ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 19, 2009
3:11 p.m.

MEMBERS PRESENT

Representative Bob Herron, Co-Chair
Representative Wes Keller, Co-Chair
Representative John Coghill
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna

MEMBERS ABSENT

Representative Lindsey Holmes

COMMITTEE CALENDAR

PRESENTATION: MEDICAID REFORM

- HEARD

PRESENTATION: COOPERATIVE EFFORTS IN MEDICAID REFORM

- HEARD

PREVIOUS COMMITTEE ACTION

No Previous Action to Record

WITNESS REGISTER

JERRY FULLER, Project Director
Office of Program Review
Office of the Commissioner
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Testified and answered questions on Medicaid Reform.

JON SHERWOOD, Medicaid Special Projects
Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska

POSITION STATEMENT: Testified and answered questions on Medicaid Reform.

VALERIE DAVIDSON, Senior Director
Legal and Intergovernmental Affairs
Alaska Native Tribal Health Consortium
Anchorage, Alaska
POSITION STATEMENT: presented a Power Point titled "Tribal Medicaid Reform Initiative."

ACTION NARRATIVE

3:11:49 PM

CO-CHAIR WES KELLER called the House Health and Social Services Standing Committee meeting to order at 3:11 p.m. Representatives Keller, Seaton, Cissna, Coghill, and Lynn were present at the call to order. Representative Herron arrived as the meeting was in progress.

Presentations: Medicaid Reform

3:12:16 PM

CO-CHAIR KELLER announced that the first order of business would be a presentation on Medicaid Reform.

3:14:21 PM

JERRY FULLER, Project Director, Office of Program Review, Office of the Commissioner, Department of Health and Social Services (DHSS), described the history of the long term care forecast for Medicaid. He offered that the forecast model was initiated for both a 3-5 year review and a 20 year review. He noted that the forecast indicated that the Medicaid budget would quadruple in 20 years. He reported that medical inflation and increased demand as the population aged were the primary reasons for the budget increase. He observed that the Pacific Health Policy Group was hired to review the Medicaid program and make recommendations to control this cost increase.

3:17:33 PM

MR. FULLER said that the review established that long term care was a major cost and suggested a search for ways to increase federal support funds. He defined long term care to include nursing homes, residential and community based services,

personal care, and pioneer homes. He noted that the review also suggested for DHSS to work more closely with the Alaska Tribal Health organizations for Medicaid managed care. He described the Federal Medical Assistance Percentage (FMAP) as the federal contribution percentage for Medicaid services, currently at 51 percent, with an increase to 57 percent after the stimulus package. He reported that Medicaid paid 100 percent for American Indians and Alaska Natives who received service through the Tribal Health organizations.

3:21:53 PM

MR. FULLER observed that two years ago the legislature appropriated $2 million dollars to review 13 recommendations from the Pacific Health Policy Group. He stated that designated grants were given to Alaska Native Tribal Health Consortium (ANTHC) to review and develop a sustainable long term health care system. He went on to discuss behavioral health services and endeavors with the Center for Medicaid Services (CMS) for a narrow array of services to treat and prevent substance abuse. He recounted that a McDowell Group report ascribed the cost from substance abuse to be $750 million.

MR. FULLER shared that Pacific Health Policy Group was investigating the potential for a waiver from CMS for substance abuse. He also noted that Pacific Health Policy Group was researching for the most effective array of provider services for substance abusers.

3:26:34 PM

REPRESENTATIVE CISSNA noted that behaviors were all correctable with treatment or relearning. She asked if the provider services could be expanded to include depression.

3:27:47 PM

MR. FULLER agreed that the service array would include mental health services, as substance abuse was very often a co-occurring disorder.

3:29:16 PM

CO-CHAIR KELLER asked about a timeline for the report from Pacific Health Policy Group.

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MR. FULLER responded that most of the research was to be finished by early to mid April, and he looked forward to a report by the end of the session. He mentioned that legislative approval was necessary for the department to implement a budget neutral waiver.

3:32:03 PM

REPRESENTATIVE SEATON asked, since Alaska's population was aging, if the increased cost for end of life health care was being addressed.

3:33:27 PM

MR. FULLER responded that this was part of the long term care plan. He advised that a properly constructed case management system could intervene earlier in a person's life to avoid the high costs at the end. He offered an example of the Wyoming Medicaid program that had "decent" results.

3:35:27 PM

REPRESENTATIVE SEATON noted that care management had a reduced expenditure, but that there could still be substantial expense at the end of life unless this was also managed.

3:37:07 PM

JON SHERWOOD, Medicaid Special Projects, Office of the Commissioner, Department of Health and Social Services (DHSS), recounted that once people were eligible for Medicare, it was the primary payer of acute and primary care. He said that Medicaid paid for most of the long term care. He shared the challenge of making sound investments in long term care while the effects were also in acute and primary care expenditures. He noted that much of the care for end of life should happen under the Medicare program. He allowed that Medicare was best suited for urban places.

3:39:47 PM

REPRESENTATIVE LYNN observed that rationing health care was a moral issue.

3:41:01 PM

MR. FULLER disclosed that palliative care was included in the Oregon priority of services. He offered his belief that the country was not ready for a serious discussion about the moral issues of health care.

3:42:13 PM

REPRESENTATIVE CISSNA referred to a chronic care study which stated that controlling the severity of chronic disease would lower the long term cost. She suggested that the hospice program in Alaska was not fully developed.

3:45:44 PM

MR. FULLER opined that there was no control over managed long term care until Medicaid and Medicare were funded together.

3:46:47 PM

CO-CHAIR KELLER talked about the preventive aspect of managed care.

3:47:59 PM

MR. FULLER expanded on the recommendation from the Pacific Health Policy Group to work with tribal organizations to configure tribal health care as managed care. He cited that Alaska did not have any private managed care. He allowed that tribal health care approximated a pre-natal through death managed care system. He said that Pacific Health Policy Group did not understand tribal health care systems. He noted that managed care required infrastructure, which both the state and the Alaska Tribal Health care lacked. He suggested that the Alaska Tribal Health care organization needed more services, which would allow better use of the FMAP payment for services. He said that federal funding was flat, and had not kept up with either inflation or population growth. He said that reimbursement did not cover the costs. He reported that a close look at the reimbursement methodologies was required to assist the tribal health service to expand their Medicaid services. He referred to Senate Bill 61 as a means to look at doing things differently.

3:54:43 PM

CO-CHAIR KELLER asked who produced the long term forecast.

MR. FULLER explained that the Lewin Group reported in 2006, and DHSS updated the forecast each year. He said that DHSS had made significant changes in order to decrease some of the costs.

3:57:33 PM

CO-CHAIR KELLER said that state spending still showed an increase. He referred to the "Progress report on Alaska Medicaid reform" handout. [Included in the members' packets.] He pointed out that the nine projects listed on the report were not reflected in the latest DHSS forecast.

MR. FULLER referred to ongoing and completed programs that had made a difference.

CO-CHAIR KELLER asked if the expenditure results of Senate Bill 61 were incorporated in the DHSS update.

MR. FULLER allowed that a number of reports were not included.

3:59:14 PM

REPRESENTATIVE CISSNA asked if any studies existed regarding the habits of senior citizens, as Alaska was the leader of habit forming conditions.

4:00:34 PM

MR. FULLER said that he was not aware of any such study.

MR. SHERWOOD explained that Senate Bill 61 was focused on ways to make Medicaid more sustainable and that much of the bill centered on long term care, as Alaska's senior population was only exceeded by Nevada. He shared that the Medicaid program projected a shift from care for children to service for the elderly and disabled. He stated that DHSS was reviewing the rate setting methodology so that home and community based program rates were more in balance with the provider costs. He explained that some health care providers were public entities, such as government or tribal providers. He said that the state match to Medicaid for public entities, and any increase to the rate, could be met by certifying public expenditures. He shared that one advantage of working with tribal partners to increase services to its beneficiaries was that there was no increase in the state match.

4:05:43 PM

CO-CHAIR KELLER asked how many Medicaid providers there were in Alaska.

MR. SHERWOOD replied that he was unsure, but that it was in the thousands, and he shared that there were 356 different in-home and community based providers.

4:06:26 PM

CO-CHAIR KELLER asked to know the number of both active and qualified providers.

4:06:41 PM

MR. SHERWOOD stated that DHSS had hired HCBS Strategies to help develop a long term care plan. He declared that the report, "Alaska Long Term Care Plan," was a most comprehensive report, and he shared some of the suggestions: improve the method of matching people with the needed services, develop the aging and disability resource center as one stop shops, explore changing the new personal care program to a cash and counseling model, and provide more support for cognitive impairments. He mentioned a new federal option for certain targeted groups with benchmark plans to be provided with a mix of services for limited managed care plans.

4:11:13 PM

REPRESENTATIVE COGHILL asked that Mr. Sherwood explain the process to change a waiver.

4:11:24 PM

MR. SHERWOOD said that it required a statement of legislative intent.

REPRESENTATIVE COGHILL clarified that the application had to be made through the state plan.

MR. SHERWOOD agreed that, along with the statement of intent, a federally approved amendment or waiver of the state plan was necessary. He said that this could take from a few months to much longer, dependent on the prior approvals for other states.

4:13:26 PM

MR. SHERWOOD, in response to Representative Coghill, said that DHSS would anticipate a significant time frame, probably longer than 6 months.

4:13:59 PM

REPRESENTATIVE COGHILL noted that this could not be done in this budget cycle.

MR. SHERWOOD offered his appreciation of the clarification. He expressed the necessity for thoughtful implementation, as the inadvertent consequences could be substantial.

4:14:43 PM

REPRESENTATIVE CISSNA asked when was the last waiver change.

MR. SHERWOOD said that the service mix for the current waivers was about the same as approved in 1993. He explained that clearer service definitions were done a few years ago.

4:17:02 PM

MR. FULLER stated that conversations regarding the best waiver would continue with Medicare and Medicaid. He highlighted that the long term goal for DHSS was to make the system more efficient and cost effective. He said that the focus was on people and dollars.

4:19:08 PM

MR. SHERWOOD summarized that some cognitive impairments might not qualify for home and community based services. He shared that consultants had suggested several federal funding sources which included: Medicaid funding for cognitive impairments of patients in the pioneer homes, technical procedural changes for the waivers, and review of the state funded pioneer home payment assistance program. He shared that another recommendation was for DHSS to involve stake holders in the sustainable planning process of a long term care strategy. He summarized that Senate Bill 61 included prior authorization of drugs, step therapy for drugs, a review of the pharmacy reimbursement for compliance with federal requirements, and a re-appraisal of the personal care program. He stated that it was important to coordinate all DHSS efforts with Alaska Tribal Health.

Cooperative Efforts in Medicaid Reform

4:25:44 PM

CO-CHAIR KELLER announced that the final order of business would be a Power Point presentation titled "Tribal Medicaid Reform Initiative." [Included in members' packets.]

4:25:51 PM

VALERIE DAVIDSON, Senior Director, Legal and Intergovernmental Affairs, Alaska Native Tribal Health Consortium (ANTHC), presented the Power Point and spoke about slide 3, "Alaska Tribal Health System." She explained that tribal health was a voluntary affiliation of more than 30 tribes and tribal organizations and noted that it was often the only health service in a community.

4:27:17 PM

MS. DAVIDSON pointed to slide 4, a map of Alaska showing Alaska Tribal Health System locations, and slide 5 "Economic Impact." She reported that tribal health employed more than 7,000 people statewide, and that it was often the only health provider in rural areas.

4:27:55 PM

MS. DAVIDSON referred to slide 6, "Alaska Native Demographics," and noted that Alaska Natives represented 20 percent of the population. She offered slide 7, "ATHS Service Population," which reflected the Alaska Native population distribution. She spoke quickly about the major health issues for Alaska Natives, slide 8, "Alaska Native Health Status."

4:28:27 PM

MS. DAVIDSON noted that slide 9, "Medical Care Service Levels," explained the multi tiered health care delivery system.

4:29:07 PM

MS. DAVIDSON examined the Alaska map on slide 10, "Referral Patterns." She spoke about the importance for access to care which was mentioned on slide 11, "Village-Based Medical Services."

4:31:20 PM

MS. DAVIDSON skipped slide 12, and explained the role of the "Alaska Native Tribal Health Consortium," slide 13.

4:32:03 PM

MS. DAVIDSON spoke briefly about the "Alaska Native Medical Center," shown on slide 14, slide 15, and slide 16. She pointed out that Alaska Tribal Health Service was also a public health agency, slide 17, "Community Health Services," and shared that wellness and prevention activities reduced the need for primary care.

4:32:56 PM

MS. DAVIDSON observed that many people believed that the federal government paid for Indian Health Services (IHS), but that funding only paid for 51 percent of the basic health care services, as shown on slide 19, "Sustainability Issues."

4:33:58 PM

MS. DAVIDSON explained the funding level gaps which restricted some services noted on slide 20, "Rationed Health Care." She said that the wait period for the limited number of "Residential Treatment Centers," slide 22, was between six to nine months. She pointed to slide 23, "Authority to bill," and explained the reimbursement sources for IHS.

4:35:02 PM

MS. DAVIDSON pointed out the FMAP savings for the State of Alaska when Medicaid patients used the IHS facilities, as shown on slide 24,"Alaska benefits."

4:35:50 PM

MS. DAVIDSON moved on to slide 25, "Medicaid Information," and read that 40 percent of Alaska's Medicaid population was Alaska Native. She pointed out that most of the non-tribal provider payments were for long term care, behavioral health, and hospital services, as IHS had historically not funded any of these.

4:37:13 PM

MS. DAVIDSON read slide 26, "Pacific Health Policy Group Report," and stated that there was both a financial and a quality of service interest to enhance the tribal provider capacity, especially for long term care.

4:37:41 PM

MS. DAVIDSON explained slide 27, "Legislature authorized SB 61, Tribal Medicaid Demonstration," which provided resources for an ANTHC statewide and regional study of several focus areas, which included long term care, behavioral health service and financial infrastructure, to establish model delivery systems.

4:38:51 PM

MS. DAVIDSON, in response to Co-Chair Herron, shared that both the state and the ANTHC were mindful to not rush in and develop service delivery systems faster than either tribal health was able to absorb or the state was able to implement. She offered her belief that a quarterly evaluation should be required for the first two years to review the reimbursement levels, the obstacles, and the necessary changes.

MS. DAVIDSON referred back to the Power Point presentation and slide 28, "Long-Term Care." She pointed out that it was not just for the elderly as there were people with disabilities who also required long term care. She observed that there were home and community based services which allowed independent living for as long as possible. She explained one recommendation that was for a short term pilot project at three existing sites of home and community based services. She said the project would see what was working and what needed to be changed to ensure that the programs were sustainable. She suggested that this would lead to an expanded state wide comprehensive system plan. She said that there would always be a need for residential services. She observed that the study identified bed needs at the sub regional level, which was especially important for traditional lifestyle communities.

4:45:13 PM

MS. DAVIDSON moved on to slide 29, "Behavioral Health," and explained some of the lessons learned from the tribal health program, which included a focus on integrated behavioral health and on primary care.

4:48:10 PM

MS. DAVIDSON said that an adequate system of care was dependent on regulatory and program support, and workforce development.

4:48:29 PM

MS. DAVIDSON identified slide 30, "Other Services & System Efficiencies," and explained the importance of care coordination. She noted that in October and November more than 371 patients had been diverted from Alaska Native Medical Center to Providence Hospital in Anchorage. She stated that implementation of electronic health records and health information exchanges would improve the system efficiency.

4:50:08 PM

MS. DAVIDSON, in response to Co-Chair Herron, explained that Alaska Native Medical Center had to pay for patients who did not have alternative resources. She emphasized that for the tribal health system to be sustainable there must be systems of care that worked in a variety of places. She quickly discussed slide 32, "Sustainability Issues," and slide 33, slide 34, and slide 35, "Sustainability Issues: Energy Crisis," and noted the increase of infectious diseases as financial pressure forced overcrowding in homes without adequate sanitation facilities.

4:53:12 PM

MS. DAVIDSON advised that alcohol and substance use was also a problem. She shared that the energy crisis was increasing the demand for care and decreasing the ability for clinics and hospitals to provide the care. She reported that every major tribal health organization had to implement cost cutting measures.

4:55:02 PM

MS. DAVIDSON returned to slide 31, "Managed Care Feasibility," and explained the difference between a managed care organization and managing the care of Alaskans. She pointed to the benefits from implementing wellness and prevention activities, looking at cost based reimbursement structures, expanding capacities, and improving efficiencies.

4:57:40 PM

CO-CHAIR HERRON requested a graph that showed the tribal cost when a patient was referred out of the Alaska Tribal Health system.

4:58:46 PM

MR. FULLER announced that it was extremely important for the state and tribal organizations to work together. He summarized that the committee could expect more discussion of choices for long term general fund savings and tribal sustainability. He noted that the Medicaid program needed to look at maximizing the FMAP for reimbursement to public providers.

5:01:45 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:01 p.m.