error rates significantly above the national rate face disallowances and may be ordered to refund federal monies
- DHSS has established a Program Integrity and Analysis function and has re-codified service regulations, as a means of bringing better clarity and oversight to the payment process; the Department also has conducted test audits to prepare for PERM
- However, the PERM audit will overlap with implementation of a new MMIS - on a schedule which appears to be very ambitious
- The legislature should monitor both processes closely because of their fiscal implications for the program

Mr. Cohen read the information and noted that the federal Payment Error Rate Measurement (PERM) audit would be phased into Alaska in the year 2008. The Legislature should keep abreast of the readiness actions DHSS is taking in this regard.

9:59:16 AM

Page 38

Alaska Medicaid
Administration

Regulations

- The updating of Medicaid regulations, beginning with HCBS waiver rules, was essential and is already yielding results
- The Department's recently-issued draft regulations for covered services comply with federal law and regulations, with only a few areas for potential follow-up by DHSS identified
- Of the 481 regulations reviewed, only 8 potential inconsistencies were detected, representing 1.66% of the total
- It appears that Alaska performed a very thorough review of applicable federal authorities when it sought to repeal existing state regulations and propose revised rules

Mr. Cohen complimented the regulation compliance efforts made by the State.

9:59:58 AM

Page 39

Alaska Medicaid
Broad-Based Reform

Planning for Reform

- The federal government in recent years has shown a willingness to grant states greater flexibility in running their Medicaid programs, if presented as parts of a comprehensive reform model
- Vermont, Massachusetts and, to a lesser extent, Florida have undertaken major reforms under the aegis of 1115a waivers
- Under such waivers, states agree to operate their programs at no greater cost than would have occurred without reform. In return, the federal government agrees to "waive" traditional rules governing how the program operates and who can be served
- Denali KidCare operates under an 1115a waiver

Mr. Wittman reiterated that "the federal government has been grappling" with the issue of increasing Medicaid program costs and has "looked to the states" for ideas of how to improve

quality of care while containing costs. The 1115a waiver would allow states to implement reforms in a flexible environment.

10:02:05 AM

Page 40

Alaska Medicaid
Broad-Based Reform

Reform Objectives

- Ensure the best use of public resources to meet Alaskans' health care needs
- Ensure the program is culturally appropriate and recognizes Alaska's unique demography
- Ensure the program is fiscally sustainable for the long term
- Encourage preventive care and early intervention
- Promote access to quality care
- Ensure the state has the necessary tools to quickly respond to client needs, changes in the delivery system and fiscal constraints

Mr. Wittman addressed reform objectives. Providing the State the flexibility to implement such things as employer sponsored insurance initiatives in which Medicaid funds could subsidize private coverage for low income individuals would be an example of how to best use public resources. This action could lessen the cost of insurance on employers, reduce the number of uninsured individuals, and lessen the amount of uncompensated care in the system.

Mr. Wittman reported that the successes of health reform initiatives in other states such as Health Management Organizations (HMOs) in controlling program costs have been mixed. The HMO approach was not deemed appropriate for Alaska as its success has been limited in other rural states. However, successful HMO quality care initiatives such as its disease management programs, 24-hour nurse line, and linking each participant to a physician, are being considered by DHSS in its effort to contain costs.

10:04:27 AM

Page 41

Alaska Medicaid
Broad-Based Reform

Reform Steps

- Define Medicaid's top programmatic needs over the next decade
- Project likely spending authority over same period
- Draft waiver proposal seeking flexibility to restructure program
- Identify specific reforms to be undertaken
    - o CAMA program
    - o Tribal health
    - o DD waiver
    - o Long Term Care

Mr. Wittman stated that one of the key elements to program reform is identifying programmatic needs and projected spending authority.

10:05:25 AM

Page 42

Medicaid Review
Summary

| Program Area | Recommendation | Action Required |
|---|---|---|
| CAMA Program | *Convert to fed-ally matched model under a Section 1115a Waiver | *Federal approval *Possible statutory action (if covered population/services change) |
| Pharmaceutical Pricing | *Differential pricing stra-tegies, by location | *Regulatory amendments |
| Personal Care Attendant (PCA) | *Comprehensive pre-admissions Screening | *Regulatory changes *Possible statutory action (if covered populations / |

services change)

10:05:42 AM

Page 43

Medicaid Review Summary

| Program Area | Recommendation | Action Required |
|---|---|---|
| Personal Care Attendant (PCA) | *Convert to waiver service<br>*Target alternatives for individuals with Alzheimer's/dementia | Federal Approval |
| Nursing Facilities | *Provider Tax<br>*6% tax allowed by Federal Law | Statutory approval |
| Developmentally Disabled | *Mandatory, uniform cost reporting tool<br>*Fixed rate increases | Regulatory changes |

Page 44

Medicaid Review Summary

| Program Area | Recommendation | Action Required |
|---|---|---|
| "Bring the Kids Home" | *Reinvest savings in early intervention/ community based services | *Evaluate options for enhanced community based services |
| Tribal Health | *Designate tribal system as managed care entity<br>*Construct | *Develop application for Section 1115a waiver<br>*Develop detailed cost-benefit |

tribally-operated nursing facility | analysis

Mr. Wittman communicated that these pages depict actions that might be required to accommodate reform measures.

Mr. Cohen advised that there were both short and long term opportunities associated with reforming the State's Medicaid program. Expansion of the federal waiver process would provide the flexibility necessary to consider additional program reforms.

10:07:10 AM

Co-Chair Hoffman invited Senator Green to join Committee members at the table.

Senator Green was impressed with the PHPG report, particularly in that it provided workable regulatory process solutions to issues as opposed to solutions requiring Legislative involvement.

10:08:03 AM

Senator Stedman asked the savings the State might anticipate by implementing PHPG's recommendations.

10:08:30 AM

Mr. Cohen responded that reforming the IHS component would provide the most monetary benefit; however, collaborative efforts between the DHSS and IHS must first occur. He reiterated that the State is currently spending $90 million annually as the State match for non-provider services.

Mr. Cohen shared that determining a definitive dollar savings amount for reforms to CAMA and other programs is difficult as some of the proposed solutions might be ultimately deemed "impractical" or infeasible. While 1115a IHS waivers take time to negotiate, the savings could potentially range between $80 to $100 million dollars over time.

Mr. Cohen stressed that in order to achieve long-term results, any reform-generated money should be reinvested into the IHS

service infrastructure for such things as a long-term nursing facility.

10:10:33 AM

Co-Chair Stedman expressed that such savings would impact the DHSS budget.

10:10:48 AM

Co-Chair Hoffman concurred.

Co-Chair Hoffman asked what incentives might be required to generate reform support from IHS entities.

10:11:07 AM

Mr. Cohen acknowledged this as being one of many challenges in the reform process. Care must be taken to ensure that the federal government or other entities do not perceive actions as an effort to solely "supplement or offset" State expenditures.

Mr. Cohen communicated that conveying the benefits of reform to Native Alaskans as well as the IHS is paramount in creating a comprehensive health care system. No such system exists today.

10:12:37 AM

Co-Chair Hoffman asked the identity of the tribal entities PHPG communicated with in Alaska.

Mr. Cohen replied that a complete listing would be provided. PHPG worked with the Eastern Aleutian tribes and the Alaska Native Health Consortium amongst others.

10:13:31 AM

Co-Chair Hoffman referred to the Alaska Medicaid Tribal Health information depicted on page 32; specifically that IHS funding had only increased one or two percent per year. This was not due to a lack of effort to obtain additional funding. To that point, he asked for assurance that obtaining the 1115a waiver would obtain additional federal dollars.

Mr. Cohen believed that additional federal funding could be obtained were 1115a waivers pertaining to the IHS programs discussed in this presentation negotiated with the federal Centers for Medicare and Medicaid Services (CMS). Such funding would offset State spending and provide opportunities for reinvestment. Nonetheless, he could not commit for the federal government.

Mr. Cohen continued that before proposing the IHS waivers to the federal government, it would be "critical to do more work within the State with the tribes, collaborate with them and private providers" to initially develop "a concept paper" that describes program objectives. "With the blessing of IHS" in the belief that the program would "strengthen the tribal delivery system", State and tribal representatives could present the concept paper and begin negotiations with CMS. While this practice has been successful in other cases and the federal government has looked to the states to be innovative in respect to the Medicaid program, "there is no guarantee" of the outcome of those negotiations.

10:15:48 AM

Co-Chair Hoffman asked how long it took other States working with PHPG to obtain the federal waiver and implement the program. He also asked the level of savings such programs generated.

10:16:11 AM

Mr. Wittman communicated that PHPG worked with Vermont, Oklahoma, New York, and Rhode Island in developing their 1115a waivers. The process in New York took approximately six months and the 1115a waiver for Vermont's managed care program took approximately 15 to 18 months. While it is typically a one to two year process, it could occur faster depending on circumstances.

10:17:10 AM

Co-Chair Hoffman stressed the importance Alaska places on the effort to "Bring the Kids Home". Addressing the needs of children in-state rather than elsewhere would result in increased services as well as cost savings. The State's current lack of infrastructure is delaying this effort.

Mr. Wittman agreed that having in-state infrastructure and an adequate provider base are necessary to serving individuals in their community. The State of Vermont identified these elements as a priority.

10:18:18 AM

Mr. Cohen specified that structural reform is the key to providing community service to all demographic groups. Investing in community based services "early on" for people in need and providing preventive behavioral care infrastructure would also produce savings. The battle is half lost when an individual is placed in inpatient or residential treatment as they have already reached "crisis level".

Mr. Cohen clarified however that a lack of services should not diminish the effort to "Bring the Kids Home". In addition to the benefit of providing services to them close to their communities, it is less expensive than sending them out of state.

Mr. Cohen reminded the Committee that a tremendous amount of money is currently spent on long-term non-tribal care for tribal beneficiaries. Another area of large expense is behavioral health treatment for Native Alaskan adolescents. This was also a component of the tribal health initiative being proposed.

10:19:46 AM

Mr. Wittman informed the Committee that the 1115a waiver granted to the State of New York has generated hundreds of millions of dollars in savings over its ten years of operation. Vermont has saved approximately $160 million over a five year period. He noted that Vermont's Medicaid budget is similar to Alaska's.

10:20:38 AM

Co-Chair Hoffman asked whether PHPG has estimated the cost of implementing its recommendations in Alaska.

Mr. Cohen understood the question to be to the cost of implementing the actions depicted on pages 42 through 44 of the presentation. PHPG had identified eight minor inconsistencies between what was specified in State regulations as compared to

the federal code of regulations. While some might argue else-wise, PHPG recommends erring on the side of caution. The costs associated with the regulatory action recommendations would be insignificant.

Mr. Wittman stated that the expense of addressing the PERM and MMIS processes has not been determined.

Mr. Wittman affirmed that the cost of addressing the recommendations would primarily be in terms of staff time. For instance, staff time would be the initial step in evaluating whether the return on constructing a nursing home, for example, would warrant the investment.

10:22:26 AM

Senator Elton asked regarding the recommendation to implement a tax on nursing homes; specifically whether the consequence of doing so might extend beyond simply increasing the cost of service.

10:22:57 AM

Mr. Wittman noted that many states have incorporated a tax on nursing homes and hospitals to provide revenue. He clarified that the Medicaid program prohibits there being "a link between the tax and the payments" of a Medicaid rate established for providers.

10:23:31 AM

Senator Elton asked whether imposing this tax might impede the business decision to expand a nursing home.

Mr. Wittman responded that "it would if the rates themselves didn't recognize the additional cost of that tax".

Mr. Cohen furthered explained that one consideration in levying the tax is whether the current rate is close to the maximum payment level mandated by the federal government.

10:24:26 AM

SENATOR JOHN COWDERY, observing that the cost of pharmaceuticals has increased dramatically in recent years, asked how this has affected the Medicaid program.

Mr. Wittman was unsure whether the PHPG comprehensive report specified the rate of the increase in pharmaceutical costs, but advised that pharmaceutical expenses, which comprise 15 to 20 percent of national Medicaid costs, are one of the leading causes of growth in state Medicaid programs. States have tried to "curb" this growth through such things as preferred drug lists, purchasing pools, and "disease management programs specific to pharmaceuticals".

Mr. Cohen noted that "Medicaid programs "have been especially hard hit" due to federal regulations pertaining to the federal Food and Drug Administration (FDA) approved drug list, because states without a managed care program are prohibited from restricting access to certain drugs.

Mr. Cohen further explained that, even though Alaska has promoted the use of less expensive generic drugs, some behavioral health drugs are new and do not yet have generic equivalents. This is an important consideration since behavioral health issues are a large component of the Medicaid program.

Mr. Cohen affirmed that DHSS like its counterparts in other states has been working to address this growing expense. To that point, the State is 85 percent compliant with its voluntary preferred drug list usage; DHSS has recently begun a program to pre-authorize certain types of drugs, specifically behavioral health drugs, that are not on the preferred drug list; and DHSS is addressing the high dispensing fees being experienced at the pharmacy level in the State.

10:27:53 AM

Senator Cowdery asked how the "average wholesale price for drugs" is determined.

Mr. Cohen was not privy to that information; drug manufacturers strive to keep their pricing mechanisms private.

10:28:58 AM

Senator Thomas opined that treatment efforts typically focus on treating symptoms rather than the cause of the behavioral problem. He asked whether there has been a national trend to redirect money in this regard.

Mr. Cohen communicated that many states with a waiver, particularly those with a managed care model, are operating under the premise that "keeping people healthy" saves money over the long term. Thus their emphasis is on preventive primary care and early intervention.

Mr. Cohen reiterated that implementing a statewide managed health care program such as an HMO in Alaska, was "not feasible". However, the nurse advice line and "some of the principles espoused by HMOs … could be replicated" within the State's Medicaid program. Larger efforts would include increasing community based service infrastructure and preventive care. The waiver program would allow the State to be creative and more flexible to "do things that are not allowed under traditional Medicaid rules".

Mr. Cohen applauded the State's efforts in addressing its provider shortage, especially in remote areas. The health aide program, which is unique to this State, is a successful example of that effort.

Mr. Cohen cautioned against reducing Medicaid program expense by enacting short-term solutions such as cutting benefits or eligibility. "This will create a hole somewhere else because the need is still going to be there." The State's situation would worsen without long-term planning and all "the quick fixes" are exhausted. Alaska should be credited for having started its planning efforts.

Mr. Wittman stated that the flexibilities provided by the waiver process would encourage such things as psychologists consulting with pediatricians. This is currently not commonplace as "there is not a reimbursement mechanism under Medicaid". As a result of its waivers, Vermont's Medicaid agency is investing money saved by not having to provide matching dollars to recruit doctors for underserved rural areas.

10:33:16 AM

Senator Olson referred to the effort to "Bring the Kids Home", as addressed on page 31 of the presentation. In addition to being required to invest in infrastructure, the State would be required to invest in more trained personnel as there are, for example, few child psychiatrists in Alaska.

10:34:03 AM

Senator Olson also questioned the current practice of placing children in out-of-state care based on a provider bid process.

10:34:26 AM

Mr. Cohen stated that service cost comparisons are included in the comprehensive report. Senator Olson's reference to a bidding process is a fair observation. In addition to the effort to save money, there is a "quality of care advantage" for caring for young people in their community.

Mr. Cohen agreed the State was lacking care providers such as child psychiatrists. "The residential care model is not the ideal model ultimately." The ideal approach would be to serve children in need "sooner through" early intervention services. To get service to communities faster, the initial effort could begin with providing mid-level professional expertise in communities similar to that provided by the health aide program.

10:36:24 AM

Senator Dyson appreciated the initiative taken by Senator Green and the expertise of PHPG in advising on the Medicaid program, specifically the effort to strengthen the village tribal health initiative. He asked whether costs associated with Medicaid services to non-Natives in remote areas could be curtailed by enhancing their ability to be treated at IHS facilities.

10:37:35 AM

Mr. Wittman agreed that the unique demographics of the State should be recognized and addressed in the waiver proposal; it would be impractical and inefficient to provide "a duplicated system in a small community".

In response to a follow-up question from Senator Dyson, Mr. Wittman stated that the federal waiver proposal should specify

that the federal tribal health care system should be available to all people residing in that area.

Senator Dyson asked for further direction in appealing to the federal government to allow such an "accommodation".

Mr. Wittman stated that the proposal should include physical location facts "and the arguments for designing a system" that would be most appropriate for the State.

Mr. Cohen identified the waiver process as "the vehicle" for presenting such a proposal.

Senator Dyson asked whether there might be an opportunity for civilians to access the "very extensive" military health care system that exists in remote areas of the State.

10:39:24 AM

Mr. Cohen recalled this issue being addressed during Medicaid discussions about rural areas in northern Maine. He would revisit those notes.

10:39:50 AM

Senator Dyson pointed out that the states of Vermont and Maine were physically very different from Alaska. Guam would be a better comparison as it was remote and had a large military component. Guam's approach to allowing civilian contractors and others to access military health care could be considered for Alaska.

10:40:22 AM

Senator Dyson appreciated Health Savings Accounts (HSAs) being recognized in the presentation as being "a possible solution" to the Medicaid issue.

10:40:36 AM

Mr. Cohen affirmed that the HSA model has become popular, particularly in the private sector. The goal of the HSA program is to empower people "to take more ownership of their care; to be better stewards of their health care dollars by putting them more under their control rather than a third party payer like a

Blue Cross handling all that for them". In the private sector, a HSA typically has a high deductible policy for catastrophic conditions. After their account is funded, the individual would utilize that money to pay for regular doctor visits. Individuals tend to carefully manage their account so it lasts the entire year.

Mr. Cohen stated that Medicaid has been considering modeling a program after the HSA. Florida has implemented a program similar to the HSA concept. In addition to providing people money for health care, additional money could be awarded for taking certain healthy actions. A waiver application for a similar plan is being considered in Vermont.

Co-Chair Hoffman noted PHPG's report was available online at http://www.legis.state.ak.us/teldocs/AKMedicaidProgramReviewFinalReportJan07.pdf.

The presentation concluded.

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**ADJOURNMENT**

Co-Chair Lyman Hoffman adjourned the meeting at 10:42:56 AM