ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 5, 2015
3:04 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Liz Vazquez, Vice Chair
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool

MEMBERS ABSENT

Representative Neal Foster
Representative Louise Stutes

OTHER LEGISLATORS PRESENT

Representative Andy Josephson

COMMITTEE CALENDAR

HOUSE BILL NO. 76
"An Act relating to the Governor's Council on Disabilities and Special Education."

- MOVED HB 76 OUT OF COMMITTEE

PRESENTATION: IMPACT OF UNCOMPENSATED CARE

- HEARD

PRESENTATION: MEDICAID EXPANSION AND REFORM

- HEARD

PREVIOUS COMMITTEE ACTION

BILL: HB 76
SHORT TITLE: GOV COUNCIL ON DISABILITIES/SPECIAL ED
SPONSOR(s): REPRESENTATIVE(s) MILLETT

01/23/15	(H)	READ THE FIRST TIME - REFERRALS
01/23/15	(H)	HSS
03/03/15	(H)	HSS AT 3:00 PM CAPITOL 106

03/03/15	(H)	Heard & Held
03/03/15	(H)	MINUTE(HSS)
03/05/15	(H)	HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

BECKY HULTBERG, President & CEO
Alaska State Hospital & Nursing Home Association
Juneau, Alaska
POSITION STATEMENT: Presented a report on the impact of uncompensated care on the health care system.

VALERIE DAVIDSON, Commissioner Designee
Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Presented a PowerPoint titled "Healthy Alaska Plan."

ACTION NARRATIVE

3:04:42 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:04 p.m. Representatives Seaton, Vazquez, Tarr, Wool, and Talerico were present at the call to order. Representative Josephson was also in attendance.

HB 76-GOV COUNCIL ON DISABILITIES/SPECIAL ED

3:05:09 PM

CHAIR SEATON announced that the first order of business would be HOUSE BILL NO. 76, "An Act relating to the Governor's Council on Disabilities and Special Education."

3:06:12 PM

REPRESENTATIVE VAZQUEZ moved to report HB 76, Version 29-LS0369\A, out of committee with individual recommendations and the accompanying zero fiscal notes.

CHAIR SEATON objected. He reopened public testimony, and after ascertaining that there was no one asking to testify, he closed public testimony.

3:06:47 PM

CHAIR SEATON removed his objection. There being no further objection, HB 76 was moved from the House Health and Social Services Standing Committee.

Presentation: Impact of Uncompensated Care

3:07:11 PM

CHAIR SEATON announced that the next order of business would be a presentation concerning the impact of uncompensated care.

BECKY HULTBERG, President & CEO, Alaska State Hospital & Nursing Home Association (ASHNHA), announced that there were two general topics: first, what is uncompensated care, why was it important to the health care system, and why was it important to have this conversation; second, what could be expected to happen to uncompensated care if Medicaid Expansion were to move forward.

3:08:26 PM

MS. HULTBERG directed attention to a handout titled "Impact of Medicaid Expansion On Hospital Uncompensated Care," [Included in members' packets] and read:

> Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides.

MS. HULTBERG pointed out that this only included the cost of the care provided, and not the billed charges, which she declared to be an important distinction. She continued to paraphrase from the handout, which read:

> Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.

MS. HULTBERG explained that hospitals would often have an application process for charity care, as patients were sometimes unable or unwilling to pay their bills. She reported that hospitals had uncompensated care because they were legally required to provide emergency medical services and appropriate stabilization regardless of whether people could pay, as

determined by the federal law, "Emergency Medical Treatment and Act of Labor Act." People could expect, no matter their economic status, to be able to receive care at a hospital emergency room. She declared that, in reality, most hospitals provided far more in care than simply emergency room care to those who could not pay. She stated that the non-tribal hospitals in Alaska provided more than $90 million in uncompensated care in 2013, reiterating that this only included the cost to the hospitals and not what they would have charged for the services. She allowed that, as the tribal hospitals had different cost reports, it was not possible to directly compare them with non-tribal hospitals. She pointed out that, in many communities, as the tribal facilities were the only provider and they were providing uncompensated care, the cost was more than $90 million. She clarified that uncompensated care was not free care, even as it was a needed service for the communities, and that it had to be paid for in some way. She explained that, with the structure of Medicare and Medicaid payments, the uncompensated care costs were passed along through higher rates for commercial payers from the insurance companies. She opined that we all pay for uncompensated care, as the $90 million was not free.

MS. HULTBERG offered an explanation for the result to uncompensated care if Medicaid were expanded. She read from the aforementioned handout:

> A Colorado study analyzed data from 465 hospitals in 30 states in the first four months of Medicaid expansion. It found that unpaid care decreased by 30 percent in expansion states and remained largely unchanged in non-expansion states.

MS. HULTBERG relayed that, contrary to earlier statements, Medicaid expansion did result in a reduction in uncompensated care because more people were covered by a payer source. She declared that, based on other reports, it was safe to assume that Medicaid expansion could result in a decrease of 20 - 30 percent of the total amount of uncompensated care, a reduction of $18 - $27 million in uncompensated care for non-tribal facilities. She reported that small and large hospitals were under an increasing regulatory and financial pressure, as the industry adapted to a rapidly changing business model, declining reimbursement, and a variety of other factors. She declared that this reduction in uncompensated care would have a huge impact on the future sustainability of small rural hospitals, as they had lower patient volumes. She stated that critical access

hospitals nationwide, those with 25 beds or less, had found it increasingly difficult to stay open. She referenced a USA Today article, reporting that since 2010, 43 critical access hospitals across the nation had closed. She noted that the closure of a critical access hospital in Alaska would most likely mean an expensive medi-vac and delayed treatment. She stated that all the hospitals were faced with a declining reimbursement from Medicare. She offered to provide these statistics for distribution to the committee. She reported that, from 2010 - 2024, Alaska hospitals would see $591 million in Medicare reductions from a variety of factors. She pointed out that the Patient Protection and Affordable Care Act had included Medicare reductions to help pay for the costs of the act, and that these reductions would happen regardless of whether states expanded Medicaid. She noted that Alaska hospitals could see another $320 million of projected cuts, and, should those cuts be enacted along with the reduction in Medicare, Alaska hospitals could experience almost $900 million in cuts over a 15 year period. She emphasized that the hospital industry was facing financial pressure, while it was also being asked to transform health care from a system that rewarded volume, "the more things you do to people the more you get paid," to one that rewarded value, "paid based on the kinds of outcomes you receive and the cost of that care." She declared that incentives within the system were not currently aligned, as hospitals were paid when people were sick, and not when people were kept well or received high quality, cost effective care.

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MS. HULTBERG presented an example of a Ketchikan hospital which had received a Centers for Medicare and Medicaid Services (CMS) innovation grant for care coordination. As a result of providing better care coordination for all of their patients, the hospital increased their quality and decreased their revenue. The subsequent question now asked of hospitals was, are you going to spend money by hiring care coordinators to reduce your revenue but to improve quality. She allowed that this did appear to be a questionable business decision, pointing out that the incentives for this were not aligned. She questioned how to transform to a more aligned model, and stated that it would be necessary to take risks and innovate, which would require capital, a necessity for any business when they take risks. She directed attention to Medicaid Expansion, as it could provide the necessary capital to become the engine of health care transformation. She declared that it was necessary for the health care system to transform in order to improve

health care outcomes. She explained that Medicaid Expansion would supply the risk capital to allow the innovation, and combined with a payment structure that would reward outcomes instead of volume, the process of transformation would begin. She declared that Medicaid needed to turn from being a cost center to the engine of transformation, because improved health care outcomes would be good for everyone.

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CHAIR SEATON allowed that this would help for a better understanding to what was necessary for reform, and what the expansion of Medicaid would mean for hospitals in Alaska.

Presentation: Medicaid Expansion and Reform

3:18:20 PM

CHAIR SEATON announced that the next order of business would be a presentation by the Department of Health and Social Services on Medicaid Expansion and Reform.

3:20:01 PM

VALERIE DAVIDSON, Commissioner Designee, Office of the Commissioner, Department of Health and Social Services (DHSS), stated that the Healthy Alaska Plan was available on the department website, relaying that it contained four components. She stated that expanding Medicaid was healthy for Alaskans, it was healthy for the economy, it was healthy for the state general fund budget, and it served as a catalyst for reform. She declared that the department wanted Alaskans to be as healthy and as productive as possible, pointing out that people could not work, hunt, or fish if they were not healthy enough to do so. She declared that the department wanted Alaskans to be healthy and able to contribute to the economy. She emphasized that an expansion of Medicaid, along with the assorted necessary reforms, would improve health outcomes, increase productivity, and reduce the number of uninsured Alaskans by half, to about 10 percent. She noted that more Alaskans would receive preventive and primary care, including behavioral health care services and help with the management of chronic, costly diseases. She reported that business owners would benefit, as there would be fewer turnovers and lost days of work from employees with unintended illnesses and injuries. She stated that state mortality would also drop, and expansion would afford the

opportunity to address pressing health issues, including access to behavioral health services.

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COMMISSIONER DAVIDSON pointed to slide 2, "Who is covered now?" and explained that currently in Alaska, an individual had to be low income, a child, a pregnant woman, or an adult with dependent children to be eligible for Medicaid. She explained that the Patient Protection and Affordable Care Act allowed adults with incomes between 100 percent to 400 percent of the federal poverty level to qualify for a subsidy to help pay for health insurance. She relayed that expanding Medicaid was originally mandatory with passage of the Patient Protection and Affordable Care Act, but the U. S. Supreme Court ruling had made Medicaid Expansion optional. This had created a gap in eligibility for adults without dependent children who earn less than 100 percent of the federal poverty level, less than $14,720 per year or about $7.07 per hour. She reported that this gap also included a married couple earning a combined income of less than $19,920 per year, or about $9.57 per hour. As these individuals did not qualify for Medicaid, they also did not qualify for a subsidy.

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COMMISSIONER DAVIDSON stated that Medicaid Expansion offered several important opportunities, slide 3, "Medicaid Expansion," which included a higher federal match resulting in an immediate economic boost to the state economy. She listed calendar years 2014, 2015, and 2016 as years for which the federal match was 100 percent. Over the subsequent three years, through 2019, the federal match would transition from 95 percent to 94 percent to 93 percent, which she pointed out was similar to the aviation match for runway improvements. For 2020 and beyond, the federal match would become 90 percent. She compared this payment with the regular Medicaid match, which was about 50 percent. She declared that she did not anticipate the federal match to drop below 90 percent, as it would require change and approval by the U. S. Congress and the President. She pointed out that Alaska had clearly stated that its participation was contingent on maintaining the 90 percent federal match, which was similar to the federal transportation funding match. She expressed appreciation for the opportunity to invest with a significant federal return on the investment, noting that Alaska currently did this with runways and roads as it was necessary to have safe roads and runways for the state population and to promote

business and contributions to the economy. She declared that this was an important infrastructure investment for the state. She suggested that investments in health care were another important infrastructure investment in Alaska, as people could not be productive if they were not healthy. She shared that Medicaid Expansion also offered the opportunity to reduce uncompensated care, as there was currently more than $90 million in uncompensated care being absorbed by state hospitals every year. She noted that other states had uncompensated care rates drop after Medicaid Expansion. She said that it also offered the opportunity for the state to save general fund monies, pointing out that this would save the state about $6.6 million of general fund expenses in 2016. She pointed out that the state would also have the chance to leverage reform opportunities.

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COMMISSIONER DAVIDSON directed attention to slide 4, "Who would be covered by Expansion?" and she listed adults without dependent children, ages 19 - 64, who were not otherwise eligible for Medicaid or Medicare: Single adults who earn up to 138 percent of the federal poverty level, $20,314 per year or married couples without dependent children earning a combined income up to $27,490 per year.

COMMISSIONER DAVIDSON moved on to slide 5, "Where are they?" She pointed out that the majority of the eligible population lived in the larger population centers, with the Anchorage and Matanuska-Susitna region accounting for about 51 percent of the eligible population, the Gulf Coast and the Interior each accounting for about 14 percent, Northern Alaska accounting for about 12 percent, Southeast Alaska accounting for about 6 percent, and Southwest Alaska accounting for about 3 percent. She concluded that about 42,000 Alaskans would be eligible for Medicaid Expansion.

COMMISSIONER DAVIDSON directed attention to slide 6 "The Expansion Population," and stated that almost 44 percent of the Medicaid Expansion population were working, while another 28 percent were unemployed, and collecting unemployment. She reminded the committee that to collect unemployment, it was necessary to have been recently employed and to be actively searching for work, hence these people were in the workforce. She pointed out that this would include seasonal work, summer jobs, or recent lay-offs. She reported that the above totaled more than 70 percent of the Medicaid Expansion population. She

explained that more than 70 percent of this population did not have affordable health care benefits, commenting that more than 43 percent had no coverage, and that 29 percent had some access to health care including Indian Health Service facilities or community health centers. She pointed out that access to these facilities were not a health insurance plan or a portable health care benefit, but were instead a limited benefit. She declared that access to a community health center on a sliding fee scale offered a very limited service, and did not allow care coverage for emergency room visits or specialty services. She emphasized that this was not insurance. She stated that everyone was impacted when an individual did not get the necessary health care, and reminded that 20 percent of the state was uninsured. She acknowledged that there were many small business owners in Alaska who were not able to provide health coverage to their employees, and although these were able bodied working Alaskans, they did not earn enough to purchase insurance on the private market. She declared that Medicaid Expansion was something that could be done to offer health care to our fellow Alaskans, and that it could save general fund dollars for the state.

COMMISSIONER DAVIDSON addressed slide 7, "How many will sign up?" and stated that, although about 42,000 Alaskans would be eligible to enroll in Medicaid Expansion, only about 20,000 would sign up in the first year with a projected 26,500 people signing up in 2021. She proclaimed that a lot of people were eligible but did not sign up, even with the current Medicaid program. She reported that a part of the Healthy Alaskans plan included a report by Evergreen Economics, a firm which had analyzed Medicaid data for Department of Health and Social Services for almost a decade. She shared that the department had conducted this report for "refreshed information" to "provide the latest, greatest analysis." She said that this latest Evergreen report provided analysis in three key areas. She said that the first area was the projection of the expansion population for the years 2016 - 2021, slide 7; the second area was the "Cost Per Enrollee," slide 8; and the third area of analysis was the total spending of services with a breakdown of federal match with the corresponding state match by year.

COMMISSIONER DAVIDSON addressed slide 8, "Cost Per Enrollee," the second piece of analysis by Evergreen Economics. She reported that the cost per enrollee was estimated at $7,250 in the first year [2016] and would increase to about $8,400 in 2021. She explained that this cost was lower than earlier reports because, when Evergreen Economics looked at the projected enrollee population, they found that 54 percent were

male, with about 20 percent of that group between the ages of 19 and 34. She shared that existing data from the Medicaid program reflected that, as younger men did not access health care services in the same manner as others, their costs were generally much lower. She stated that working age adults currently enrolled in the Medicaid program were used as a proxy for the expansion population, and that the average spending per enrollee between 2009 - 2013 grew on an average annual basis by 1 percent. Although this amount was $6,560 in 2013, the projected estimate per enrollee was $7,250 because a portion of the projected enrollees were in the catastrophic beneficiary population who were covered at 100 percent by the state general fund and there needed to be compensation for this. She declared that the cost per enrollee would range from $7,250 in [2016] to $8,433 in [2021].

COMMISSIONER DAVIDSON spoke about slide 11, "New Federal Dollars," which reviewed the total spending on services, including both federal and state shares. She pointed out that the projected federal revenue in 2016 would be about $145 million and would result in more than $1 billion in new federal revenue during the first six years. She emphasized that every day of delay to Medicaid Expansion in 2016 would cost the state $398,452 in lost federal revenue.

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COMMISSIONER DAVIDSON moved on to slide 12, "Saves Money," expressing her agreement that it was an important question to ask how much free money was going to cost. She explained that the state match was zero in 2016, and would transition to a cost of $19,587,000 in 2021 as the state match transitioned up 10 percent. She noted that the administrative costs for expansion, including enrollment and claims processing, would begin at $1.3 million and increase to about $1.6 million in 2016.

COMMISSIONER DAVIDSON declared that there were also potential offsets to the state budget, slide 13, "Saves Money." She directed attention to state fund savings which were currently being paid 100 percent with state general funds. She anticipated that many of these aforementioned 100 percent beneficiaries could be transitioned with Medicaid Expansion to a 10 percent cost to the state general funds. She reported potential savings of $1 million during the first year of expansion [2016] and transitioning to $1.5 million [2021] for Alaskans who were not eligible for Medicaid and in the Chronic & Acute Medical Assistance (CAMA) program; about $4.1 million in

the first year [2016] and increasing to about $7 million in [2021] for inmates in the Department of Corrections who were admitted to an overnight stay in a medical facility out of the prison. She reported that the first year savings estimate was conservative to allow time for enrollment. She noted that another cost saving opportunity would be in the reduction of recidivism, which she offered to discuss later in the presentation. She shared that the third anticipated cost savings offset was with behavioral health grants. She reported that the state currently provided these grants to a number of behavioral health providers, and she offered a conservative estimate that this savings would grow from $1.5 million in the first year [2016] to about $16 million in annual savings [2021]. She allowed that this would take time for enrollment and "to ramp up these programs." She shared that these were only some of the initial offsets identified, and she expected to see more savings through additional reform opportunities. She stated that slide 14, "Saves Money," combined the information from the last three slides, pointing to the net savings for the general fund and the corresponding federal revenue on the bottom two lines. She expressed thanks to the Alaska Mental Health Trust Authority for its provision of the necessary funds to pay the cost of administration during the first year.

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COMMISSIONER DAVIDSON returned to slide 9, "Reducing Recidivism," and directed attention to the link to the recidivism reduction plan presented to the House Finance Committee. She shared that Medicaid Expansion had been recommended in this report as a means to finance an anti-recidivism effort. She reported that, although some of the prison population was able to access behavioral health services, once they were released from prison it was a challenge for continued access to these services as they were not eligible for Medicaid and there was not a payer source to provide care. She referenced the March 2012, Judicial Council analysis of the Department of Corrections' substance treatment program, which reflected a 12 percent rate of recidivism versus a 20 percent rate in the control group, within 12 months of release from custody. She shared a 2009 report from ISER (Institute of Social and Economic Research) that explained how Alaska could limit the number of inmates and stem the rising costs, while keeping the public safe and using state dollars efficiently. The report detailed that if there was not a change to policy, the number of Alaska inmates was likely to double by 2030. However, if the state spent an additional $4 million annually to

expand existing education and substance abuse programs, the prison population might be 10 percent smaller in 2030. She shared that more recent information showed other states with issues similar to Alaska had focused on providing behavioral health services earlier and more efficiently, and had recognized a drop in recidivism rates. She stated that the rate of recidivism fell 25 percent in Michigan between 2007 and 2012, after the state connected newly released prisoners, on the day of their release, to a medical home in the community. She spoke about Texas, which had its recidivism rate drop 22 percent from 2000 - 2007, partly due to its expanded rehabilitation and treatment programs. She said that other states were looking at Texas as a model for its investment in behavioral health services. She noted that Texas had been in a similar situation as Alaska was currently. They also had a limited state budget, and were also faced with building another state prison to accommodate the increasing prison population. She raised the question for investing in behavioral health services to make Alaskans healthier, or for building another prison. She pointed out that Texas had used 100 percent state general funds, and, as Alaska had a shortage of funds, Medicaid expansion could help fund this payment for behavioral health services, subsequently leading to a lower rate of recidivism.

3:54:50 PM

COMMISSIONER DAVIDSON shared slide 10, "Improving Health," and stated that an increase of access to health care resulted in improved health outcomes and a reduction by half of the uninsured population. She said that more Alaskans would receive preventive and primary care, which included behavioral health care services. This availability of health care services would help to manage costly chronic disease. She stated that uninsured adults were much less likely than insured adults to receive preventive services or screenings for the most prevalent, costly, and preventable or controllable health care problems. She reported that the five most common causes of death in Alaska were cancer, heart disease, unintentional injuries, stroke and chronic lower respiratory disease. She pointed out that four of these were preventable or treatable if caught early. She shared that, through the experiences of other states, it could be expected for the Alaska mortality rate to drop. She cited a recent Harvard University study which compared the mortality rates for adults for five years prior and five years following the dates the states undertook a significant health reform effort to expand coverage. This analysis found that for every 830 adults who gained health

insurance, one death per year was prevented. She suggested that applying this analysis to the 20,000 expected enrollees would result in about 30 saved lives. She reported that Alaska had challenges for access by survivors of domestic violence and sexual assault, as many people did not have coverage. She shared that access to health care was showing a positive improvement to the homeless population in other states. She cited a Kaiser Family Foundation report which indicated that Medicaid expansion was already contributing to improved access to care as well as broader benefits to the homeless.

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COMMISSIONER DAVIDSON addressed slide 15, "Reform is Necessary," declaring that reform was necessary, and sharing that reform efforts had already been undertaken at Department of Health and Social Services. She expressed recognition for the budget challenge, and referenced the governor's request to review a 25 percent cut in funding in four years. She declared that DHSS reform efforts were enhanced with expansion opportunities, and that they wanted the Medicaid program to be a sustainable program. She relayed that the DHSS budget was $2.7 billion, with $1.7 billion of this for Medicaid. She added that $700 million of this was from the state general fund, with the majority of the rest paid by a federal match, which she declared was an important distinction. She stated that reform was an opportunity to identify and implement efficiencies, to make improvements, to deploy innovations, and to minimize the impact to the most vulnerable Alaskans. She declared that it was necessary to have a conversation that went beyond rate freezes, and beyond cutting eligibility and optional services, to find the health plan that was right for Alaska.

COMMISSIONER DAVIDSON presented slide 16, "Building on Reforms Underway," and she listed some that were currently underway at DHSS: Control the overutilization of hospital emergency room services. She reported that about 5,000 individuals utilized about $29 million in annual emergency room visits. She said that the department had started a care management program to direct these individuals to more appropriate levels of care, with a target of $7 million in savings. She said that this would necessitate a regulation change to increase the mandatory number of participants. She discussed the second and third points on slide 16, and shared that it was necessary to "crack down" on providers found to be fraudulent, which she deemed to be an issue in any program. She declared that the department had targeted about $15 million in annual avoided costs, sharing

an anecdote for the requirement that personal care attendants individually enroll as Medicaid providers, instead of a previous requirement that only the hiring organization had to enroll as the Medicaid provider. She stated that this allowed the department to review payments to individual providers and notice any discrepancies. She shared that there were opportunities in home and community-based service improvements, which were Patient Protection and Affordable Care Act options available since 2010. She said there were options through the 1915(i) waiver which would replace funding for services for those who did not meet nursing level of care but did meet other criteria, currently using 100 percent state general funds, with funding from federally matched Medicaid services. She explained that the 1915(a) waiver could replace existing Medicaid home and community-based waiver services, currently at a 50 percent federal match, with 1915(k) Medicaid services matched at a 56 percent federal rate. She declared that the target annual savings was for $24 million upon full implementation in two or three years. She discussed coordination of three Patient-Centered Medical home initiatives, with a goal to help people with chronic health issues receive appropriate care in an appropriate setting, reduce hospitalization, and reduce the "high dollar emergency room visits." She expressed the aim for a reduction of costs by $78,000 - $165,000 per thousand enrollees annually.

COMMISSIONER DAVIDSON shared that another opportunity was for coordination with the Alaska Tribal Health System, with regard to a Medicaid beneficiary who was an IHS beneficiary and who received their services in an IHS facility. She relayed that this was completely separate from Medicaid Expansion, and the department anticipated about 10 percent savings, $15 million annually, through policy and agreements. She went on to explain that this opportunity could be even more aggressive by investigating waiver options, which she opined could save about $100 million in state general funds annually. She relayed that the Division of Senior and Disabilities Services was also investigating other opportunities.

4:09:17 PM

COMMISSIONER DAVIDSON identified slide 17, "Additional Reforms," and mentioned $20 million in savings in the Fiscal Year 2016 budget, which included some tribal cost shifts recognized in the partnership with the Alaska Tribal Health system. She reported that any new facility which had the opportunity to expand its level of service had a downward cost shift, as they would have

previously needed to refer those services, often resulting in a lower match. She listed a number of increased services throughout the state that offered additional opportunities for savings, noting that there was a target savings of $10 million in FY 2016.

4:11:55 PM

CHAIR SEATON asked whether the $10 million savings was for the combination of services.

COMMISSIONER DAVIDSON replied that the savings was for the combination of those services, and she opined that it was a conservative estimate. She returned attention to slide 17, pointing to a change in eligibility requirements for personal care assistance services from one to two or more activities of daily living. She detailed that there was close work with the primary care provider association to ensure that individuals were getting the right amount of care at the right time. She relayed that there were other opportunities for savings in durable medical equipment, vision, and audiology. She spoke about the increase to the number of individuals added to the Super Utilizer contract for management of care resulting in a general fund savings of about $2.5 million in FY 2016. She noted that $1 million in general fund savings had been identified for dental services in FY 2016. She stated that there was a focus on clearer program standards, stronger admission criteria, review for residential psychiatric treatment centers and acute psychiatric service settings, and revision of requirements for recipient support services. She acknowledged that transportation guidelines to services out of the area for family groups needed to be reviewed for savings.

4:15:30 PM

COMMISSIONER DAVIDSON declared that reform was a process and that reform efforts had already been started. She stated that Alaska was different than other states, and that the state should require development of its own model. She directed attention to slide 18, "Designing Reform," and lauded the generous support of the Alaska Mental Health Trust Authority for its Requests for Proposal (RFPs) asking for technical assistance to build the Alaska plan, which included a review of the reform efforts underway in other states for both Medicaid and Medicaid Expansion. She ensured that every report would be put on the department website so that the public would be aware of the direction and have the opportunity for input. She declared

that, as this was challenging and complicated, a diversity of opinion was necessary and important. She opined that reform would look different to everyone. She pointed out that Alaskans had made tough decisions before, and it was done best when Alaskans spoke with each other.

4:20:27 PM

COMMISSIONER DAVIDSON moved on to slides 19 and 20, "Additional Reform Options," and discussed some of the additional reform options for evaluation, including those other states had reviewed. She explained payment reform, a review of the fee for service payment structure which incentivized high service volume and rewarded inefficiencies in the delivery system, with a transition to an alternative payment mechanism that would drive improved value. She declared that the department would strengthen primary care with patient centered medical home opportunities, and make it easier to access primary care providers. She explained that care management would ensure that the right care was provided in the right setting at the right time in the right place. She referenced the care model of the Mayo Clinic. She stated that it was necessary to review workforce innovation, including new provider types such as community health aides, behavioral health aides, and dental health aide therapists, which allowed the next level of provider to offer care at the upper end. She pointed to the opportunities to maximize federal match and to improve tele-health capacity to the general population.

COMMISSIONER DAVIDSON said that reform options and strategies should increase prevention and responsibility. She relayed that cost sharing for adults already existed in the Medicaid program for physician visits, prescription drugs, and out-patient and in-patient hospital care. She noted that other states had reviewed health saving accounts (HSAs) to help pay for co-payments and deductibles. She suggested choice restrictions to direct services and enrollees to the appropriate care. She talked about incentives for healthy behaviors including shared responsibility. She spoke about increasing access to preventative services and work assistance benefits for the Medicaid Expansion group.

4:28:13 PM

COMMISSIONER DAVIDSON allowed that these suggestions for health care would help people along on a path to self-sufficiency. She spoke about slide 21, "Impact to the Economy," and noted that

improving the health of Alaskans was also good for the Alaska economy, as this would bring more than $1 billion in new federal revenue, 4000 new jobs based on the economic multiplier effect for new revenues, and $1.2 billion in wages and salaries paid to Alaskans. She pointed out that, as Medicaid also paid for medically necessary travel, there would be an increase in the travel industry for hotel accommodations and related needs. She shared that her department had received many calls from people worried about the Alaska economy given the budget challenges. She declared that it was necessary to be careful and responsible during the transition to a smaller size state government. She stated that the department was looking for other opportunities for diverse revenue in Alaska. She allowed that it would take time to finance and build many of the opportunities before there was a significant impact on the state revenue. In the meantime, Medicaid expansion was "the fastest, earliest way for us to be able to infuse additional resources into our economy in Alaska." She noted that this infusion would be $145 million in 2016 alone, almost $390,000 each day, and would go a long way toward shoring up the losses from shrinking the state budget. She expressed her appreciation that Medicaid Expansion was not just an economic benefit that only went to Anchorage, Fairbanks, and Juneau, but accrued to every community in the state where health care was provided. She declared the desire for Alaskans to be as healthy as possible and able to contribute to the economy.

4:33:05 PM

CHAIR SEATON submitted some questions from the committee: What is Medicaid Reform?; What are some appropriate examples of Reform from other states and how would they work in Alaska?; and, While examining super-utilizers for reform, has the Department considered Medicaid Health Home Model, which provides 90 percent operational funding federal match for homes which target specific high-cost Medicaid patients during the first two [operating] years? He asked if this was what she had addressed earlier.

4:34:34 PM

COMMISSIONER DAVIDSON, in response, explained that the home health model was also called the Patient Centered Medical Home model, and was one of the reforms being explored by the state. She reiterated that the DHSS intent was for the proposed contracted consultant to do a thorough analysis, with recommendations for implementation in Alaska.

CHAIR SEATON resumed his questions, and asked: Is Medicaid reform best accomplished through statute or regulation?

COMMISSIONER DAVIDSON replied that Medicaid reform can be done through both statute and regulation, that it depended on whether it was voluntary or compulsory. She referenced slide 16, "Building on Reforms Underway," and reported that hospital room utilization control was already underway through simple policy, but if it was under regulation, it would become a mandatory requirement. She directed attention to the second and third bullet points on the slide, and stated that, as fraud, waste, and abuse had been addressed internally in DHSS through policy, it did not require regulation. Referencing the third bullet point, she explained that DHSS would pursue a waiver with CMS for the home and community-based service improvements. Moving on to the fourth bullet, she relayed that a regulations change would be required to expand or compel participation with the Patient-centered Medical Home initiatives. She declared that coordination with the Alaska Tribal Health System providers could be accomplished with policy and agreements with those providers, although the real opportunities for additional savings was with the waiver opportunities currently being negotiated with CMS.

CHAIR SEATON questioned the match and the operational funding amounts available for the Medicaid home health model and the home and community based services, and asked whether this was being pursued.

COMMISSIONER DAVIDSON explained that DHSS was pursuing two waivers for the home and community based services, 1915(i) for a 50 percent match, and 1915(k) for a 56 percent match. She explained that the Medicaid home health model was for the aforementioned patient-centered medical home models, of which there were three currently underway in Alaska. She shared a desire to explore additional opportunities for savings, especially in tribal health.

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REPRESENTATIVE TARR asked whether the transition of the Anchorage Neighborhood Health Center to a patient centered medical home model was a possibility for more immediate participation.

COMMISSIONER DAVIDSON expressed her agreement.

CHAIR SEATON resumed his questions and asked, if [Medicaid] reform and expansion were accomplished in different time frames, could expansion legislation integrate a delayed implementation timeline.

COMMISSIONER DAVIDSON emphasized that significant reform efforts had already been underway for some time, and that additional reform efforts were being undertaken during the next several years, even prior to the hiring of the contractor to address additional reform options. She offered her belief that it would be difficult to develop a plan for a delay on expansion based on reform, and she declared that the department did not recommend it. She suggested that this would delay Medicaid expansion for at least another year, with a subsequent loss of $145 million from federal revenues to Alaska. She advocated for building upon the reforms already undertaken and already planned, while a longer term plan for additional reform options for the entire Medicaid population was being developed. She stated that Alaska had delayed long enough, and it was time to move forward.

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CHAIR SEATON relayed that a lot of people in the building were wary of passing [Medicaid] expansion prior to implementation of [Medicaid] reforms. He asked whether a bill for Medicaid expansion could have elements of reform with delayed implementation to allow time for these [Medicaid] reforms.

COMMISSIONER DAVIDSON suggested that there was a need to expand and provide additional health care services to Alaskans as quickly as possible while also undertaking reform efforts. She posed the question of waiting for [Medicaid] expansion until reform was completed, and declared, as reform was already underway, "gosh darn it, let's start those expansion efforts." She opined that, although some others had ideas for reform efforts, the department had already started with its reforms and the state budget left no choice but for reform.

CHAIR SEATON stated that there were significant road blocks to moving forward, if there was not something to ensure that "more drastic, more pervasive reform is going to take place." He suggested that DHSS put reforms in the proposed bill with delayed effective dates in order to give time for implementation. He offered his belief that this would "speed the Medicaid expansion bill along because we would be in law saying that these reforms will be developed over this period of time and getting that commitment." He opined that this was

important to develop a working relationship and trust going forward. He asked if reform and expansion needed to be combined so the conversion of charity care cases into participants at a higher federal reimbursement rate means providers receive enough income to accomplish reform?

COMMISSIONER DAVIDSON offered her belief that the earlier presentation by ASHNA supported that the combination of reform and expansion would more quickly reduce the burden on providers for uncompensated care, as well as the increased cost to those already insured. She reported that, in Arizona, the hospitals had seen a 30 percent reduction in uncompensated care in the first six months of expansion. She relayed that 27 states plus the District of Columbia had expanded Medicaid. She referenced another presentation which had declared that this expansion had not worked for two states in particular, as the rates of enrollment and the costs were higher. She pointed out that this information was based on data from 1999 - 2011, which was prior to the authorization of Medicaid Expansion under the Patient Protection and Affordable Care Act on January 1, 2014. She declared that if comparing "blueberries to blueberries" it was necessary to discuss the relevant year, 2014. She reported that, in Arkansas, about 240,000 people had enrolled, the rate of uninsured was cut in half, and the rural hospitals were doing better, noting that they had similar challenges to Alaska. She noted that the University of Arkansas hospital had its rate of uncompensated care drop from 14 percent to 4 percent. She shared that Arkansas, similar to Alaska, had a legislative task force for recommendations of future improvements. She declared that it was important to track the progress and make adjustments for any newly implemented programs. She referenced that the uncompensated care in Arizona was reduced by 30 percent in the first six months. She opined that states must be really thoughtful and thorough in designing their Medicaid programs. She stated that the department had outlined some of its reform efforts already undertaken, as well as some new reform efforts. She pointed out the DHSS had underlined a defined, concrete strategy for future reform. She acknowledged that ideas for reform came from many directions in order to create a thoughtful reform package that worked for all Alaskans and was consistent with the unique challenges for remoteness faced by Alaska.

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COMMISSIONER DAVIDSON commented that employer provided health insurance had been declining for 20 years, long before the Patient Protection and Affordable Care Act. She declared that

Alaskans make really tough decisions, which were done best in conjunction with other Alaskans. She emphasized that it was not possible to purchase a health plan at an affordable cost with an income of $20,000 each year, pointing out that 20 percent of the state population was uninsured.

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CHAIR SEATON asked if some types of reform would lower provider participation, and, if so, how was it possible to protect against this.

COMMISSIONER DAVIDSON explained that reform had to proceed with the full participation of everyone who had a stake in the outcome. She stated that a goal of any reform by the state had to look at maximizing rather than minimizing provider participation and to be a responsible partner with the patients and providers. She emphasized that it was necessary to have many conversations to develop a plan that worked for Alaska.

CHAIR SEATON asked, if Medicaid expansion required parity between mental health and physical health services, how would the state address behavioral or mental health services given the current limited services for these.

COMMISSIONER DAVIDSON shared her excitement for behavioral health parity with Medicaid expansion. She pointed out that the continual challenges for the state required availability of a full array of behavioral health services. She offered her belief that Medicaid expansion would spur additional development of behavioral health services, as many people in the expansion population did not have any coverage and were not able to receive services. She declared that grants could not be a target for cuts, as behavioral health providers needed to have a level of certainty in order to plan for and provide service. She stated that behavioral health parity was "awesome."

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REPRESENTATIVE TARR asked if there was more information about individuals with mental health services, noting that a challenge existed for those individuals without good access to care, as often they did not take their medications, resulting in the associated problems for family and community.

COMMISSIONER DAVIDSON said that she would provide that information.

CHAIR SEATON asked if the department was looking into additional funding, such as a provider tax or a copay or a surcharge from major providers of Medicaid Expansion. He opined that the providers would see the benefits from converting charity care to fully compensated care, whereas the state was absorbing the risk. He asked if there was any mechanism for sharing of the revenue by those receiving this increased revenue because of the expansion.

COMMISSIONER DAVIDSON replied that, once the proposed contractor provided technical assistance, all potential reform opportunities and payment opportunities would be on the table. She stated that the department would do this responsibly and would listen to the opportunities and to the impacts on the providers.

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CHAIR SEATON opened up discussion on the presentation.

REPRESENTATIVE WOOL reflected on the increase of the incoming federal dollars, and even though the state payment also increased over time, it resulted in a state net gain. He added that there were also more jobs and improved health care for those who did not currently have health care. He relayed that there were concerns for the cost and the risk of federal withdrawal of payments, even as the state maintained that it would withdraw from the Medicaid Expansion program if federal funding stopped. He pointed out that this same concern for federal withdrawal of funding was not an issue for road projects. He asked what were the other big risks, offering his belief that it was a win - win situation.

COMMISSIONER DAVIDSON expressed her agreement that in 2021 there was a net savings to the state, and she corrected the amount on slide 11 to be $224,500,000. She noted that the state did not often have the opportunity to invest state general fund dollars to leverage significant federal dollars, which would allow Alaska to realize a net savings. She suggested that the concerns were mainly philosophical and a policy distinction. She emphasized that the perspective of DHSS was that it was important to invest in the health care of people. She reiterated that Alaskans did not turn their backs on Alaskans who needed help, but instead offered help and assistance. She stated that Medicaid expansion was a way to do this. She acknowledged to those people who believed that Medicaid

expansion would lead to the end of the world and that the federal government would implode, that there were not any guarantees. She stated that it was necessary to continue to live for today while planning for the future, and that it was not likely for the federal government to reduce its future match. She clarified that the federal medical assistance percentage (FMAP) was determined by the Centers for Medicare and Medicaid Services (CDC) which reviewed the average income for the average citizen in a state. As Alaska had higher incomes, even though there was a higher cost of living, Alaska had the lowest possible federal match, 50 percent. She relayed that there had previously been an enhanced FMAP to Alaska of 58 percent, the result of an appropriations rider by the late Senator Ted Stevens, Chair of the Senate Appropriations Committee.

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CHAIR SEATON announced that the questions submitted by Representative Vazquez would be posted. He noted that she would not be available for the House Health and Social Services Standing Committee meetings during the following week.

REPRESENTATIVE VAZQUEZ clarified that, although she would prefer to ask the questions in person, she may participate telephonically. She declared that she would like to modify some of the questions in light of the testimony.

CHAIR SEATON asked that any other committee members' questions be submitted in writing so that the department would have the opportunity to prepare its responses. He asked that DHSS prepare a presentation based on full participation as well as half participation for Medicaid Expansion.

COMMISSIONER DAVIDSON said it would include the cost to the state and the additional receipt authority.

REPRESENTATIVE TARR asked if the reform measures and their target savings could also be listed.

REPRESENTATIVE TALERICO asked about the provider tax or co-pay from major providers, as there had been a report regarding $91 million in uncompensated care from non-tribal Alaska hospitals. He asked if any net income information was available, as it would help during discussion regarding the co-pay from providers.

CHAIR SEATON asked about an estimate for the charity care in those hospitals, as using a percentage of recovery would then provide "a full gamut of what a provider fee might provide."

REPRESENTATIVE TALERICO suggested that the net income could better clarify a proposed co-pay from the providers.

REPRESENTATIVE VAZQUEZ stated that she would have very specific questions on that subject. She asked that a person from the rate review office be available to answer questions regarding the uncompensated care on course reports, and its subsequent reimbursement through Medicaid.

REPRESENTATIVE VAZQUEZ [Due to technical difficulties, part of this discussion was indecipherable] asked that someone versed in the eligibility system and someone able to update the status of litigation or negotiations on the two systems be available. She [indisc] asked for someone knowledgeable about the eligibility of personal care assistant services in the activities of daily living to be available. She asked for a graph detailing the number of Medicaid enrollees during the past ten years and another graph displaying total Medicaid expenditures.

5:13:33 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:13 p.m.