

HOUSE FINANCE COMMITTEE
March 29, 2016
1:34 p.m.

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CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 1:34 p.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 Cathy Munoz
Representative Lance Pruitt
Representative Tammie Wilson

MEMBERS ABSENT

Representative Scott Kawasaki

ALSO PRESENT

John Skidmore, Director, Criminal Division, Department of Law; John Boucher, Deputy Commissioner, Department of Administration; Janey Hovenden, Director, Division of Corporations, Business and Professional Licensing, Department of Commerce, Community and Economic Development; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Vicky Wilson, Director, Division of Pioneer Homes, Department of Health and Social Services; Karen Forrest, Deputy Commissioner, Department of Health and Social Services; Jeff Jessee, Chief Executive Officer, Alaska Mental Health Trust Authority; Stacie Kraly, Chief Assistant Attorney General, Human Service, Department of Law; Senator Pete Kelly, Sponsor.

SUMMARY

CSSB 74(FIN) am

MEDICAID REFORM;TELEMEDICINE;DRUG DATABASE

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

Co-Chair Thompson discussed the meeting agenda.

#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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JOHN SKIDMORE, DIRECTOR, CRIMINAL DIVISION, DEPARTMENT OF LAW, spoke to the fiscal note from the Department of Law (DOL) for SB 74. He detailed the bill asked for a couple of positions to be placed into the Medicaid Fraud Unit of the DOL Criminal Division. The department had initially contemplated placing the positions in the Civil Division because it would be dealing with civil work; however, DOL had elected to move the positions into the Medicaid Fraud Unit because the unit had 75 percent federal match for 25 percent state funds. Therefore, the work could be done at a lower cost to the state. He believed the note had changed slightly since its last version to indicate the fund source was General Fund (GF) with federal match instead of GF only.

Co-Chair Thompson noted that the committee was addressing fiscal note OMB Component Number 2203 dated 3/18/16.

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AT EASE

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RECONVENED

Co-Chair Thompson reiterated that the committee was addressing the DOL fiscal note.

Vice-Chair Saddler remarked the note included a cost of \$365,000. He asked if DOL anticipated any recovery of Medicaid fraud proceeds that would help diminish the fiscal note.

Mr. Skidmore in the affirmative. He detailed it was difficult to tell what the recoveries would be because the cases had not yet been received. Based on recoveries in past years, the department anticipated recoveries from the

False Claims Act to more than cover the positions and 25 percent state cost listed in the fiscal note.

Vice-Chair Saddler asked for clarification. He wondered if the fiscal note included the anticipated recoveries. He asked if the \$365,000 per year was after or before recoveries.

Mr. Skidmore answered that because the \$365,000 was based on General Funds and there were not funds going directly to DOL, he did not know if the note reflected DOL's anticipation that recoveries going into the General Fund would exceed the \$365,000. The change in revenues should be reflected in the \$500,000 figure listed in the "change in revenues" row. The \$500,000 exceeded the \$365,000 in the fund source and operating expenditure.

Vice-Chair Saddler asked for verification DOL anticipated recovering \$500,000, while the fiscal note showed \$365,000 in expenditures. He surmised there would be a net of \$135,000.

Mr. Skidmore answered in the affirmative.

Representative Wilson referred to the last paragraph on page 2 of the fiscal note related to the proposed Medical Assistance False Claim and Reporting Act and provision on seizure and forfeiture of real property require involvement of DOL. She asked for verification the bill would give the department authority it did not currently have on the civil side.

Mr. Skidmore answered in the affirmative. He explained the department believed the False Claims Act would allow the department to pursue civil cases it was not currently able to pursue; it was currently only able to pursue criminal cases.

Representative Wilson asked if the bill added fines and forfeiture.

Mr. Skidmore answered that the False Claims Act allowed the state to pursue claims of fraudulent billing into the medical system (i.e. restitution or forfeiture). The state would have the ability to collect the funds that should not have been collected in the first place.

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Representative Guttenberg pointed to the second to last paragraph on page 2 of the DOL fiscal note related to the barring of certain actions including actions based on evidence known to the state. He wondered if a situation was considered known to the state if someone knew about a fraudulent action with a provider and a state employee was complicit in the act.

Mr. Skidmore answered that the term "known to the state" meant the information was known to the lawyers that would be prosecuting the case; the term did not refer to a state employee who may be involved in the fraud.

Representative Guttenberg asked if a whistle blower would be precluded from being party to the situation if the lawyers were aware of the situation but had not yet brought the case. He asked for further clarification.

Mr. Skidmore replied that the section addressed circumstances in which there may already be a criminal investigation ongoing. For example, if a person came forward with information that Doctor A was fraudulently billing Medicaid and the department already had investigators working on the case, the department would inform the person it was already pursuing the issue. The person would be barred from pursuing the issue.

Representative Guttenberg spoke to the 75 percent federal funding. He asked if there was a division of the rewards when the department took action and prevailed. Mr. Skidmore answered that the funds were divided 50/50 between the state and the federal government in terms of the recovered funds.

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Representative Guttenberg asked how fraudulent funds were divided when returned. He wondered how the formula was different from the rewarding of the attorneys.

Mr. Skidmore spoke to the federal Medicaid program that provided funding to the state for distribution. There was a Medicaid Fraud Unit that was funded 75 percent with federal funds and 25 percent state funds. When fraud occurred within Medicaid distributions and the state acted to

recover the funds, anything recovered by the state was split 50/50 with the federal government. He referred to page 1 of the fiscal note and explained the intake of \$500,000 represented the state's portion.

Representative Guttenberg explained his assumption that not all of the money was federal; there was a federal/state match. He relayed Mr. Skidmore had answered his question.

Co-Chair Thompson noted Representative Gara had joined the meeting.

Representative Munoz asked about the existing penalties for a civil fraud violation. Mr. Skidmore asked for clarification.

Representative Munoz asked if there were penalties in current law for Medicaid fraud. Mr. Skidmore was not aware of any existing penalties; however, he did not handle most civil cases. He did not believe the state had the ability to go after individuals for false claims the way the bill would establish; the provision established in the bill was new.

Representative Munoz asked for the distinction between criminal and civil fraud cases. Mr. Skidmore answered that a person did not receive a criminal conviction for which they could potentially go to jail; because the penalty did not occur there was also a lower burden of proof associated with a civil case, which would be a preponderance of the evidence instead of beyond a reasonable doubt.

Vice-Chair Saddler read from page 7, lines 17 through 20 of the legislation:

A beneficiary of an intentional or inadvertent submission of a false or fraudulent claim under the medical assistance program who later discovers the claim is false or fraudulent shall disclose the false or fraudulent claim to the state not later than 60 days after discovering the false claim.

Vice-Chair Saddler asked if someone disclosing within the 60-day time period was still subject to any interest or penalties for overpayment.

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Mr. Skidmore was happy to look into the question and would follow up.

Co-Chair Thompson asked for the information in writing. He noted Representative Gattis had joined the meeting. He asked the Department of Administration (DOA) to address its fiscal note.

JOHN BOUCHER, DEPUTY COMMISSIONER, DEPARTMENT OF ADMINISTRATION, relayed that DOA's role in the legislation appeared in Section 40 of the bill. The section required DOA in collaboration with the legislative finance committees to procure a study to determine the feasibility of creating a health care authority that could coordinate health care plans; and consolidate purchasing effectiveness for retired state employees, teachers, medical assistance recipients, the University of Alaska, state corporations, and school district employees. The study must be completed before June 2017. The primary reason for the study was to determine the feasibility for the authority to study the needs to understand a current suite of benefits, cost-sharing, and payment for all employees and individuals whose health care benefits were funded directly or indirectly by the State of Alaska. The study would require evaluation of a number of health care benefit delivery programs funded directly and indirectly by the state. He expounded that when the department had done research on similar type studies (e.g. the Hay study from several years ago with \$350,000) it estimated the cost of the study could be up to \$700,000 to complete. The project would be ambitious and would require a project staff manager for slightly over one year including the three-month period following June 2017 in order to wrap up the study, coordinate, review the input and output from the proposed review and comment period, and guide the agency on the next steps.

Representative Wilson asked for the financial figures listed on the fiscal note. The note also indicated one person would be hired.

Mr. Boucher replied that the amount was \$834,600 in FY 17 and \$33,600 in FY 18. The FY 17 cost represented one-quarter of the staff cost (i.e. funding for the position for three months in FY 18).

Co-Chair Thompson noted that the committee was addressing fiscal note OMB Component Number 45 dated 3/6/16.

Vice-Chair Saddler referred to Mr. Boucher's testimony about studies that had been conducted. He asked if the study would be ab initio or whether the department had developed prior information that would be a useful foundation.

Mr. Boucher answered the bill included specific direction to try to leverage previous studies including the Hay study. The provision included such a broad group of programs, the department believed it would still require a significant amount of data collection.

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Representative Guttenberg asked if department anticipated doing the study in-house or contracting it out. Mr. Boucher replied that it would be a contract.

Co-Chair Thompson relayed the committee would address the fiscal notes from the Department of Commerce, Community and Economic Development (DCCED) [Note: Co-Chair Thompson originally relayed the committee would hear from the Department of Health and Social Services (DHSS); however, he corrected they would hear from DCCED first].

JANEY HOVENDEN, DIRECTOR, DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT, addressed fiscal note OMB Component Number 2360. The bill impacted the division in two ways. First, it expanded the Prescription Drug Monitoring Program (PDMP), which would require pharmacists or practitioners dispensing controlled substances to submit to the board for inclusion in the PDMP on a weekly basis; pharmacists or practitioners prescribing or dispensing controlled substances would be required to register with the PDMP in a format established by the Board of Pharmacy; required the notification of other boards; and allowed the practitioner or pharmacists to delegate access to the PDMP to employees on their behalf. The expansion of the PDMP would require a program coordinator at a range 18 (on the state pay scale) to be located in Juneau, which would include the expanded registrations, reporting, collaborations, engagement with the state opioid control program, grant writing and reporting, vendor solicitation,

and other. Second, the bill expanded telemedicine for medical and social workers, professional counselors, psychologists, psychological associates, marital and family therapists. She relayed that after the limited expansion in 2014, the department understood the volume expansion increased licensure; therefore, DCCED anticipated the need of two additional occupational licensing examiners to review the increases, as well as two additional investigators. The fiscal note included \$3,000 for travel for the new program coordinator to attend Board of Pharmacy meetings; it also included some regulation and legal costs and printing and postage for \$12,000. The department anticipated there would probably be extra legal costs and investigations in future years due to the increase. She explained that it was a bit more costly to conduct investigations across state lines related to telemedicine. The fiscal note included \$560,000 in the first year [FY 17] for the two different sections she had spoken about and the five additional employees.

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Co-Chair Neuman observed DCCED would accept federal funds related to the PDMP. He asked if any other federal regulations came with the funds. He remarked there was generally a "carrot stick" attached to federal funds.

Ms. Hovenden did not believe there were any other carrots related to the PDMP. She did not know for certain.

Co-Chair Thompson noted they would follow up on the issue.

Representative Guttenberg pointed to language in the first paragraph on page 2 of the fiscal note: "the bill allows licensed practitioners and licensed pharmacists to delegate access to the PDMP on their behalf to an agent or employee of the practitioner." He observed a licensed practitioner or pharmacist could delegate authority to an office clerical worker with no experience. He asked how far out it left a pharmacist or practitioner in their licensing requirements.

Ms. Hovenden replied that the licensee's license would be held liable for any misuse or misconduct by the employee they delegated authority to.

Representative Guttenberg asked if it was a common practice for pharmacists and practitioners to delegate authority to people without a license or certificate.

Ms. Hovenden answered that employees regularly had access to patient files and databases. She explained it was the licensee's license that would be in jeopardy for misuse.

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Vice-Chair Saddler asked if any other professional licensing boards allowed delegation of authority to access information about an individual to others. He suspected the Board of Medicine did, but he wondered about psychiatrists, social workers, physical therapists, or others.

Ms. Hovenden was not aware of any, but she would follow up.

Vice-Chair Saddler asked if the anticipated expenditure of \$607,400 would be matched by the revenues generated from license fees charged to licensees. He asked for verification the cost would be a net zero to the state; the fees would be passed along to licenses.

Ms. Hovenden answered in the affirmative; the funds came from receipt supported services paid by all licensees. The fiscal note would give the division spending authority over the funds.

Vice-Chair Saddler understood that a large part of the increase was expected to be the cost of licensing and verifying the qualifications for telehealth practitioners. However, the fiscal note only included \$3,000 for travel. He wondered if the cost would come out of the services or travel lines on the fiscal note if it were necessary to travel outside of Alaska to investigate the fitness of a telehealth provider.

Ms. Hovenden did not anticipate that investigators would need to travel out of state to conduct any investigations. There were already licensees outside of the state and the division had certain tools it could utilize to cooperate with other states. The \$3,000 was merely for the program coordinator to travel to the Board of Pharmacy [meetings].

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Representative Wilson asked for verification that the fiscal note did not contain federal funds. Ms. Hovenden answered that the funding was not guaranteed [into the future], but currently the PDMP was currently paid for with a federal grant through a reimbursable services agreement (RSA) with DHSS.

Representative Wilson asked if the database would continue after there were no federal funds in the future. Ms. Hovenden replied in the negative. She elaborated there had been discussion about creating a registration fee that would help sustain the PDMP in the long-term, but she did not believe it was in the current bill version.

Representative Wilson believed a corrected fiscal note was needed because she wanted to understand current and potential federal funds being provided. She referred to the five new positions and wondered how many professionals would be required to register to access the database.

Ms. Hovenden asked for clarification.

Representative Wilson explained the department was proposing to hire five additional employees due to the database and telehealth portions of the bill. She referred to Ms. Hovenden's remark about considering how much to charge for registration once the federal funds were no longer available. She asked how many individuals would have to register in the system. She wondered if only Medicaid providers or all professionals would have to enter prescriptions.

Ms. Hovenden answered that she did not have the number. She referred to the Board of Nursing, optometrists, and veterinarians and believed there were approximately 8,000 individuals with the licensed ability to prescribe.

Representative Wilson requested an updated fiscal note if there was federal and other funding that the state may have to backfill. She wanted to know how many providers the state may have to charge to maintain the system.

Co-Chair Thompson replied his office would follow up with the information.

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Co-Chair Neuman referred to the second to last paragraph on page 3 of the fiscal note related to the PDMP. He noted there had been plenty of discussions about federal Medicaid reform. He detailed the cost would be covered by Board of Pharmacy licensees in absence of federal funds. He asked if the Board of Pharmacy or pharmacists around the state had been asked about the fact that they may have to pay for the funds in the future.

Ms. Hovenden replied that the Board of Pharmacy was aware of the issue and it made them nervous. She explained that when the PDMP had been put under the Board of Pharmacy it had been a concern; it was the distinct intent the licensee of the Board of Pharmacy would not have to pay for the program. Thus far, the licensees had not been responsible for paying the cost. The fiscal note reflected the cost without any federal grant funding to the program because there was no guarantee for future federal grants.

Co-Chair Neuman noted that for past three years the legislature had been chosen not to fund the PDMP. He detailed the department had chosen not to abide by the request of the legislature and had found its independent funding for the program. He stated the department had been instructed not to fund the program. He furthered the legislature heard all of the "budget restraints and a lot of crying and screaming from the department about how you're cutting and reducing our budget, but they can find other money for programs that the legislature said we don't want funded."

Representative Gattis asked if the state had to abide by federal criteria in order to receive the federal funds related to the PDMP. She wondered if the state would not receive the money if it did not follow the requirements.

Ms. Hovenden was not aware of any, but she would follow up.

Representative Gattis stated in her experience it had been necessary to abide by requirements in order to get the money.

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Co-Chair Thompson asked if the pharmaceutical tracking and information gathered [in the PDMP] was shared with the federal government.

Ms. Hovenden answered she would follow up during the meeting the following day and would be accompanied by the PDMP manager.

Representative Gara referred to the provision requiring pharmacists to take part in the PDMP. He asked if it applied to all physicians for all prescriptions or only to Medicaid services.

Ms. Hovenden answered the provision applied to all physicians.

Vice-Chair Saddler looked at page 3 of the fiscal note and observed that \$108,600 for legal costs and appeals was a precise number. He asked if the number was based on the experience of other boards or was specific to the Board of Pharmacy.

Ms. Hovenden replied that there was a formula, which was probably based on past practice. She would follow up with her administrative officer to determine how the figure had been calculated. She reminded the committee the provision impacted other many other boards apart from the Board of Pharmacy. She believed it represented an accumulation of past investigations, but she needed to confirm that information.

Vice-Chair Saddler remarked it was a new expansion of the range of services and how they were provided by telemedicine. He did not know if the existing standard formulas would apply.

Representative Gara asked if there was a separate hearing on the database.

Co-Chair Thompson replied that the hearing was the following day.

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Co-Chair Thompson relayed the committee would address fiscal notes from DHSS.

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, addressed a summary document from the department titled "DHSS Fiscal

Impacts for CSSB074(FIN)am, version UA" dated March 21, 2016 (copy on file). He detailed there were many DHSS fiscal notes; some of the provisions impacted more than one component and some components reflected the impact of multiple provisions. He relayed it was difficult to get a big picture of the bill's impact merely by looking at the individual fiscal notes. He pointed to the first table at the top of the document showed the fund sources. He specified the bill would result in a net reduction in GF in FY 17 of \$31.6 million, which would increase to over \$113 million by FY 22. The bill would also result in total fund reductions beginning in FY 19 and growing through FY 22. The second table showed permanent and long-term non-permanent positions: 15 positions were added in FY 17 including 4 to work on enhanced tribal claiming; and 8 three-year non-permanent positions intended to help the Divisions of Health Care Services and Senior and Disabilities Services with the transitions involved in the numerous program changes - the state portion of the positions was funded by the Alaska Mental Health Trust Authority (AMHTA). Position reductions were anticipated to begin in FY 19; the positions would peak at 17 in FY 18 and would gradually be reduced to 5 as efficiencies were achieved as a result of reform.

Mr. Sherwood addressed the third table showing capital budget costs, which totaled \$10.4 million. Most of the costs were around making Medicaid Management Information System (MMIS) changes to implement various program changes. Page 2 of the document included a table showing savings measures and associated summaries. The table did not include every provision in the bill that impacted the department; therefore, it did not perfectly match the fund source table on page 1. The largest reduction came from the implementation of the federal tribal claiming policy. He pointed out that savings were also included in budgets currently before the two legislative houses.

Co-Chair Thompson acknowledged the bill sponsor, Senator Pete Kelly in the committee room. He noted that Representative Pruitt had joined the meeting.

Mr. Sherwood noted that bill included provisions to develop a more effective integrated behavioral health system through an 1115 demonstration waiver. The department did not project direct behavioral health savings, but it did expect substantial savings and positive impacts throughout

state and local government once the new system was in place. The biggest impacts would be to the criminal justice system, but there would be possible savings to child protection and public assistance programs as well. He underscored that a specific savings for those programs had not yet been identified. He relayed that several weeks earlier AMHTA had met and committed to help finance Medicaid reform. The department's fiscal notes reflected some of the contributions and other contributions would be provided as direct support from the trust. The department deeply appreciated the support from AMHTA.

Co-Chair Thompson referred to the first fiscal note from DHSS, OMB Component Number 2671. Mr. Sherwood confirmed it was the first note he would address.

Vice-Chair Saddler referenced the summary document provided by DHSS and noted he was interested in the expenditures compared to savings in the table. He asked if the capital budget costs represented a particular year or the entire six-year period. He wondered if the costs tended to be frontend-loaded if they reflected the six-year period.

Mr. Sherwood answered the costs in the chart were intended to cover capital costs throughout the six years of the project. Most of the costs would involve expenditures beginning in year one or two of the program.

Vice-Chair Saddler asked if the savings measure on page 2 incorporated into the grand total chart at the top of page 1. Mr. Sherwood replied in the affirmative.

Representative Gara surmised that it looked as if roughly 85 percent of the savings (\$103 million) in FY 22 came from a combination of the federal tribal policy program and the 1915 waivers. He remarked that many legislators had accidentally referred to the federal tribal policy as a waiver; however, it was the program that let the state get full reimbursement for certain treatment of Indian Health Service (IHS) and Medicaid-eligible patients. He asked for the accuracy of his statement.

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Mr. Sherwood replied in the affirmative. The change in policy did allow certain services provided by non-tribal

providers could receive 100 percent federal funds through a tribal referral.

Representative Gara asked for verification that the federal tribal policy was a combination of travel and treatment of IHS patients in a non-IHS facility. He noted the state had previously paid for the services.

Mr. Sherwood replied in the affirmative. He detailed that travel and services received by Medicaid and IHS-eligible individuals resulting from a referral to a non-tribal provider from a tribal provider would be covered under the new policy (provided certain conditions were met).

Representative Gara asked for verification the coverage would be 100 percent and had previously been paid by the state.

Mr. Sherwood replied in the affirmative. He specified the services typically would have been matched at 50 percent federal.

Representative Gara surmised the federal coverage had increased from 50 to 100 percent. Mr. Sherwood replied in the affirmative.

Co-Chair Neuman pointed to page 2 of the DHSS summary document. He asked if the text shown in red represented a decrement or savings to the state. He asked if the \$33 million in FY 17 was a decrement or an expected savings.

Mr. Sherwood answered that the number represented savings to the state. He detailed the \$33 million represented a decrease in the department's budget.

Co-Chair Thompson asked if the savings went to the state's Undesignated General Fund (UGF). Mr. Sherwood answered in the affirmative.

Co-Chair Neuman asked for clarification that the numbers [shown in red] represented expected UGF savings to the state. Mr. Sherwood answered in the affirmative. The red numbers shown in parenthesis represented savings to the state. He noted some of the items in the early years had an initial startup cost.

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Mr. Sherwood addressed OMB Component Number 2671 related to the Division of Alaska Pioneer Homes dated 3/17/16. Section 35 of the legislation required Pioneer Home residents to provide proof of application to Medicaid in the decision letter regarding their Medicaid application in order to receive payment assistance. With the proposed change in law, the division estimated it would increase Medicaid revenues shown as interagency receipts and decrease GF expenditures by slightly over \$1 million per year. The switch showed as a fund source change, but not as a change in expenditures. He elaborated there would be a switch from GF to interagency receipts in the amount of \$1,066,700 annually.

Vice-Chair Saddler for verification that level-3 [Pioneer Home] residents required the lowest level of care. Mr. Sherwood responded that level-3 was the highest and most intensive level of care.

Vice-Chair Saddler believed more people were moving towards the need for level-3 care. He observed the fiscal note showed the same dollar amount over multiple years. He asked if there was an expectation of more Medicaid coverage over time as more people progressed to level-3.

Mr. Sherwood deferred the question to a colleague.

VICKY WILSON, DIRECTOR, DIVISION OF PIONEER HOMES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that the division expected there would be increases in the level-3 residents, but the division did not feel it could make an accurate calculation. She detailed the numbers had held pretty steady throughout the years, although there had been increases and decreases from year-to-year; it had been difficult to make a projection.

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Mr. Sherwood addressed OMB Component Number 2665 related to the Division of Behavioral Health dated 3/17/16. He relayed that the bill called on DHSS to coordinate with AMHTA to manage a comprehensive and integrated behavioral health system. The department would plan and implement significant behavioral health reforms and would apply for an 1115 waiver as part of the process. As a result of the changes made to the behavioral health systems, together with the

anticipated use of an administrative services organization to perform many of the functions required for the 1115 waiver, the division expected to be able to reduce staff beginning in FY 18. He continued that staff would be reduced by two in FY 18 and four in subsequent years, which produced a reduction of \$226,700 in FY 18 and \$453,400 in FY 19 going forward (half of the reduction was in GF).

Representative Wilson remarked that page 2 of the fiscal note addressed how savings would be realized in the Department of Corrections (DOC), Department of Public Safety (DPS), the Alaska Court System, and the Office of Children's Services (OCS). She asked for detail.

Mr. Sherwood thought the savings being referred to were the benefits accrued to the state as a result of reforming the behavioral health system and the implementation of the 1115 demonstration waiver for behavioral health. The actual reductions in the fiscal note only related to the behavioral health administration. He referred to his earlier testimony that DHSS did not feel it could predict or specify savings the state would achieve in the other areas as a result of the improvements.

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Representative Wilson clarified that her question pertained to how the reductions would affect the agencies the fiscal note language referred to. She cited OCS as an example. She believed most of the OCS families were in the Medicaid system and most services received were delegated by OCS. She surmised the families were directed where to go for service. She wondered how the waiver changed the system and produced any savings.

KAREN FORREST, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, answered that the department was looking forward to expanding access to mental health counseling and substance abuse treatment services across the state. As the ability for Alaskans to access the services expanded, the department anticipated it would have a significant impact on other sectors of the state's communities. For example, particularly for parents dealing with substance abuse issues through OCS and working to get into treatment to meet requirements in order to keep their children at home. The more the state was able to expand

access and have a robust continuum of care for Alaskans it would impact other service sectors across the state.

Representative Wilson asked for data pertaining to how long parents were waiting to access services required in order to get their children back from state custody. She listed services such as counseling, drug treatment, and other.

Ms. Forrest thought the requested data would be very helpful and she looked forward to working with OCS and the Division of Behavioral Health in order to see if the information was something that could be gathered.

Co-Chair Thompson asked if Ms. Forrest could provide the data to his office for distribution to the committee. Ms. Forrest answered in the affirmative.

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Co-Chair Neuman referred to page 2 of the fiscal note, which included language about the addition of a new subsection in Section 30 of the bill requiring the department to seek 1115 demonstration waivers from the federal government, Centers for Medicare and Medicaid Services (CMS). He asked if it required the department to seek the waivers or to obtain them. He wondered what would happen if the waivers were or were not obtained.

Ms. Forrest explained the bill required DHSS to seek the waiver, which was a negotiation with CMS. The department would have to meet certain criteria in order to have its application approved and DHSS was dedicated and willing to do the work in order to reach some agreement. She felt strongly based on consultation DHSS had received that it would put forward a strong application. The department recognized the behavioral health system needed reform and that doing so through the waiver with legislative support was very important.

Co-Chair Neuman asked about the criteria that Ms. Forrest mentioned. Ms. Forrest answered that one of the important things DHSS had to meet was budget neutrality. As the department looked to more innovative ways of serving the behavioral health population, the federal government did not want the department to spend more than the federal government was already spending. Additionally, it was necessary to create an efficient and effective health care

system. For example, DHSS would have to demonstrate health outcomes. There was a whole host of requirements the department would have to meet, but essentially DHSS had to prove it was increasing access, improving the quality, and improving health outcomes.

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Co-Chair Neuman understood DHSS had to meet budget neutrality. He did not know if federal funds had to meet state funds if acquired or if DHSS had to meet certain budget goals within a plan established by the department. He wondered if it was possible that it would cost the state more money in the future if the goals were not met.

Ms. Forrest answered in the negative. Through budget neutrality DHSS had to provide extensive information five years back and projections five years forward, which would receive significant analysis by DHSS and CMS. In terms of state funding, DHSS understood its budget would not be increasing and that the state was moving more towards a Medicaid-based system versus a grant-based system.

Co-Chair Neuman wanted to learn more about what 1115 demonstration waivers were. He understood they related to IHS components, but did not know what they were for behavioral health and how much they cover. He was uncertain about what the state was stepping into.

Ms. Forrest answered that some of the policy decisions would be made through the negotiations as the department looked at the costs going forward. She would provide further information about the 1115 waiver to Co-Chair Neuman's office.

Vice-Chair Saddler referred to \$291,000 in MHTAAR [Mental Health Trust Authority Authorized Receipts] money for each of the three years. He referenced a budget sheet in committee packets provided by AMHTA titled "Alaska Mental Health Trust Authority Medicaid Reform Implementation Support" dated 3/16/16 (copy on file) and observed the MHTAAR funds requested were \$308,300 [for health care services staffing needs]. He asked about the difference.

Mr. Sherwood asked for clarification.

Vice-Chair Saddler pointed to \$291,000 under fund source MHTAAR for FY 17 through FY 19. He realized he was looking at a different fiscal note and withdrew his question.

Mr. Sherwood moved on to fiscal note OMB Component Number 242 for the Division of Health Care Services. The medical assistance administration section included many of the administrative and support components for the Medicaid program. He detailed many parts of the bill impacted the section including fraud and abuse prevention, primary care case management, health homes, emergency room reduction project, and the coordinated care demonstration. The largest portion of the fiscal note was for personal services and two positions would be added to work on the primary care case management in managed care sections of the bill (i.e. health homes, telemedicine sections, the emergency room demonstration projects) - those positions would be 50 percent federally funded. In FY 17 through FY 19 the state match would come from AMHTA and for FY 20 and beyond the match would be GF, it would be the point at which the programs would all be demonstrating savings. The department also proposed adding four long-term non-permanent positions for FY 17 through FY 19 with state match provided by AMHTA to assist with the startup of the behavioral health related system changes to the MMIS to handle the increased workload related to fraud and abuse provisions and to work on the hospital emergency room demonstration.

Mr. Sherwood continued to address fiscal note OMB Component Number 242. The services line had been increased by \$75,000 per year to accommodate the higher appeal volume associated with the fraud and abuse provisions, which would be included in funds going to the Office of Administrative Hearings. The fiscal note totaled \$697,600 in FY 17, \$679,900 in FY 18 and FY 19, and \$316,200 in FY 20 through FY 22. There was minimal GF cost in FY 17 through FY 19 due to the contribution from AMHTA; the cost would be \$57,700 the first year and \$48,900 in FY 18 and FY 19. Beginning in FY 20 the GF cost was 50 percent or \$158,100 per year.

[2:42:17 PM](#)

Vice-Chair Saddler pointed to a reference that provisions in the bill would authorize DHSS to assess interest and penalties on overpayments (page 2, paragraph 1 of the fiscal note). He asked about anticipated revenue from

interest and penalties on overpayments. He assumed the language meant overpayments to a provider.

Mr. Sherwood answered in the affirmative. He asked for verification Vice-Chair Saddler was interested in the amount that would be recovered.

Vice-Chair Saddler explained he did not know if it would cost the state much in foregone penalties or interest if the bill included some provision to give forgiveness to providers for disclosing an overpayment and repaying the amount within 60 days.

Mr. Sherwood answered he could address the information on recoveries associated with the provisions in the health care Medicaid services fiscal note later in the meeting.

Representative Wilson asked for verification that the DHSS could seize property from medical assistance providers.

Mr. Sherwood answered that under the bill DHSS would have the authority to seize assets of a provider (in order to protect the state from the provider dispersing the assets prior to fully adjudicating the case) after going to court and establishing a credible case of fraud.

Representative Wilson asked for verification that the authority pertained to civil cases. Mr. Sherwood answered that he would have to review the statute. He detailed the authority applied to criminal cases, but he was uncertain it applied to civil cases.

Co-Chair Thompson interjected he was getting an indication from an attorney in the audience that the authority did not apply to civil cases.

Mr. Sherwood agreed that a state attorney in the room had confirmed the authority only applied to criminal cases.

Representative Wilson thought the language on the second page of the fiscal note "...impose civil fines, and seize property of medical assistance providers..." was confusing. She thought the information would have been in a DOL fiscal note. She was surprised DHSS would be the department responsible for taking the cases to court.

Mr. Sherwood apologized for the confusion. He clarified that the lead-in language was generally covering the provisions of the bill addressing fraud and abuse and did not necessarily mean to imply there would be an explicit expense in the current fiscal note for each of those activities.

[2:45:59 PM](#)

Co-Chair Neuman referred back to a presentation from the Menges Group [heard in the 3/29/16 morning meeting and titled "Medicaid Reform Options" dated March 29, 2016 (copy on file)]. He mentioned the report was full of acronyms and noted primary case management was not recommended in the Menges Group presentation. However, he pointed to language on page 2 of the fiscal note "Section 29, pp. 28-29, direct the department to implement the Primary Care Case Management system..." He thought the Menges Group recommended against the Medicaid case management.

Mr. Sherwood replied that the Menges Group was not recommending broad-based implementation of primary care case management to the total Medicaid population. The bill required the department to target certain individuals including individuals with higher hospitalization, which was very similar if not identical to the Menges Group recommendation to look at doing care management for people with a high volume of hospitalizations. He believed it was a case of semantics - primary care case management could be done broadly or in a more targeted way. The bill was possibly not as targeted as the Menges Group recommended, but not as broad-based as what it had recommended against.

Co-Chair Neuman replied that was what he thought, but he did not believe it was what the committee had been hearing. He remarked that the Menges Group had heard concerns about the issue, but the fiscal note specified the department would go ahead with the work. He wondered about the purpose of hiring consultants if the state did not do as they recommended. He asked for the difference between the Menges Group report recommendations compared to the information in the DHSS fiscal note. He requested the specific location the issue was addressed in the Menges Group report.

Mr. Sherwood would follow up with the explanation.

[2:49:00 PM](#)

Mr. Sherwood spoke to the fiscal note OMB Component Number 2696 related for the DHSS Office of Rate Review. The Office of Rate Review was responsible for setting most of the Medicaid rates; Sections 28, 30, and 31 of the legislation all contain provisions that would require payment reform or innovative payment methods. Under Section 30 the department would need to apply for an 1115 demonstration waiver focused on innovative payment models. The department assumed it would issue a one-time contract for \$500,000 in FY 17 to analyze and implement the payment models and a continuing \$100,000 contract in subsequent years for ongoing actuarial work updating and maintaining the rates. Section 31 of the bill required an annual actuary report on the coordinating care demonstration projects. The department had increased the ongoing actuarial contract by \$100,000 to reflect the additional work; therefore, the combined cost of ongoing actuarial services would be \$200,000 per year from FY 18 going forward. The costs would be \$500,000 in the first year and \$200,000 in subsequent years, which would be made up of split 50/50 between federal funds and GF.

Vice-Chair Saddler referred to the last paragraph on page 2 of the fiscal note related to contracting with a third-party actuary to review the demonstration projects. He asked about the thought process that determined mostly separate people on the project review committee and having the actuary recommend the program description. He wondered if there was any continuity between the two review bodies.

Mr. Sherwood believed the purpose of the actuary was to do the independent evaluation. He detailed when a change such as the one under discussion was implemented it was compared to a baseline to determine its effectiveness, which typically involved an actuarial assessment. The idea was the process would inform DHSS and the legislature about how effective the demonstrations were.

Vice-Chair Saddler surmised the policy work would be done when the demonstration projects were designed and the actuary would look at the numbers to see how well it worked. He believed the actuary would be required to accept the policy assumptions that had already been made and would make tweaks to the finances. He asked if his statement was accurate.

Mr. Sherwood replied that he was uncertain about how the actuary would approach the process. He agreed the actuary would not be expected to speculate on an alternative design in terms of evaluating the project as it was implemented and as the data became available to determine whether it was achieving its intended outcomes.

[2:53:26 PM](#)

Mr. Sherwood spoke to the fiscal note OMB Component Number 237 related to fraud investigation by the Division of Public Assistance pertaining to Sections 24 and 31 of the legislation. Under Section 24 the division would need to contract with a third-party to provide a computerized system of income asset and identity verification to deter and avoid fraud in Public Assistance benefits. The system would have to be cost-effective and save more than it cost. There was a startup cost of \$650,000 in FY 17, which included \$250,000 to make changes to the ARIES [Alaska's Resource for Integrated Eligibility Services] system to enable integration with the new system in the current work processes; and \$400,000 for associated implementation costs such as documentation, user acceptance, testing, training, and support. The work was almost all state funded. He furthered that savings were expected beginning in FY 18 as certain aspects duplicated, somewhat different, but similar verification systems already built into the ARIES system and paid for by the federal government. He elaborated the division estimated it would have the ability to reduce its fraud investigation staff by one half of a position by deterring and identifying fraud upfront before there was an individual receiving benefits; potentially fraudulent applicants would be screened out - as a result the number of investigations would decline. The department anticipated a \$46,000 reduction in personal services beginning in FY 18 composed of 50/50 federal funds and state GF.

Mr. Sherwood relayed that Section 31 of the bill required DHSS to refer Medicaid recipients to community resources, the Department of Labor and Workforce Development (DLWD), and universities for education and career opportunities. The department expected the requirement to have a one-time expense of \$30,000 in FY 17 to create notices within the eligibility system to support the referrals, which would be funded 75 percent with federal funds and 25 percent state GF.

Representative Wilson asked if it was the same program DHSS could use for [emergency room (ER)] super-utilizers to determine the number of times they visit the ER.

Mr. Sherwood replied in the negative. He explained that it was a different system that looked at a variety of private databases, which would give the department additional information about whether a person was residing in another state, shielding assets, or having unidentifiable sources of income, when making eligibility determinations for Medicaid and other assistance programs.

Representative Wilson believed the system was capable of providing many different pieces of information. She wondered why the program could not keep track of super-utilizers and prescription billing. She noted prescriptions were all billed to Medicaid.

Mr. Sherwood answered that he was not familiar with the capabilities of the systems in terms of tracking medical expenses. He elaborated it was not the department's understanding that tracking medical expenses was the bill sponsor's intent; therefore DHSS had not looked into the issue. The department could search for additional information about the ability to do some of those things; DHSS had other systems that integrated its health care spending information and it may not be cost-effective to try to incorporate health care spending information from another system into the system focused on individuals' financial eligibility.

Representative Wilson recalled when the system had been introduced, the legislature had been told how amazing it would be and all of the things it could do. She reasoned it made sense to determine whether the existing system could do much of the work before considering spending even more money. She thought it may save money versus costing more.

[2:58:43 PM](#)

Representative Gattis requested a side-by-side comparison of the systems and databases compiled in the bill to determine where there may cross over.

Mr. Sherwood addressed fiscal note OMB Component Number 2663 related to the Division of Senior and Disability Services. Section 30 of the bill required the department to

apply for 1915(i) and 1915(k) options, which would increase the federal funds received to provide home and community-based services. The Division of Senior and Disabilities Services anticipated implementing a new assessment tool for use in its existing waivers and for the 1915(i) and 1915(k) options. The department anticipated the need to add positions to plan, develop, and manage the two options; it would add one permanent position in FY 17 to begin the work and two additional positions in FY 18 as the options began. The department believed it was important to get the design and implementation of the options right; while they generate considerable GF savings it was paramount for the department to ensure eligibility requirements and service limits were well designed and strictly enforced in order to achieve savings. Additionally, AMHTA had agreed to fund the state's share of four non-permanent positions in FY 17 through FY 19 to assist in developing the data capabilities, provider certification, quality assurance, and policy development around the efforts. He continued that in addition to the position costs there would be costs associated with modifying the automated services plan (the division's management information system).

Mr. Sherwood relayed the department estimated a cost of \$550,000 to be spread out over the first three years, which would be 90 percent federal funded (reflected in the services line of the fiscal note). In FY 18 and FY 19 the services line included costs totaling \$346,900 for assessing individuals for the 1915(i) option. He elaborated the individuals would be coming from grant programs to the new Medicaid option and did not currently receive that level of assessment; the costs were one-half GF. The cost of implementing a new assessment tool would be \$2,575,000 (50 percent would be paid with federal funds and 50 percent would be paid by AMHTA). The total FY 17 costs were \$3,157,500, but only \$71,100 would be GF. The FY 18 cost was \$1,034,900 with about \$297,000 GF. He relayed expenditures would continue to fall - costs in FY 20 through FY 22 would be \$343,200 annually with about 171,600 in GF.

Co-Chair Neuman asked for the OMB Component Number of the fiscal note under discussion. Mr. Sherwood answered that he was referring to OMB component 2663.

[3:03:29 PM](#)

Vice-Chair Saddler looked at the \$146,800 MHTAAR funds for FY 19 compared to \$213,000 at the top of page 3 on the document provided by the AMHTA ["Alaska Mental Health Trust Authority Medicaid Reform Implementation Support" dated March 16, 2016 (copy on file)]. He asked about the discrepancy between the numbers.

JEFF JESSEE, CHIEF EXECUTIVE OFFICER, ALASKA MENTAL HEALTH TRUST AUTHORITY, answered he would have to confirm the information with the department. He relayed when the overall package had been negotiated they had been working with estimates for some of the costs, which was the data he had taken to the AMHTA board on the 19th [of March]. There had not been ample time for DHSS to fine tune the numbers; therefore, the actual numbers were coming in slightly under those approved by the trust. He relayed the additional funds would be restricted and deposited back into the trust.

Representative Gara referred to the three annual AMHTA contributions of \$2.15 million in the first year, which increased to approximately \$3 million in the third year. He did not want to see money shuffled around to serve one group of people but not another. He asked if the contributions would displace services for any other trust beneficiaries. He reasoned there was a finite amount of money coming out of the trust.

Mr. Jessee requested to defer the question until after the completion of the fiscal notes. He planned to provide an overall vision of the trust's philosophy later in the meeting.

[3:06:32 PM](#)

Mr. Sherwood spoke to OMB component 2875 related to general relief/temporary assisted living. The fiscal note was the first of three consecutive notes reflecting the reduction of 100 percent GF funding home and community-based services as a result of the implementation of the 1915(i) option in Section 30 of the legislation. The expenditures would be offset in a later Medicaid fiscal note where the expense would be 50 percent GF and 50 percent federal. The current note was for general relief/temporary assisted living program, which paid for assisted living homecare for vulnerable adults who did not qualify for Medicaid home and community-based waived services. With the implementation

of the 1915(i), Medicaid would be able to pay for a substantial amount of the services covered under the program. Beginning in FY 19 the program would be reduced by almost \$4.7 million GF annually.

Co-Chair Neuman observed some of the fiscal notes did not include money for travel (e.g. OMB Component Numbers 2875 and 2663). He read from the last sentence on page 2 of the current fiscal note "changes to the State Plan and regulations are required to implement the new option and would involve extensive public comment." He remarked generally when things involved significant public comment it cost the state money. He wondered about the cost.

Mr. Jessee replied that when he addressed the AMHTA package later in the meeting it would show the trust had agreed in a number of instances to fund the public process; it would be more efficient and cost-effective for the trust to do off budget.

Mr. Sherwood addressed OMB Component Number 2787 for senior community based grants, the second of three similar notes showing reductions to a 100 percent GF program as a result of adding the 1915(i) option under Section 30 of the bill. The senior grants paid for adult daycare, in-home services, and other, which could be covered by the 1915(i) option for Medicaid eligible individuals. Beginning in FY 19 the grants would be reduced by \$735,200 GF per year to reflect a certain number of individuals would receive the services through the 1915(i) option.

[3:10:09 PM](#)

Co-Chair Neuman referred to language in the second paragraph on page 2 of the fiscal note: "Section 28, p. 25 lines 27-29 charge the Department with 'reducing the cost of...senior and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver.'" He asked what would happen if the other waivers were not received and the department was still directed to reduce costs. He asked about the backup plan if things did not work as anticipated.

Mr. Sherwood answered that the department did not see a substantial barrier to getting the 1915(i) option approved; however, if a barrier was encountered the department would

have to look at different ways to control utilization within the program. In absence of the ability to use the tools in the bill, the natural way to reduce cost would be to look at controlling utilization as much as possible to get the optimal benefit for the services the state was paying for. He noted the division director was available for further detail.

Co-Chair Neuman expressed consternation that the bill required cost reductions in senior disability services, but the department did not know which services would be reduced or by how much.

Mr. Sherwood addressed OMB Component Number 309 related to community developmental disabilities grants, the last of three similar notes showing reductions to a 100 percent GF program as a result of adding the 1915(i) option under Section 30 of the bill. The grants provided home and community-based services to support individuals with developmental disabilities. The department projected it would begin the 1915(i) option for the group mid-way through FY 18 and would reduce grants annually by \$11,635,800 GF in FY 19 through FY 22; the reduction would be \$5,817,900 GF in FY 18. The community developmental disabilities grants were the largest grant program that would be refinanced by the 1915(i) option. He detailed in terms of priority, due to the large size, the department had been advised to not do all of the work at one time. They had selected services that would provide the most savings to start on January 1 of FY 18.

[3:14:10 PM](#)

Vice-Chair Saddler recalled the legislature's budget included a 5 percent reduction to the grant line. He asked for verification the funding assumed FY 17 as a baseline; it would be a replacement of state money with waiver money at the same level of service.

Mr. Sherwood believed so. He detailed the funds would be to replace the GF in the grant line with the federal and GF in the Medicaid option.

Representative Wilson noted in reference to the last three fiscal notes, the waivers were temporary for a period of five years with the possibility of renewal. She for

verification that after the five-year period the issue would come before the legislature for approval of GF.

Mr. Sherwood replied that the options did not have a specific time limit. He detailed that with the 1915(i) option if benefits were targeted to specific groups it required re-approval of the targeting every five years. As optional services they were not subject to the routine renewal the way a waiver would be.

Representative Munoz asked if the change would result in the same level or expanded services for the specific user population.

Mr. Sherwood replied that it was the department's goal to provide the same level of service to the same individuals currently receiving service, but through a different mechanism.

[3:16:23 PM](#)

Mr. Sherwood addressed OMB Component Number 317 for the Commissioner's Office. Section 40 of the legislation directed DHSS to conduct feasibility studies on privatizing the Alaska Pioneer Homes, certain Division of Juvenile Justice facilities, and the Alaska Psychiatric Institute (API). To conduct the three studies, the department estimated a cost of \$735,000 GF in FY 17. Section 38 required the department to implement the new federal policy on tribal Medicaid reimbursement. The fiscal note included the creation of a new tribal federal liaison section to aggressively move forward to implement the policy in order to maximize the enhanced federal claiming in the minimum amount of time. The section would be responsible for working with CMS, tribal providers, and non-tribal providers on the development of implementation of referrals, care plans, and claiming for services provided to tribal members by non-tribal providers. Once implemented, the section would also provide oversight to the processes to ensure the department continued to meet the requirements for claiming the enhanced funds. The work included four positions at an annual cost of \$579,400 (50 percent federal funds and 50 percent GF). He noted the positions were also included in the House and Senate budgets.

Vice-Chair Saddler believed the cost of the positions were accounted for in the operating budget and in the bill. He asked if there was double dipping.

Mr. Sherwood answered that the addition had been included as a result of discussions with the Senate Finance Committee. The amount was not included in the governor's budget; therefore, it had not seemed appropriate to include the amount in the "included in governor's FY2017 request" column on the fiscal note. The department wanted the expenditure to be recognized as part of the package. He elaborated the department appreciated and had tried to identify there was potential duplication, which was something that needed to be watched in the final budget process to ensure there was no double dipping and that reductions were not taken twice in the service category (those savings were shown in both locations as well).

Vice-Chair Saddler pointed to the first paragraph on page 2 of the fiscal note related to Section 40 of the legislation asking DHSS to conduct a study analyzing select facilities of the Division of Juvenile Justice for privatization. He wondered if the language was referring to any particular facilities.

Mr. Sherwood answered the department understood the issue to be its call. He believed there were some logical choices to look at in terms of utilization and support. He deferred the question to Ms. Forrest for further detail.

Ms. Forrest echoed Mr. Sherwood's response. She stated that the language left the issue to DHSS to decide how to procure for the feasibility study. There were eight juvenile facilities: four were combined treatment and detention facilities and the remaining four were smaller and located in rural areas. She detailed it would be necessary to look at balancing the needs between rural and urban as well as at the utilization numbers.

[3:21:08 PM](#)

Representative Munoz thought the department had solicited for letters of interest regarding privatization management of the Alaska Pioneer Homes. She asked for detail.

Mr. Sherwood replied that DHSS had initiated a request for letters of interest regarding assumption of some or all of

the responsibilities of operating the Pioneers Homes and had received four responses. One of the responders had been looking at very limited management, one was interested primarily in one of the homes and potentially other homes, and two were entities from out-of-state operating assisted living facilities in other places. He detailed none of the responders was willing to take on the responsibility without substantial continued support from the state. There was some interest, but he believed there was probably not interest in assuming as much responsibility as some people may envision or the interest had not been seen as of yet. He continued the homes operated with a substantial state subsidy and included provisions ensuring people's ability to pay did not keep them from receiving services in the home. As of yet, no one was willing to step up to offer to take over that responsibility.

Representative Gara spoke to Section 40 of the bill that requiring studies on many state facilities. He provided a scenario where the state wanted to privatize the facilities. In that scenario, he wondered why the state would spend money on a study. He asked why the state would not merely invite prospective entities to provide information on what they were willing to do.

Mr. Sherwood answered that conducting a feasibility study was a requirement in the department's current bargaining agreements.

Representative Gara asked why the department would not just wait to see if an entity was interested prior to conducting a study. He wondered why the state should spend the money on a study before knowing whether it was needed.

Mr. Sherwood answered that one of the challenges, which DHSS had experienced with the letters of interest, in order to get down to the detail required it meant asking people to invest significant money upfront to do the analysis and prepare a proposal of what it would look like for the entity to take over. He specified if the state was not certain it would pass the feasibility test, there may not be the interest from people and the willingness to invest if the feasibility study had not yet been conducted.

[3:25:17 PM](#)

Representative Gara remarked that privatization had been discussed numerous times and recalled that the former Palin Administration had considered the issue. He asked if the state had spent money on feasibility studies on privatizing the Pioneer Home in the past.

Mr. Sherwood answered that he was not aware of an instance where the state had spent money on a study related to privatization in the past.

Representative Gara asked what efforts had been made to look at privatizing the Pioneer Homes when the issue had arisen under the Palin Administration.

Mr. Sherwood replied in the negative. He relayed the department would follow up on the question.

Representative Gara remarked that Representative Munoz spent time at the Juneau Pioneer Home and other legislators with homes in their districts also spent time in the facilities. He stressed the idea of privatization caused significant angst for the residents in the homes. He believed it caused substantial nervousness every time the issue arose, which was frequent. He was concerned about the provision.

Co-Chair Thompson commented that the overall budget had caused consternation across the entire state in areas such as Department of Transportation and Public Facilities, University, and the Department of Education and Early Development. He understood Representative Gara's comments.

Mr. Sherwood addressed fiscal note OMB Component Number 2660. The fiscal note was the first of three consecutive notes related to Medicaid services. The current note applied to behavioral health and reflected two different parts of the legislation. First, it applied to Sections 28 and 30 to manage a comprehensive integrated behavioral health program and to do an 1115 demonstration project. Second, the provision in Section 38 of the bill, which would implement the new federal policy on 100 percent federal claiming on tribal services. There were several different types of expenses related to the behavioral health redesign and 1115 waivers. He detailed there were increases to the grants and benefits line to reflect the increase in Medicaid expenditures related to filling the gaps in the state's behavioral health system and eventually

covering larger substance abuse treatment facilities under the 1115 waivers. The note included a blended match rate for different Medicaid populations whose federal match rate varied between 50 and 100 percent. The waiver would begin in FY 18 and grow over time. There were increases to the service line in FY 18 to reflect the cost of paying an administrative services organization to develop and manage a network of providers; manage utilization; monitor outcomes; and audit for fraud, waste, and abuse. The state's share was paid by the AMHTA through FY 19; subsequent to FY 19 the cost would be 50 percent federal and 50 percent state GF. There was a two-year cost in FY 17 and FY 18 for consulting contracts in the services line, to assist DHSS in designing and implementing the managed behavioral health care system and developing the waivers. There was also a contract in FY 17 and FY 18 to develop a prospective payment system for certified community behavioral health centers - the state's share would be paid by AMHTA.

Mr. Sherwood pointed out the expenses were all summarized in a table on page 3 of the fiscal note. The note reflected a capital need of \$2,348,000 for one-time MMIS changes (90 percent federal/10 percent AMHTA). The fiscal note also reflected the change in federal policy around claiming 100 percent federal funds for services provided to tribal beneficiaries. The department estimated shifting some of the behavioral health services, particularly residential psychiatric treatment services to 100 percent claiming from 50 percent federal claiming. While the particular change did not impact total expenditures, it impacted fund sources for behavioral health Medicaid, reducing GF and increasing federal funds. The table at the bottom of page 3 of the fiscal note showed the department's projections related to the shift for behavioral health services. The total FY 17 appropriation request was \$850,000 with no GF. The note showed the FY 17 tribal claiming fund shift in the column for the governor's request as the portion had already been included in the governor's budget. In FY 18 the administrative services organizations and the 1115 waiver services expenditures would begin showing up in operating expenditures at almost \$5 million; the expenditures would be almost \$10 million in FY 19, slightly over \$14 million in FY 20, and just over \$19 million in FY 21 and FY 22.

Mr. Sherwood relayed the fund sources for FY 18 and beyond showed the savings in the tribal claiming more than offset

the increase in GF expenditures until FY 20, when GF expenditures would increase by \$396,000; the GF increase in FY 21 and FY 22 was about \$1.2 million. However, as a result of the 1115 waiver, DHSS expected benefits to accrue to other divisions within the department, the criminal justice system, the courts, DPS, and DOC. He noted those benefits were not quantifiable at present.

[3:31:45 PM](#)

Vice-Chair Saddler pointed to the first paragraph on page 2. He discussed previous presentations by the Menges Group and Health Management Associates regarding the inability of other states to require Medicaid recipients to avail themselves of employment assistance as a condition of receiving Medicaid services. He referenced language in the fiscal note related to managing an integrated behavioral health program including housing, employment, and criminal justice. He asked if it was appropriate for the bill to include the guidance for the behavioral services plan to address employment.

Mr. Sherwood answered that the particular reference in the fiscal note [OMB Component Number 2660] was related to supportive services that could help people with behavioral health issues to either obtain or sustain a program. As opposed to a requirement for a person to be employed to receive services, the language referred to supports provided to people addressing their behavioral health issues in order to help them attain or maintain their employment.

Mr. Sherwood addressed OMB Component Number 2077 related to health care Medicaid services. He explained that it was the most complex of the fiscal notes. The note included impacts from the numerous fraud and abuse provisions; the reform provisions including primary care, health homes, telehealth, health information infrastructure, emergency room project, coordinated care demonstrations; and the transportation component of the tribal claiming policy. Several sections of the bill contained the provider fraud and abuse provisions including the False Claims Act, the ability to assess interest on audit recoveries, providers self-review to identify overpayments, the authority to issue civil fines, and the ability to invoke civil forfeiture against fraudulent providers. The provisions

resulted in enhanced recoveries and abatements and were summarized on pages 2 and 3 of the fiscal note.

Mr. Sherwood relayed Section 28 of the bill provided for electronic distribution of an explanation of benefits (EOB) to Medicaid recipients. The department intended to use the My Alaska portal for the electronic distribution. He detailed there was an initial setup cost of \$707,500 in FY 17 and ongoing costs of \$93,500 for user license and maintenance fees (50 percent GF and 50 percent federal). The section also directed DHSS to provide for stakeholder involvement in setting annual targets for quality and cost-effectiveness. The department estimated an annual cost of \$5,000 for consultant services to facilitate meetings and compile a report; the cost would be funded by AMHTA from FY 17 through FY 19. Section 29 directed DHSS to implement a primary care case management system. He specified DHSS would contract with an administrative services organization (ASO) for a monthly per-member, per-month fee beginning in the second quarter of FY 18.

Mr. Sherwood communicated DHSS projected primary care case management would reduce many services but would increase physician services as well as incur fees to the ASO. The net impact would be a \$596,400 reduction in FY 17, which would increase to a reduction exceeding \$9.5 million in FY 22. Section 30 directed the department to implement the Health Homes two years later, which would bring a net savings of \$3,430,000. He detailed the program provided more intensive care management for individuals with chronic conditions. There would also be startup costs for MMIS and ongoing operations. The startup capital costs would be \$1 million for the primary care case management and Health Homes projects (90 percent federal funds and 10 percent GF). The ongoing operation cost would be \$65,000 for each.

Mr. Sherwood relayed Section 30 directed the department to provide incentives for telehealth including increasing capabilities for and reimbursement of telehealth. The department had included a \$5,000 contract in the services line in FY 17 to convene a workgroup and identify the barriers and potential, which would be paid for by AMHTA. The department projected savings in telehealth beginning in FY 18 starting at \$1.3 million and growing to \$13.3 million in FY 22. Section 31 authorized DHSS to support private initiatives to reduce ER usage. The department's role would include data sharing support for the PDMP, support for

electronic health record sharing, and development of a shared savings model. He furthered DHSS anticipated implementing the shared savings model beginning in FY 19. For the purposes of estimating cost DHSS had assumed one-time expenses to interface the PDMP and connect pharmacies with the health information exchange at a cost of \$765,000 in FY 17 (90 percent federal funds and 10 percent GF); it had also assumed \$20,000 in annual operating costs. The department anticipated a one-time cost of \$1 million for MMIS changes (90 percent federal funds and 10 percent GF) and \$65,000 in annual operating costs.

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Mr. Sherwood continued to address the fiscal note OMB Component Number 2077. The department expected net savings to the state (after shared savings with providers) of \$2,240,000 annually. Section 31 authorized DHSS to contract with one or more coordinated care projects. The note reflected DHSS's assumption the projects would be implemented in FY 19 and the expectation of an annual net savings of \$1.5 million GF. There would be startup costs for technical development and consulting with \$3,885,000 in capital costs (90 percent federal funds and 10 percent GF) and ongoing maintenance costs reflected in the service line of \$318,000 for provider outreach and support (50 percent federal funds and 50 percent GF). Section 38 directed DHSS to implement the federal policy on Medicaid tribal reimbursement. The department estimated the health care Medicaid services component would see a shift from GF to federal funds for travel and ambulance services; it merely a change in fund source and not a change in total expenditures. With aggressive startup efforts DHSS estimated it would begin with a \$26.7 million shift in FY 17, which would eventually grow to \$44.2 million in FY 21 and FY 22 (illustrated in a table on page 6 of the fiscal note).

Mr. Sherwood relayed Section 39 directed DHSS to implement a health information infrastructure plan to support transformation of the health care system in Alaska. The department estimated a one-time services cost of \$5,000 in FY 17 for a consultant to facilitate meetings and compile a report of recommendations to be funded by AMHTA; it also estimated capital costs of \$775,000 (90 percent federal funds and 10 percent GF) to fund requirements for a development road map and gap analysis and design and

engineering implementation plan with phases and achievement goals. The combined impact of all of the changes in the fiscal note was an increase in expenditures in the FY 17 appropriation request of \$337,200 with a \$20.2 million reduction in the GF match. The fiscal note also showed the FY 17 impacts of the tribal policy change, which were already included in the governor's proposed budget. There was a decrease of almost \$3.8 million in total expenditures in FY 18 and a reduction in GF match exceeding \$35 million. In FY 19, when most of the projects would have started, there was a net reduction of over \$16 million in total operating expenditures and a \$45 million reduction in GF match; the reduction continued to grow until it exceeded over \$60 million in GF match by FY 22. Combined capital costs for all of the projects included in the fiscal note were \$6.9 million (90 percent federal funds and 10 percent GF).

[3:41:52 PM](#)

Representative Wilson referred to civil forfeiture recoveries on page 3 of the fiscal note. She remarked the department had repeatedly stated it was not civil forfeiture. However, she observed the note showed an annual recovery from civil forfeiture of \$282,500. She wondered where the money would come from. She noted DHSS could not currently "do it now."

Mr. Sherwood answered that the forfeiture essentially allowed the department to protect assets of a provider while it pursued criminal cases against them. Currently the state may receive judgements against providers; however, they had no assets left by the time the criminal conviction occurred. The provision would enable the department to "seize and freeze" or restrict providers' access to their assets while the case was underway; if the state prevailed it would recover against any assets. The \$282,500 represented increased recovery by preserving the provider assets.

Representative Wilson asked how the specific \$282,500 figure had been derived.

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Mr. Sherwood replied the calculation was described in the fiscal note based on historic overpayments and restitution

amounts due from providers who may be subject to civil forfeiture. The department estimated there was approximately \$2.8 million annually that would be subject to the provision, but DHSS estimated only about 10 percent of the total would be recoverable through civil forfeiture.

Representative Wilson asked for verification that in a criminal case there was no way through the criminal process to freeze any assets whatsoever and that it had to be done in the civil process.

Mr. Sherwood replied the question would be best directed to an attorney in terms of what aspects fell under criminal versus civil law. He detailed the provision allowed the state to preserve the assets prior to a criminal conviction. The process was referred to as civil forfeiture because it came before the criminal conviction had been obtained.

[3:46:05 PM](#)

STACIE KRALY, CHIEF ASSISTANT ATTORNEY GENERAL, HUMAN SERVICE, DEPARTMENT OF LAW, addressed the question by Representative Wilson. She agreed with Mr. Sherwood's response. There was currently no mechanism to seize property through a criminal prosecution; therefore, the Department of Law (DOL) had asked for the bill to create a separate process, which would be done through a civil forfeiture. The provision would enable the state petition the court and show probable cause that criminal fraud had occurred; if the court agreed it would grant authority to place liens or to seize certain assets identified by the state. At the end of the proceeding, should an individual be convicted of the fraud, the state would provide the court with the amount owed to the state to request permission to have the assets forfeited to the state to offset the criminal fraud.

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Representative Wilson asked for verification that currently the state's criminal attorneys could not freeze the assets of individuals. She found it hard to believe.

Ms. Kraly replied there were very limited seizure provisions under existing state statute. She was most familiar with the statute enabling the state to seek

seizure and forfeiture of fishing gear in response to fish and game violations. There was broad federal authority for seizure and forfeiture of assets related to the commission of a crime for things such as drug arrests; the similar authority did not exist in state statute. The provision provided a very limited capture of assets for forfeiture for individuals convicted of Medicaid fraud. She explained that a Mr. Peterson had convicted a number of individuals for Medicaid fraud, some of which were corporations or businesses. She detailed that when the department had moved to recover the hundreds of thousands of dollars it had identified in fraudulent payments, all of the assets had been dissipated - there were no assets remaining to go after. She continued the offenders had transferred interest in their homes, cashed out their bank accounts, sold boats and RV's and other. The previous DHSS commissioner Bill Streur had been interested in determining a way to make the state whole. One of the ways to make the state whole was to seek seizure and forfeiture in the narrow circumstances where criminal Medicaid fraud had been established.

Representative Wilson corrected that the individuals had not yet been convicted. She stated the provision applied to cases where individuals had not yet been convicted. She clarified she did not want anyone to commit fraud, but she believed freezing a person's assets while they waited for the case to be decided could ruin that person's life. She referred to fish and game cases where people had been found not guilty but had not been able to get their things back. She stated that the provision could have negative consequences on providers because the [legal] system was not as fast as it should be related to criminal cases. She was nervous about taking the situation down to a lower threshold. She was unconvinced there was not another way of recouping the state's cost.

[3:50:58 PM](#)

Vice-Chair Saddler asked about interest charged to a Medicaid provider who may find out they had inadvertently overpaid and repaid the amount within 60 days (as per the bill). He asked if someone under the scenario was likely to be subject to interest and penalties.

Mr. Sherwood answered in the negative. He explained intention was to start the clock on interest when the state had come to the conclusion of an audit process (either when

the final audit was issued and not disputed or the appeal of an audit had come to conclusion). The provision was not intended to address self-reporting of overpayments when a timely repayment was made or a repayment plan was worked out.

Vice-Chair Saddler asked for verification someone in the scenario was not subject to interest. Mr. Sherwood agreed.

Vice-Chair Saddler asked where he would find documentation that interest would only begin at the end of an audit. He noted he was starting on page 7, line 17 of the bill.

Mr. Sherwood referred to page 23, lines 2 through 7 of the bill. He relayed that the interest was referring to the state's audit statute AS 47.05.020. The section addressed the date interest would start. He read from the section which governed when the audit would begin: "the date of issuance of the final agency decision is the later of the department's written notification of the decision and the provider's appeal rights or if timely appealed by the provider the final agency decision." Provisions on lines 21 and 22 made clear that the interest in penalties did not apply to the section regarding self-identified overpayments.

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Mr. Sherwood spoke to OMB Component Number 2662 related to the impact on the senior and disabilities Medicaid services component for the addition of the 1915(i) and 1915(k) Medicaid options and the impact of the tribal claiming policy change. Section 30 of the bill directed DHSS to apply for the 1915(i) option for home and community-based services and shifted coverage of services from other programs with 100 percent GF to Medicaid (50 percent federal funds). The shifts had been outlined in the previous fiscal notes he had discussed. The actual Medicaid expenditures appeared in the current fiscal note (50 percent federal and 50 percent GF); the GF increase had been offset in other fiscal notes. Section 30 also directed the department to implement the 1915(k) option for home and community-based services, which would cover personal care services currently provided to Medicaid 1915(c) waiver recipients; however, the 1915(k) services came with an additional 6 percent federal match. He detailed the federal match for the services had changed from 50 percent to 56

percent. The department expected the shift to reduce GF match by slightly over \$2.5 million per year in FY 18. The implementation of the two options would require a capital cost of \$1.2 million to make changes to the MMIS (90 percent federal and 10 percent GF).

Mr. Sherwood relayed Section 38 of the bill directed DHSS to implement the new federal policy on tribal claiming, which would shift some nursing home and home and community-based services presently claimed at 50 percent federal funds to 100 percent federal funds. Implementation would begin with nursing homes in FY 17 and would expand to home and community-based waiver services in FY 19. He explained the delay was to give a chance for some of the other federal changes occurring with the home and community-based services providers. The shift would grow from \$2.9 million in FY 17 to over \$42 million in FY 22. The combined impact of the provisions for FY 17 was a zero dollar change in operating costs with a \$2.9 million shift in GF match to federal funds in the governor's request. The fund source shifts continued in FY 18 with the addition of the 1915(k) option; increased spending would begin associated with the 1915(i) option halfway through the year. The expenditure increase in FY 18 was slightly over \$5.6 million, but the net reduction in GF was almost \$4.8 million. In FY 19 and beyond, when the 1915(i) had been fully implemented, annual expenditures would increase to about \$17 million, but due to growth in tribal claiming for long-term care services, the GF match continued to reduce for the remaining years of the fiscal note for a net reduction of almost \$17.2 million in FY 19, growing to almost \$36.6 million in FY 22.

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Vice-Chair Saddler referred to a one-time capital expenditure of \$1.2 million for MMIS changes on page 3 of the fiscal note. He asked if the MMIS would be ready to handle benefits of the reform in the bill.

Mr. Sherwood replied in the affirmative. He detailed the changes were not easy and it would be necessary to do them in stages.

Co-Chair Thompson asked if the MMIS was federally certified. Mr. Sherwood replied in the negative. He stated that the department was scheduled to have its certification review in June 2016.

Mr. Jessee addressed the document titled "Alaska Mental Health Trust Authority Medicaid Reform Implementation Support" (copy on file). He discussed that the AMHTA trustees had testified early on in the SB 74 process that they believed Medicaid reform was the most important thing that had happened to the beneficiaries and the trust since its creation in 1995. He detailed the current Medicaid program was unsustainable and the state's behavioral health system did not provide comprehensive care in an efficient and effective manner, which left many beneficiaries unserved. The trustees had signaled early in the process they intended to step forward and provide some financial assistance to the state as the trust had on many other initiatives over the years (i.e. the trustees had spent nearly \$16 million in trust funds over a seven-year period on the Bring the Kids Home initiative in order to allow the legislature to repurpose well over \$30 million in GF from out-of-state programs into in-state services).

Mr. Jessee continued that when the trust had begun to look at the development of the bill, much of the focus had been on substantive provisions. At the point when fiscal notes started to be discussed it was clear there were certain areas that were more difficult for the Senate Finance Committee and presumably the House Finance Committee to fund, given the state's fiscal gap and the different directives to try to be efficient and effective with state resources. For example, one of the things that came out early on were all of the new positions required to do the work - the non-permanent positions necessary to do the work or backfill the jobs of people currently at the department so they can use their specialized expertise to get the things underway. The trust understood why it had been the case - adding state employees at state expense in the current environment was certainly problematic. The trust had then asked the department how it was going to get the work done because failure was not an option. The answer had been the department would work longer, harder, smarter, and faster. He stated that the trust believed DHSS already worked fast, smart, hard, and long; therefore, it had not seemed like an efficacious strategy. The document showed areas where the trust had stepped forward acknowledging it was necessary to have people to get the job done.

Mr. Jessee relayed the trust had stepped forward to help with travel expenses. He remarked the state was a long way

from the places that had already accomplished a significant number of the results it was looking for. The trust had learned over the years with programs like Housing First and Bring the Kids Home that doing site visits and taking groups of individuals to places that had successfully done the types of things the state was trying to do was very valuable. Not only because seeing was believing and connecting with peers with a similar perspective could be helpful, but also because teams would have several days together to start to gain a common understanding of the goal. Currently additional state funds for out-of-state travel was not looked upon very favorably, but it was something the trustees were willing to provide.

Mr. Jessee relayed there were a number of one-time expenses the trust would fund that it felt were essential to get done on time. He pointed out the process of getting the substantive elements in the bill was what created the necessary questions including what the state was trying to accomplish and how fast it needed to work to accomplish the goals. When the fiscal notes had initially been submitted they had not anticipated all of the steps required to meet each of the substantive requirements in the timeline. The trust had sat down with Charlie Currie's associate Stephanie Colston [Medicaid consultants] and the department to determine exactly what was necessary in each of the steps in order to get the work done on time and where the resources would come from.

[4:05:33 PM](#)

Mr. Jessee began on page 1 of the AMHTA document. He relayed items 1 through 4 were built around the 1115 waiver process. Item 1 related to the Division of Behavioral Health capacity assessment and development. The department had discussed that the division's role would change in FY 17 and FY 18 with an administrative services organization - eventually there may be fewer people at the division. He furthered there needed to be an assessment of the knowledge, skills, and abilities of current staff compared to what the division's job would have to be in the future and how to get from here to there.

Representative Gara noted it was up to other committee members, but he felt the fiscal notes and MHTAAR portions had been covered already. He was interested in the overall

question about the AMHTA approach, but he believed the committee understood the individual fiscal notes.

Mr. Jessee explained that the trust investments were not included in the fiscal notes. The expenditures represented additional resources AMHTA was making available outside of the state budget. He moved to item 2 related to provider capacity, what they needed to do in the future, and how to provide technical assistance to providers to ensure they were ready to implement the new system. Item 3 related to the waiver and was represented in the fiscal notes. He relayed the actuarial analysis was funded in the fiscal notes.

Vice-Chair Saddler looked at item 2 and asked what "CCG" stood for. Mr. Jessee replied that it was referring to the Charlie Currie Group.

Mr. Jessee addressed item 4: the ASO. The trust had stepped forward to fund travel costs. He referred to the note addressing travel for three DHSS staff, one AMHTA staff, and one consultant and remarked the item was flexible and may not be the precise makeup of the team. The funding for travel acknowledged the need to see some of the ASOs and how they operate. Additionally, the trustees had agreed to pick up the cost of the ASO state match for FY 18 and FY 19 that directly supplanted GF in the fiscal notes. He moved to item 5 on page 2 of the document related to primary care integration. One of the things needed for a waiver was to demonstrate the state was implementing evidence-based practices which would increase the program's effectiveness. The item would support pilot programs to screen brief intervention referral and treatment in two hospital ERs. He detailed many ER visits were a result of substance abuse (e.g. from driving while intoxicated or other accidents). He furthered that evidence showed screening and brief intervention in the ER for the substance abuse issues was an effective strategy to reduce drinking and subsequent ER visits. Additionally, AMHTA would fund a standardized screening and assessment instrument in three federally qualified health centers and behavioral health centers. He spoke to the need to begin standardizing assessment instruments, which the trust would fund off budget.

[4:09:51 PM](#)

Mr. Jessee addressed item 6 related to funds for a prospective payment pilot with a substance abuse or a substance abuse and mental health provider. Item 7 related to funding for data. He discussed the need to hook providers up to the health information exchange. Initially, the thought had been rather than ask for the money in a fiscal note, the cost would be left to the providers as an unfunded mandate. He noted it was not a substantial amount of money, but he reasoned the state was asking providers to do a significant amount in terms of changing their entire system and how they operate in many ways. The trustees had agreed to cover the cost of the connectivity. Item 7 would enhance AKAIMS [Alaska's Automated Information Management System] to full capacity. Currently the provider had to enter all of their information into AKAIMS and then had to reenter all of the data in the health information exchange. He reasoned that process was ridiculous and was part of what drove up administrative costs. The trust was willing to fund work that would enable the data to automatically populate the health information exchange when entered into AKAIMS, which should significantly reduce the administrative burdens on nonprofits.

Vice-Chair Saddler remarked on "the principle that you don't put bald tires on a new car" in relation to the proposal to enhance the health information exchange. He asked about the assessment of the program. He asked for detail on the program's age, how it operated, and whether it was an appropriate vehicle to add utility to. Alternatively, he wondered if it should be replaced.

Mr. Sherwood replied that the health information exchange had been created as a nonprofit through legislation about six years earlier; it was up and running and was continuing to bring additional providers on board. He relayed that it did not yet have the ideal level of participation; therefore, some of the funds in the fiscal notes were meant to encourage participation. He detailed the program did have the capabilities to allow providers to share information as appropriate. The program was funded by provider assessment and DHSS. The department had also accessed some federal funds to maintain the program over the years.

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Vice-Chair Saddler asked if the program was managed, operated, and owned by DHSS or owned by a private nonprofit organization.

Mr. Sherwood answered the health information exchange was a nonprofit with an independent board, which was a decision made by the legislature when it had established the program. The department had frequent meetings with the organization related to planning and budgeting.

Vice-Chair Saddler remarked that he would have numerous technical questions related to the PDMP and the health information exchange regarding control and privacy measures when the items were discussed more in depth.

Mr. Jessee addressed item 8 on page 2, which included a relatively small allocation to assist DHSS with running a couple of workgroups. He moved to page 3 (item 9) of the document and remarked that trust beneficiaries included more than just behavioral health. In senior and disabilities services the 1915(i) and 1915(k) options were also critical to beneficiaries. He referred to Vice-Chair Saddler's statement about not putting bald tires on a new car and stated the assessment tool listed was "that type of an initiative." He elaborated the current assessment tool was inadequate in several important respects. First, the tool was primarily a deficit-based model - it looked at people's deficits and not their assets. He reasoned that costs could be reduced when helping people maximize what they could do instead of focusing on what they could not do and throwing money at trying to solve their problems. Second, the tool had very poor interrater reliability. He detailed if two people used the same tool to evaluate the same person they may come to very different answers. There were now more advanced tools that solved most of those problems. He communicated the department had found it difficult to fit a new assessment tool into its fiscal notes due to the current fiscal climate and effort to be frugal with resources. The trustees understood that a state of the art assessment tool was needed if the system was going to be built around the state plan amendments and waivers and had therefore agreed to pay for it.

Mr. Jessee relayed item 9 also included funding for four long-term non-permanent positions, expansion of the Aging and Disability Resources Centers to four additional sites (one of the core way services would be delivered), national

best practice site visits, and outreach for consumers and provider engagement. Community involvement in the processes was critical to the trust. He referenced an earlier presentation [from the morning meeting] from Agnew::Beck, which showed over 500 citizens had been involved in the process funded by the trust in order to ensure the broadest possible input. Item 10 related to health care services staffing needs was also included in the fiscal notes - the trust had committed funds to pay for two new staff positions.

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Mr. Jessee addressed item 11 on page 3, which included two items not directly related to Medicaid reform, but were included in AMHTA's funding package. First, funding would be appropriated for the [federal] ABLE Act, which allowed people with disabilities to create what amounted to a health savings account that would not be considered an asset for purposes of public benefit - he noted it was a tremendous piece of legislation. Second, funding would be appropriated for a technical assistance contract for providers. He stated that many of the state's providers were not as proficient at billing Medicaid as needed.

Mr. Jessee spoke to how the trust would pay for all of the items totaling almost \$10 million over three years. He discussed that when Medicaid expansion had been going through, because of the timing exigency, the trustees had gone into the trust's budget reserve in order to fund part of the initiative. He characterized the move as an extraordinary step on the part of the trustees and not one they intended to make a common practice. In order to determine how the trust would come up with the \$10 million it had reviewed all of its prior allocations. He detailed trust authority allocations were good for 4 years; every year one of the allocations lapsed and rolled forward into future years. The money was typically left "out there" to account for unexpected events that may require additional resources in the specific areas. He referred to the exercise as sweeping "under the seat cushions," which included almost all of the prior year allocations from 2013 to 2015.

Mr. Jessee relayed the action would have two consequences for the trust: 1) it would reduce the trust's flexibility as it moved forward because the funds would not be

available if unforeseen issues arose with current strategies; and 2) the trustees would have somewhat lower revenue to spend in future years because the funds would not be lapsing in future years. The trust would have to tighten its belt moving forward. Additionally, the trust had looked at current FY 16 to determine what was classified as essential work to meet its two major priorities including Medicaid reform and criminal justice reform. The trust had determined areas where funding had not already been committed for FY 16 or if there were programs where it could claw back some money prior to the year-end. The trust had also gone through all of its focus areas for FY 17 to identify places it could shift funds to forward the effort under SB 74, particularly in areas where something was not already planned. For example, the substance abuse prevention and treatment focus area still had a considerable amount of unallocated money for FY 17. He reasoned what better place to utilize some of the funds than in reforming the state's Medicaid system. The trust would look a little different going forward but it had been faced with prioritizing and rethinking its strategies in order to commit nearly \$10 million over 3 years to assist with Medicaid reform.

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Representative Wilson spoke to an earlier question related to OCS. She remarked Mr. Jessee had relayed the trust would talk to providers. She stated sadly enough many people involved in OCS probably did not even know they qualified for Medicaid. She asked if AMHTA would have a better idea about which services were missing that may be causing children to be out of the home longer because parents were on waitlists trying to get services.

Mr. Jessee replied in the affirmative. He it was something the state's behavioral health system should be working hand-in-glove with OCS to ensure that every parent running into trouble due to a behavioral health problem was getting treatment or support for recovery as quickly and as comprehensively as possible. He continued it would drive down foster home placements and adverse childhood experiences.

Representative Wilson would greatly appreciate if one of the trust's focus groups could reach out to parents to help

them better understand the options available. She noted she would participate in the work as much as she was permitted.

Mr. Jessee thanked Representative Wilson for the suggestion.

Vice-Chair Saddler thanked AMHTA for allocating a significant amount of money for the projects. He understood the trust had reworked its finances to dedicate resources to the effort, which gave him increased confidence in the worthwhile nature of work.

Representative Gara remarked sometimes AMHTA would fund things so the state did not have to pay for them and when AMHTA was no longer able to fund the items the state picked up the expenses. He spoke to the importance of some of the efforts. He asked if the trust's contributions (of approximately \$10 million) to the fiscal notes would reduce AMHTA's contributions to other state services and grants in the budget.

Mr. Jessee did not believe any MHTAAR had been negatively impacted in FY 16. The trust had already made those commitments to the state and would not renege on the contribution. The belt tightening had been in authority grants AMHTA administered itself and not in what it had already committed to the state.

[4:24:09 PM](#)

Representative Gara noted that administrative belt tightening was fine. He asked if there were services the trust could not give to its beneficiaries as a result of its contribution to the cost of SB 74.

Mr. Jessee answered with an example related to substance abuse prevention and treatment in FY 17. The specific area had several hundred thousand dollars for undeveloped strategies to reduce the substance abuse problems in the state. A project that had not yet been developed would lose funding; however, the trust had considered the highest and best use for the funds and had determined it would be better to contribute to the bill's effort of Medicaid reform, which was critical and would provide far more services to the same beneficiaries for generations to come.

Representative Gara asked how much on average the trust spun off in the past few years in terms of assets spent on beneficiaries through the budget. Mr. Jessee replied that the trustees had about \$24 million to \$25 million per year, which funded the trust administrative budget, the Trust Land Office under the Department of Natural Resources, funds that went through state government as MHTAAR, and authority grants administered by the trust.

Representative Gara asked if the trust's MHTAAR contribution to the budget would decrease as a result of providing funds for items in the bill. Mr. Jessee answered that a sizeable amount of the funding was in the fiscal notes and would go through the state. He believed it would have been allocated between MHTAAR and authority grants about the same way if funds were not directed at the bill package. He added MHTAAR and authority grant expenditures were generally pretty evenly balanced.

Representative Gara remarked he had a feeling he was chasing something he would not get on the record.

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

Co-Chair Thompson addressed the schedule for the following meeting.

ADJOURNMENT

[4:27:58 PM](#)

The meeting was adjourned at 4:27 p.m.