

HOUSE FINANCE COMMITTEE

April 8, 2015

8:35 a.m.

8:35:45 AM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 8:35 a.m.

MEMBERS PRESENT

Representative Mark Neuman, Co-Chair
Representative Steve Thompson, Co-Chair
Representative Dan Saddler, Vice-Chair
Representative Bryce Edgmon
Representative Les Gara
Representative Lynn Gattis
Representative David Guttenberg
Representative Scott Kawasaki
Representative Cathy Munoz
Representative Lance Pruitt
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Valerie Davidson, Commissioner, Department of Health and Social Services; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Becky Hultberg, Senior Vice President and Chief Executive Officer, Alaska State Hospital and Nursing Home Association; Albert Wall, Director, Division of Behavioral Health, Department of Health and Social Services; David Teal, Director, Legislative Finance Division.

PRESENT VIA TELECONFERENCE

Margaret Brodie, Director, Division of Health Care Services, Department of Health and Social Services.

SUMMARY

HB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

HB 148 was HEARD and HELD in committee for further consideration.

[8:36:28 AM](#)

#hb148

HOUSE BILL NO. 148

"An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

Representative Wilson wanted to understand how the provider tax would work and how much revenue the tax would generate.

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, explained that the provider tax provision required the Department of Health and Social Services (DHSS) to recommend a provider tax appropriate for Alaska. The legislation mandated the department to utilize an independent third party to analyze provider taxes in other states and meet with providers and stakeholders to accomplish the mandate. She detailed that other states exempted small providers from a tax in favor of taxing hospital and nursing homes based on their entire revenue and not solely on Medicaid receipts. Alaska was one of the few states that did not tax providers. The legislature would receive a report on the provider tax recommendation. Additional legislation would be required in order to implement a provider tax.

Representative Wilson wondered why the state would initiate a provider tax and how the revenue would be spent.

Commissioner Davidson voiced that Alaska was actually the only state in the country that did not collect a provider tax. In light of the budget difficulties, the tax was proposed as a way to continue to provide programs and services. She believed that the providers should contribute by having "skin in the game." Many other business in Alaska were taxed.

Representative Wilson announced that the provider tax was not related to Medicaid expansion and could be implemented regardless of expansion.

Commissioner Davidson responded in the affirmative. She added that a state was able to implement a provider tax at any time as long as the tax complied with federal regulations and the legislature chose to enact a tax.

Representative Wilson felt that Medicaid and Medicare underpaid providers and the tax was unfair.

Vice-Chair Saddler asked whether a healthcare provider tax would only be levied on for profit providers.

Commissioner Davidson answered that the department would ask the third party provider to review how other states levied the tax. She shared that some states levied a provider tax on both for profit and non-profit providers.

Vice-Chair Saddler asked how much of Alaska's hospital and nursing home care were for profit versus non-profit businesses.

[8:43:02 AM](#)

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES; responded that most of the hospitals in Alaska were non-profit facilities. He expounded that Alaska Regional Hospital was a for profit facility and was aware of only one private nursing home facility located in Anchorage.

Vice-Chair Saddler asked whether it was fair to assume that a provider tax would cover non-profits in order to raise enough revenue.

Mr. Sherwood responded that a broad based tax would have to include non-profits.

Vice-Chair Saddler declared that federal law placed a limit on the amount a provider tax could impose. He asked whether the cap was 6 percent.

Mr. Sherwood replied in the affirmative.

Vice-Chair Saddler asked how much a 6 percent provider tax would raise on for profit and non-profit providers in the state.

Mr. Sherwood did not know the answer but offered to provide an estimate.

Vice-Chair Saddler asked whether the provider tax would raise enough to cover the state's share of Medicaid expansion.

Mr. Sherwood did not know but would provide the information.

MARGARET BRODIE, DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), replied that she also did not have the information but would provide it to the committee.

Co-Chair Neuman wanted verification that Alaska was the only state without a provider tax.

Commissioner Davidson responded in the affirmative.

Co-Chair Neuman remembered that a tax was levied on Medicaid patients who utilized hospital services and was reimbursed back to the state to cover the hospital costs for non-covered patient's emergency room visits.

Commissioner Davidson explained that a provider tax would be levied on a hospitals' entire revenue base. Currently, the state taxed for profit hospitals and the taxes were factored into the rates charged to the patients. Other states implemented provider taxes as a means to fund Medicaid expansion.

Co-Chair Neuman commented that he was trying to follow the tax. He asked how a 6 percent tax would flow through the system.

Mr. Sherwood replied that the tax revenue would be deposited into the state's general fund. He elaborated that the cost to the provider would be factored into the Medicaid rates. When Medicaid reimbursed the provider the cost of the tax to the provider would be included in the payment. The federal government capped a provider tax because it paid the Medicaid portion of the tax via

reimbursement. The limit was a way to avoid states purposely inflating the federal match rate.

Co-Chair Neuman requested hearing expert testimony from the hospital association.

Representative Gara announced that without a provider tax, implementation of Medicaid expansion was estimated to save the state \$6.6 million in the first year and increase to \$20 million each year for the next five years and totaled over \$100 million in state savings. He asked for verification.

Commissioner Davidson responded in the affirmative and added that in the out years the projected savings were actually \$24.5 million per year.

Representative Gara pointed out that administrative costs for expansion would be approximately \$2 million in the first year. The costs would be split between the Alaska Mental Health Trust Authority (AMHTA) and the federal government. He heard concerns from some legislators about who would fund administrative costs in succeeding years. He opined that the state gained financially from expansion in state savings. He wondered whether the provider tax proposal was put forward as a response to concerns over administrative costs.

Commissioner Davidson confirmed his assumption.

Representative Gara notified the committee that his wife was employed at Providence Hospital. He shared that even though Providence Hospital was a non-profit it was extremely profitable and some years subsidized other state's hospitals. He asked whether the provider tax rates would be lower for hospitals that made less revenue.

Commissioner Davidson confirmed his statement.

Representative Gara related that HB 148 did not establish a provider tax on page 2. The legislation provided for the development of a provider tax that would be recommended to the legislature to enact. He asked for verification.

Commissioner Davidson affirmed his statement. She indicated that in order to implement a provider tax legislation was required.

Representative Gara asked how many other states had a provider tax.

Commissioner Davidson replied that 49 other states had a provider tax.

Representative Pruitt referred to page 9 of the bill and asked whether the provision was expanding Denali Kid Care.

Commissioner Davidson responded that HB 158 did not expand eligibility. She elaborated that a provision under the Affordable Care Act (ACA) changed the way states used "income disregards" for determining Medicaid eligibility. The ACA established a new rule called, "modified adjusted gross income" that set disregards aside and required states to calculate the income disregard and adjust income after the disregard versus before the disregard, but was essentially "the same number." Eligibility was not increased, the bill merely reflected the new ACA requirement. She added that questions arose regarding why the ACA changed the modified adjusted gross income. She explained that as the federally facilitated marketplace [health insurance] plans were developed the eligibility change to using modified adjusted gross income for determining eligibility for both Medicaid and a marketplace plan subsidy was commonly required as a way to make determinations easier.

Representative Pruitt stated that modified adjusted gross income was not always different than adjusted gross income. He cited eligibility percentages from the bill and inquired how the state determined that 25 percent for pregnant women and 28 percent for children under the age of 19 was correct and not just a random number that separated the difference between modified and adjusted gross income. He asked whether data was used to support the numbers.

Mr. Sherwood informed the committee that the federal government performed a survey called, "The Survey of Income and Program Participation" (SIPP) which provided demographic information about the types of expenditures that applied to income disregards specific to each state. Calculations for each state were made to determine what impact the disregard loss was and provide an adjustment. Each state was required to either use its own data or the survey data. The state accepted the survey's adjustment with one modifier to account for the permanent fund

dividend income disregard. He shared that most states utilized the SIPP conversion process and Alaska used the SIPP plus one that included the permanent fund dividend disregard. He offered that Alaska used the process to formulate the Denali Kid Care eligibility numbers in the bill. The disregards impacted each eligibility category slightly different than the previous calculations, which explained the two different eligibility percentages between pregnant women and children.

[8:57:01 AM](#)

Representative Pruitt wanted to be clear that the department did not anticipate an increase due to the change.

Mr. Sherwood responded in the affirmative. He furthered that the required modified adjusted gross income standards were currently in effect. The modification required a statute change to reflect the required federal recalculation of adjusted income.

Representative Pruitt relayed a story about a young woman suffering with a brain tumor who was forced to pay \$750 out-of-pocket to see a specialist who was turned away after a 15 minute consultation. He read that Alaskans paid three times the national average for a primary care visit. He expressed frustration over the situation. The woman was not on Medicaid and he wanted assurance that a similar situation would not happen with Medicaid providers. He noted the bill's references to payment reform. He wanted an outline of what payment reform entailed. He wondered whether payment reform would cause someone in a similar situation to pay more.

Commissioner Davidson expressed concern that the woman was not getting the care she needed. She explained Alaska utilized a fee for service model. She provided an example of someone visiting a doctor multiple times for strep throat. The provider was paid for each visit under the fee for service model. Payment reform provided opportunities to change the fee for service system. She noted paying for outcomes as an alternative; the doctor would be incentivized to figure out why the patient was repeatedly getting strep throat and prevent another outbreak therefore, reducing the number of future visits. She restated that Alaska was a fee for service state and the

department intended to change the dynamic. The department wanted to reform Medicaid not only for expansion but for everyone. She emphasized that the way the state delivered care was not sustainable and change was imperative. The payment reform language in the bill was purposely broad. She relayed that some had suggested a switch to a managed care system. She contended that managed care was developed in the 1970's and was an outdated system. The rest of the country was implementing different types of payment models, i.e., patient centered medical home, super utilizers, accountable care organizations, etc. New ways of paying for and delivering healthcare were being tested by the CMS Innovation Center. The state was interested in implementing an innovative type of payment reform. She noted that one of the challenges the state had was a small population spread over a large geographic area. She exemplified telemedicine as one method to extend the healthcare reach without transporting the patient for service when appropriate. The best payment reform opportunities would examine how the state delivered appropriate care and how it was paid for.

Representative Pruitt voiced that the state's healthcare system did not enforce cost control and that many providers favored expansion because of that. He asked how to avoid higher costs getting shifted to non-Medicaid patients if the state "started to narrow the scope of payment". He suggested that maybe the state needed Medical reform rather than Medicaid reform. He felt that medical costs in the state were "out of control" due to price gouging. He reiterated his concern that implementing cost controls for Medicaid would shift higher costs to other payers and wondered how to prevent that scenario with Medicaid payment reform.

Commissioner Davidson responded that currently many of the providers were shifting costs to cover uncompensated care. She detailed that other states such as Arizona that adopted Medicaid expansion reduced their uncompensated care costs by 30 percent in the first year of expansion. She emphasized that the state had to work with providers and could not implement reforms alone because the state needed providers to offer services for the agreed upon price. The department released an RFP (request for proposal) to hire a third party contractor to examine what type of reform was happening in other states and she intended to include stakeholders in the discussion. She relayed from personal experience that she wanted to see the doctor engage in

healthy outcomes by asking a patient how they can work together to improve other health concerns. She wanted to figure out how providers and patients can jointly own health outcomes. She revealed that providers supported payment reform as long as they had the opportunity to participate in the process. Providers were aware of the severe budget challenges ahead for the state and recognized the need "to do things differently." She thought that the budget challenges inspired innovation.

Representative Pruitt referred to a report that revealed the 300 specialists in Alaska that collectively billed over \$1 billion. He deduced that a specialist provider would be reticent to work with the state on reform. He asked how the state would engage the providers to "buy in" to reform and in some cases "be the bad guy" and how the state would "bridge the gap."

Commissioner Davidson responded that the first step was simply to try. She reported that the state was very clear with providers that the current system was not sustainable and if a provider wanted to continue providing services for Medicaid or individuals' reform had to occur. The state was a significant purchaser of healthcare in a variety of settings; Medicaid and state employees and retiree health plans. The state was in a good bargaining position. She contended that the state was currently in a position to coordinate collective negotiations with providers on behalf of Medicaid and the insurance plans.

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Vice-Chair Saddler asked what the primary elements of payment reform were.

Commissioner Davidson defined that payment reform analyzed the ability to provide better quality service and provide the service at lower costs. Payment reform was focused on value; the value for services provided.

Vice-Chair Saddler wanted a better definition of what payment reform was.

Mr. Sherwood indicated that payment reform was not just one thing. He added that several options were available and were not mutually exclusive. One option bundled payments at different levels in a variety of ways. He provided

examples: bundle all payments related to a knee surgery, bundle for "larger episodes of service" such as a hospitalization, or bundle payments even more globally for accountable care organizations and community care organizations. He highlighted that typically, payment reform involved a payment method that provided incentives for quality called, "pay for performance." Specific standards were expected of the provider, and if met or exceeded different payment levels from base payments to enhanced payments were awarded. He conveyed that accountable and community care organizations were entities that "conglomerated" providers and agreed to share the benefits from improved performance. He provided an example of an agreement between a hospital and community physicians to enhance primary care and reduce emergency room expenditures. The state or the payer could monitor the outcomes or the accountable or community care providers could monitor themselves.

Vice-Chair Saddler asked about the difference between accountable care versus managed care organizations. He asked whether accountable care organizations existed in Alaska.

Mr. Sherwood replied that each model had a legal definition. He explained that a managed care organization operated much like an insurance company and attempted to achieve savings through utilization oversight and control by negotiating favorable rates with providers in its network. An accountable care organization was comprised of providers that collectively carried out utilization control and oversight and payment distribution themselves without an outside entity.

Vice-Chair Saddler asked whether there was an accountable care organization in Alaska.

Mr. Sherwood replied in the negative.

Vice-Chair Saddler wanted to know what the impacts of Medicaid expansion would be on Denali Kid Care (SCHIP program).

Mr. Sherwood responded that expansion would not impact Denali Kid Care.

Vice-Chair Saddler referenced the claim that 4000 new jobs would be created in the state through Medicaid expansion. He wanted to know what the claim was based on.

Commissioner Davidson responded that the information was derived from an independent study by the organization Northern Economics. The organization performed an economic impact study on the infusion of approximately \$1 billion of new federal dollars flowing into the state. She offered that not all of the jobs would be in healthcare.

Vice-Chair Saddler asked whether the study's conclusion was based on the infusion of \$1 billion into the economy equaled 4000 jobs.

Commissioner Davidson indicated that the 4000 figure was the result of the analysis and took the mid-range between a high and low number.

Vice-Chair Saddler asked whether the study was available.

Commissioner Davidson answered in the affirmative and would distribute the study to the committee.

Representative Gara commented that Alaska had the highest costs for medical care in the country and the highest increases in costs annually. He stated that the situation "had nothing to do with Medicaid expansion" and could not be attributed to any past administrations. He maintained that that there had been a number of proposals from past governors and governor's commissions that were not acted on by the legislature. He understood that Alaska was one of the most generous states that allowed provider billing at the top range of costs at the 80th percentile. He shared that other states endorsed the median costs. He noted that the information was presented in every prior administration and the legislature chose to ignore action. He asked whether DHSS was aware of the rule and if it could be changed in regulation or by statute.

Mr. Sherwood responded that the agency only established a very small percentage of the Medicaid rates and was not aware of how the state insurance payers established rates. Medicaid rates were established from the Medicare formula with an added adjustment. He mentioned that nursing homes and hospital rates were based on a cost-based rate that was facility specific and paid at the facility's projected

costs. He remembered that the median rate was utilized when pricing new durable medical equipment. He would provide additional information about when the department applied the median rate.

Representative Gara announced that he had a great deal of respect for the prior commissioner [Bill Streuer] of DHSS. He stated that Alaska had been one of the few state's that did not cover lung transplants for cystic fibrosis. He related that a citizen from the Matanuska-Susitna Valley asked Rep. Gara for help to obtain a lung transplant. He worked with the previous commissioner and currently the state provided the coverage. He warned that in an effort to achieve savings, "waivers could not be stripped without human consequences."

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Co-Chair Neuman requested information regarding a hospital tax.

BECKY HULTBERG, SENIOR VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, voiced that the association conducted research about provider taxes and provided information. She explained that 49 states had a provider tax because the tax was used as a mechanism to leverage federal participation to increase provider rates and allow a tax to obtain Medicaid match funding. She deemed that the tax was a potential mechanism to help the state and not harm providers. She detailed that a provider tax helped in two ways. First, a provider tax leveraged federal dish payments. She elaborated that provider taxes leveraged an additional disproportionate share for hospital payments from Medicaid, known as "dish" payments. She defined that "Dish" payments were authorized for hospitals that performed a high percentage of uncompensated care. A provider tax can also lavage additional federal reimbursement when the Medicaid rate was lower than the Medicare rate, which most likely applied to Alaska for inpatient services. Therefore, an Alaskan provider tax could be employed to leverage additional federal matching funds up to the Medicare rate. She pointed out that the mechanism was complex and required additional consulting assistance to determine whether provider taxes would be beneficial to the state and positive to providers. She informed the committee that the answer was not known yet

but the association thought that the issue was worthy of further exploration.

Representative Wilson thought that Medicaid was paying more than Medicare.

Ms. Hultberg replied that the statement applied to outpatient care. She suspected the reverse was true for inpatient care. Medicaid is a relatively better payer in Alaska than other states. The association was surprised to discover that inpatient Medicaid rates were likely lower than the Medicare rate.

Representative Wilson understood that the provider tax was unworkable if Medicaid was paying more than Medicare. She stated that a provider tax would be based on all of the provider's revenues and the tax would be levied on providers that did not accept Medicaid and Medicare. She asked for more details on the provider tax.

Ms. Hultberg responded that there were 19 different types of providers that could be taxed under the federal program. Typically the tax was only levied on hospitals and nursing homes and was also known as a "hospital" tax. She expounded that federal regulation required that the tax was broadly applied. All providers within a certain category had to be taxed whether the provider accepted Medicaid or not. However, subcategories were allowed. She provided the example within the hospital category. She explained that a subcategory of hospitals called "prospective payment system" hospitals, which were large versus "critical access" hospital, which were small and less able to pay the tax.

Representative Edgmon suggested that if the department estimated revenue expected from a provider tax the figure would be "highly speculative" until the association's study was completed.

Ms. Hultberg agreed with the statement. She explained that many variables existed for the manner that the tax could be levied and subgroups could be taxed and would be highly speculative at this time.

Representative Guttenberg spoke in regards to circular billing. He observed that the tax was used to capture federal funds and "at the end of the day everyone raised

rates because the tax increased costs. He wanted to know who ultimately paid for circular billing.

Ms. Hultberg answered that through matching federal dollars the cost of the tax was offset and was net neutral for the facility therefore, rates were not increased. She added that if it was true that costs to providers increased then the costs would be allocated to other payers where the rate was not fixed.

Representative Guttenberg provided a reform scenario where the savings were not evenly distributed to all entities and providers raised rates which ultimately negated any savings in the system. He wondered whether there were guarantees that rates would not be increased with implementation of a provider tax.

Ms. Hultberg agreed and emphasized the importance of thoroughly studying the issue before implementation. She maintained that it would not be beneficial if a provider tax resulted in increased rates. She believed there was an opportunity to examine the issue because it was possible a provider tax would be a net positive for the state and net neutral for providers.

Representative Guttenberg asked the department to provide the legal definitions for managed care and accountable care. He referred to billing reform and described issues with repeated patient billing until claims were processed and thought it was onerous for the patient and costly to the system. He asked whether the department figured out how to streamline the billing process.

Mr. Sherwood empathized with the issue. He detailed that providers did not bill Medicaid recipients, the state was billed and providers accepted payment from the state. The reconciliation was between the state and the providers and Medicaid patients were not billed. He added that the department had its own challenges with individuals that had other insurance. The state contracted with a company to help recover third-party payments.

[9:37:14 AM](#)

Representative Guttenberg referred to his wife's medical experience with Medicare and his state insurance and the difficulties with billing from providers. He stated that he

had received bills. He referred to a charge master that providers used for billing. He asked how hospitals and providers used the charge master and how it fit into reform.

Mr. Sherwood responded that the state did not have access to provider's rate schedules and moved away from the usual and customary charge approach. The department did not set rates based on what providers charged and utilized a separate methodology. The department was aware of what a provider normally charged for a service since it was included on the billing claim but had no need for the information. A condition of Medicaid was that the provider accepted a Medicaid rate as payment in full.

Representative Gara stated that the collective goal was to curb healthcare costs for everyone in the state. He relayed that Alaska Regional Hospital's chief executive officer deduced that with the additional revenue from Medicaid expansion, the hospital could establish an on-campus medical clinic and treat patients who went to the emergency room (ER) for non-emergency care. The cost savings would spread through the system. He asked whether the scenario was "a way to bend the cost curve" through Medicaid expansion and what was the potential for clinics beyond Alaska Regional Hospital.

Commissioner Davidson answered in the affirmative and stated the opportunity existed for other facilities. She reported that the emergency room was legally required to provide services, therefore individuals with no other resources for medical services go to the emergency room, typically after an illness progressed. Once more people had access to healthcare the state could help direct patients to the appropriate providers. She referenced the Superutilizer Program and gave credit to her predecessor William Streur, for implementing cost saving measures. She offered that the superutilizer program was designed for individuals with excessive use of the ER. Currently the program was voluntary but HB 148 would establish it in statute. She explained that when an individual with multiple ER visits was flagged in the system as a superutilizer a contractor would contact the person, discuss the condition, recommended the appropriate primary care provider and followed up with the patient. She emphasized the enthusiastic response for the program; 2000 people had voluntarily enrolled. She noted that other

providers indicated that they would like to engage in the same type of involved patient care.

Representative Gara reiterated his question regarding Alaska Regional Hospital's plan for building a clinic on the same campus. He asked whether the plan would be allowed under federal law.

Commissioner Davidson answered in the affirmative. She remarked that the ER at the Alaska Native Medical Center had a similar program in place.

Vice-Chair Saddler asked if an individual who went to the ER for treatment could decline to be sidetracked.

Mr. Sherwood responded that a patient could always decline care with the exception of involuntary commitments. The hospital was required to triage and stabilize the patient, once stabilized the hospital fulfilled its requirement. He was uncertain at what clinical point the hospital could legally relinquish care.

Vice-Chair Saddler wanted to clarify that there would not be any obligation to force the patient into primary care treatment if the patient objected.

Commissioner Davidson pointed out that once the patient was triaged and stabilized and was referred to primary care the hospital was absolved from further treatment and the patient could decline care from a clinic or alternate provider.

[9:49:44 AM](#)

Vice-Chair Saddler asked whether a healthcare provider was obligated to accept a Medicaid patient.

Mr. Sherwood responded that there was no obligation.

Vice-Chair Saddler asked if the department analyzed the effects of expanding Medicaid on the recipients of Medicare. He shared concerns that a higher population of Medicaid recipients would crowd out Medicare patients at clinics.

Mr. Sherwood reported that the department had not done any formal analysis.

Vice-Chair Saddler asked whether the issue had been discussed and if so, list some providers that engaged in the discussions.

Mr. Sherwood responded that the department engaged in discussions with provider organizations who felt they could meet the anticipated expanded demand. He reported that the issue was discussed with the Primary Care Association, Behavioral Health, and Tribal Behavioral Health as a partial list.

Vice-Chair Saddler confirmed that the department had not analyzed the effect of adding 20,000 more Medicaid patients on the rest of the healthcare system.

Mr. Sherwood responded in the affirmative that no quantitative analysis was performed.

Representative Edgmon remarked that the discussion on Medicaid expansion and reform was far reaching. He wanted to know what the role of the Alaska Health Care Commission (AHCC) was in Medicaid expansion and whether DHSS relied on the commission for any data.

Commissioner Davidson responded that the commission had provided helpful information on payment reform and factors that contributed to the high costs of Medicaid in Alaska. However she shared that the commission's budget was completely cut and would not be a resource moving forward.

Co-Chair Thompson directed attention to the fiscal notes. He referenced the new DHSS fiscal note allocated to the Behavioral Health Treatment and Recovery Grants, OMB (Office of Management and Budget) component number 3099.

Mr. Sherwood explained that the fiscal note reduced general fund grant funding for behavioral health treatment and recovery grants. Medicaid expansion would cover the behavioral health grant services for Medicaid recipients currently receiving the grants. The reduction increased in the out years as the conversion from grant to Medicaid increased. Additionally, beginning in FY 2018 a 1915 (i) [Home and Community Based Services] option became available that provided home and community based services for behavioral health that further reduced funding for behavioral health treatment grants, which would be replaced by Medicaid dollars.

Vice-Chair Saddler asked when the savings began for the 1915 I option.

Mr. Sherwood replied that the savings began in FY 2018.

Vice-Chair Saddler suggested it was a 2.5 year process from implementation of the 1915 (i) option and realized savings.

Mr. Sherwood stated the process would take 2 years.

Representative Wilson asked what the process would be for the individual receiving the mental health grants.

Mr. Sherwood answered that the grants services were an option and waivers were not required. However, a person must meet a functional standard impairment determined by the state to establish the need for the option. The individual would participate in an assessment process similar to the waiver process.

Representative Wilson asked whether the 1915 (i) program was an option the state could decline.

Mr. Sherwood concurred that the program was optional.

Commissioner Davidson stated that the state currently paid for and provided the service. Through the 1915 (i) option the federal government paid 50 percent of the program's cost.

Representative Wilson requested actual figures for the grant programs and number of recipients being served. She announced that some viewed the federal assistance as opportunity while others thought that they were "more charges." She wanted to more thoroughly understand the grant programs.

Co-Chair Neuman announced that he wanted to find opportunities to reduce the state's costs. He asked whether accepting the 1915 (i) option was dependent on accepting Medicaid expansion.

Commissioner Davidson answered that the option could be pursued without expansion.

[10:00:02 AM](#)

Vice-Chair Saddler referenced the 1115 waivers and noted that the waivers must be renewed every 5 years and the state was not committed to renewal. He wanted to know if the same renewal option applied to the 1915(i) option.

Mr. Sherwood responded that the 1915 (i) options did not have a similar renewal period.

Vice-Chair Saddler understood that 1115 waivers were required to be budget neutral and asked if that applied to the 1915 (i) option.

Mr. Sherwood answered in the negative.

Co-Chair Thompson referred to the new DHSS fiscal note, OMB component number 2665, allocated for the Behavioral Health Administration.

Mr. Sherwood detailed that the fiscal note added one staff position to work on the development, implementation, and oversight of the 1915 (i) option. The amount in the first year was higher than the out years due to the cost of adding the position. The 1915(i) option provided a federal match of 50 percent.

Representative Wilson asked how many people one position would serve.

ALBERT WALL, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, explained that the estimated number of recipients for the 1915 (i) option was 1000. The oversight was needed for program approval and the staff provided administration of the program for the provider group that delivered the services.

Representative Wilson wanted to know how much work was demanded of the additional staffer.

Mr. Wall articulated that there was one other staffer that performed similar work with other programs and that the load would be divided out amongst the staff.

Co-Chair Neuman believed that the fiscal note revealed that the option qualified the state for 50 percent federal matching funds and would pay for between \$56 thousand and \$60 thousand of the staffs' annual wages with general funds covering the remaining 50 percent. The state would save

between \$5 million and \$20 million in overall savings by accepting 1915 (i) option.

Commissioner Davidson stated that under a previous version of the fiscal note that the savings were calculated at \$3.5 million per year.

DAVID TEAL, DIRECTOR, LEGISLATIVE FINANCE DIVISION, notified the committee that it was a standard policy not to reflect increases in the out years for personal services.

Co-Chair Thompson moved to the new DHSS fiscal note, component number of 2330, allocated for Catastrophic and Chronic Illness Assistance.

Mr. Sherwood explained that the fiscal note served very low income individuals with chronic conditions that did not currently qualify for Medicaid. Medicaid expansion would cover all of the individuals currently being served in the program. The fiscal note showed a reduction in general funds that increased in the out years.

Co-Chair Neuman wondered whether the constituent with a brain tumor that Representative Pruitt referred to would fall under the catastrophic category if she qualified under poverty levels.

Mr. Sherwood responded that the Chronic and Acute Medical Assistance (CAMA) program provided maintenance medications with individuals for chronic conditions such as; mental illness, hypertension, seizure disorders and were awaiting for a disability determination from the Social Security Administration before they could qualify for Medicaid or Medicare. Cancer was also covered but the benefit were limited to physicians, drugs, and some cancer therapies.

Co-Chair Neuman asked if the state currently provided CAMA services and at what cost.

Mr. Sherwood stated that the state provided the services to approximately 500 recipients at a cost to the state of approximately \$1.5 million annually in general funds.

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Mr. Teal clarified that many of the fiscal notes were linked and that with Medicaid expansion the CAMA program

would go away. He explained that roughly half of the general fund savings accounted for in the fiscal note showed up as a Medicaid expense included in another Medicaid fiscal note related to expansion.

Mr. Sherwood stated that he anticipated that the CAMA recipients would be covered under expansion by 100 percent federal funds in the first year of expansion which dropped to 90 percent in subsequent years. The general fund increase in the out years would be much smaller than under the current 50/50 match.

Co-Chair Thompson referred to the new DHSS fiscal note, component number 242, allocated for Medical Assistance Administration.

Mr. Sherwood elaborated that the fiscal note contained administrative costs for Medicaid expansion and reform. The costs added four positions that eventually grew to six. One of the positions was needed to implement the 1115 tribal demonstration waiver and the other positions were associated with Medicaid expansion.

Co-Chair Neuman thought that the AMHTA would contribute funding in the first year of expansion. He asked for clarification.

Mr. Sherwood pointed to the MHTAAR fund source on the fiscal note and explained that covered one expansion position.

Co-Chair Thompson moved to the new DHSS fiscal note, component number 2696, allocated to Rate Review.

Mr. Sherwood expounded that the fiscal note was related to costs associated with Medicaid reform. One provision required a demonstration project focused on coordinated care that included a global payment fee structure. The costs reflected the need to contract with an actuary to assist in determining appropriate pricing and payment. The bulk of the work would occur in the first year with ongoing consulting work for monitoring the rates.

Vice-Chair Saddler cited a reference to "managed care" in the third paragraph of the fiscal note analysis. He noted the commissioner's previous allusion to managed care as an

old model that should not be pursued and asked for a reconciliation of the opposing positions.

Commissioner Davidson replied that the "managed care system" referenced in the fiscal note related to managing the care of a population versus a managed care organization as a specific legal structure.

Co-Chair Neuman asked whether general fund expenses for expansion could be supplanted by provider tax revenues if Medicaid Expansion was implemented.

Mr. Sherwood thought that the answer lied in the legislative authority to retroactively appropriate funds.

Commissioner Davidson reminded the committee that separate legislation was required to impose a provider tax.

Vice-Chair Saddler referred to paragraph three of the fiscal note analysis and wanted to better understand what a managed care system that included a global payment structure involved.

Mr. Sherwood indicated that the language was referring to an accountable care or community care organization that operated in a geographic region where providers came together.

Commissioner Davidson specified that some kind of global payment models enacted via fees based per member per month or based upon disease burden, disease complexity, or patient complexity were examples. An actuary would assist in figuring out a more complex payment model fee structure.

Vice-Chair Saddler wanted to ensure all stakeholders would be involved in the implementation of an accountable care organization.

Mr. Teal clarified that the first paragraph of the fiscal note analysis estimated the cost of the consultant's contract at \$175 thousand. He assumed that the department would absorb the cost and asked for confirmation.

Commissioner Davidson answered in the affirmative.

ADJOURNMENT

10:22:32 AM

The meeting was adjourned at 10:22 a.m.