ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 19, 2015
3:05 p.m.

MEMBERS PRESENT

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

MEMBERS ABSENT

Representative Neal Foster

OTHER LEGISLATORS PRESENT

Representative Dan Saddler

COMMITTEE CALENDAR

PRESENTATION: MEDICAID 101

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

JON SHERWOOD, Deputy Commissioner
Medicaid and Health Care Policy
Office of the Commissioner
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Presented a PowerPoint and answered questions during the presentation on Medicaid 101.

MARGARET BRODIE, Director
Director's Office
Division of Health Care Services
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Presented a PowerPoint and answered questions during the presentation on Medicaid 101.

ACTION NARRATIVE

3:05:17 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:05 p.m. Representatives Talerico, Wool, Stutes, and Seaton were present at the call to order. Representatives Tarr and Vazquez arrived as the meeting was in progress. Representative Saddler was also in attendance.

PRESENTATION: Medicaid 101

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CHAIR SEATON announced that the only order of business would be a presentation on Medicaid.

3:07:24 PM

JON SHERWOOD, Deputy Commissioner, Medicaid and Health Care Policy, Office of the Commissioner, Department of Health and Social Services, introduced himself.

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MARGARET BRODIE, Director, Director's Office, Division of Health Care Services, Department of Health and Social Services, began a PowerPoint on Medicaid, [Included in members' packets] which she said was intended to provide an overview of the Medicaid program on a national as well as a state level. She turned to slide 2, "Medicaid Goals," and outlined the goals, which included to integrate and coordinate services and to strategically leverage technology. She shared that the Centers for Medicare and Medicaid Services (CMS) has a vision for how it would like to see the different enterprise systems established for eligibility or claims processing. The CMS also would like to implement sound policy, practice fiscal responsibility, and measure and improve performance.

MS. BRODIE, turning to slide 3, "Medicaid Services Overview," provided a brief history of the Medicaid program, which is a shared program by the federal government and states that began

in 1965. She reported that each state runs its program differently, with different options, waivers, and populations. Currently, Medicaid provides insurance to more than 80 million people, she reported, and in 2014, 138,300 of 158,853 people enrolled in Alaska actually utilized the services.

MS. BRODIE directed attention to slide 4, "The Role of Medicaid," which outlined where the 80 million people are located, including that 33 million children and 19 million adults obtain Medicaid health insurance coverage; 10 million elderly and disabled person receive assistance as Medicare beneficiaries; and 1.5 million institutional residents and 2.9 million community-based residents receive long-term care assistance. She reported that support for the health care system and safety-net provide 16 percent of national health spending, which represents half of long-term care spending. The state capacity for health coverage in FY 2015 for federal match rates [Federal Medical Assistance Percentage (FMAP)] ranged from 50 to 73.6 percent, with Alaska currently at a 50 percent federal matching rate, which is the floor and the lowest possible rate. In fact, if a floor did not exist the FMAP rate would be 42.1 percent, she said. She turned to slide 5, "Medicaid is an Integral Health Care Component," which highlighted that Medicaid in Alaska provides services, helps the economy, and provides jobs. She turned to slide 6, "Services," and said the Medicaid program supports providers as one of many payers in the system, and it also serves as a safety net for individuals, children, and elders, by providing basic health coverage for those who would otherwise be uninsured.

MS. BRODIE turned to slide 7, "Economy," and highlighted that Medicaid is the primary payer for long-term care services, not just in Alaska, but nationally, for behavioral health services and for anti-psychotic medications. The health care expenditures in Alaska were $7.5 billion in the last census, of which Medicaid represented approximately 18 percent, and in 2014 Medicaid provided 34,100 health care jobs [slide 8]. She directed attention to slide 9, "Who Pays for Health Care in Alaska?" She reported that the University of Alaska Anchorage Institute of Social and Economic Research (ISER) provided the statistics depicted in the pie chart on this slide. She pointed to the bottom of the pie chart, to two slices representing Medicaid, with the red slice indicating the federal share at 12 percent and the yellow slice indicating the state general fund payments at 5.5 percent. In addition, government employers are the largest payers of health care in Alaska at 22 percent, with self-insurance at 11 percent, employer premiums at 8.5 percent,

and again the combined federal and state Medicaid share at 17.5 percent.

MS. BRODIE directed attention to slide 10, "Medicaid Expenditures by Service FY 2013," and pointed out these expenditures actually cover long-term care, premiums for enrollees to participate in the Medicare program, payments to managed care organizations (MCOs) at 31.1 percent, other acute care at 9.5 percent, inpatient hospital costs at 13.5 percent, and pharmacy costs at 1.5 percent.

REPRESENTATIVE STUTES asked for further clarification on who makes the premium payments for Medicare.

MS. BRODIE answered the State of Alaska's Medicaid program makes the premium payments to Medicare since it represents the payer of last resort. She emphasized the state's goal, which is to have an insurance company or any entity pay for services prior to the state payment.

REPRESENTATIVE STUTES maintained her interest in the premium payments for Medicare.

MR. SHERWOOD replied that most Medicare recipients are required to pay premiums for Medicare Part B. Most Medicaid recipients are low-income individuals, but some Medicaid recipients are also Medicare eligible. The premium coverage relates to Medicare individuals who receive Medicare, not to contributions withheld by employers for employees; however, once the low-income recipient goes on Medicare and must pay the Medicare Part B premium, Medicaid picks up the premium costs because it is cost-effective to first allow Medicare coverage before Medicaid pays.

MR. SHERWOOD clarified that a small number of individuals must also pay Medicare Part A, and in those instances, the state would also pay those costs since it is cost effective to do so.

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MS. BRODIE directed attention to slide 11, "Top 5% of Enrollees Account for More than Half of Medicaid Spending," and reported that the top 5 percent of enrollees spend 53 percent of Medicaid funds and 95 percent spend 47 percent of the funds. She turned to slide 12, "Medicaid Enrollees and Expenditures," and detailed the percentage of Medicaid expenditures, with disabled at 42

percent, the elderly at 21 percent, adults at 15 percent, and children at 21 percent.

MS. BRODIE directed attention to slide 13, "FY2014 Total Medicaid Recipients," referred to the pie chart and read the breakdown of recipients in Alaska: children - 59.6 percent, adults - 26 percent, disabled adults - 12.1 percent, elderly - 5.6 percent, and disabled children - 1.5 percent. She commented that Alaska has a higher percentage for covering children than many states. She reviewed slide 14, "Medicaid Service Population," which provided another way of looking at the population served in Alaska.

REPRESENTATIVE STUTES asked if the higher percentage of children served was for the dollar amount paid or the number covered.

MS. BRODIE clarified that it was the percentage of children participating in the Medicaid program.

MS. BRODIE moved on to slide 15, "Growth in Per-Enrollee Medicaid Spending vs. Other Health Spending," which she said indicated the annual rate of growth from 2007 through 2012. She pointed out that Medicaid has not increased as much as other types of health care coverage, noting that private health care insurance increased by 4.6 per enrollee while Medicaid only increased by 3.1 percent.

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CHAIR SEATON asked for further clarification on whether this is dollar increases or numbers of participants.

MS. BRODIE replied this was the percent of increase in spending by type of coverage.

MS. BRODIE turned to slide 16, "Federal Medical Assistance Percentage (FMAP)," and pointed out that this indicated the FMAP rates in the Lower 48, with Alaska at 50 percent; however, the state receives 65 percent for Title 21 children.

MR. SHERWOOD, in response to Chair Seaton, explained that Title 21, also known as CHIP [Children's Health Insurance Program], refers to children who are covered at somewhat higher rates than the rest of the children, with an enhanced federal match rate. Some states have a stand-alone CHIP program, other states cover them through Medicaid, with some states electing for a combination of both. Alaska has elected to cover Title 21

children through the Medicaid program, but as Ms. Brodie mentioned, at a higher federal match rate. In further response to Chair Seaton, he agreed that the Title 21 children are ones above the poverty line, although he noted that the CHIP is triggered by age.

CHAIR SEATON asked for the Title 16 definition.

MR. SHERWOOD answered that Title 16 refers to the Supplemental Security Income Program (SSI). He explained that Title 16 provides coverage for a number of elderly and disabled who often qualify for Medicaid; however, Medicaid falls under Title 19. Thus the department often differentiates between Title 19 Medicaid recipients and Title 21 Medicaid recipients, or the CHIP component.

CHAIR SEATON asked for further clarification on the categories of children.

MR. SHERWOOD answered that the category for Medicaid Title 19 children includes children below the poverty line and younger children up to 133 percent of poverty using the traditional standards; however, the categories have been further complicated since they were converted in 2014 to the new modified adjusted gross income standards. He apologized for not having those specific figures with him today.

CHAIR SEATON, in response to Representative Stutes, asked to review a few of the previous slides for members.

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REPRESENTATIVE WOOL asked if there were two categories of poverty level for those children in the CHIP [Children's Health Insurance Program].

MR. SHERWOOD answered that there are not two categories of poverty levels. He explained that the CHIP starts where the traditional Medicaid coverage ends. The standard for children through the age of 5 in the regular Medicaid was higher than the standard for children ages 6 to 18; however, the break point for regular Medicaid to CHIP is different for younger children than older children, he said.

CHAIR SEATON asked to return to slide 11, and related his understanding that the top 5 percent of spenders accounted for 53 percent of the expenses.

MS. BRODIE answered yes. She explained that slide 12, "Medicaid Enrollees and Expenditures" identifies them as the disabled and the elderly.

CHAIR SEATON asked whether any specific diseases or causes accounted for the top 5 percent of spenders that account for 53 percent of the expenditures.

MR. SHERWOOD answered that it does not relate to Medicaid enrollees with a particular disease, but to a combination of issues for individuals who needed an intense level of long-term support, such as nursing home services. He added that this category also included people with acute episodes that resulted in extensive surgery or prolonged hospitalization; however not all seniors and disabled are high spenders. Typically high spenders include enrollees who had an event that put them in hospitals for significant periods of time, or in nursing homes, or those who received extensive long-term support in their own homes or communities.

MS. BRODIE directed attention to slide 12, "Medicaid Enrollees and Expenditures," which showed the correlation between the percentage of each enrollee by type, including disabled and elderly adults and children, and the amount of spending attributed to them. She clarified that the department has not said that there are not high cost individuals outside the elderly or disabled category since there are a few in other categories.

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MS. BRODIE moved on to slide 13, "FY2014 Total Medicaid Recipients," and reported that nearly 60 percent of Medicaid recipients are children, 5.6 percent are elderly, 12.1 percent are disabled adults, and 26 percent are adults who are typically single parents or two-parent households with young children. She turned to slide 14 "Medicaid Service Population," which showed the population being served and how these core services fall in the department's priorities.

CHAIR SEATON asked whether the three priorities influence the state's Medicaid expenditures.

MS. BRODIE replied that the department has actually gone through an exercise to tie every single activity - whether it is Medicaid or a division activity - to one of these core services.

She explained the department used a matrix to go down to the lowest level to identify the core service that will be affected for every potential program cut or expansion.

CHAIR SEATON asked if cuts in funding could eliminate an entire department priority. He asked for further clarification on the categories for priority 1, 2, or 3.

MR. SHERWOOD answered that the slide identified three different priorities, however, they are not prioritized in order so it is not a numbered order of precedence.

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REPRESENTATIVE TARR, referring to slide 13, asked for clarification on whether the age of the children identified on the pie at 59.6 percent is for children up to the 18 years of age.

MS. BRODIE answered that is correct.

REPRESENTATIVE TARR reflected that slide 14 "Medicaid Service Population" showed a category split for children in the ages of [5-12], 13-17, and 18-24.

MS. BRODIE directed attention to slide 15, "Growth in Per-Enrollee Medicaid Spending vs. Other Health Spending," which depicted the annual growth in actual health care expenses from 2007 to 2012. She reported that Medicaid expenditures rose 3.1 percent while private health insurance per enrollee increased by 4.6 percent. She pointed out the graph for Medical Care CPI [Consumer Price Index] at 3.1, but explained a separate index exists for medical care than for everything else.

MS. BRODIE directed attention to slide 16, "Federal Medical Assistance Percentage (FMAP)," and explained that this map depicted the FMAP rates in the Lower 48, with the highest FMAP rates primarily falling in the southern states. She explained that the FMAP rates vary, for example, the Title 19 Medicaid rate receives 50 percent federal match and the Title 21, or CHIP children, receives 65 percent federal match. She also reported women being treated for breast or cervical cancer receive 90 percent federal match, people engaged with family planning activities receive 90 percent federal match, and beneficiaries of Indian Health Service (IHS) who receive their services at an IHS facility, receive 100 percent federal match. She stated that the division continually monitors claims and utilization.

For example, the division reviews assistance for women who had babies in an IHS facility, because according to the federal rules, the state can't claim 100 percent for a non-Native person in an IHS facility. However, she explained, that once the baby is born and begins to receive IHS services, the state can cover the pregnancy under the 100 percent rate for IHS participants. She recapped IHS coverage for mothers, such that the state would receive a 50 percent federal match up until the baby is born, but the department could later reclaim it at 100 percent. She emphasized that the department does attempt to obtain the maximum federal participation.

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MS. BRODIE, in response to Representative Tarr, clarified that the 50 percent figure on slide 16 was for federal match for the basic Title 19 Medicaid recipients. She said the average FMAP federal match typically would be at 63 percent, once blended, but she predicted this rate will continue to rise due to the state's activities.

MS. BRODIE directed attention to slide 17, "Alaska Medicaid Organizational Chart," which showed the composition of the Medicaid program organization. She pointed out that people often think of Medicaid as just one entity; however, the department represents the single entity. She listed positions on the Medicaid organization chart, which included the Commissioner, the Deputy Commissioner for Medicaid and Health Care Policy, and Deputy Commissioner for Family, Community, and Integrated Services. She stated that the Division of Public Assistance, the Division of Health Care Services, and the Division of Senior & Disabilities Services were under the Deputy Commissioner for Medicaid and Health Care Policy. The Adult Preventive Dental program was also under the Division of Health Care Services, she said.

MS. BRODIE explained that the Children's Services Medicaid and Behavioral Health Medicaid were under the Deputy Commissioner for Family, Community, and Integrated Services. She clarified that the Division of Behavioral Health now runs the Children's Services Medicaid program.

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MR. SHERWOOD, in response to Representative Stutes, explained the map on slide 16, such that the colors represented the basic FMAP - federal match rate or share - for Medicaid in each state.

He highlighted that the formula compared per capita income between the states. States with high per capita income would have a low federal match rate whereas states with low per capita income would have a high federal match rate. As previously mentioned, many Southern states, with historically lower incomes have higher federal match rates, while Northeastern states and the Midwest, with historically higher incomes, receive lower federal match rates. Alaska with its high per capita income, has a lower federal match rate; however, no adjustment was made for the cost of living. Therefore, Alaska has almost always been at the floor for the FMAP, he said.

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MS. BRODIE, in response to Representative Stutes, agreed that was what was meant by the "floor." She then directed attention to slide 18 "Alaska Medicaid," and said that the Divisions of Public Assistance and Health Care Services determine the eligibility for every type of Medicaid, while the Division of Health Care Services administers the Medicaid program and pays the claims. She added that the Divisions of Health Care Services, Behavioral Health, and Senior and Disability Services (SDS) Home and Community Based Services are the divisions that provide services by monitoring and licensing entities.

MS. BRODIE directed attention to slide 19, "All Medicaid Direct Services Beneficiaries & Expenditures," which showed the Expenditures and enrollment figures for FY 2014. She indicated that these figure were taken out of the MMIS [Medicaid Management Information System], which identified the dollar amount of the claims. In response to Chair Seaton she identified MMIS as the Medicaid Management Information System, which she stated was the computer system used to pay claims.

MS. BRODIE returned to slide 19, which identified the dollar amount of claims paid and the number of individuals for claims paid in a fiscal year. She reiterated that these figures were taken from the Medicaid Management Information System because in reality the number of Medicaid enrollees increased in 2014.

MS. BRODIE moved on to slide 20 "Allocation Summary 2007 - 2016," which was provided by the Legislative Finance Division and identified the spending by the different divisions. The top pink line depicted health care services, the blue line referred to behavioral health services expenditures, and the bottom line depicted Children's Medicaid Services and adult dental figures.

CHAIR SEATON asked for the reason why the top two lines are showing such a dramatic upturn as compared to the other line.

MS. BRODIE answered that the lines went up dramatically. She identified the lines in question as the amount of general fund expenditures. The state received American Recovery and Reinvestment Act (ARRA) funding, but the state also had enhanced federal funding during that period of time that was lost, after which the line dramatically rose, she said. She pointed out that every line on the graph has leveled off in the last few years.

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REPRESENTATIVE VAZQUEZ asked if the FMAP federal rate hasn't changed, whether a block grant occurred.

MR. SHERWOOD answered that was due to an enhancement in the FMAP federal rate. Although the basic rate was still calculated, the federal government gave all states an add-on rate; however, he said he did not recall the exact percentage states received during the economic recession period. This type of additional funding has happened several times over the course of Medicaid, in which the Congress decided that, due to the general state of the national economy, it would provide an enhancement to the federal matching rate for Medicaid. He further explained that the increase shows up over the course of a few years because the timing of the enhanced rate doesn't coincide perfectly with Alaska's fiscal year. Thus the changes, which occurred mid-year, were worked in over the course of a couple of years.

MS. BRODIE directed attention to slide 21, "General Fund 2006-2015," which she said depicted the total general fund spending from the FY 06-FY 15 Governor's Medicaid formula appropriations.

MS. BRODIE directed attention to slide 22, "Controlling Growth in Medicaid," and pointed out that the last two slides depicted what the department has done in the past few years. She highlighted that the options to control Medicaid costs are limited; however, the state has options, for example, it could change its eligibility criteria or its covered services. She said the state could choose to eliminate coverage for inpatient hospital services, which is not an option, but that issue would be covered later. However, the state could change the rates it pays to providers for services or equipment, or it might decide to implement utilization controls, such that a recipient would be limited to five sessions of a service instead of having

unlimited access to the service. Further, the state could work on its compliance/anti-fraud efforts or it could work to improve innovation in service delivery or try to maximize its revenue.

MS. BRODIE cautioned that although eligibility criteria could be changed, it takes significant time to do so. She highlighted that she and Mr. Sherwood previously worked on the last eligibility change, but it took over a year to get the federal government to agree with the state. She concluded that it is not simple to make a change and it would require significant negotiations and substantial work to accomplish.

CHAIR SEATON asked whether that type of change would include going from 200 percent of poverty level to 175 percent.

MR. SHERWOOD answered that the department has previously done so. He recalled that in 2003, the state reduced eligibility at one time to 150 percent of the poverty level and the standard was frozen, which illustrated an example of reducing eligibility. However, eligibility requirements are complicated, and it can be difficult in some cases to ensure that the state meets its maintenance requirements, although he said he did not wish to go into detail at this time. He suggested that the expansion group would not be subject to any maintenance of effort group so it would be a relatively easy one to change.

MS. BRODIE directed attention to slide 23, "Covered Services," and shared that the state has mandatory and optional services it provides through the Medicaid program, which are outlined on slide 24. Although the state can limit certain benefits, typically those limits merely create cost shifts. For example, drugs are considered an optional service; however, if the state stopped covering pharmacy costs, the burden would shift to another area of Medicaid. Thus, if the state no longer allowed recipients with hypertension to obtain prescriptions, these patients will end up with heart attacks or strokes and in an emergency room, as inpatients. In addition, these patients would need further rehabilitation. In fact, these patients could end up in nursing homes for a period of time, which would be very costly, as opposed to the state paying $30 per month for their medications.

MS. BRODIE turned to another optional service, personal home health care, but pointed out these recipients were already qualified to be in institutions so they would need an institutional level of care. If the state denied them home health care, the state would then need to find nursing home beds

for these individuals. She reminded members that the state did not build its Medicaid program on a nursing home model, but, instead, based it on a home and community-based model. If the state denied optional personal home health care services, she predicted that the state would not have enough institutional beds to meet their needs. She turned to optional therapies, and recalled her earlier scenario in which patients were denied their medications and suffered strokes. She said many stroke patients need speech therapy in order to learn to talk or walk again. She cautioned that if the state does not provide optional Medicaid services, recipients will simply end up in nursing homes or hospitals, which would result in cost shifts, often at higher rates. In response to Chair Seaton, she explained the abbreviations for the therapies, including physical therapy (PT), occupational therapy (OP) and speech language pathology (SLP). She said that the state doesn't have a choice with respect to mandatory services since these services must be provided if the state has a Medicaid program.

CHAIR SEATON asked whether slide 24, "Mandatory VS Optional Services" referred to the services required for every Medicaid program or if these services would be required as part of the state negotiated plan with the federal government.

MS. BRODIE answered that the aforementioned mandatory services are ones required by every Medicaid program in each state and territory.

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MS. BRODIE directed attention to slide 25, "Rates," which she said was one thing other states have closely reviewed. Last year, the CMS [Centers for Medicare and Medicaid Services] mandated that states must raise the rates paid to physicians to at least the level of Medicare. In fact, a number of other states had to raise their rates because they were lower than the Medicare rates; however, Alaska's rates were not lower, she said. She remarked that some states often "play games" with the rates, for example, by freezing them for years. She said that Alaska has experienced several instances when its rates were frozen due to regulations, such that its regulations spoke to a specific date and time and did not allow for any updates. In fact, Alaska currently uses the 2006 rates for durable medical equipment for that very reason, she said. In addition, providers have rights during rate changes and recipients have rights to an appeal process, therefore, litigation often occurs.

At any given point in time, states have active litigation related to rate reductions or the methodology being changed.

MS. BRODIE emphasized that states must receive approval from the Centers for Medicare and Medicaid Services (CMS) for any changes they make. Thus for every Medicaid change, Alaska must prepare a state plan amendment. She emphasized the need to be proactive and seek prior approval in order to avoid accruing three months of expenditures only to find out that the CMS denied the change. She pointed out that CMS considers whether the proposed change would impact access or quality of care for recipients. If such a denial were to occur, the state would be 100 percent responsible for the expenditures.

CHAIR SEATON asked for further clarification that if the proposed change impacts access or quality of care for recipients, it might not be approved.

MR. SHERWOOD stated his agreement. He explained the standard, such that Medicaid services have to be accessible to Medicaid recipients to the same extent those services would be available to the general public. This does not mean the state must pay to ensure that a neurosurgeon would be available in each community, but if the general public has access to the neurosurgeon's services, Alaska's Medicaid recipients must have the same access. He noted that CMS can deny a plan if the state's reduction would adversely impact access to the point that there was a substantial difference in access.

MS. BRODIE shared that the CMS imposes a start/stop time for plan amendments so when the state requests a plan amendment, the CMS starts the clock. In the event the CMS believes the proposed plan change will impact access or quality of care, the agency will send a letter indicating the state has "x" amount of time to resolve the issue; however, it also offers technical assistance to states. She characterized this process as being helpful, since the department might overlook an impact to the quality of care or access.

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MS. BRODIE directed attention to slide 26, "Utilization Controls," and reported that the state manages its costs with utilization controls. Some of these controls consist of computer system edits; for example, if a claim comes in by a 30-year old male for a hysterectomy, the system would edit the

claim for appropriateness. She related her understanding that over 8,000 edits are applied to each claim prior to payment.

REPRESENTATIVE VAZQUEZ asked whether any edits were turned off.

MS. BRODIE answered, yes. In further response to Representative Vazquez she responded that there were about eight edits purposefully turned off.

REPRESENTATIVE VAZQUEZ asked if the MMIS [Medicaid Management Information Systems], now known as the [Alaska Medicaid Health] Enterprise system is broken, as everyone in the provider community is aware that it is, how can the state rely on the information with respect to utilization costs.

MS. BRODIE replied that the [Alaska Medicaid Health] Enterprise [AMHE] system, also known as the MMIS, had vastly improved in the last three months. In fact, the state has been paying 97 percent accurately and correctly the first time, she said. She reported that the department has been working through its backlog of claims that were paid incorrectly, with two more big deployments scheduled to go out in the next two weekends. She said the department hoped this would be the last of payment issues; however, as the department has worked through the defects in the system related to payments, it has found 27 additional defects. She further reported that the department has successfully addressed 22 defects to date and hoped not to discover any additional ones. She concluded by stating that the AMHE has vastly improved.

MS. BRODIE returned to slide 26, "Utilization Controls," and highlighted another control used for cost control was "prior authorization." She stated that recipients must obtain prior authorizations for such items as an extended hospital stay, in which recipients must obtain prior approval for the fourth day and beyond. Patients would also need to obtain prior authorization for other types of care, including long-term care services, travel, and behavioral health services. In addition, these prior authorizations limit eligibility for the number of services recipients can receive.

MS. BRODIE indicated the department conducts post-payment reviews, which includes reviewing medical documents to ensure that the documents support the claims just paid. She noted there are hard or soft edits in the system. One of the edits the department turned off related to behavioral health payments. An issue arose and the department was unable to make significant

health payments. Health insurance was supposed to pay for behavioral health claims but the insurance industry was not reacting well to the [Patient Protection and] Affordable Care Act (ACA) so providers were not being paid. Therefore the department has temporarily turned off the edit that required billing insurance first, followed by Medicaid coverage; instead, with the edit turned off, Medicaid now pays the claims and then bills the insurance providers.

MS. BRODIE turned to another utilization control, new edits and audits for fee-for-service (FFS) [slide 26]. She stated that the National Correct Coding Initiative [NCCI] edits previously pertained to Medicare; however, about two years ago it also applied to Medicaid and the state has mandatory quarterly updates it needs to apply.

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MS. BRODIE directed attention to slide 27, "States that Contract with Managed Care Organizations (MCOs)," which related to a map that indicates the number of states with 100 percent managed care and those without managed care.

REPRESENTATIVE WOOL asked whether population or the number of providers determined those managed care and those without managed care. He related his understanding that Alaska does not have sufficient providers to have a proper managed care system.

MS. BRODIE answered that the type of care varies for each state. Granted, Alaska does not have a large population; however, she said she was unsure whether Alaska could attract big businesses who provide managed care. She indicated that there was not currently any managed care organization in Alaska.

MR. SHERWOOD remarked that typically managed care organizations charge per member per month fees, with an assumption of risk. Thus states must meet a certain population size before entities would be willing to assume the risk. Further, one of the advantages and reasons managed care organizations are willing to take on that risk is that they can negotiate favorable rates. In areas without multiple providers for the same service, these entities often lack a good bargaining position, which may well contribute to the lack of managed care in Alaska; however, he could not attest to that being the only reason these organizations do not operate in Alaska. In response to Chair Seaton, he answered that the managed care organizations would negotiate rates with the direct health care providers, such as

hospitals, pharmacies, and physicians who provide the actual services. Typically these managed care organizations would offer a certain number of providers a contract with a certain rate, he explained.

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REPRESENTATIVE TARR referenced the patient-centered medical home model which the Anchorage Neighborhood Health Center used, and asked whether this was a good alternative for managed care and administration of the continuum of care.

MR. SHERWOOD replied that the department was seriously looking at this as a way to bring "more explicit care management into the system" when it was not possible to access more conventional managed care organizations.

CHAIR SEATON asked whether a community with a community health service would fit under this model, as the services were most often in a regional center or a larger hospital. He asked for more definite parameters for managed care in Alaska.

MR. SHERWOOD shared that he was not a managed care expert. He explained that there were a number of degrees of care management which were included in the area of managed care. He said that the more recent models, community care organizations and accountable care organizations, looked at providing bundled payment for services and allowed for sharing of cost and reward for efficiencies. He noted that the department was reviewing these models, and had had discussions with entities interested in pursuing these models, although these discussions were still in preliminary stages. He declared that most communities in Alaska still needed some services outside their system. He pointed out that this would become a point of negotiation so that the "hard cases" were not just shipped out.

MS. BRODIE acknowledged that there were some patient-centered medical home models, including a pilot program at Providence Alaska Medical Center in Anchorage. She spoke about the managed care operations and their contracts with the state Medicaid agencies for provision of all services for an agreed upon amount per member per month. As neither the managed care operations nor the state had planned for the costs of the very expensive specialty drugs which had come on the market, it had become necessary for re-negotiation of these contracts, with removal of pharmacy coverages because of the specialty drugs.

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MS. BRODIE directed attention to slide 28, "Compliance/Anti-Fraud," and declared that fraud in Medicaid was a reality. She stated that the department had a fraud control unit which worked with the Department of Law and program integrity unit. She shared that the program integrity unit worked from the commissioner's office and worked closely with the Divisions of Behavioral Health, Senior and Disabilities Services, and Health Care Services. She noted that the task force worked on every area of fraud, but that it was "always a politically popular reduction." She acknowledged that she did not have figures for the return of investment for the fraud unit, but stated that it did bring to a stop these fraudulent claims.

REPRESENTATIVE WOOL asked if this was a reference to reimbursement for false claims by providers.

MS. BRODIE replied it could be providers or recipients.

REPRESENTATIVE WOOL asked for an example for recipient fraud.

MS. BRODIE explained that a recipient may not be eligible for Medicaid, as they may not have been honest about their income or their resources. She stated that, in some cases, the recipient could be in collusion with the provider.

REPRESENTATIVE TARR referenced the Medicaid Task Force which was responsible for reviewing this, and asked whether the task force had been responsible for uncovering new ways to identify fraud, or had this been recognized by other means.

MS. BRODIE explained that there was now a coordinated effort across departments and divisions to address fraud, whereas the effort had previously been "in silos."

MR. SHERWOOD explained that there had been systems changes, offering as an example that each attendant in the personal care program was required to enroll as a rendering provider. This collaboration of resources allowed the department to better review claims for work if the department suspected any fraud.

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MS. BRODIE skipped slide 29, and addressed slide 30, "FY 2014 Medicaid Expenditures by Division," which depicted where the money was spent by division. She relayed that Health Care

Services spent 53 percent, Senior and Disabilities Services spent 33 percent, Behavioral Health spent 12 percent, and Adult Dental and the Office of Children's Services Medicaid each spent 1 percent. She clarified that Health Care Services was basic medical care, the in-patient and out-patient hospital care, the physician services, the lab and x-ray services, and any other basic medical service. She explained that Senior and Disabilities Services included home and community based waivers and nursing homes. She noted that Behavioral Health Services covered behavioral health. She explained that the Office of Children's Services Medicaid paid for children in facilities, and that the Adult Preventative Dental had a specific yearly limit for an individual's dental work. She noted that two years of this service, which was the cost of a set of dentures, could be combined in one year, with a subsequent loss of any benefit for the following year.

MR. SHERWOOD reported that this addition was the most recent level of coverage, and he offered his belief that its expansion had brought concern for potential growth in the use of this service. There had been a request for it to have a separate budget structure from the other services.

CHAIR SEATON asked whether the remainder of dental care was included in health care services.

MR. SHERWOOD clarified that all children's dental and any emergency dental, treatment for acute pain and infection that could lead to hospitalization, were included in health care services.

MS. BRODIE moved on to slide 31, "Services Requiring Prior Authorization to Contain Costs," which specifically outlined the services which needed prior authorization. She pointed out that the high cost imaging was for MRIs performed by physicians who owned the MRI machine, as assurance by a third party contractor for medical necessity was required.

4:12:29 PM

REPRESENTATIVE TARR asked what was included by the waiver services for a child with special needs.

MR. SHERWOOD explained that the waiver services were prior authorized as a total service plan for an individual. However, use of another service would not be authorized if it was duplicative. He allowed that this sometimes required more

research to better understand what some services would entail, in order to avoid overlap.

REPRESENTATIVE TARR asked if every waiver established a comprehensive plan that included community support.

MR. SHERWOOD expressed his agreement that a complete picture which identified adequacy with other supports, without duplication, was the goal for a plan of care. He noted that a goal was also to promote independence and integration.

4:16:05 PM

REPRESENTATIVE VAZQUEZ asked which division funded the Tax Equity and Fiscal Responsibility Act (TEFRA) program.

MR. SHERWOOD replied that TEFRA was an eligibility option which did not pay for a specific service. He said that most of the services available to a child on TEFRA would be paid through the Division of Health Care Services, and was typically the primary and acute care services. He allowed that there might be some behavioral health or personal care services through TEFRA eligibility. He declared that this was the Tax Equity and Fiscal Responsibility Act of 198[2], and it included an option to allow eligibility for children to be considered as if they were living in an institution and met that institutional level of care. He explained that parental income and assets did not count for eligibility determination if a child lived in an institution. He offered some background for the act, explaining that some children in institutions and hospitals could not go home because Medicaid paid the bills while in the hospital, but would not offer coverage at home. This special option allowed for coverage of children who met an institutional level of care when they returned home to the care of their parents. He reported that Alaska also covered in-patient psychiatric hospital level of care, and intermediate care facilities for individuals with intellectual disabilities.

MS. BRODIE returned attention to slide 31, noting that certain drugs also required prior authorizations.

CHAIR SEATON asked what types of drugs required the authorization.

MS. BRODIE replied that behavioral drugs and the new specialty drugs were included. She noted that the drug for Hepatitis C cost a lot, but that, as the Medicaid population had a higher

rate than the general population, it was included under certain criteria. One of these criteria included sobriety for six months and stage 3 for fibrosis of the liver. She stated that there had since been negotiation with other drug companies, and the price had been lowered, so the department had redefined the criteria for coverage to include stage 2. She reported that new types of drugs were coming that would also be high cost.

4:20:42 PM

REPRESENTATIVE TARR asked about limitations for certain combinations of drugs for treatment under the Patient Protection and Affordable Care Act, and whether there would be this same impact on Medicaid, in order to deliver the best health outcome possible.

MS. BRODIE replied that the department reviewed these requests on a one by one basis because there were so many new and experimental drugs, as well as new therapies. She added that this was even more typical for children, and that there were fair hearing rights if the initial request was denied.

MR. SHERWOOD added that some of the drug coverage through various insurance plans used tiered pricing and were given a very high co-pay. He noted that, although Medicaid typically restricted the amount of co-pay, the tiered pricing was not the same degree of consideration as the limits on cost sharing He directed attention to the adequacy for the number of drugs in the insurer's formulary.

REPRESENTATIVE TARR asked if there should be more concern for the number of drugs available in the pool to ensure the option for a drug that worked.

MR. SHERWOOD expressed his agreement.

4:23:51 PM

CHAIR SEATON, referencing slide 31, asked if Ms. Brodie had addressed cost containment for behavioral health.

MS. BRODIE explained that all behavioral health services had to have prior authorization, and that their plan of care was similar to that of the Division of Senior and Disabilities Services.

MS. BRODIE addressed slide 32, "Other Savings," and noted that including the rendering providers on claims was an important aspect for the detection of fraud. She reported that, as the behavioral health providers did not list the rendering providers, this next step would be for them to detail the rendering, referring, ordering, and prescribing providers on claims. This information was necessary to better facilitate the detection of fraud.

REPRESENTATIVE WOOL asked for the definition of a rendering provider.

MS. BRODIE explained that this was an individual who provided the services. She offered an example for a PCA (personal care attendant) agency which employed many attendants who provided the services to recipients. She reported that the agency would bill the department for these services, but, in the past, it was unclear who exactly provided the services. She stated that it was now required to list the individuals who provided each service. She pointed out that, currently, the behavioral health providers did not have to list exactly who provided the services to the Medicaid recipients. She offered her belief that, as these recipients were a very vulnerable population, it was necessary for the department to know the service providers and each of their backgrounds in order to ensure the safety of the recipients.

MS. BRODIE continued with slide 32, and allowed that auditing providers was not a popular subject. She shared that steps had recently been taken to help the providers by removing some of the burden, and she explained that the problem in Alaska was that not many of the providers only provided one service, but provided an array of services. She reported that, as a provider could be audited for one specific service, they could subsequently be audited for another service. She shared that current practice was to now audit all the lines of service by a provider. She addressed that another savings would be for partnerships with the tribes to look for efficiencies, as they had a huge health care network.

4:28:19 PM

MS. BRODIE moved on to slide 33, "Additional Savings," and listed that commercial insurance recoupment would save general fund dollars. She reported that the department worked with a company which researched existing insurance policies for every Medicaid recipient, as the custodial parent may not be aware of

these policies. She spoke about the substitution to generic medication, and offered an anecdote for a drug that was soon to be available as a generic, which could save the state millions of dollars. She pointed out that generic medications were required, if available, although this could be overruled for medical necessity.

CHAIR SEATON asked about the percentage of prescriptions which required the brand name.

MS. BRODIE replied that some drugs did not have generic equivalents, and she offered to research the response.

MS. BRODIE returned attention to slide 33, and explained that a negative balance was possible when a provider had made an adjustment to its claim, and the result was that the provider owed money to the department. She said that, as more than 155,000 claims were processed each week, this happened routinely. She explained that every May the department sent an amnesty letter to each provider with a negative balance, offering that each of these providers pay or be subject to an audit. She reported that this letter had a 98 percent success rate. She explained that surveillance and utilization reviews were detailed reviews of claims for patterns of over utilization, offering an example of a drug seeker going from emergency room to emergency room, or to clinics, for medication without a prescription. She shared that, although they were not able to do as many reviews as preferred, the division was mandated for a certain number. She shared that each of the Medicaid agencies had quality assurance sections.

MS. BRODIE discussed slide 34 "Independent Review," and explained the pain management contract which allowed for a nationally certified, independent pain management specialist to review the prescriptions for pain medications to ensure these were the proper medication and the proper dosage for the condition. She allowed that, although many doctors did not like the oversight, there had been a stop to these questionable prescriptions. She explained that the contract for psychotropic medication review for children in Office of Children's Services (OCS), the Division of Juvenile Justice (DJJ) custody, and those on Medicaid, was being rolled out one at a time, beginning with OCS. She shared that there was national concern that children in state custody or on public assistance were being over medicated, and that this review would ensure that this did not happen in Alaska.

4:35:06 PM

MS. BRODIE referred to slide 35, "Future Cost Containment Strategies," and explained that updates to regulations for payment for durable medical equipment were coming, which would allow for the use of used equipment. She noted that there would not be a drastic savings, as some equipment could not be re-used.

REPRESENTATIVE TARR noted that this had been a suggestion from the Key Campaign during its visit to the capital.

MR. SHERWOOD expressed agreement that soon to be released regulations, with a price schedule, would allow for the payment for gently used durable medical equipment. He declared that there would not be any special structure, but it would reimburse providers for used equipment.

MS. BRODIE continued and stated that collecting the patient share of cost for waiver recipients, which maintained their eligibility for Medicaid, had regulation changes beginning July 1, 2015, to now allow the state to collect on a monthly basis, similar to that for the working disabled.

MR. SHERWOOD said that this cost of care obligation applied to people who needed long term care, nursing home care, or home and community based waiver care services. He stated that there were some modest co-pays for other services applied to adults, although the recipients for these long term services were in a special category which required payment of all their income above a certain level toward their cost of care.

MS. BRODIE discussed a project for the acuity rate which would now pay for the service provided. She explained that, regardless of the needs for an individual in an assisted living home, the department currently paid the same rate, which eliminated any incentive for the assisted living home to work with people having higher needs. Under the proposed plan, a person with more needs would receive a higher payment. She opined that this would open up more living assistance for those with higher needs.

MS. BRODIE discussed the automated service plan, a computer system that she declared was working. She explained that this system would "talk directly" to the Medicaid Management Information System (MMIS) system and upload the service

authorizations for individuals, instead of the current manual process.

CHAIR SEATON asked for an explanation to the automated service plan.

MR. SHERWOOD explained that the automated service plan was a computer system that automated the process for evaluation of individuals for long term services and support, such as waivers, nursing homes, and personal care, administered through the Division of Seniors and Disabilities Services. He pointed out that this would put all assessment and care planning into the system, and allow it to be transferred between the providers and the agency for approvals. This data could be transferred to the MMIS system for prior authorizations, and would eliminate the need to manually process the information. He opined that this plan would gain substantial efficiencies, especially as the demand for these covered services had historically been growing, but the number of staff had not increased.

4:42:38 PM

MS. BRODIE explained slide 36, "Expenditures Avoided," and said that the blue was the status quo, and that the brown line reflected health care price inflation. She reminded the committee that health care had its own inflation index, as depicted here. She pointed out that the enrollment and the utilization and intensity of services both added to the cost, although nothing compared to the health care price inflation. She stated that the focus needed to be on this inflation.

MR. SHERWOOD offered his belief that this argued the need to partner with other players to finance health care services, if there was going to be reform. He pointed out that Medicaid alone would not influence the spending, as the department was required to pay enough to ensure adequate access to health care and could not simply freeze or lower its rates in order to compete for provider participation. He allowed that, although the department could hold off raising prices for a period, eventually it would run into an access issue. He declared that it was critical for everyone to reduce health care inflation.

CHAIR SEATON asked about the calculated medical inflation rate used on the chart.

MR. SHERWOOD replied that it was just under 3 percent.

MS. BRODIE directed attention to slide 37, "Expenditures Avoided," which depicted the cost differences from the initiatives already put in place. She noted that the top line reflected what spending would have been with no change, and the bottom line depicted the projected savings through 2033, without including the aforementioned initiatives.

CHAIR SEATON asked if the average annual increase reflected a combination of all the different factors including increased enrollment and medical price inflation.

MS. BRODIE expressed her agreement.

4:47:05 PM

REPRESENTATIVE VAZQUEZ reflected that slide 3 stated that Alaska had 158,853 enrolled in Medicaid in 2014, whereas slide 13 stated a total of 165,783 Medicaid recipients. She asked for an explanation for this discrepancy.

MS. BRODIE explained that this would depend on how the data was pulled. She pointed to slide 3, which stated that Alaska had 158,853 enrollees with 138,300 people using the services, and reported that this information was drawn from the eligibility system. Information on the slide with the bar graph was taken from the MMIS and was based on claims actually paid, although it did not incorporate all the recipients who used services, as some behavior health providers had not yet been paid. She stated that the information from slide 13 was drawn specifically from the numbers reported to the Medicaid budget. She pointed out that these were all drawn from different sources at different points in time.

REPRESENTATIVE VAZQUEZ said that, although she was able to understand the concept for enrolled individuals, slide 13 lead her to believe that these enrollees, now Medicaid recipient beneficiaries, totaled 165,783. She asked if there were 7,000 more recipients than enrollees.

MS. BRODIE explained that there could be duplication to the categories, offering an example of a child being included in one category, and then, after becoming disabled, being included in the second category, as well. She pointed out that an adult could be initially in the adult category, then become part of the adult disabled category, and then also move into the elderly category. She explained that the expenditures for each individual were for that specific category.

REPRESENTATIVE VAZQUEZ asked for an example.

MR. SHERWOOD offered another example. He described a 64 year old who started the year eligible in the disability category, and received services. Then, during the year, this person turned 65 years of age and again received services. This individual would then be included in the elderly category for those services received. He reported that some individuals were also subject to retroactive eligibility determinations, which could be reflected in the data depending on when it was reported. He noted that this could be typically for disabled or for those eligibilities acquired through the Fair Hearing process.

CHAIR SEATON asked for further information.

REPRESENTATIVE VAZQUEZ, addressing Mr. Sherwood, declared that after a family eligibility determination, the children were enrolled individually in Medicaid, and not as a family block. She stated that she did not understand the discrepancy for 7,000 more recipients than enrollees.

4:53:36 PM

REPRESENTATIVE TARR noted that she understood the examples offered by Mr. Sherwood. She asked whether a child eligible for dental services through Denali Kid Care, but not diagnosed for autism spectrum disorder, would have their dental service billed through the general children category, and then have their subsequent early intervention services for autism provided and billed through the disabled children category. She noted that the same child would have then billed through two categories of service.

CHAIR SEATON asked for actual data to support the explanations for discrepancy.

REPRESENTATIVE TARR asked about [indisc.] and whether it was included in the projections. She noted that a goal of the Patient Protection and Affordable Care Act was to decrease this by widening the pool of individuals purchasing health care. She asked if there was a standard amount of reduction, or was it too early to realize any effect from these cost control measures.

MR. SHERWOOD said that he did not have a number he associated with the act and how all the provisions would work together. He

acknowledged that some assumptions were built in when the act was costed out, although these were relative to specific changes to specific government programs. He stated that he did not know if there was a more general estimate.

REPRESENTATIVE STUTES referenced slide 22, which read: "controlling growth in Medicaid," and surmised that this was the opposite of what would happen with Medicaid Expansion. She expressed her concern for how these related.

MS. BRODIE explained that this was about controlling the dollar costs for Medicaid from the general fund.

REPRESENTATIVE VAZQUEZ asked how reimbursement rates were determined for Medicaid doctors.

MR. SHERWOOD explained that the department used the resource based relative value system to determine payment levels, the same system as used by Medicare. This system used a number of different factors for calculation to capture the various costs of practice in delivering a particular service to an individual. He reported that these factors were multiplied together, and that Alaska used a basic Medicare formula with an adjuster, a multiplier which increased the Medicare rate by about 30 percent. He offered to provide more explicit information for specifics to the formula.

REPRESENTATIVE VAZQUEZ asked if this formula was used for other providers.

MR. SHERWOOD said that the rate for facilities, hospitals, and nursing homes was based on the cost of doing business, established from the cost reports submitted by each. The department would then calculate rates using an inflation factor, and then re-base every four years based on the cost reports. He reported that for other services the department used a collection of historical methods, which included studies for cost or price that fixed a rate which may or may not have included an inflation factor. He said that most of the behavioral health rates were not regularly inflated, although other rates were inflated. He said that the same methodology used for physicians was used for similar practitioners, including physician assistants, advanced nurse practitioners, and community health aides. He reported that facilities in the tribal health system were paid at a federally established encounter rate that was done in conjunction between Indian Health Service and the Centers for Medicare and Medicaid

Services. He stated that for pharmacies the department used a formula for both a dispensing fee and a national cost of acquisition.

CHAIR SEATON, referencing the pharmaceuticals, asked if there was anything in statute to prevent negotiation of lower prices for drug purchases.

MR. SHERWOOD replied that a federal statute required that drug manufacturers provide rebates to Medicaid agencies. He said that this statute also dictated how much of the rebate went to the federal government and how much to the state. He pointed out that states were allowed to negotiate supplemental rebates, although recent changes in federal law to mandatory rebates diminished the opportunity for many supplemental rebates.

CHAIR SEATON asked that the department notify the committee if there were any statutory roadblocks for lowering costs.

5:02:24 PM

REPRESENTATIVE VAZQUEZ asked about the recommendations from an audit on the Department of Health and Social Services issued by the Division of Legislative Audit in 2014.

MR. SHERWOOD replied that he was generally familiar with this, and that there were recommendations every year, with some repeat recommendations when the department was still in progress for resolution to these. He asked if Representative Vazquez had any specifics, noting that he did not recollect all the recommendations related to Medicaid in 2014.

CHAIR SEATON asked if Representative Vazquez was referencing the initial required performance audit.

MR. SHERWOOD explained that there was the Statewide Single Audit each year which audited all programs receiving federal funds, including Medicaid, and that the Department of Health and Social Services was also currently involved in the process of the performance audit, which was not yet complete.

CHAIR SEATON acknowledged that the performance audit of the Department of Health and Social Services was the first of the audits to all the departments.

REPRESENTATIVE TARR reported that the Department of Corrections had been the first of these performance audits.

REPRESENTATIVE VAZQUEZ declared that "legislative audits have been done for years and I'm interested in the latest legislative audit, the recommendations, and what specific steps the department is taking to implement those recommendations."

MR. SHERWOOD said they would provide the information.

REPRESENTATIVE TARR suggested that it would be helpful to understand the unexpected outcome if the rates were too low, as an increase of rates can be beneficial to the state by adding federal dollars to defer the cost, and then realizing a cost savings.

5:06:07 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:06 p.m.