ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 24, 2015
3:03 p.m.

MEMBERS PRESENT

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

MEMBERS ABSENT

Representative Neal Foster
Representative Adam Wool

COMMITTEE CALENDAR

CONFIRMATION HEARING(S):

Department of Health and Social Services, Commissioner

Valerie Davidson - Juneau

- CONFIRMATION(S) ADVANCED

Alaska State Medical Board

Dr. Steven Craig Humphreys - Soldotna

- CONFIRMATION(S) ADVANCED

HOUSE BILL NO. 148
"An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 148

SHORT TITLE: MEDICAL ASSISTANCE COVERAGE; REFORM
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

03/18/15	(H)	READ THE FIRST TIME - REFERRALS
03/18/15	(H)	HSS, FIN
03/24/15	(H)	HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

VALERIE DAVIDSON, Commissioner Designee
Office of the Commissioner
Department of Health & Social Services
Juneau, Alaska
POSITION STATEMENT: As appointee to Commissioner, Department of Health and Social Services, discussed her background and answered questions.

STEVEN CRAIG HUMPHREYS, MD
Soldotna, Alaska
POSITION STATEMENT: As an appointee to the State Medical Board, discussed his background and answered questions.

VALERIE DAVIDSON, Commissioner Designee
Office of the Commissioner
Department of Health & Social Services
Juneau, Alaska
POSITION STATEMENT: Presented an overview in support of HB 148.

JON SHERWOOD, Deputy Commissioner
Office of the Commissioner
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Presented a section analysis of HB 148.

ACTION NARRATIVE

3:03:16 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Stutes, Talerico, Tarr, Vazquez, and Seaton were present at the call to order. Representatives Wool, and Foster arrived as the meeting was in progress.

CONFIRMATION HEARING(S):

3:03:41 PM

CHAIR SEATON announced that the first order of business would be confirmation hearings for the Department of Health and Social Services, Commissioner, and the Alaska State Medical Board.

Department of Health and Social Services, Commissioner

3:06:59 PM

VALERIE DAVIDSON, Commissioner Designee, Office of the Commissioner, Department of Health and Social Services (DHSS), introduced herself and discussed her background and her family background. She shared that she had been born in Bethel, and that her father had followed Yupik tradition and moved to his wife's home village after their marriage. She relayed that she had been in the Head Start early childhood education program in Aniak. She offered anecdotes of the many members of her family and her village who worked in the health industry. She reported that she had started college at University of Alaska Fairbanks, and then, when she transferred to University of Alaska Southeast, she also worked as staff in the Alaska State Legislature. She shared her experiences as a teacher in Juneau, and subsequently as a Head Start teacher in Klawock. Her three years of post-graduate studies were in Albuquerque at the University of New Mexico, the only time she had ever lived out of Alaska. She returned to Alaska and initially worked for her regional corporation, before moving back to Bethel and working for the Yukon-Kuskokwim Health Corporation, first as general counsel, and then as executive vice president. After 7 years, she began work with the Alaska Native Tribal Health Consortium (ANTHC) in Anchorage, where she worked for 8 years. She acknowledged that the position as commissioner of DHSS was a "really big job, this is a really complicated department, and [she] certainly did not anticipate that we were going to be in this challenging budget time." She stated that she had never shied away from hard work, and she shared a household rule espoused by her mother, "there is no such thing as can't." She declared that "anything is possible if you work hard enough, if you own the problem, if you're honest about where those problems are, and if you commit to being able to get them done." She noted that her passions included health care, and her priorities for the department included an expansion of coverage and access for Alaskans, as well as reform of the Medicaid program. She expressed recognition that the current Medicaid program was not sustainable. She addressed child welfare issues, noting that Alaska had a record number, almost 2500 children, in out-of-home placements. She relayed that the third priority for the

department was to improve state relationships with tribes and the federal government. She declared that neither tribes, nor the state, nor the federal government can solve the problems on their own, and that even two out of the three were not enough to solve the problems. She pointed out that all three needed to better work together to move the efforts for improvement to health, child welfare, and other issues forward. She declared that this needed to be a priority to get the necessary attention. She referenced the priorities for health improvements that she had discussed previously with the committee.

3:18:16 PM

REPRESENTATIVE VAZQUEZ asked about the largest budget for which Commissioner Davidson had been responsible.

COMMISSIONER DAVIDSON, in response, said that this depended on the method of calculation, and relayed that, as executive vice president, she had been responsible for the Yukon-Kuskokwim Health Corporation when the CEO was not available, as well as direction of the technology and other departments. She noted that the budget for Yukon-Kuskokwim Health Corporation at that time had been about $135 million. She relayed that her responsibility at the Alaska Native Tribal Health Consortium had been for legal and intergovernmental affairs, which had a smaller budget. She explained that she had also served as the co-lead negotiator for the Alaska Tribal Health Compact, a group representing about 7,000 employees with contributions of almost $2 billion into the economy of the state. She relayed that she was proud to be a village girl, as it was necessary to work together with others to survive in a rural community. She pointed to the breadth of collaboration in tribal health, as in many parts of Alaska, tribal health [Indian Health Services] was the only provider in the community. She pointed out that other states had elaborate investments in infrastructure and county health systems, whereas Alaska did not have any county health systems, possibly because tribal health, in partnership with the federal government, had built that infrastructure. She relayed that the tribal health system had negotiated an agreement to extend additional services in rural communities to veterans, as previously it had been necessary for veterans to fly to Anchorage for assessment and determination for eligibility of services. Often, this necessitated many return trips to Anchorage. She declared that this was challenging for both the veteran and their family, as often the family was receiving care through the local [tribal health] clinic. She declared that

veterans living in rural communities could now receive care at the tribal health clinic, regardless of whether they were Alaska Native, and the clinic would be reimbursed for those services. She reported that the tribal health system was only funded at 50 percent of the funding needed to provide basic health care services. She stated that, as those funding limitations required innovation, programs such as the community health aide were developed. She pointed out that the tribal health system leads the state for on-time immunizations for children. She listed behavioral health aide and dental health aide programs as other innovative means to provide services with a limited amount of resources.

COMMISSIONER DAVIDSON stated that the U. S. Congress recognized that the federal government had a trust responsibility to Indian Health Service (IHS) beneficiaries, and that IHS was the payer of last resort.

3:26:16 PM

REPRESENTATIVE FOSTER noted that, as there were 35 villages in his district, there was a goal for the funding of new or remodeled village clinics, with training to locals in the health care industry. He asked what had been her most meaningful addition to rural health care.

COMMISSIONER DAVIDSON replied that all the prior DHSS commissioners had brought different strengths and backgrounds to the position, and her background and strength was with tribal health. She shared that under previous commissioners there had been improvements in behavioral health, in social work, and in health care delivery models. With her background in tribal health, she declared that she would like to move forward with health clinics and adequate sanitation facilities, pointing out that this was all connected in small communities. She reminded the committee that infants in communities without adequate sanitation facilities were 11 times more likely to be hospitalized for respiratory infections, and 5 times more likely to be hospitalized for skin infections, based on studies of villages in Southwest Alaska by the Centers for Disease Control and Prevention (CDC) and Alaska Native Tribal Health Consortium (ANTHC). She related that these babies were sick enough to be medevacked to a hospital for these infections. She stated that one out of every three babies in a community without adequate sanitation facilities will be in the hospital sometime during the year. She offered an anecdote of a preventable disease that was particularly deadly for infants and the elderly and was very

expensive for the state. She stated that the tribal health system had done a remarkable job of bringing employment to the small communities, noting that the dental health aide therapy program was a mid-level dental provider authorized in more than 50 other countries. The United States was the only industrialized country that did not have mid-level dental practice as a part of its standard oral health practice. She lauded the efforts of the Southeast Alaska Regional Health Consortium to develop and introduce this additional health care delivery system to Alaska. She reported that ANTHC had started a training program, as well, and she explained the depth of the training.

3:33:38 PM

COMMISSIONER DAVIDSON relayed that there were currently more than 25 certified dental health aide therapists practicing in rural communities, and they provided oral health services, from cavities to simple extractions. She noted that they were limited to services within the scope of their practice. She declared that these were jobs in rural communities that would not have been there without this innovation from the tribal health system, and she stated that there was now the opportunity to do even more of this. She acknowledged the opportunities to provide home and community based services that were not routinely available in small communities. She noted that the department was working with the Division of Senior and Disabilities Services and tribal health to review the concept for a universal worker in order to extend home and community based services to the rural communities, so that people would not have to move to a larger community to get the needed care.

3:35:23 PM

REPRESENTATIVE VAZQUEZ repeated her earlier question to Commissioner Davidson regarding the largest budget for which she had personal responsibility.

COMMISSIONER DAVIDSON replied that she had been directly responsible for the $50 million budget with the Yukon Kuskokwim Health Corporation, with an additional $25 million budget for the expanded tele-health services system.

3:36:31 PM

REPRESENTATIVE VAZQUEZ asked about the largest number of employees Commissioner Davidson had directly supervised.

COMMISSIONER DAVIDSON replied that this was about 75 employees at the Yukon Kuskokwim Health Corporation.

3:37:03 PM

REPRESENTATIVE VAZQUEZ asked about the commissioner's experience in the private health arena.

COMMISSIONER DAVIDSON replied that, although she had not worked directly for a private health provider, she had worked in partnership with many private health providers during her time with tribal health. She offered examples for groups with whom she had worked, and directed attention to contract health services purchased from private providers. She reported that she had served for 10 years as the chair of the National Tribal Technical Advisory group to the Centers for Medicare and Medicaid Services (CMS), providing guidance and direction to CMS for provisions of policies applied to tribal health, Indian health systems, individual American Indians and Alaska Natives, and urban Indian health programs. She stated that there were possible implications that could be devastating for Indian Health Service beneficiaries. She detailed her service on the U. S. Medicaid Commission.

3:40:58 PM

REPRESENTATIVE VAZQUEZ repeated her question regarding full time employment in a non-tribal, non-Native health organization.

COMMISSIONER DAVIDSON pointed out that this was the first thing she had said in her response.

3:41:36 PM

REPRESENTATIVE TALERICO acknowledged that there were high health care costs in Alaska, especially for the specialty services, and he asked whether there were things the department could do to bring some of these costs under control.

COMMISSIONER DAVIDSON noted that, as the state population was small especially compared to other states and health care markets, and that travel would always be an issue given the state geography, there would always be a challenge for the cost of specialists. She noted that DHSS had a role with regard to Medicaid, but that there were opportunities with other departments, as well, including the Department of Administration

- a large purchaser of health care services in Alaska. She shared that uncompensated care and payment reform must be a part of the path forward. She reported that budget challenges in Alaska recognized the need for a balance between ensuring that providers were paid at a sustainable rate which allowed them to continue to provide services, while addressing the reality of the budget pressures. She offered her belief that one of the challenges was that everyone had an idea for reform, and that change had to happen. In terms of budget and health care policy, she shared that this was not the first time that Alaskans had tough challenges. She declared that Alaska did best when everyone comes to the table and has a conversation together to arrive at a solution that mostly worked for everyone. She compared this to tribal politics, and how it could get rough very quickly. She pointed out how difficult it was to get the 229 Alaska tribes to agree, stating that this was not an easy task. She stated that it was necessary for everyone to put ideas on the table, then have the disagreements with refreshing honesty, ensuring that everyone understands the implications of the decisions. She acknowledged that some disagreements could take several long days to work through, but that it took a commitment to reach resolution. She declared that this was her biggest strength, the ability to bring people together for conversations about moving forward, and to remain open to listening to the ideas of others.

3:49:10 PM

REPRESENTATIVE STUTES asked whether Commissioner Davidson was comfortable with the idea of moving forward with Medicaid expansion with the possibility of cancelling the program a year down the road.

COMMISSIONER DAVIDSON expressed her agreement that she was an advocate of Medicaid expansion, and that she also recognized that health care and health reform was an evolving process. She pointed out that health reform did not start and stop on one day, but that it happens over time. She clarified that DHSS had explicitly asked for clarification that Alaska could choose to withdraw from participation in Medicaid expansion at any time. She indicated the letter to Governor Walker which stated that Alaska could choose to withdraw from participation if the federal match was below 90 percent, there was standard waiver language which required a transition after withdrawal, and there was not any penalty for choosing to discontinue participation in Medicaid.

REPRESENTATIVE VAZQUEZ said that she had specific questions with regard to the aforementioned letter.

3:52:58 PM

REPRESENTATIVE TALERICO referenced a proposed bill for the reuse of durable medical equipment by Medicaid recipients. He asked whether it was preferable for this to be in statute or regulation.

COMMISSIONER DAVIDSON replied that DHSS supported the re-use of durable medical equipment after it had been properly treated and sterilized. She offered her belief that mandatory re-use may require that this be statutory.

3:53:49 PM

REPRESENTATIVE TARR asked for her vision of Department of Health and Social Services in four years.

COMMISSIONER DAVIDSON shared that DHSS had made significant improvements for expanded health care coverage to Alaskans who need access to care, while also bending the cost curve for Medicaid, as its $700 million general fund budget could offer the biggest opportunity for savings. She shared that DHSS could utilize some reform opportunities to bend the cost curve to realize savings without impacting individuals and maintaining care for vulnerable Alaskans. She referenced her work on the U. S. Department of Justice Advisory Committee on American Indian and Alaska Native Children Exposed to Violence. She reported that, although Alaska Native children comprised about 20 percent of the state population, they were about 62 percent of the children in out-of-home placements, a disproportionality that was a problem. She expressed her enthusiasm for working with tribal organizations and the federal government to change this dynamic, reflecting on a recent meeting with stakeholders to plan a future session for changing this dynamic and making it easier for families to access the court system and keep children within the extended family. She offered her belief that extended families should be offered the opportunity to "keep kids safe at the community level" and provide care close to home in a culturally appropriate setting. She declared that this would lead to better outcomes.

3:58:14 PM

REPRESENTATIVE TARR opined that there was a goal for prevention efforts to transition away from crisis intervention, and asked for suggestions for accomplishment of this goal.

COMMISSIONER DAVIDSON replied that it was not possible to improve on health care, child welfare, and Medicaid if there was not a focus on prevention and wellness activities. She reflected on the question that was never asked when visiting the doctor, which was "what is it about your health that you would like to improve this year, and how can we work together to help you get there." She declared that this could be the most important question. She suggested the health care delivery system needed to be redesigned to put prevention, wellness, and partnerships with families and individuals at the front of the conversation. She declared that this was not an easy task, and that the changes necessitated by the decreasing budget allowed a bold approach to do things differently, as the current systems were not sustainable. She acknowledged that many of the changes began in the previous administrations and were building upon that good work. She declared that "people can do the most amazing things under the most impossible conditions for the right reasons." She acknowledged her experiences that children and families were always the right reasons, especially for improving the health of families and the safety of communities, while focusing on wellness and prevention. She encouraged people to become partners in the improvement of their health and their position, even though it may not be easy.

4:02:28 PM

REPRESENTATIVE VAZQUEZ referenced a March 6 letter received from The [U. S.] Secretary of Health and Human Services, Sylvia M. Burwell [Included in members' packets]. She directed attention to the third line of the third paragraph, which stated: "We generally encourage states that eliminate any coverage category elected at state option to plan for a smooth transition process for phasing out that coverage. For that reason, states' 1115 demonstrations included a standard phase out term and condition." She asked what specifically about this standard phase out term and condition.

COMMISSIONER DAVIDSON replied that although she was familiar with this, she did not have one to share with the committee. She said that these phase out provisions were common in health coverage, including Medicaid and employer sponsored health plans. She declared that part of being a responsible health care provider was to ensure the people covered were aware of

what to expect and had a reasonable amount of time to allow planning for a different level of coverage.

4:04:26 PM

REPRESENTATIVE WOOL asked for an example of any other main problem in the department, and further asked whether there was a workable solution. He inquired as to what the department was doing really well.

COMMISSIONER DAVIDSON acknowledged that there were some systems challenges, and that two computer systems were in transition. She listed the conversion of the old eligibility information system which would now do Medicaid enrollments with the modified adjusted gross income (MAGI) standard, and was running about one year behind schedule. She noted that there were some backlogs in eligibility determinations for the Division of Public Assistance. She declared that DHSS had been very honest and up-front about these problems, and she lauded the current governor's commitment to transparency. She reflected on her mother's statement: "you can't solve the problem if you don't own it and recognize that it's your problem." She pointed to the additional challenges with the Medicaid Management Information System (MMIS), a payment system replacing another old system, which had also been delayed for quite some time. She reported that many providers were not getting paid, and that department staff were working "around the clock to make sure that providers could be paid." She noted that there had been advance payments to the larger providers to ensure continuance of services. She stated that this MMIS contract was with Xerox, which had made significant improvements for the timely and accurate payment to the new claims. She noted that there were, however, many challenges with a significant number of pending claims filed prior to those improvements. She declared that she would not blame this on the federal government or anyone else, that she and the department would own the problem in order to move forward. She offered her belief that, as much as she loved the commitment to transparency, it did come with a few drawbacks. She declared that, with transparency, people knew your problems. She showcased the highlights from the Division of Juvenile Justice, including its reduction of recidivism and its work with kids and the communities. She shared that the division was also teaching families how to avoid this unhealthy behavior going forward. She noted that there were also opportunities for improvement with over utilizers of the emergency departments.

4:11:20 PM

REPRESENTATIVE VAZQUEZ moved to advance the confirmation of Valerie Davidson, appointee as commissioner, Department of Health and Social Services, to a joint session of the House and Senate for consideration. She noted that each member's signature on the committee's report in no way reflects the member's vote during the joint floor session. There being no objection, the confirmation was advanced.

4:11:48 PM

The committee took an at-ease from 4:11 p.m. to 4:14 p.m.

Alaska State Medical Board

4:14:16 PM

CHAIR SEATON announced that the next order of business would be the confirmation hearing for Dr. Steven Humphreys.

4:14:48 PM

STEVEN CRAIG HUMPHREYS, MD, shared his background growing up in Alaska and practicing medicine outside of the state. He reported that he had returned to Alaska with his spinal practice about five years prior, declaring how glad he was "to be home." He offered his reason for applying to be an appointee to the board, as he had a lot of interaction with surgery centers and hospitals, was involvement with parts of the community that were underserved. He relayed that he had been exposed to underserved populations since he was young, as his mother was a teacher. He said that the combination of being the son of a teacher, his work as a medical director, and his return to Alaska led him to want to give more back, particularly to underserved areas. He suggested that his insights as an Alaskan would be helpful in making changes in people's lives.

4:18:07 PM

CHAIR SEATON noted that his numerous research publications for technical spine surgery and alternatives were impressive.

REPRESENTATIVE VAZQUEZ asked Dr. Humphreys about his postgraduate training, pointing to discrepancies in the dates.

DR. HUMPHREYS offered his belief that he had made a typographical error.

REPRESENTATIVE VAZQUEZ asked whether there were typographical errors for some of the other listings.

DR. HUMPHREYS offered the correct dates, describing his five years at Notre Dame, with four years of medical training and a subsequent internship year.

4:21:43 PM

REPRESENTATIVE FOSTER asked about his work on the Alaska Pipeline, pointing to the possible typographic errors for those dates, as well.

DR. HUMPHREYS shared that, during the pipeline construction, he was a "glorified go-fer" at the sea water injection facility for ARCO through an employment company.

4:23:16 PM

REPRESENTATIVE FOSTER, noting that Dr. Humphreys had worked at Kenai Spine in Alaska for the last four years, asked about his understanding for the state issues in the healthcare industry, both urban and rural.

DR. HUMPHREYS replied that growing up in Alaska gave him some insights, noting that there was a certain level of trust when people knew you. He shared an anecdote about people calling him for medical advice. He stated that he had an idea of the organization of health care in the state from talking with people at various hospitals. He opined that organization could be improved, and offered an example of the development of a phone app to help with his practice. He noted that better access to health care was also an issue that should be addressed. He expressed his interest in learning more.

REPRESENTATIVE VAZQUEZ asked Dr. Humphreys about the distinction between his professional experiences versus clinical appointments on his resume.

DR. HUMPHREYS said that he could have combined those.

REPRESENTATIVE VAZQUEZ asked whether Dr. Humphreys ever had a complaint filed against him through a state medical board or a disciplinary board.

DR. HUMPHREYS said that he had one complaint which had been dropped very quickly, although he could not remember exactly what it concerned. He stated that none had been substantiated.

REPRESENTATIVE VAZQUEZ asked about the subject matter of that complaint.

DR. HUMPHREYS offered his belief that it was not major, and that it may have been about a follow up appointment being cancelled.

4:30:02 PM

REPRESENTATIVE VAZQUEZ moved to advance the confirmation of Dr. Steven Craig Humphreys, appointee to the Alaska State Medical Board, to a joint session of the House and Senate for consideration. She noted that each member's signature on the committee's report in no way reflects the member's vote during the joint floor session. There being no objection, the confirmation was advanced.

4:30:54 PM

The committee took a brief at-ease.

HB 148-MEDICAL ASSISTANCE COVERAGE; REFORM

4:32:46 PM

CHAIR SEATON announced that the final order of business would be HOUSE BILL NO. 148, "An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

4:33:36 PM

VALERIE DAVIDSON, Commissioner Designee, Office of the Commissioner, Department of Health & Social Services, said the bill provided for health care reform in the Medicaid Program, and improved the health of Alaskans by extending health care coverage through Medicaid expansion for up to 42,000 Alaskans who were eligible. She noted that the bill also identifies savings through the fiscal notes identified earlier by recognizing savings opportunities that can be transitioned to Medicaid simply because the federal government will be paying

that portion. She further noted that it infuses approximately $1.1 billion in federal resources into the Alaska economy for the initial five - six years. She explained that HB 148 improves health coverage through expansion, and covers individuals with incomes up to 138 percent of the federal poverty level. She remarked that technically it is 133 percent plus a 5 percent disregard. She related that eligible individuals are single adults with annual incomes of up to $20,314 per year, with an approximate hourly earnings of $9.76 per hour based upon a 40-hour work week. She offered that a married couple earning a combined income of approximately $27,490 per year, or a combined hourly income of $13.21 per hour based upon a 40-hour work week [is eligible]. It would extend coverage to Alaskans between the ages of 19 - 64 who do not qualify for any other reason, such as, a disabling condition. She said that although approximately 42,000 Alaskans would be eligible for the expansion, only about 20,000 would actually sign up in the first year - increasing to approximately 26,000 by the year 2021.

4:36:36 PM

COMMISSIONER DAVIDSON continued her overview and pointed out that the study performed by Evergreen Economics showed that approximately 44 percent of the people in the expansion population have jobs, another 29 percent are collecting unemployment which means they are actively seeking work. In terms of the federal match, she explained, under the Patient Protection and Affordable Care Act the match is 100 percent for the initial three hard calendar years, 2014 - 2016. The federal contribution match in 2016 equals 100 percent federal match, 2017 equals 95 percent, 2018 equals 94 percent, 2019 equals 93 percent, and 2020 equals 90 percent, with the match remaining constant at 90 percent after 2020. She stated that this compares to the regular Medicaid Program which is matched at approximately 50 percent, although there is a higher match available for children. In terms of projection of the average per enrollee cost of Medicaid, Evergreen Economics, which has performed Medicaid analysis for Alaska for almost a decade, estimates that the average cost per enrollee will start at approximately $7,250, and increase over time. She remarked that new federal revenue in year one was expected to be $141 million, increasing to $204.9 million in the year 2021, a total of $1 billion in new federal revenue in Alaska. She conveyed that some savings have been identified which include savings that DHSS currently pays for services. For example, she related, the Department of Corrections services provided for inmates who are

out of the facility for an overnight stay are eligible for coverage. Additionally, in 2016 there is approximately $1 million in savings for Chronic and Acute Medical Assistance programs or CAMA programs, and approximately $1.5 million in behavioral health grants. Additionally, she related, the bill is clear that there is a provision making Alaska's continued participation in Medicaid expansion contingent on the federal match remaining at or above 90 percent. She further related that the bill also directs the Department of Health & Social Services (DHSS) to submit to the legislature no later than January 25, 2016, a proposal to authorize a provider tax to offset some of the costs of the Medicaid Program. She pointed out that another equally important portion of the bill is Medicaid reform, a process that evolves over time by building upon the reform efforts already undertaken by DHSS. She advised this includes maximizing the existing 100 percent federal match opportunities by working with tribal partners to increase the IHS trust fund beneficiaries who receive services from tribal providers who are also Medicaid beneficiaries. She said that when three things come together, IHS beneficiary, Medicaid beneficiary, and receiving care in an IHS facility, it is 100 percent federally matched. She expressed that this was true before Medicaid expansion, during expansion, and after Medicaid expansion. Essentially, she pointed out, there are opportunities to leverage those federal funds.

4:41:26 PM

COMMISSIONER DAVIDSON stated that additional reforms include 1915(i) and 1915(k) options to take advantage of additional Federal Medical Assistance Percentage (FMAP) opportunities. DHSS would use the 1915(i) option to serve Alaskans who do not meet the nursing level of care, but meet other criteria. For example, she expressed, they may have Alzheimer's related diseases, traumatic brain injury, or severe mental illness. She described this as a savings increasing to the 50 percent match by the regular Medicaid Program. She indicated that DHSS anticipates the reforms to be in regular Medicaid, as well as the expansion population. Currently, DHSS serves people with Alzheimer's disease, traumatic brain injury, or severe mental illness, with 100 percent state general funds, but by moving them to a 1915(i) option, DHSS would increase the federal match from zero percent to fifty percent. She conveyed that the other option is a 1915(k) option to replace existing home and community based services, a waiver services, which increases the match from 50 to 56 percent. In terms of other reform opportunities, she pointed out that DHSS also included

demonstration project authority to review payment reform, whether those are bundling payments or innovative service delivery models, to allow DHSS to have explicit, express broad authority that allows pursuing other opportunities as they arise, and recognizing that reform is a process. She reiterated that reform is a process that needs broad authority to take advantage of things as they arise. She opined that there are incredible opportunities for tele-health, especially in Alaska with its large geography and small population. She remarked that, as DHSS and the federal government have audit requirements, providers are seeing a doubling up of audits and spending a lot of time on administration rather than being able to provide programs and services. She advised that those audits should be streamlined to better coordinate both state and federal requirements.

4:45:16 PM

COMMISSIONER DAVIDSON continued her overview and noted that a critical piece of the legislation would allow emergency regulation authority to implement savings opportunities quickly. Currently, a Request for Proposal (RFP) recently closed, requesting that a contractor review opportunities for reform in Alaska, and ways to change the way Medicaid and health care is provided. She said those opportunities will allow the state to move forward, evaluating what other states have done, evaluating how they might work in Alaska, and developing a plan to work with stakeholders so that the process is transparent. She pointed out that there is a link between the broad demonstration project authority and the RFP, acknowledging that DHSS does not have all of the best ideas and that some of those may come from this process.

4:47:09 PM

JON SHERWOOD, Deputy Commissioner, Office of the Commissioner, Department of Health & Social Services (DHSS), said that in addition to the provisions regarding expansion and reform, the Department of Health & Social Services (DHSS) is also making technical amendments to the statute in order to bring it into conformity with federal law. He said it is the department's intention to make clear the standard under which it is operating.

4:48:07 PM

CHAIR SEATON asked that Mr. Sherwood point out sections where there are changes to conform to the law and not a proposed expansion reform.

4:48:38 PM

MR. SHERWOOD responded yes, and offered a sectional analysis as follows [original punctuation provided]:

> Sectional Analysis:
>
> Section 1 Adopts intent language and legislative findings related to Medicaid expansion and the need to reform the existing Medicaid program, including instructing the Department of Health and Social Services (DHSS) to propose legislation to implement a provider tax in January 2016, to help offset the cost of the Medicaid program.
>
> Section 2 Amends AS 44.23.075 to exclude the expansion population from the current Permanent Fund Hold Harmless program.
>
> Section 3 Amends AS 47.05.200(a) to clarify the minimum number of audits that DHSS should conduct each year, along with instructions that DHSS, should to the extent possible, minimize duplicative state and federal audits for Medicaid providers.
>
> Section 4 Amends AS 47.05.200(b) to allow DHSS to impose interest penalties on identified overpayments using the post judgment statutory rate.
>
> Section 5 Adopts AS 47.05.250 that authorizes DHSS to develop provider fines though regulation for violations of AS 47.05, AS 47.07 or regulations adopted under those chapters.
>
> Section 6 Amends AS 47.07.020(b) including technical corrections related to eligibility for Medicaid authorized under the Affordable Care Act. This section also provides the authority for DHSS to expand Medicaid to adults aged 19-64 who are not caring for dependent children, are not disabled or pregnant, and who earn at or below 138 percent of the federal poverty guidelines for Alaska including the 5 percent income disregard.

Section 7 and 8 Amends AS 47.07.020(g) and (m) to clarify when DHSS may impose transfer of asset penalties when determining eligibility for Medicaid.

Section 9 and 10 Amends AS 47.07.036(b) and adds AS 47.07.036(d) to outline cost containment and reform measures that DHSS must undertake, including seeking demonstration waivers, applying for other options under the Medicaid Act and improving telemedicine for Medicaid recipients.

Section 11 and 12 Amends AS 47.07.900(4) and (17) to remove the requirement that behavioral health providers be a grantee of the state of Alaska in order to bill Medicaid.

Section 13 Instructs DHSS to amend any state plan it has with the federal government to be consistent with this Act.

Section 14 Authorizes DHSS to engage in emergency rule making under the Alaska Administrative Code to implement Medicaid reform measures and the provisions of this Act.

Section 15 Instruct the Revisor of Statutes to make technical amendments to the title of AS 47.07.036 to conform to amendments in this Act.

Section 16 Provides that Section 13 and 14 are effective immediately

Section 17 Provides that Section 1- 12 and 15 of the Act are effective on July 1, 2015.

4:48:40 PM

MR. SHERWOOD said Section 1 is the findings and intent language around the bill expansion and reform which includes the provision instructing DHSS to propose legislation for a provider tax by next session. He noted that Section 2 is the first of the technical amendments to reflect or accommodate changes in federal law. The provision amends the hold harmless provisions in statute for treatment of receipt of the Permanent Fund Dividend. He remarked that within the Patient Protection and Affordable Care Act states were required in their Medicaid

Programs to change the way they determined income for children, pregnant women, and parent caretaker relatives to tax based rules for income. As a result, DHSS now counts income using a modified adjusted gross income (MAGI). He pointed out that this differs from previously as it tends to look more toward annual income and does not allow income disregards. He pointed out that in adding the expansion group there was no easy way to reconcile these MAGI-based Methodology rules with the hold harmless statute. Previously, he said, the Permanent Fund Dividend (PFD) was always counted as income under a monthly receipt, whereas, under MAGI it is annualized. The statute does not provide for that kind of situation. He remarked that once the PFD is annualized it becomes a very small amount of monthly income as the check is divided by 12. He said that there would be individuals slightly over income for the expansion group, but these individuals would have the federal market available to obtain substantially subsidized health insurance. He reiterated that, in these cases, the individual would go from Medicaid coverage to a substantially subsidized federal coverage. The decision was made to exempt this group from the hold harmless provision and allow them to move into the exchange.

4:51:48 PM

REPRESENTATIVE WOOL asked whether an individual on the fence could opt not to receive a PFD.

MR. SHERWOOD said he would check under the new federal regulations as a development of income requirement stated that an individual entitled to an income must apply for and pursue it.

4:52:30 PM

REPRESENTATIVE VAZQUEZ questioned how the hold harmless provision applies at the present time and how this would change.

MR. SHERWOOD responded that presently when determining eligibility for Medicaid, the statute instructs the state whether it is possible under federal requirements to disregard the PFD and not count it as income. In this case there is no asset test for the expansion group, but individuals can have up to four months of hold harmless coverage which means the state replaces the federal benefit that is provided. Essentially, he explained, DHSS would continue to leave them on Medicaid but for those 1 - 4 months that they were ineligible due to receipt of the PFD, DHSS would not claim federal funds for those

individuals. In that case, the lost federal revenue is actually paid out of the PFD account and not the general fund account.

4:54:11 PM

COMMISSIONER DAVIDSON explained that with this provision, the PFD hold harmless provision does not apply to the expansion population.

4:54:22 PM

REPRESENTATIVE VAZQUEZ asked for an example.

COMMISSIONER DAVIDSON offered a scenario of an individual who is potentially eligible for Medicaid expansion, but has an income almost at 138 percent of the federal poverty level. When that individual receives a PFD that puts them over 138 percent of the federal poverty level, they would not be eligible for expansion. Rather, the individual would then be directed to the federally facilitated market place in Alaska where they could choose to purchase a substantially subsidized market place plan.

4:55:11 PM

CHAIR SEATON offered that this also relates to other programs, such as, food stamps. In the event an individual earns too much money, they don't qualify. The PFD actually pays the difference of what the individual was losing in their benefits in receiving the PFD. He pointed out that the hold harmless was not being changed, it just does not apply to the expansion population.

MR. SHERWOOD answered "That is correct."

4:56:08 PM

REPRESENTATIVE VAZQUEZ questioned whether the department had considered that the hold harmless also applies to food stamps and asked whether there had been any thought about excluding food stamp recipients in the hold harmless program.

COMMISSIONER DAVIDSON replied that the food stamp program is not a subject of this bill.

4:56:45 PM

MR. SHERWOOD said that Section 3 is the provision which reduces the mandatory number of audits required under the statute. He

offered that since the law passed there has been an increase in the amount of oversight of providers through other state and federal initiatives. The Division of Quality Assurance in the department [indisc.] 14 different kinds of oversights the providers can be subject to depending upon the type of provider, federal or state. He opined that one of the prime purposes of audits is the sentinel effect and DHSS believes there is enough activity that it is achieving that. He explained that the section also gives DHSS clear authority to coordinate the audits to avoid duplication with other state or federal audit activities.

4:57:57 PM

CHAIR SEATON conveyed there had been a discussion regarding certain audits being identified as being an acceptable substitute when there is coordination in receiving the results of these audits. He asked if DHSS was still thinking that would work in some instances.

MR. SHERWOOD responded that DHSS does coordinate among the audits which also avoids any duplicative penalties. To the extent possible, the department would take the federal audit as part of the DHSS oversight strategy.

4:59:04 PM

MR. SHERWOOD stated that Section 4 allows the department to impose penalties on overpayments when the overpayment determinations become final. This section creates an incentive for prompt resolution when there are audit findings as there is a disincentive for the provider to drag out the dispute of the findings.

4:59:39 PM

REPRESENTATIVE VAZQUEZ referred to [Sec. 4, AS 47.05.200(b)], page 3, lines 17-20, which read:

> (b) ... **The department may assess interest penalties on any identified overpayment. Interest under this section shall be calculated using the statutory rates for post-judgement interest accruing from the date of the issuance of the final audit.**

REPRESENTATIVE VAZQUEZ asked what statutory rate for post-judgement interest is being applied.

MR. SHERWOOD answered that the language came from "our legal folks," and he assumed it was clear as to which one. He agreed to research the answer and get back to the committee.

REPRESENTATIVE VAZQUEZ said it should clearly be set forth what statutory rate it is making reference to for avoiding confusion.

5:01:03 PM

MR. SHERWOOD conveyed that Section 5 allows DHSS to impose fines on providers for violation of statute or regulations. Currently the only financial recovery with providers is through the audit. He said it has been discovered that it makes more sense for both parties to assess a fine. He offered as an example, if there was evidence of poor documentation that was not systemic, DHSS may choose to impose a fine rather than actually performing an audit where both sides have to drill down to determine what the evidence shows. He conveyed that there may be occasions when an audit is over-kill or impractical and simply assessing a financial penalty for failing to follow the statute or regulations is a more appropriate and efficient tool.

CHAIR SEATON asked whether the fine was in dispute or someone prefers an audit, would that fine language be permissive and be part of the regulations that can be challenged.

MR. SHERWOOD responded in the affirmative and stated that by adding it as a sanction there is an appeal process for any substantial sanction.

5:02:36 PM

REPRESENTATIVE VAZQUEZ referred to [Sec. 5, AS 47.05.250(a)], page 3, lines 22-23, which read:

> (a) ...The department may adopt regulations to impose a civil fine against a provider who violates AS 47.05 ...

REPRESENTATIVE VAZQUEZ noted that AS 47.05 deals with medical assistance fraud. She said if this legislation passes, it appears the department may adopt regulations to impose a civil fine against a provider who violates. Usually, she opined, in a criminal case there is restitution to be made, so why would DHSS need a separate section.

MR. SHERWOOD offered that this does not extend simply to the fraud provisions of AS 47.05, but to the other administrative provisions of AS 47.05 and AS 47.07, essentially the Medicaid statute. All violations of regulations governing Medicaid would be subject to fines.

REPRESENTATIVE VAZQUEZ reiterated her question whether a criminal case under AS 47.05 deals with Medicaid fraud and spells out the criminal sanctions. She pointed out that it is clearly a criminal process, and asked why this particular provision is included in that it interferes with the criminal statute. She noted that restitution is in criminal cases, and the criminal code sets forth the parameters of that restitution.

MR. SHERWOOD advised that this provision was intended to allow DHSS to impose fines for violations of regulation which were not necessarily criminal. He offered that if the question is whether this language is appropriately placed in this section or in AS 47.07, he would consult with the Department of Law (DOL) to provide an answer.

5:05:36 PM

REPRESENTATIVE TARR referred to [Sec. 5, AS 47.05.250(b)], page 3, lines 25-26, which read:

> (b) A fine imposed under this section may not be less than $100 or more than $25,000 for each occurrence.

REPRESENTATIVE TARR said the provision reads like a problem that does not meet the standard of a criminal proceeding. The department wants a mechanism to encourage good behavior and the threat of a fine will likely do that.

MR. SHERWOOD answered that her statement was a good assessment. Certainly, he said, the deterrent effect is in knowing there are some situations in which DHSS is not likely to pursue a full blown audit simply to obtain a modest recovery. Generally, he offered, all of DHSS sanctions tend to be progressive so initial and minor occurrences tend to be modest fines, and repeat or serious offenses tend to be higher fines.

5:06:53 PM

REPRESENTATIVE VAZQUEZ commented that there may be a need to include a provision for fines but as this covers all of AS 47.05, which also covers Medicaid fraud, she suggested there

should be an explicit exception to the criminal statutes, which includes criminal charges, and follows a whole criminal process and not a civil process.

CHAIR SEATON asked [Mr. Sherwood] to check with the legal department to determine if there should be an exception for fraud. He stated that if there is actually fraud DHSS does not want to be submitting a fine for criminal penalties.

5:08:22 PM

MR. SHERWOOD continued with the sectional analysis and stated that Section 6 amends the Medicaid eligibility statutes to bring the statute in line with the new MAGI rules, and adds the expansion group. He referred to MAGI [indisc.] several categories of coverage including many categories for children. The legislation amends AS 47.07.020(b)(8) in that it better describes a group of children that are already covered. He explained that the language dated back to the early 1990s, which artfully describes a category of children who weren't ineligible because they did not meet the old deprivation standards for Aid to Families with Dependent Children (AFDC). He offered that DHSS was making technical amendments to clarify this language to what has always been the coverage for these children who do not meet the deprivation requirements. He indicated that as the program has evolved this language has become antiquated and DHSS does not have people who would track that kind of policy back that far. The other changes related to MAGI have to do with eligibility categories for pregnant women and children and their income levels are set in statute as a percentage of the federal poverty level, he explained. He reiterated that MAGI gets rid of all income disregards that are applied before determining eligibility. The federal government made DHSS calculate the value of those disregards and adjust the income standards upward to reflect the loss of disregards for existing categories of Medicaid, he stated. This legislation is changing the numbers in the statute to match those new MAGI adjusted amounts. He offered that it appears income standards are going up, but in truth it is the equivalent standard. He pointed out that instead of applying the standard after DHSS has taken out the income disregards it is now applying the standard of gross income. Another way of looking at it, he advised, is that the disregards have been built into the standard.

5:11:19 PM

REPRESENTATIVE VAZQUEZ asked for an example of at least two to three income disregards that are taken into consideration.

MR. SHERWOOD replied that the disregards that come to mind include earned income disregards, child care disregards, a child support disregard, and the PFD disregard.

REPRESENTATIVE VAZQUEZ asked that Mr. Sherwood explain the definition of disregard, and how it is reviewed by department personnel determining eligibility.

MR. SHERWOOD answered that when determining an individual's eligibility the department typically starts with their gross income for the month, then determines whether adjustments need to be made. In that instance, a disregard may be a complete disregard of a certain type of income, or a partial disregard of earned income, and the amount of disregard is subtracted from the individual's income. Subsequently, he related, once all of the disregards have been subtracted, the department reviews the remaining income and in the old method would compare it to the income standard.

5:14:29 PM

MR. SHERWOOD advised that another part of Section 6 adds the expansion group and it contains the provision that the expansion group is covered only if the federal match rate is at least 90 percent. He referred to Sections 7-8 and advised they are technical amendments which clarify that individuals determined eligible using MAGI standards are not subject to transfer of asset penalties. He explained that transfer of asset penalties are applied to individuals who receive long term care, nursing home care, and home and community based waivers. In these circumstances, an individual has been found to have given away assets in order to qualify for Medicaid, or for any purpose other than to receive some sort of direct benefit to themselves. He pointed out that they may be ineligible for Medicaid for a period of time - approximately equivalent to the value of the transfer. He remarked that the legislation clarified that MAGI standards are not subject to the transfer of asset penalty. He explained that all the categories of Medicaid that cover individuals who are aged, blind, and disabled do not use MAGI standards. He said that the over whelming majority, almost the entirety of the individuals receiving long term care, qualify under those standards for aged, blind, and disabled.

5:16:03 PM

MR. SHERWOOD referred to Sections 9 - 10 and advised that the amendments to the cost containment statutes in the Medicaid statute include the reform initiatives, the Section 1115 waivers, the 1915(i) and 1915(k) options, other demonstration authorities, and enhancement and incentivizing telehealth. He advised that Sections 11 - 12 amend the statute to remove the Medicaid requirement that behavioral health providers be grant recipients. He conveyed that Section 13 instructs the department to amend the state plan in accordance with the legislation. He further conveyed that Section 14 gives clear authority to issue emergency regulations for reform and cost containment. Section 15 includes Reviser of Statutes instructions. Sections 16 - 17 are effective dates, and he noted that Sections 13 - 14 are effective immediately, while the rest of the Act is effective on July 1, 2015.

5:18:09 PM

REPRESENTATIVE TARR asked for clarification that the committee will not consider amendments on Thursday but get them out for distribution.

CHAIR SEATON said the committee may consider amendments on Thursday, before the public testimony comes in, so people will know what is on the table.

5:18:26 PM

REPRESENTATIVE VAZQUEZ advised she will have many questions and stated it is only fair for the committee to have time to clarify certain provisions in order to understand what this bill does and does not do.

CHAIR SEATON expressed his agreement.

5:19:11 PM

COMMISSIONER DAVISDON offered members to forward their questions to her in the meantime.

CHAIR SEATON asked the members to forward questions to Commissioner Davidson and there may be written responses back with information.

REPRESENTATIVE VAZQUEZ requested that the questions and answers be distributed to every committee member.

CHAIR SEATON offered that questions could be submitted to him, and he would forward the questions and receive the answers.

[HB 148 was held over]

5:20:27 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:20 p.m.