

HOUSE FINANCE COMMITTEE  
March 24, 2016  
1:32 p.m.

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CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 1:32 p.m.

MEMBERS PRESENT

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

Representative Mark Neuman, Co-Chair

ALSO PRESENT

Heather Shadduck, Staff, Senator Pete Kelly; Pam Perry, Regional Vice President, Medical Health Plan, Texas, Amerigroup; Jocelyn Pemberton, Executive Director, Alaska Hospitalist Group, LLC; Rick Davis, CEO, Central Peninsula Hospital, Soldotna; Valerie Davidson, Commissioner, Department of Health and Social Services; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services.

PRESENT VIA TELECONFERENCE

Carol Steckel, Senior Director, Wellness Health Plan, Florida; Nancy Merriman, Alaska Primary Care Association, Anchorage.

SUMMARY

CSSB 74(FIN) am

MEDICAID REFORM;TELEMEDICINE;DRUG DATABASE

CSSB 74(FIN) am was HEARD and HELD in committee for further consideration.

#sb74

CS FOR SENATE BILL NO. 74(FIN) am

"An Act relating to diagnosis, treatment, and prescription of drugs without a physical examination by a physician; relating to the delivery of services by a licensed professional counselor, marriage and family therapist, psychologist, psychological associate, and social worker by audio, video, or data communications; relating to the duties of the State Medical Board; relating to limitations of actions; establishing the Alaska Medical Assistance False Claim and Reporting Act; relating to medical assistance programs administered by the Department of Health and Social Services; relating to the controlled substance prescription database; relating to the duties of the Board of Pharmacy; relating to the duties of the Department of Commerce, Community, and Economic Development; relating to accounting for program receipts; relating to public record status of records related to the Alaska Medical Assistance False Claim and Reporting Act; establishing a telemedicine business registry; relating to competitive bidding for medical assistance products and services; relating to verification of eligibility for public assistance programs administered by the Department of Health and Social Services; relating to annual audits of state medical assistance providers; relating to reporting overpayments of medical assistance payments; establishing authority to assess civil penalties for violations of medical assistance program requirements; relating to seizure and forfeiture of property for medical assistance fraud; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to Alaska Pioneers' Homes and Alaska Veterans' Homes; relating to the duties of the Department of Administration; relating to the Alaska Mental Health Trust Authority; relating to feasibility studies for the provision of specified state services; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89, Alaska Rules of Civil Procedure, and Rule

37, Alaska Rules of Criminal Procedure; and providing for an effective date."

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Co-Chair Thompson discussed the meeting agenda.

HEATHER SHADDUCK, STAFF, SENATOR PETE KELLY, referenced a handout she had previously provided the committee titled "SB 74 - Medicaid Reform Topic and Section Reference" (copy on file). She pointed to page 1 of the document and cited "Coordinated Care Projects/Payment Reform" that associated two sections of the bill with the topic as follows:

Sec. 31 - Coordinated Care Demonstration Projects -  
pages 31 - 34

Sec. 28 - Medicaid Reform Program (a)(8) - Redesigning  
the payment process - page 26

Ms. Shadduck noted that the focus of the discussion would be Section 31. She noted that the topic of payment reform was complicated; she provided two additional documents as an aide. One was titled "The Payment Reform Glossary," (copy on file) that contained definitions and explanations of the terminology used to describe methods of payment for Healthcare services. The other was titled "Alaska Medicaid Redesign: Approaches to Coordinated Care and Value-based Purchasing," (copy on file) that provided the entire spectrum of models of care in chart form for quick reference during the discussions. She spoke to the process of choosing options for value based purchasing. She shared that Senator Kelly had initially examined a full risk, capitated care, and managed care program. The administration had come forward with "a pitch for accountable care organizations," which were a step down from managed care. Through the testimony process a coordinated care project that "allowed anyone to compete," was chosen. She addressed page 31, line 16 of the bill related to coordinated care. She read the following:

Sec. 47.07.039. Coordinated care demonstration projects. The department shall contract with one or more third parties to implement one or more coordinated care demonstration projects...

Ms. Shadduck explained that the provision sought to coordinate "whole person" care; primary care and or

behavioral care that "connected the individual to other services and social supports as necessary." She added that under Section a, on page 32, line 1, there was a list of 8 items the projects could include. A project must include three out of the eight items. She listed the items as follows:

- (1) comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;
- (2) care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;
- (3) health promotion;
- (4) comprehensive transitional care and follow-up care after inpatient treatment;
- (5) referral to community and social support services, including career and education training services available through the Department of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources;
- (6) sustainability and the ability to achieve similar results in other regions of the state;
- (7) integration and coordination of benefits, services, and utilization management;
- (8) local accountability for health and resource allocation.

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Ms. Shadduck explained that a project would be reviewed by a project review committee (line 17, page 32). The committee was comprised of the following:

- (1) the commissioner of the department, or the commissioner's designee;
- (2) the commissioner of administration, or the commissioner's designee;
- (3) the chief executive officer of the Alaska Mental Health Trust Authority, or the chief executive officer's designee;
- (4) two representatives of stakeholder groups, appointed by the governor for staggered three-year terms;
- (5) a nonvoting member who is a member of the senate, appointed by the president of the senate; and

(6) a nonvoting member who is a member of the house of representatives, appointed by the speaker of the house of representatives

Ms. Shadduck turned to page 33, Subsection (c) of the bill. She relayed that the subsection outlined the types of organizations that the Department of Health and Social Services (DHSS) could contract with: a managed care organization, primary care case manager, accountable care organization, prepaid ambulatory health plan, or provider-led entity. The payments could include innovative payments such as: global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures. She continued with Subsection (d) on line 10, page 33:

(d) A proposal for a demonstration project under this section must include, in addition to the elements required under (a) of this section, information demonstrating how the project will implement additional cost-saving measures including innovations to reduce the cost of care for medical assistance recipients through the expanded use of telehealth for primary care, urgent care, and behavioral health services...

Ms. Shadduck reported that Subsection (e) page 33, line 17, addressed the third-party review. She noted the following:

(e) The department shall contract with a third-party actuary to review demonstration projects established under this section. The actuary shall review each demonstration project after one year of implementation and make recommendations for the implementation of a similar project on a statewide basis. The actuary shall evaluate each project based on cost savings for the medical assistance program, health outcomes for participants in the project, and the ability to achieve similar results on a statewide basis. On or before December 31 of each year starting in 2018, the actuary shall submit a final report to the department regarding any demonstration project that has been in operation for at least one year.

Ms. Shadduck offered that Subsection (f) on line 26, page 33 required the department to prepare a plan regarding regional or statewide implementation of a coordinated care

project based on the results of the demonstration projects. On or before November 15, 2019, the department shall submit a plan to the legislature stating the projects they chose for a wider launch. She remarked that the final Subsection (g) referred to an earlier definition for telehealth.

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Ms. Shadduck commented that the coordinated care provisions were linked to a provision in Section 28 that instructed the department to implement redesigned fee agreements that included items like bundled rates and global payments.

Representative Wilson thought it was atypical to put a detailed pilot project in statute. She questioned why a bill was necessary to implement the pilot project. Ms. Shadduck answered that the department could do pilot projects "all the day long." She thought that the legislature should set the benchmarks for reform and lay out the process for pilot projects that would "lead to a full on change" on how the state would pay for Medicaid. She voiced that the goal was to achieve a new and different payment model and a departure from fee for service. Representative Wilson commented that her reason made it appear that the legislature did not trust DHSS. She wondered whether the coordinated care project had been modelled after another program. Ms. Shadduck replied that the language in SB 74 had been modified from the original that mandated DHSS to implement a managed care organization (MCO) and expanded it based on the feedback from the Senate Medicaid reform subcommittee. She reiterated the provision that mandated the department to contract with one or more third parties. She clarified that the issue was not trust but the desire to contract with groups outside of the department. Representative Wilson asked where the model was developed. She wondered whether it was a completely new plan or was based on a successful model.

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Ms. Shadduck replied that over the past two years the sponsor had heard various testimony from many contractors, stakeholders, organizations including ACO's and MCO's, and through the committee process about which projects the reform process should utilize and took ideas from all of them. She shared that the language had been crafted by the sponsor. The Senate was cautious of initially choosing just

one method in order to allow for the best projects to prove themselves, based on the analysis from the actuarial review, and then launch on a statewide or regional basis. Representative Wilson was concerned about putting a pilot project into statute, which would make the program much more difficult to make adjustments to. Ms. Shadduck clarified that the structure for starting the projects were set in statute, but the department managed the contracts and could terminate projects that were failing.

Vice-Chair Saddler referred to the Project Review Committee established on page 32 of the legislation. He wondered whether the make-up of the committee was the best possible mix of participants. Ms. Shadduck revealed that the make-up of the review panel was the focus of much discussion. She answered that the commissioner of the Department of Health and Social Services (DHSS) had significant knowledge of the Medicaid program. She spoke to the reasons for including the other positions on the committee. She noted that the Commissioner of Administration's familiarity with the statewide health plans would offer a different perspective. The chief executive officer of the Alaska Mental Health Trust Authority (AMHTA) offered information on how to integrate behavioral health into whole person care. Stakeholder group representatives were chosen since they provided the services. Finally, members of the legislature were included to ensure that the legislative intent was being met. However, due to the separation of powers the legislative members had to abstain from voting.

Vice-Chair Saddler wondered whether a "more precise" definition of stakeholder groups was considered. Ms. Shadduck answered that the idea of narrowing the focus to an entity that actually managed the type of health plans in a Medicaid and non-Medicaid setting was discussed. Vice-Chair Saddler cited page 31, line 30 of the legislation:

...and must include three or more of the following  
31 elements:...

Vice-Chair Saddler questioned why so much discretion was given to the department.

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Ms. Shadduck replied that the first iteration only required one programmatic element but the sponsor determined that a

higher threshold was necessary. However, the sponsor wanted to keep the door open to as many different options as possible.

Vice-Chair Saddler stated there were many goals in the section and wondered how achievable they were. Ms. Shadduck answered that it was difficult to measure. She shared that the larger goal was to eliminate the fee for service model and the projects were the "baby steps" towards that goal and were more quantifiable. Vice-Chair Saddler surmised that the immediate goal was to test the waters and gain information that informed the next steps forward. Ms. Shadduck answered in the affirmative.

Representative Gara referenced redesigning the payment process on page 26 [part of the Medical assistance reform program provisions]. He was concerned that in cases of life threatening or serious conditions, the managed care process would not allow the patients to find the provider that would best serve the patient; in-state or out-of state. He asked for clarification. Ms. Shadduck replied that Medicaid individuals had the option to choose providers. However, she reported that the state could not force providers to accept Medicaid. She deferred to the department for a detailed response.

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Representative Gara wanted to hear further from the department. He believed in patient choice in the instances he described.

Representative Gattis asked what the difference between managed care, accountable care, and coordinated care was. Ms. Shadduck referred to the chart she provided titled "Alaska Medicaid Redesign: Approaches to Coordinated Care and Value-based Purchasing." She pointed out that managed care and accountable care and all of the other models listed on the chart fell under the banner of coordinated care. She restated that all of the models could be tested under the coordinated care approach defined in the legislation. The project was set up to allow all models to compete equally under the bill.

Representative Gattis had been under the impression that the bill included great savings. She stressed that it was the time to take a "bold" approach to achieve savings. She stated that if a true opportunity existed that was proven

to produce savings she would choose that model as opposed to a pilot project.

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Ms. Shadduck thought that her perspective was accurate. She shared that providers had offered feedback that they were fearful of a radical project failing and needed to ensure that a new approach would work in both rural and urban settings. Representative Gattis stated that from time to time programs that work in the Lower 48 can work in Alaska. She was not convinced that an existing program would not work in the state. She believed it was time to find great savings and boldly implement an entirely new approach.

Representative Guttenberg addressed the coordinated care demonstration projects. He expressed concern that the projects were not able to integrate with each other. He wondered how contractors with different data bases would coordinate their project with the other projects chosen to remain as part of the reform system.

Ms. Shadduck answered that the sponsor's goal was to find projects that would be sustainable and duplicative from the outset. She detailed that the intent of establishing the review committee was to evaluate the proposals and assess the projects guided by the items listed in the bill. The process included the filter of the review committee to accomplish the goal of implementing successful payment reforms. The recommendations for reforms for wider implementation were due in a report to the legislature by November 15, 2019. Representative Guttenberg did not want to micromanage. He simply wanted to ensure that the projects were able to integrate with other projects and worked when necessary. Ms. Shadduck replied that the intent was for all of the programs to integrate with each other from the outset.

Representative Kawasaki had general questions on managed care. Ms. Shadduck noted that other speakers would address the topic.

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Co-Chair Thompson introduced the following speaker.

PAM PERRY, REGIONAL VICE PRESIDENT, MEDICAL HEALTH PLAN, TEXAS, AMERIGROUP, provided prepared remarks:

Honorable Chair and distinguished members of the Alaska House Finance Committee. My name is Pam Perry, and I am Regional Vice President for Public Affairs at Anthem, one of the nation's leading health benefits companies. We serve more than 38 million Americans, including 5.8 million Medicaid members in 19 states, soon to be 20 next month as we launch our Medicaid operations in Iowa. Anthem has deep organizational expertise and passion for serving individuals with complex needs through a variety of state-sponsored programs.

As one of the few remaining states without managed care for Medicaid, we are pleased to see Alaska consider this model as you seek to reform your Medicaid program.

Section 29 of Senate Bill 74 includes a provision to allow managed care organizations to compete for the opportunity to improve access to care and quality improvements for Alaska's Medicaid beneficiaries. We believe that a robust competitive environment among models in this initiative will ensure the best outcome, in terms of innovation, quality of care and cost savings.

Managed care is a proven, patient-centered approach, and Managed Care Organizations, or MCOs, work directly with providers to ensure the right care is delivered at the right time and in the right place. MCOs are accountable for the care of their members, and are able to bring all patient care into a coordinated plan by the timely and effective use of data and care managers.

MCOs work with state agency and legislative partners to design, implement, and measure improvements to care. MCOs hire local staff, who understand the culture, landscape and needs of clients. MCOs develop and implement innovative programs that draw upon the latest best practices in areas as local provider networks, service coordination, care management, specialized populations, and value-based purchasing, customized to meet state-specific needs.

MCOs work directly with members, especially those with complex medical and behavioral health conditions, to understand their health needs. We help ensure our members have a health home, understand how to access care and are educated about their medical needs. MCOs also work with a range of organizations that serve our members to address non-medical, but critical needs such as housing, coordination with other social services, and employment.

These assurances, innovations, and accountability are not available via the fee for service system, which may be nicknamed 'fend for self.' Service is not patient centric, there is virtually no incentive for providers to accept

Medicaid patients or to innovate, and unnecessary expenses are incurred, health care is compromised, and taxpayer dollars are wasted.

There will be challenges in any Medicaid model, but much about the art and science of Medicaid managed care has evolved, and Alaska will benefit from lessons learned in other states.

I would suggest that a level playing field exist for the types of entities that participate in the demonstration, meaning that the requirements to participate are equivalent across the models seeking to participate. Also, MCOs may require a Certificate of Authority and other models may not, so we would respectfully request network adequacy not be required in the COA application, as this will be managed by the Medicaid agency.

The roadblocks to success identified in consultant reports are issues that have all been dealt with in other markets and I am confident that in collaboration, we can find solutions for Alaska. We are eager to partner with the State of Alaska in overcoming these barriers. Thank you.

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Ms. Perry elaborated that the Amerigroup Company served a number of rural states with "rural frontier geography" such as Texas, Nevada, Washington, and New Mexico. She observed

that many of the challenges identified in the consultants' reports could be overcome.

Co-Chair Thompson stated that the state was spending \$1.4 billion of General Fund (GF) dollars on the issue. He wondered if managed care would truly save the state money. Ms. Perry answered that the Center for Medicare and Medicaid (CMS) set criteria for managed care plans. She delineated that the federal government required managed care programs to provide 5 percent savings over a fee for service program. Savings were "built into the system" of managed care. Managed Care Organizations (MCO) were paid a capitated rate; per member, per month rate for its membership and had to operate within its budget. She communicated that the risk transferred from the state to the MCO which provided greater budget predictability, care coordination, health outcomes, and cost savings. She provided some examples from recent state studies that had identified Medicaid savings. Louisiana had launched its program in 2011 and discovered that MCO's had saved the state approximately \$440 million. She reported that Milliman's [actuarial consultants] analysis found that over the last 6 years MCO's reduced Medicaid costs by \$3.8 billion and further predicted an \$3.3 billion in additional savings over the next 3 years and \$7.1 billion over the subsequent 9 years. She relayed that most states established a program after defining the geography, populations, and services up front, which better quantified savings. She endorsed the approach over allowing the companies to define the parameters.

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Co-Chair Thompson offered that Alaska was different. He noted that Amerigroup was currently operating in 19 states. He wondered if all were experiencing up to 5 percent in savings. Ms. Perry answered that the savings varied. She shared that Iowa was the newest state set to launch next week that expected to save \$51 million and she was looking forward to tracking the results. She qualified that some "phenomena" occurred when setting up managed care. When implementing capitated payments some residual fee for service claims would still require payment for services already rendered overlapping the new system. She referred to the situation as "financing the tail." The phenomena may challenge the initial savings estimates. In addition, the design of the program affected the savings and "tended" to

accelerate over time. She expounded that many states began managed care with smaller programs and as the program matures grow it over time. The more "robust" program would produce greater savings. Fewer savings would be gained, the more a state parceled out different aspects of care, carve out services, or limit populations and geography.

Vice-Chair Saddler understood that multiple MCO's operating in a market resulted in more competitive efficiencies with the MCO model. Ms. Perry responded that CMS set certain regulations and requirements about how the managed care programs operated and one required providing options, with limited exceptions for rural jurisdictions. Medicaid mandated choice for the member, providers, and competition in order to manage the program effectively. More states chose statewide participation over regional participation. She communicated that since enrollee's participation in MCO's was mandatory, Medicaid required choice between at least two plans.

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Ms. Perry interjected that Oklahoma had a managed care system until 2008 and returned to fee for service, but currently intended to return to managed care for age, blind, and disabled beneficiaries statewide. The state solicited a request for information last year and received 22 proposals, which indicated the level of interest from MCO's. She continued that Iowa, with a Medicaid population of 520 thousand through a statewide program, received 11 responses from MCO's for a request for proposals (RFP) and made three awards. She believed that Alaska would attract "robust interest" with a well-designed, sustainable program.

Vice-Chair Saddler noted that coordinated care in Alaska would specifically serve Medical Assistance recipients totaling approximately 170 thousand individuals. He asked how a managed care model would work encompassing all of the state's health care populations such as retirees, employees, and teachers as well as Medicaid beneficiaries through a health care authority. He wondered how an MCO model would work in that situation as opposed to exclusively serving Medicaid recipients. Ms. Perry was uncertain. She noted that Delaware was the only state that implemented an inclusive plan. She reported that the type of plan was a relatively new phenomenon and its success

depended on how well it was designed. The model had been tested in New Mexico but only for behavioral health and she did not know the results. She offered that the MCO model starting out with a Medicaid population was common and many experienced companies were in existence.

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Vice-Chair Saddler wondered whether the demonstration process in SB 74 was a "typical" model other states adopted to transition away from fee for service. Ms. Perry replied in the negative. Many states proceeded in a more "comprehensive and directive manner" based on the many years of experience, information and analysis, and trial and errors with Medicaid and in transitioning away from a fee for service model. She thought that the "uncertainty" with the bill's approach may lead to ineffective models that could only serve regional areas of the state.

Vice-Chair Saddler referred to the 8 elements for coordinated care listed in the bill and asked which three of the 8 were essential for managed care. Ms. Perry replied that number 1, 7, and 8 were the most important.

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Representative Kawasaki asked whether Anthem was a for profit agency. Ms. Perry answered in the affirmative. Representative Kawasaki asked how a MCO realized profits. Ms. Perry explained that a state contracted with an MCO and set forth a contract that outlined the geographic area, services, and population of the program. The MCO received a capitated rate depending on the beneficiary make-up, i.e., how many children, developmentally disabled, etc. She elaborated that "within the rate," the MCO had to provide a network of providers and services, and negotiated contracts within the network. The Medicaid waiver offered a state flexibility when designing a program. She reminded the committee that a "menu approach" was associated with the fee for service model but "under managed care the "silos did not exist" which enabled MCO's to coordinate care around a recipient's needs. Potentially, care and outcomes were improved and costs to the state were less. She remarked that the Medicaid MCO was able to make a profit of between 2 and 4 percent per year.

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Representative Kawasaki asked about the capitation rate and wondered how the rate was set. Ms. Perry responded that the state, working in conjunction with a consulting actuary set the rate based on its fee for service experience. The reduction rate was built into the capitation rate. She noted that some states accepted bid rates; i.e., an MCO set the rate it wanted. She cautioned against accepting bid rates and stated "that it was not an ideal situation." A state needed to maintain certainty over rates and ensure the rates were actuarially sound.

Representative Kawasaki asked her to discuss the situation where an MCO was serving one rural area and how it impacted a smaller rural area without an MCO. Ms. Perry answered that the legislation addressed the issue through provisions that enhanced the ability of an MCO to serve a rural population such as telemedicine. She furthered that options existed to encourage the participation of physicians in Medicaid in rural areas. She shared that in other states the company incentivized providers to set up satellite offices serving rural areas, open one or two days a week. She believed there were "innovations" that could be "hatched" in Alaska that were only possible under a managed care program.

Representative Gara referred to the negotiated contracts. He mentioned the higher medical costs in Alaska and noted that it was often less expensive to send a patient out of state for treatment. He wondered whether a patient could choose a physician outside of Alaska with a managed care system. Ms. Perry answered affirmatively. She qualified that depended on what the state allowed regarding out of state providers. She communicated that "out of network contracting" existed within a managed care system that enabled the MCO to negotiate with providers out of the contracts scope. However, some states dictated the parameters of out of network contracting.

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Representative Gara mentioned having had prostate cancer and his ability to obtain the "best doctor in the country" at a much lower rate than charged in Alaska. He wondered whether she was aware of any other states that allowed Medicaid to negotiate a rate with the doctor of the patients choosing. Ms. Perry answered that it depended on

what the state allowed and whether the service was a covered benefit under the Medicaid program. She reminded the committee that certain benefit restrictions applied under Medicaid that did not exist under commercial health care coverage. The MCO was guided by the contractual arrangement with the state. She surmised that ultimately the state and federal government were paying for the program and would likely identify a provider who could serve a broader range of members. Representative Gara maintained his concern.

Representative Munoz referred to the previous day's testimony from an Emergency Room (ER) doctor who provided an example of over utilization of ER services and spoke about an individual who had received 22 CT scans in one year. She asked how an MCO would prevent a similar situation. Ms. Perry answered that a member of a MCO had a health home, primary care provider, and other necessary services or service providers addressed through care coordinators. She related that the MCO would work with the provider to ensure the member was seeing their primary care provider and following up with the member to ensure they understood how to manage their condition and had the appropriate follow up visits with their primary provider or specialists. She voiced that a coordination occurred under managed care that did not exist under the fee for service model.

Representative Munoz pointed to page 29 of the bill and cited the expansion of 1915i and 1915k programs with reimbursement rates set at 50 percent. She thought that the reimbursement rate was much higher under Medicaid expansion. Ms. Perry stated she would familiarize herself with the issue and provide follow up.

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CAROL STECKEL, SENIOR DIRECTOR, WELLCARE HEALTH PLAN, FLORIDA (via teleconference), read from prepared testimony as follows:

Mr. Chairman, members of the committee, thank you for allowing me to participate by phone today. My name is Carol Steckel; I am Senior Director for Alliance Development at WellCare Health Plans. I very much appreciate the work you are doing to reform the Medicaid program. I have served as a Medicaid

Director in Alabama and North Carolina and had the honor of chairing the national association of Medicaid Directors for several years. In that capacity, I had the opportunity to work with your previous Director of DHHS, Bill Streur, and learned from him a great deal about the unique challenges faced by Alaska Medicaid.

WellCare is headquartered in Tampa, Florida, and serves more than 3.8 million members who are participants in Medicare, Medicaid and the Children's Health Insurance Program. We offer Medicaid managed care services in 9 states (soon to be 10) serving the full spectrum of Medicaid beneficiaries from healthy mothers and their children to individuals with severe physical, mental and developmental disabilities. For more than 25 years WellCare has focused exclusively on serving individuals who receive their health care services through government programs. It is based on both my personal experience running large and complex Medicaid programs and WellCare's long experience that I offer our comments today.

We appreciate the thoughtful approach you are taking in reforming the Alaska's Medicaid program. We believe that Medicaid managed care would be an important tool in assisting you to achieve the goals laid out in the Menges report.

An integrated, fully capitated MCO model ensures members with diverse and complex needs receive all of the physical, behavioral and social benefits and services they need to take control of their health. It also ensures that barriers and gaps in care are effectively and efficiently identified and mitigated so that members can achieve their individual goals for health, wellness and quality of life. Unlike Alaska's current fee for service program, risk based managed care offers a single point of entry through which members are able to access the full array of needed health services and care coordination they need without having to navigate multiple agencies, providers and community partners.

The true success of Medicaid managed care is that we succeed when our members succeed. The beauty of adopting a full risk managed care model is that when done correctly, a managed care partner like WellCare

is responsible for the needs of the whole member, eliminating the fragmentation and duplication inherent in Alaska's current system, In addition, unlike the many less integrated models identified in the Agnew Beck report, a risk based managed care approach can incorporate those initiatives such as health homes, patient centered medical homes and accountable care organization within the managed care model. Thus, a full risk managed care program is the only model that creates a single, accountable plan partner responsible for enhancing each members' quality of life, improve health outcomes and control costs.

In order to achieve these goals we utilize a holistic, member centered, care management model designed to serve the unique needs of each of our members. Our care plan platform, which has been built and proven in the service of nearly 2.4 million Medicaid members nationwide, integrates physical health including pharmacy and behavioral health with the social needs of our members to empower the member to fully manage their health care needs. A successful managed care organization uses a robust network of provider partners and has the flexibility to offer supplemental benefits over and above the current Medicaid benefit package. WellCare designs its products to improve each members' health and quality of life.

Much of what affects our member's health occurs outside of the doctor's office. WellCare is unique in its commitment to the member by linking three components - physical health, behavioral health and the social determinants of health - those issues that prevent a member from taking control of their health. WellCare's distinctive CommUnity Commitment program is designed to create lasting connections between our health plan and the social service agencies and community organizations already deeply rooted in each community. Our CommUnity Commitment program evaluates community needs, catalogues existing resources, connects our members to needed social support services and, where appropriate, supports these agencies to expand or enhance services to meet the needs of our members and the communities where they live.

In addition to improving quality and controlling costs, utilizing full risk managed care aligns with the goals laid out by the Legislative leaders in

Alaska. Leveraging the contracting lessons learned in the 38 states that utilize a Medicaid managed care model, plans can and should be held to performance standards aligned with achieving the state's accountability goals. Examples of such standards include quality withholds and service level agreements for data submission. In addition, by placing a managed care plan fully at risk for the cost of care, the plan and the state are aligned in their incentives to vigorously identify and root out any fraudulent or abusive activity.

Medicaid managed care provides budget predictability and bends the cost curve while improving a member's quality of care. Some examples are:

- In its first seven years of Medicaid managed care, Georgia's cost growth rate was 2.64 percent, while the fee-for-service growth rate was estimated at 6.18 percent. Managed care's cost containment resulted in a savings of over \$940 million.
- From 2011-2015, moving to a managed care model has saved Kentucky more than \$1.3 billion in state and federal funds while simultaneously improving the delivery of health care services to the state's Medicaid population
- Louisiana saved \$135.9 million in its first full year of Medicaid managed care and a recent found that the state's capitated managed care program saves the state approximately \$30 per recipient per month, a greater than 12 percent reduction in costs over fee-for-service Medicaid spending
- Between 2010 and 2013, Missouri saved an average of \$27 million per year from its Medicaid managed care program

In closing, our experience has shown that even in states where full risk managed care was viewed as "impossible" by many of the state's stakeholders, Medicaid managed care has not only been successfully implemented but has grown to additional geographies and populations. We have no doubt that the same would be true in Alaska.

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Representative Wilson asked whether the state could have accomplished the same goal by simply issuing an RFP. Ms. Steckel deferred the question to staff in Alaska. Representative Wilson questioned how WellCare procured contracts with other states and how detailed the states criteria for the contract was.

Ms. Steckel answered that it varied depending on the state. She explained that all states utilized an RFP or competitive bid process to award a managed care contract. Some states set very specific criteria written into its RFP. The MCO could better achieve a state's expectations when the criteria was specific and clearly delineated.

Representative Gattis expressed doubt that utilizing a statewide MCO was currently the wrong approach.

Vice-Chair Saddler asked whether WellCare would likely bid on any of the coordinated care contracts in the state. Ms. Steckel responded that WellCare was interested and was waiting for the RFP. She reiterated that a well-crafted RFP created a more advantageous scenario for an MCO to participate in the state. She pointed out that when a state moved to a managed care system it sparked "robust" competition among MCO's. She divulged that if the state parceled out services and benefits to smaller portions of the Medicaid population it would lose the sense of comprehensive care coordination and weakened the ability for managed care to achieve optimal results. Vice-Chair Saddler assumed that the MCO industry would endorse the state taking an aggressive approach and fully embrace managed care. He requested that Ms. Steckel share her thoughts on the "sample and plan process" in the legislation. Ms. Steckel replied that she understood the "trepidation," but there was much to learn from the 39 states that had already adopted a managed care approach and to look to their "sophisticated" experiences with MCO's as pilot projects, where managing contracts to meet goals had already been "played out." She thought that the answers to the lessons to be learned through Alaska's pilot were out there in some of the other states.

[2:52:12 PM](#)

NANCY MERRIMAN, ALASKA PRIMARY CARE ASSOCIATION, ANCHORAGE (via teleconference), read from a statement:

Good afternoon, Co-Chairs Thompson and Neuman, and members of the House Finance Committee. For the record, my name is Nancy Merriman, and I am the Executive Director of the Alaska Primary Care Association. APCA is a statewide membership organization of Alaskan Community Health Centers. Across our system of 29 organizations and about 170 clinics, 1 in 7 Alaskans receive primary medical, dental and behavioral health care. A little over 24% of Community Health Center patients are enrolled in the Medicaid program.

Thank you for the opportunity to provide comments today on Senate Bill 74 on medical assistance reform. We appreciate the time the House Finance Committee is spending to learn about the details of the Medicaid program and the complexities of the healthcare landscape. We share the goals of providing quality care and improving health outcomes, while making the system more sustainable. Today my comments center on Accountable Care Organizations (ACOs), and primary care's role in them.

ACOs are formal, legal networks of healthcare providers who take responsibility for a defined patient population's health. They align their clinical programs to focus on getting patients the most efficient care possible, and are incentivized to reduce the total cost of care and to maximize clinical outcomes for an assigned patient population. Often, they do this with the addition of new data sets that allow them to target high-risk, high-cost patients who are using the healthcare system inefficiently. For example, in a very successful Medicare ACO program, the providers receive half of the savings they create against a target established by Medicare.

Safety Net primary care providers, especially Community Health Centers, are well-positioned to lead and coordinate ACO formation and operation, and addressing the healthcare needs of Medicaid patients for the following reasons:

1. Health Centers have served these populations historically. There is a trust between patients and providers, and Health Centers are situated in

- communities where high-risk and high-cost patients are likely to live.
2. They have the know-how, infrastructure and operating principles to most effectively plan for the population health outcomes of these groups.
  3. Health Centers have the EHR data - and are continually improving their data analytics capabilities - to be accountable for performance and quality.
  4. Value-based payments, such as Medical Home payments or shared savings payments, will allow for the key component for ACOs: primary care case management.
  5. Care coordination in Health Centers involves a team-based approach and relies on good electronic and other communication with patients' other providers.

ACOs are being fostered across the country by CMS for Medicare patients. And about 10 states now have Medicaid ACOs.

[2:56:43 PM](#)

Ms. Merriman continued to read from prepared remarks:

The characteristics of successful State-run ACO programs that lead to successful Safety Net ACOs are:

1. The program does not alter the base compensation for the Safety Net providers, nor the hospitals, in its initial years.
2. The program allows for ACOs to operate state-wide or across geographies larger than a single region.
3. The program does not require a hospital to be the sponsor of the ACO, but does allow for the ACO to enter into participation agreements and gain-sharing agreements with hospitals and other providers.
4. The program offers some financial incentives to provide the primary care case management function, which can include care coordination payments and/or shared savings payments.
5. The State commits to providing key data on the attributed Medicaid population to the Safety Net ACO so that it can prioritize the use of its resources.

We hope that as the Alaska State House considers the ongoing development of an ACO or ACO-like program, it will leave room for innovation in the healthcare

provider delivery system that would include the emergence of Safety Net- or Health Center-led ACOs.

Representative Wilson asked whether accountable care was done in conjunction to managed care or if a state chose one or the other. Ms. Merriman answered that an Accountable Care Organization (ACO) differed from an MCO. She defined that an ACO was a group of providers. Representative Wilson asked whether "a person would be taking advantage of one program or the other." Ms. Merriman answered in the affirmative. Representative Wilson asked for the page number in the legislation that referred to ACO's. Ms. Merriman pointed to Section 31, page 33 of the bill.

Vice-Chair Saddler asked whether Alaska's "disparate geography and distribution of health care facilities" was an unsurmountable challenge for managed care. Ms. Merriman believed that Alaska's rural geography had been the issue that the department and legislature had struggled with. She believed an ACO scenario would fit the rural situation better in rural communities. Vice-Chair Saddler asked whether there were sufficient primary care facilities and providers in Alaska to accommodate the shift in care. Ms. Merriman answered that the workforce needs of the healthcare industry was challenging. She elaborated that Medicaid reform allowed a variety of healthcare providers to "practice at the top of their licensure." She had "worked with the Alaska Mental Health Trust Authority (AMHTA) to craft language in the legislation regarding behavioral health providers who were situated in a variety of care sites including community health centers." She thought that care coordination allowed a variety of providers to participate in a patients care leaving the most complicated and serious cases to physicians and nurse practitioners.

[3:02:05 PM](#)

Vice-Chair Saddler requested clarification regarding primary care and coordinated care would allow more advanced practitioners and M.D.'s (medical doctors) time for the more serious and complicated cases. Ms. Merriman responded that Medicaid reform allowed the expansion of services at the "lower level" of providers so the midlevel providers could practice at the top of their licensure and the physicians could focus on cases that required their level

of skill and expertise. She added that care coordinators could perform "a critical role in a patient's care."

Representative Gattis referred to an answer to a question by Vice-Chair Saddler stating that a rural village situation being better served by an ACO. She wanted to hear the managed care response to the question and was interested in the comparison. Ms. Steckel answered that an MCO could include a subset of ACO's and primary care medical homes and sought to meet the needs of rural communities through telemedicine or other means. The MCO worked with the communities in rural areas to link with providers in more populous areas.

[3:05:38 PM](#)

JOCELYN PEMBERTON, EXECUTIVE DIRECTOR, ALASKA HOSPITALIST GROUP, LLC, read from a prepared statement:

For the record, my name is Jocelyn Pemberton and I am the executive director for The Alaska Hospitalist Group, a large physician practice as well as a founding member of Alaska Innovative Medicine (AIM), a local physician driven, Care Coordination Company. More importantly, I was born and raised in Alaska, I'm raising my three beautiful girls in Anchorage and I am watching my parents grow old in Alaska.

I agree with the other comments that we need to bend the cost curve and that the pure fee for service model ultimately needs to change. Financial incentives need to be aligned between patients, providers and payers, in this case, the State. As you know, this is much easier said than done.

The vast majority of our provider community are in private practice; Alaskan physicians and nurse practitioners running small businesses to provide medical care in their community. To make sweeping changes in the payment model is extremely risky and could be a hugely damaging to our industry, especially in pediatrics which often have 50% or greater percentage of Medicaid patients. However, there are models that would allow physicians that are willing to take risk and participate in shared savings to do so, thereby aligning the incentives.

The model that we have experience with is the Bundled Payment for Care Improvement, or BPCI, which is a demonstration project we are participating in with Medicare. Essentially, BPCI sets a cost, based on historical data, for the episode of care initiated from a hospitalization plus 90 days post discharge and aligns incentives to provide better care at a lower cost. For example, the total cost for a patient with a hip fracture might be \$20,000 on average. If we are able to provide services for less, by working to avoid readmissions for example, there are shared savings back to the providers who are working to reduce cost and improve outcomes. BPCI allows for utilization management by incentivizing models of care the prevent re-hospitalizations, over-utilization of the ER or duplicative testing, rather than merely slashing payments to providers or restricting access for patients.

We appreciate the work that the legislature has done and the recognition of the impact care coordination can bring to the Medicaid program. As physicians, we have recognized this as well and have created Alaska Innovative Medicine or AIM for short. AIM is a local, physician driven care coordination company, a result of a collaboration between primary care physicians and hospitalists. AIM has initially contracted with Premera Blue Cross to improve the care of their high risk members. AIM has a multi-disciplinary approach including case managers, social workers, a clinical nursing staff, dieticians etc.

Think of AIM as a mobile patient centered medical home deploying services as needed. AIM social workers collaborate with Primary Care Physicians as well as specialists to best support the health plan for the patient. Our clinical nursing staff, as well as our physicians are able to meet patients in their home to avoid over ER utilization, educate on medications and nutrition to promote health. With the local provider relationships and Alaskan experience, the AIM model has the ability to have huge impact to improve patient care and reduce cost in our state.

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Co-Chair Thompson asked about the term "hospitalist." Ms. Pemberton replied that it was a primary care physician working in the hospital and providing care for the hospitalized medical patients.

Representative Gara asked whether there had been any progress between the ACO and DHSS towards utilization of the provider model instead of managed care in order to save money. Ms. Pemberton relayed that she had engaged in several discussions with the department but that the model was a fairly new; formed January 1, 2015.

3:12:50 PM

RICK DAVIS, CEO, CENTRAL PENINSULA HOSPITAL, SOLDOTNA, read from prepared remarks:

Mr. Chairman, members of the committee, thank you for the opportunity to testify today. For the record, my name is Rick Davis and I am the Chief Executive Officer at Central Peninsula Hospital in Soldotna. Central Peninsula Hospital is a 49 bed acute care hospital that is owned by the Kenai Peninsula Borough and leased to CPGH, Inc., a local nonprofit Corporation.

I was asked to provide testimony today to the House Finance Committee regarding Managed Care and Accountable Care Organizations as they pertain to SB 74, Medicaid Reform.

The Centers for Medicare and Medicaid Services defines ACO's as groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of this coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

The CMS definition I just provided speaks directly to Medicare, however my discussion about ACO's today will refer to specifically Medicaid. In this context, I am talking about an Accountable Care-like structure that I will refer to as a Coordinated Care Organization, or CCO. The key to the effectiveness of both the ACO and

the CCO models is that both of these relationship structures take the majority of the risk away from the payer, and place it directly on the providers. These relationships make the provider responsible for maintaining low cost and high quality, or the provider suffers the consequences - not the payer. Which makes a lot of sense because the provider and the patient are the only two entities who really have the ability to affect health outcomes.

A Managed Care Organization differs from an ACO or CCO in that MCO plans are a type of health insurance. MCOs have contracts with health care providers and medical facilities to provide care for members at reduced costs in return for steering of patients to those providers. The obvious difference between Managed Care Organizations and Accountable or Coordinated Care Organizations is that - in the MCO model - the payer is taking on the risk both in terms of quality and cost. Instead of as I mentioned earlier, the providers taking that risk in the ACO/CCO model.

Now I'd like to give you some background about why and how CPH became interested in a variant of an ACO and our desire to pilot a demonstration project on the Kenai Peninsula.

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Mr. Davis continued to read from a statement:

Because we are a single stand-alone community hospital and are not part of a system or affiliated with a larger hospital, CPH must be diligent when considering future financial risk. We are keenly aware of the changing health care landscape and believe that a major transformation is beginning to take place. The changes I am referring to will cause reimbursements for health care services to be directly tied to quality, outcomes, and efficiency. This type of payment transformation is moving health care away from volume and towards value.

We have already begun to see these changes take place under Medicare with Value Based Purchasing and bundled payments. Because of this, we have elected to be

proactive and prepare for anticipated changes in an effort to lessen the impact of shrinking reimbursements going forward. Nearly two years ago, we began to explore different options and payment models in order to better prepare for the compression on reimbursement as it begins to show up in Alaska.

We are interested in piloting an ACO variant that is based on an existing Community Care Organization or CCO that is operating in Eastern Oregon. Data released in February in the Journal of American Medical Association indicates that: Compared with a 2011 baseline, the Oregon Health Authority reported that per-member per-month spending for inpatient care had decreased in 2014 by 14.8%. Per-member per-month spending on outpatient care was also lower, by 2.4%. However, outpatient spending trends masked a 19.2% increase in spending on primary care services because care transitioned away from high cost specialty care, and over to the Primary Care Medical Homes that are part of the CCO. This improved coordination of care - lead by the primary care provider is the key to lowering costs and improving care.

We would anticipate this model covering the entire Medicaid population on the Kenai Peninsula. CCO's differ from ACO's in their acceptance of full financial risk in the form of the global budget. They are similar in that they are both locally governed; are accountable for access, quality and health spending; and both emphasize primary care medical homes. Both require Robust Data Systems to support a Clinically Integrated network for clinical and business functions in addition to permitting the flow of data required to make informed decisions.

The CCO would operate on a fixed global budget, reduce medical cost inflation as part of the contract, improve the quality of care and outcomes and create a healthier population. The current Alaska trend of growth per capita for Medicaid expenditures averages just over 6% per year and we believe this demonstration could help put Medicaid on a predictable and sustainable path by reducing the growth trend in per capita Medicaid expenditures.

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Mr. Davis continued to read from prepared remarks:

We view the CCO as the next step beyond traditional managed care. This belief is simply based on the funding structure and risk bearing nature of the program. More importantly, providers will no longer be paid for treating illness but instead for providing a highly coordinated system that prevents illness and the high costs associated with it.

The CCO structure requires a great deal of front-end work to bring the stakeholders together and agree on a payment structure within the organization. We will need to form a network, a shared savings distribution program, and develop quality targets and metrics for accountability.

Currently, Alaska does not utilize Managed Care Organizations or Managed Health Plans. There are different kinds of managed care, and we encourage you to structure any legislation broadly enough to allow for local innovation like CCO's. We believe that a provider-led model like a CCO will work on the Kenai Peninsula and we are willing to pilot it.

A CCO will have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. We believe a CCO will be better able to coordinate services and also focus on prevention, chronic illness management and patient-centered care. We would have flexibility within our budget to provide services alongside medical benefits with the goal of meeting the Triple Aim of better health, better care and lower per capita costs for the population we serve.

Thank you for the opportunity to testify and please give consideration to a global budget CCO demonstration in any legislation you discharge from the subcommittee.

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Vice-Chair Saddler referenced the handout titled "Alaska Medicaid Redesign: Approaches to Coordinated Care and Value-based Purchasing," and asked where a Coordinated Care Organization (CCO) would be listed on the chart's

continuum. Mr. Davis answered that he put the CCO between the ACO and the MCO. He delineated that the CCO would assume the full risk in contract with an insurance partner. Vice-Chair Saddler asked if the bill currently allowed a CCO to submit an application for the demonstration project. Mr. Davis answered in the affirmative.

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Representative Gara asked whether Medicaid allowed the department to negotiate a rate with a doctor of the patients choosing in cases of serious illness.

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that the answer was complicated. She elaborated that Medicaid required that care must be provided in the closest community as possible. Federal law required provider choice for Medicaid beneficiaries but the state mandated that care must be provided in their home community to avoid unnecessary travel.

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, clarified that if care was not accessible in a community, the state would pay the travel costs for a person to receive care. Regulations would not prevent an enrollee from seeing a Medicaid provider in another community, but the travel costs would not be covered by the state if a Medicaid provider was available in their community.

Representative Gara reiterated his question regarding patient choice. Mr. Sherwood replied in the negative. He reported that when travel was necessary the department allowed a person to travel to the closest community and if the community was in another state and there was not a significant difference in expense DHSS would most likely authorize travel to the community of choice. He exemplified a person wanting to see a provider in Portland as opposed to the designated Medicaid provider in Seattle. He added that the provider had to agree to enroll in the Medicaid program and accept the allotted rate. The department did not negotiate individual rates for providers.

Representative Gara asked what it meant that a provider had to be enrolled in a Medicaid program. Mr. Sherwood answered that an out-of-state provider would have to be enrolled in the Alaska Medicaid program. He revealed that if a

recipient was in another state and needed treatment, the default was that the state would pay the particular state's Medicaid rate or refer to regulation to determine how to pay an appropriate rate if the provider would not enroll in Alaska's Medicaid program.

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Representative Gara asked whether anything in the bill would prevent the process Mr. Sherwood described from happening. Mr. Sherwood answered in the negative. He added that a proposal under a managed care model that would restrict freedom of choice was possible in the future under provisions of reform.

Representative Wilson recalled testimony from Central Peninsula Hospital (CPH) the previous session that adopted a similar CCO model and reported that the hospital in Unalaska had as well. She wondered whether there would be a negative impact on the entities or communities that already employed a coordinated care model if Medicaid adopted a statewide plan. Commissioner Davidson answered that one of the things the department liked about the bill was that it offered flexibility to allow the use of different models that fit different communities. She illustrated that what worked in Unalaska might not work in Anchorage. She referred to testimony from CPH that noted its interest in a CCO model, which might differ from a model the Bethel region was interested in piloting. The department appreciated the broad flexibility the bill provided to tailor demonstration projects to models chosen by communities that worked for them. Representative Wilson voiced concern about putting the pilot projects in statute. She supported the overall concepts of the bill and felt that the specific provisions in statute would limit the department from piloting other possible models not listed in the bill. She wondered why the department could not issue an RFP under direction from the legislature based on the best ideas from other states without adopting legislation.

Commissioner Davidson answered that the bill allowed the department to do just what she described; issue an RFP with defined criteria. She cited page 33 of the legislation, under subsections d, e, and f, lines 10 through 31 and noted that the proposals must include cost saving measures, innovation, integrate behavioral health, telehealth, and

actuarial follow up. She reported that the department wanted an independent actuary to show whether the program had achieved its goal and would work on a wider basis. She believed the provisions benefitted the legislature.

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Representative Wilson did not disagree with anything in the bill. She disagreed with the use of statute. She believed that there were existing models working well. She did not want to "tie the state's hands" any further. She declared that she liked the ideas in the legislation but felt they were not necessary to place in statute in order for the department to implement. Commissioner Davidson understood her concern. She shared the department's concern. She commented that even though the projects existed in another state, some regions of Alaska were very unique and did not exist elsewhere in the country. She noted that in large remote road less regions travel was critical to access care. She added that communities lacking adequate sanitation facilities impacted public health. She emphasized that things were uniquely different in rural Alaska. She understood that other companies may have had experience in rural areas in other states, but she repeated that Alaska was very different. The demonstration projects were necessary to prove effective in rural Alaska with its unique set of challenges. Representative Wilson asked whether the committee was going to hear from any of the Native organizations related to what they may be doing in their regions of the state. Co-Chair Thompson would look into the idea.

Vice-Chair Saddler agreed that Alaska was unique, but believed it was not so unique. He asked whether the commissioner envisioned how the process would play out in the next 3, 5, or 10 years. Commissioner Davidson answered that there were different things that could be done on a regional or community basis. She felt that what worked in Anchorage or Juneau may not work in Bethel or another community. She cited page 33, Subsection (e) of the bill that provided for actuarial analysis and emphasized that it would provide critically beneficial information for the department on how to proceed.

Vice-Chair Saddler referred to page 32, line 17, Section 2 of the bill, which set up a project review committee and page 33, line 17 that allowed the department to contract

with a third party. He asked whether there would be some value in using the project review committee to help evaluate the demonstration projects as well. Commissioner Davidson answered that the provisions took place at two different points in time. She clarified that the project review committee would decide which projects would be selected to move forward. The actuarial analysis took place after the projects were implemented.

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Vice-Chair Saddler pointed to page 33, Subsection (f) and read the following:

(f) The department shall prepare a plan regarding regional or statewide implementation of a coordinated care project based on the results of the demonstration projects under this section. On or before November 15, 2019, the department shall submit the plan to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the plan is available. On or before November 15 of each year thereafter, the department shall submit a report regarding any changes or recommendations regarding the plan developed under this subsection to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available.

Vice-Chair Saddler did not understand what the implication of the subsection was. He asked whether the plan would be statewide or if there would be 10 different regional plans. Commissioner Davidson responded that the subsection and bill contemplated both options. She offered that some services may work on a statewide basis and some may only work on a regional basis. The legislation provided the flexibility that would allow both to happen. She exemplified that Medicaid related travel was currently arranged on a statewide basis and in the past some of the travel had been arranged on regional basis, which she felt might work better. She noted that recently a national policy change was made to address travel differently and could be beneficial to the state.

Representative Munoz pointed to page 29 of the bill related to the reimbursement rates for the expanded Medicaid program and wondered whether the 90 percent rate applied to

any of the options under discussion. Mr. Sherwood referenced page 29, Section 30, and paragraph d items 1, 2, and 3.

(d) Notwithstanding (a) - (c) of this section, the department may

(1) apply for a section 1915(i) option under 42 U.S.C. 1396n to improve services and care through home and community-based services to obtain a 50 percent federal match;

(2) apply for a section 1915(k) option under 42 U.S.C. 1396n to provide home and community-based services and support to increase the federal match for these programs from 50 percent to 56 percent;

(3) apply for a section 1945 option under 42 U.S.C. 1396w-4 to provide coordinated care through health homes for individuals with chronic conditions and to increase the federal match for the services to 90 percent for the first eight quarters the required state plan amendment is in effect;

Mr. Sherwood explained that (d) (1) was the 1915i option for Home and Community based services, which provided 50 percent coverage of some state funded program's Medicaid services and a portion of that population were eligible for the enhanced rate. He continued that the "K" option was another home and community based program intended for people to meet institutional levels of care, which would receive an extra 6 percent over the base match rate and were not eligible for the enhanced rate. He reported that the last option, Section 1945 regarding health homes for individuals with chronic conditions, allowed for the enhanced rate of 90 percent federal match for the first 8 quarters of the program.

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Representative Munoz pointed to section 1915i and asked whether the expanded population that might qualify for a higher rate was the 90 percent enhanced rate. Mr. Sherwood replied in the affirmative and clarified that the rate would begin at 100 percent and drop to 90 percent over the next few years. He expounded that an individual who was eligible in the expansion group receiving the services listed would qualify for the higher rate. Representative Munoz asked why the legislation would reference the 50

percent rate if the expanded population was eligible for the higher rate. She also wondered what the rate was expected to be after two years for the 1945 population. Mr. Sherwood answered that after 8 quarters the rate would fall to 50 percent.

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Ms. Shadduck clarified that if the state chose managed care, the consultants recommended that three or more organizations should be involved. She elaborated that if an MCO dropped out beginning with only two the state was "on the hook" and the situation complicated the interactions with rural populations and tribal health. She added that the sponsor felt that the "the feedback loop for the legislature" in the form of the review committee and actuarial results were an important provisions to place in statute. She reminded the committee that the legislature had seats on the "RFP review committee" and if the reform provisions were not in statute the department would not have to be accountable to the legislature. She emphasized the flexibility that existed in the bill and noted that if in the future the CMS offered other options for innovation the department was authorized to utilize them. She cited the language in Subsection C, on page 33, "the department may contract with..." which was not exclusive language and suggested amended language that quelled the concerns that the bill restricted other areas of innovation and reform.

CSSB 74(FIN) am was HEARD and HELD in committee for further consideration.

Co-Chair Thompson discussed the schedule for the following day.

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ADJOURNMENT

[3:54:06 PM](#)

The meeting was adjourned at 3:54 p.m.