ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 26, 2015
3:04 p.m.

MEMBERS PRESENT

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

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

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
03/24/15	(H)	Heard & Held
03/24/15	(H)	MINUTE(HSS)
03/26/15	(H)	HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

JON SHERWOOD, Deputy Commissioner
Medicaid and Health Care Policy

Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: During the hearing on HB 148, testified on behalf of the administration.

REMOND HENDERSON, Deputy Commissioner
Office of the Commissioner
Department of Corrections (DOC)
Juneau, Alaska
POSITION STATEMENT: Answered questions related to HB 148.

LAURA BROOKS, Division Operations Manager
Office of the Commissioner
Department of Corrections (DOC)
Anchorage, Alaska
POSITION STATEMENT: Answered questions related to HB 148.

ALBERT WALL, Director
Central Office
Division of Behavioral Health
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Answered questions related to HB 148.

VALERIE DAVIDSON, Commissioner Designee
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: During the hearing on HB 148, testified on behalf of the administration.

ILONA FARR, MD
Alaska Family Medical Care, LLC
Anchorage, Alaska
POSITION STATEMENT: Testified in opposition of HB 148.

BECKY HULTBERG, President, CEO
Alaska State Hospital & Nursing Home Association (ASHNHA)
Juneau, Alaska
POSITION STATEMENT: Testified in support of HB 148.

JOHN GAGUINE
Juneau, Alaska
POSITION STATEMENT: Testified in support of HB 148.

ALYSON CURREY
Juneau, Alaska

POSITION STATEMENT: Testified in support of HB 148.

MELISSA ENGEL
Juneau, Alaska
POSITION STATEMENT: Testified in support of HB 148.

KARENZA BOTT
Juneau, Alaska
POSITION STATEMENT: Testified in support of HB 148.

VERNE BOERNER, President, CEO
Alaska Native Health Board (ANHB)
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 148.

MICHAEL DZURISIN
Location unknown
POSITION STATEMENT: Testified in support of HB 148.

ROBIN SMITH
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 148.

ANDREW SMALLWOOD
Cordova, Alaska
POSITION STATEMENT: Testified in support of HB 148.

JEFF JESSEE, Chief Executive Officer
Alaska Mental Health Trust Authority
Department of Revenue
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 148.

ACTION NARRATIVE

3:04:22 PM

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

HB 148-MEDICAL ASSISTANCE COVERAGE; REFORM

3:04:47 PM

CHAIR SEATON announced that the only 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."

3:07:46 PM

JON SHERWOOD, Deputy Commissioner, Medicaid and Health Care Policy, Office of the Commissioner, Department of Health and Social Services (DHSS), said he will be reviewing the fiscal notes [Included in members' packets]. Overall for Fiscal Year (FY) 2016, there would be an appropriation of over $146 million with an actual reduction in undesignated general funds (UGF) of over $2 million. In 2021 total expenditure would rise to $215 million and a reduction in undesignated general funds of almost $98 million.

3:08:50 PM

MR. SHERWOOD explained fiscal note 1 [dated 3/18/15] is a small increase for the Department of Administration (DOA), Office of Administrative Hearings. Fiscal note 2 [dated 3/18/15] is for the Department of Corrections (DOC), [Physical Health Care], reflecting a reduction in expenditures as a result of the expansion. Inmates who receive in-patient care could become eligible for Medicaid coverage when receiving in-patient treatment while physically out of the correctional facility overnight. This would allow the Department of Corrections to bill those expenditures to Medicaid.

3:09:25 PM

CHAIR SEATON observed the reduction would be $4.1 million in FY 2016, but $7 million in FY 2017 and thereafter. He asked why the difference.

MR. SHERWOOD deferred to the Department of Corrections, but said his understanding is that DOC doesn't anticipate being able to achieve the maximum savings in the first year. Part of it may be that DOC is paying for care that was already provided in the previous year. Also, DOC may not be able to get everyone enrolled in the early part of the year.

CHAIR SEATON inquired whether there is any correlation with recidivism or being able to provide behavioral health services

as inmates exit the corrections system and are still on probation.

MR. SHERWOOD offered his belief that, although there is a potential for savings, he doesn't believe this fiscal note reflects savings associated with that. He deferred to DOC.

3:11:10 PM

REPRESENTATIVE WOOL asked for clarification that the $7 million in savings would be for overnight hospital stays for prisoners in state custody, not a day trip for medical treatment.

MR. SHERWOOD confirmed the aforementioned is correct. An inmate must actually be staying out of the facility overnight so the inmate would no longer be considered to be residing in the facility on that day.

REPRESENTATIVE TARR added the prison population is aging and therefore the health care needs are more significant as far as extended stay care.

3:12:54 PM

REMOND HENDERSON, Deputy Commissioner, Office of the Commissioner, Department of Corrections (DOC), addressed Representative Seaton's first question about fiscal note 2, explaining the difference between the $4 million reduction in FY 2016 and $7 million in reduction for each of the out years is because DOC will not be fully ramped up in the first year and only expects to achieve a 50 percent savings that first year. The DOC analyzed actual medical bills for individuals institutionalized in a hospital for 24 hours or more in fiscal years 2012, 2013, 2014, and 2015. The estimates arrived at fiscal note 2 are 80 - 90 percent of what was seen in that analysis. For example, in FY 2014, $8.5 million was spent for individuals who were in care for 24 hours or more; 90 percent of that is $7 million. For FY 2015 through January, the expenditure is already $5.5 million for people who would be potentially eligible under Medicaid, which equates to almost $9 million. Therefore, DOC believes $7 million is a reasonable amount.

3:15:09 PM

LAURA BROOKS, Division Operations Manager, Office of the Commissioner, Department of Corrections (DOC), addressed

Representative Seaton's second question about behavioral health follow up as people transition from prison into probation. She said the department has staff who work to link those offenders to community resources upon release from DOC facilities. If DOC can ensure that these individuals in custody are set up and ready to go for Medicaid upon release, there will not be a lapse in services as is often experienced now. However, in terms of a fiscal note, she said she doesn't believe that is going to result in any direct savings to the department because those are services that are already provided in the community. There is research that addresses that those who have their criminogenic needs met, which includes things like stable medical and behavioral health care, have a reduced likelihood of returning to corrections and reduced recidivism in the long run. Responding further, she confirmed the fiscal note does not include those who [have been released and] are now out in the community.

3:16:39 PM

MR. SHERWOOD addressed fiscal note 3 [dated 3/18/15] for the Department of Health and Social Services, Behavioral Health Administration, explaining it will be the cost of adding one position for the 1915(i) option [under Medicaid] which would be able to cover individuals. Some individuals that are currently served through [Division of Senior and Disability Services] in grant programs and some are served through [Division of Behavioral Health]. Different benefit packages are allowed to be designed for different populations under that option, and it is anticipated that one person would be required for the development and then the ongoing operation and maintenance of that component. The expenditure starts at $120,400 [for FY 2016], which includes some one-time expenses for adding the position, and then goes down to $112,800 in the subsequent fiscal years.

CHAIR SEATON asked where that employee would be located.

ALBERT WALL, Director, Central Office, Division of Behavioral Health, Department of Health and Social Services (DHSS), replied that position is anticipated to be in Anchorage.

CHAIR SEATON presumed "that one position will be doing whether somebody's coming out of Juneau or Fairbanks or anything else."

MR. WALL responded correct.

REPRESENTATIVE TARR observed the position would be called Health Program Manager II, and requested a description of the position.

MR. WALL answered the Health Program Manager II handles a variety of issues, including policy and regulatory writing, and program oversight for various programs that are health related. This person provides program approval and oversight that is not specifically for a clinical position, which is done by a mental health clinician.

REPRESENTATIVE TARR surmised this person would be experienced in health care and would be a higher level position.

MR. WALL replied this position will require a very high level of expertise in Medicaid services and the regulations that govern those services.

CHAIR SEATON understood there would be two services: one under [Division of Senior and Disability Services] and one under [Division of Behavioral Health].

MR. SHERWOOD responded the two division services that are currently provided by general funds could be put under 1915(i). One is the Division of Behavioral Health and the other is the Division of Senior and Disability Services. Different populations can be served under this option; for example, individuals with dementia, traumatic brain injury, developmental disabilities who don't meet the institutional criteria for service under one of the department's existing waivers, as well as individuals with severe mental illness or other behavioral issues might qualify.

3:21:16 PM

MR. SHERWOOD turned to fiscal note 4 [dated 3/18/15] for the Department of Health and Social Services, Behavioral Health Treatment and Recovery grants. He said those are the general funds services, some of which could be shifted to Medicaid under 1915(i), and some of which are from the expansion itself as individuals not currently eligible for Medicaid, but with behavioral health needs, are able to get Medicaid through the expansion. A reduction to the grants is anticipated as a result of people now paying for their services funded through Medicaid instead of through the grants. That begins as a reduction of nearly $1.6 million [in FY 2016] and increases to a reduction of $19.5 million in FY 2021. That is a combination of both the

expansion that would occur in FY 2016 and FY 2017, and then in FY 2018 the reductions are related to the addition of 1915(i).

REPRESENTATIVE TARR surmised that the smaller amount in FY 2016 is because it is the year in which people will begin the transition to Medicaid billing.

MR. SHERWOOD answered yes, and explained the department does not have a way to effectively compel everyone to come forward and identify themselves as potentially Medicaid eligible and apply on the first day. It may take some time to get individuals into the system.

3:23:40 PM

MR. SHERWOOD discussed fiscal note 5 [dated 3/18/15] for the Department of Health and Social Services, Behavioral Health Medicaid Services, stating this is the actual increase to the Medicaid expenditures around behavioral health. Like the grants, it stems from two sources: the expansion which starts in FY 2016 and then the additions of 1915(i) services which would begin in FY 2018. It is almost $4.8 million in FY 2016, increasing to $26.6 million in FY 2021.

REPRESENTATIVE STUTES asked whether this includes 1915(i) services.

MR. SHERWOOD replied yes, it is 1915(i) services for the behavioral health side.

REPRESENTATIVE TARR surmised the first year there is no general fund match because the state is at 100 percent federal reimbursement which steps down in the ensuing years.

MR. SHERWOOD responded the expansion is initially 100 percent federal, stepping down over this period to 90 percent. With the retention of the 100 percent tribal match, Alaska's match rate will always be effectively higher. The 1915(i) services will go predominantly to people who may already be Medicaid eligible but who do not meet an institutional level of care to get the [state's] waiver services. The anticipation is that those services will be provided pretty much at the base match rate of 50 percent. He believed that in this fiscal note the average is about 56 percent because Behavioral Health serves individuals on Denali Kid Care and through tribal health systems. But the 1915(i) services are not at the same enhanced match rate as the expansion services.

3:26:42 PM

MR. SHERWOOD moved to fiscal note 6 [dated 3/18/15] for Department of Health and Social Services, Adult Preventative Dental Medicaid Services. He said this fiscal note reflects the portion of the increase in spending related to Medicaid expansion for this particular allocation in the Medicaid services budget. [The department] allocated all preventative dental and medical services separately and this expansion is targeted on the adult population, so a portion of the expenditures would fall under this Medicaid services component.

REPRESENTATIVE STUTES recalled a presentation in which Mr. Sherwood indicated this was one of the items that was cut out in the 1990s to save money. She inquired whether this expansion would put it back in.

MR. SHERWOOD answered [the department] cut adult dental service in the 1990s but then restored it later in the 1990s. The service that was cut was what [the department] referred to as emergency dental or coverage of acute pain and infection. This is an enhanced dental service for adults that was added by the legislature, he believed, in the early 2000s. It goes beyond emergency care, which is something that would put a person in the hospital if left untreated, and provides basic dental services such as filling of cavities, restoration, and dentures. It has been available for about 10 years.

REPRESENTATIVE STUTES, stating it appears that this is also preventative, presumed it is cleaning and those sorts of things. She asked how many states provide dental coverage.

MR. SHERWOOD replied he does not know how many states provide for adults and added it is an optional service. He offered to provide this information to the committee.

3:30:04 PM

MR. SHERWOOD reviewed fiscal note 7 [dated 3/18/15] for Department of Health and Social Services, Health Care Medicaid Services. He explained Health Care Medicaid Services covers the bulk of primary and acute care provided by [the department] through the Medicaid program. Two things are included in this fiscal note. One is the net increase in Medicaid spending as a result of adding the expansion group. The other is the impacts of the Section 1115 waiver for tribal services, which is a

provision included in HB 148. The expansion starts immediately in FY 2016. Some savings are anticipated from the Section 1115 waiver in FY 2017, with savings ramping up through FY 2021. The net impact of the Section 1115 waiver is not an increase in Medicaid spending, but a shifting of Medicaid spending from non-tribal to tribal facilities and therefore the department is projecting a change in the federal match rate. This service would drop from 50 percent general funds to 0 percent general funds, which is why the line for federal receipts increases more than the line for total operating expenditures. Even though there would be a required general fund match for the expansion piece, the total general fund match is actually a reduction because of reducing the amount needed for those services provided to tribal members that would be served in the waiver.

3:32:40 PM

MR. SHERWOOD addressed fiscal note 8 [dated 3/18/15] for the Department of Health and Social Services, Senior and Disabilities Medicaid Services. It would begin with a small amount of the total projected expenditure for expansion allocated to Senior and Disabilities Medicaid Services, he said, and then in FY 2018 it would be a more substantial increase as the 1915(i) option is brought in. Also in HB 148 is the 1915(k) option in which some services from [the department's] current home and community based waivers are converted to the (k) option and get an extra 6 percent of federal match. So, fiscal note 8 includes three things: the expansion; the 1915(i) increase, which is offset by reductions to grant programs that will be discussed in subsequent fiscal notes; and the 1915(k) option, which shifts money from general funds to federal funds. The total expenditure in the first year of FY 2016 is $2.9 million and by FY 2021 the total expenditure is up to $21.3 million.

3:34:25 PM

MR. SHERWOOD stated fiscal note 9 [dated 3/18/15] for the Department of Health and Social Services, Catastrophic and Chronic Illness Assistance, is the reductions for the Chronic and Acute Medical Assistance (CAMA) Program. Almost all of the individuals who are eligible for CAMA right now, he said, would be eligible for the Medicaid expansion and it is anticipated that in the first year about two-thirds of the cost would be moved out of the CAMA Program and into the Medicaid expansion, eventually reducing CAMA by $1.4 million.

CHAIR SEATON inquired about the number of participants.

MR. SHERWOOD responded it would be under 500.

3:35:41 PM

MR. SHERWOOD said fiscal note 10 [dated 3/18/15] for the Department of Health and Social Services, Medical Assistance Administration, constitutes the administrative side of health care services. It includes staffing for the expansion and the Section 1115 waiver. One position would be added in FY 2018 for the waiver because this waiver typically comes with an extensive amount of federal oversight and data reporting that someone will have to track and provide to the federal government. The other four positions would be around the Medicaid expansion.

MR. SHERWOOD explained fiscal note 11 [dated 3/18/15] for the Department of Health and Social Services, Rate Review, is very small at $4,500 [in FY 2016]. One provision of HB 148 has to do with evaluating and developing a proposal for a provider tax and this has some funding for meetings in Juneau and Fairbanks. [The department] anticipates doing the work and absorbing most of the cost with existing staff and budget, but the funding is for stakeholder meetings in two locations. The staff for this office is based in Anchorage so no funding was included for a meeting in Anchorage or the Anchorage area.

3:37:52 PM

VALERIE DAVIDSON, Commissioner Designee, Department of Health and Social Services, pointed out that implementing a provider tax is complicated. Since Alaska hasn't had a provider tax, but other states have, the department is using FY 2015 funds to work on a request for proposals (RFP) to secure an independent contractor who can analyze what other states have done and look at the Alaska information to help the department to develop recommendations for provider tax that might work in Alaska.

CHAIR SEATON noted there is an amendment in this regard.

REPRESENTATIVE TARR asked whether the contractor would work in conjunction with staff and do the stakeholder meetings.

COMMISSIONER DAVIDSON answered correct. Given the timelines in the bill in order to be ready to deliver the report, the department needs to get started now and is using FY 2015 funds to accomplish that. Therefore, the independent contractor dollar amount is not included in the FY 2016 fiscal note.

REPRESENTATIVE TARR observed there is a 50 percent federal match to this. Offering her understanding that part of Medicaid expansion included administrative support, she inquired whether that is only available for FY 2017 or would administrative support dollars still be available after that if needed.

MR. SHERWOOD replied the department can receive funding for ongoing administrative activities of Medicaid. In terms of 50 percent federal match, that is the standard percent for Medicaid administrative expenses that is available to the department this year and throughout the foreseeable future.

3:40:28 PM

CHAIR SEATON referenced the distribution of a multi-page document on provider taxes, the complications, and the federal requirements. He said the document backs up why outside help might be necessary.

REPRESENTATIVE STUTES observed that fiscal note 10 provides for five additional staff members, but said she didn't see any other provision for staff members on the other fiscal notes. She recalled that in a prior presentation the committee was told it would take approximately 26 new staff members to facilitate this expansion. She asked how the other 21 new staff members will be paid for.

MR. SHERWOOD responded this will be addressed in the fiscal notes he has yet to review.

3:41:59 PM

MR. SHERWOOD turned to fiscal note 12 [dated 3/18/15] for the Department of Health and Social Services, Community Developmental Disabilities Grants, saying this is within the Division of Senior and Disabilities Services. These are anticipated reductions in grants for services that would be provided through the 1915(i) option. It is a pure general fund reduction, he said, since those are state grant programs.

MR. SHERWOOD said fiscal note 13 [dated 3/18/150] for the department of Health and Social Services, Senior Community Based Grants, is similar and is a reduction for 1915(i) in a different grant component in the budget of the Division of Senior and Disabilities Services.

3:42:53 PM

MR. SHERWOOD explained that fiscal note 14 [dated 3/18/15] for the Department of Health and Social Services, General Relief/ Temporary Assisted Living, is another program in the Division of Senior and Disabilities Services. It is an entitlement program, not a grant program, for vulnerable adults who need assisted living care because they have needs that cannot be met in a regular community setting. If they are not eligible for Medicaid coverage of that care, [the department] provides that care through this program. With the implementation of 1915(i), the department believes it would be able to reduce, not eliminate, the amount of individuals it would have to cover through the General Relief/Temporary Assisted Living Program.

CHAIR SEATON surmised fiscal note 14 is not the full amount of the program, but just the amount anticipated to change after the passage of HB 148.

MR. SHERWOOD concurred, offering his belief that the full amount of the program is just under $8 million.

MR. SHERWOOD reviewed fiscal note 15 [3/18/15] for the Department of Health and Social Services, Senior and Disabilities Services Administration, saying it is largely around 1915(i), but to some extent is also around 1915(k). System changes would be required to the division's information system, called the automated service plan, as well as one additional staff person in the first year for the development of 1915(i) and 1915(k). As 1915(i) and 1915(k) come up, additional staff people would be needed, with a total projection in the out years of three staff people. There is a difference in the amount of staffing between the Division of Senior and Disabilities Services and the Division of Behavioral Health. This is because the 1915(i) option requires an assessment of the individuals receiving the senior grants, something not currently done. This increase in assessment would not occur in the behavioral health population.

MR. SHERWOOD explained fiscal note 16 [dated 3/18/15] for the Department of Health and Social Services, Public Assistance Field Services, is the increase in work for the administration and eligibility determination of people who are going to be covered through the expansion. The anticipation is that 23 new positions would be added beginning in FY 2016. The startup cost for the first year assumes $2.7 million and in the out years it

is $2.3 million. The funding is 50 percent state and 50 percent federally.

3:47:00 PM

REPRESENTATIVE STUTES understood this would not include the five people from fiscal note 10, thus it would be a total of 28 people.

MR. SHERWOOD answered there are a couple of other positions in other fiscal notes. In FY 2016, the cumulative total is 29 positions, growing to 31 in 2017, 32 in FY 2018 and 2019, and 33 in 2020 and 2021.

3:48:08 PM

REPRESENTATIVE STUTES posited that currently it costs the state a certain amount of dollars per individual covered by Medicaid. She asked whether the department has any figures on what it will cost the state to cover that same individual starting in FY 2016 up through FY 2021 with Medicaid expansion in effect.

CHAIR SEATON inquired whether Representative Stutes is talking about the average recipient or the current recipient.

REPRESENTATIVE STUTES said she is talking about what the state is paying today for one individual. However many people there are, there is going to be an average cost per individual. After the expansion, even with more people, there is still going to be an average cost with the projected increase of people. She said she realizes this is a ballpark figure, but she would like to see what the average cost would be from FY 2016 through FY 2021 for that same individual with Medicaid expansion in effect.

MR. SHERWOOD replied the department will calculate what that difference will be, but he can say that since this is one of the less expensive populations to serve, the department expects that the average cost per average recipient adding Medicaid expansion will go down, not up.

3:50:35 PM

CHAIR SEATON understood the expansion population includes single adults between the ages of 19 and 64. He further understood that is why the expansion population would generally be assumed to be in a healthier condition than people with old age problems and children covered under other programs.

MR. SHERWOOD confirmed Chair Seaton is correct, saying the most expensive population to serve is the elderly and individuals with disabilities. The population over 65 is ineligible for the Medicaid expansion and people with the most substantial disabilities and low incomes would already be covered by Medicaid through one of the categories that covers adults with disabilities. The department believes this population is much more comparable to its population of adults who are on Medicaid because they are parents of children and historically that has been a less expensive population for the department to service.

3:52:18 PM

REPRESENTATIVE STUTES understood the second group of people would be an average of all people covered by Medicaid, not just the new expansion.

COMMISSIONER DAVIDSON reported that when Evergreen Economics did the analysis of the expansion population, it was found that 54 percent of the eligible expansion are men and 20 percent of that group is between 19 and 34 years of age. Men and younger men are typically the lowest cost beneficiary to cover. Therefore the department expects the average cost to actually decrease.

3:53:26 PM

REPRESENTATIVE WOOL understood the reimbursement rate of this added population is much higher, which he surmised would lower the average cost per Medicaid recipient, expansion and non-expansion population.

MR. SHERWOOD responded it would lower the average general fund cost. The total costs of providing coverage would be equal, but because the federal match rate is much better, the average general funds per person would be much lower, so that would lower the average general funds even more than it would lower the overall average.

REPRESENTATIVE WOOL noted everyone is asking what the average cost is per recipient, but people in this building want to know what the average cost is for the state per recipient. So, although a person might consume $7,000 in services, what is the state responsible for? The expansion population getting a 90 percent reimbursement at worst is going to further lower the expense. He posited that maybe Representative Stutes is trying to get at the number for what the state is on the hook for.

CHAIR SEATON said he thinks what is wanted is both sets of numbers. He requested the department to provide a table with the average cost that is provided in Medicaid and what is the average cost in state general funds for the population over those fiscal year spans.

3:55:27 PM

REPRESENTATIVE WOOL understood from a prior day's testimony that 138,000 people are currently Medicaid recipients in the State of Alaska, and the expansion would add another 20,000 - 27,000 people over the next five or six years.

MR. SHERWOOD answered he thinks the number of 138,000 referred to was the number of people who actually receive services. When talking about the number that would be added by expansion, that is the number of enrollees and not everyone who enrolls may receive a service that year. In regard to the number of 138,000 recipients that was referenced, he said he thinks the number of actual enrollees for that year was over 150,000. He declared he would follow up and provide the committee with the specific numbers.

CHAIR SEATON clarified the committee is asking the department to provide information regarding the 20,000 - 27,000 as well as the full number of 40,000 to see what the effects of 100 percent enrollment would be.

CHAIR SEATON, responding to Representative Vazquez, said the committee has asked the department to provide the average cost per person as well as the average general fund cost.

3:57:41 PM

MR. SHERWOOD, responding to Representative Vazquez, said the total expenditure in FY 2016 for all the fiscal notes for the Department of Health and Social Services is $146,549,600. That figure grows over the next five years and in FY 2021 is $215,160,900. Of that, the federal portion exceeds the total expenditures and would reduce general funds in the amount of $2,320,800 in FY 2016 and further reduce general funds by $97,916,400 in FY 2021.

4:00:03 PM

REPRESENTATIVE TARR recalled that if all newly eligible Medicaid expansion folks enrolled the spending per enrollee would be $7,248 for everyone, but the spending for the smaller group that is expected to enroll is $6,560. She presumed these are the numbers separating out the expansion population and asked whether the question being asked by Representative Stutes is to take those people and put them into the overall population and average it.

MR. SHERWOOD replied he doesn't think the department ever estimated the cost of enrollees for the expansion population would be as low as $6,500 per year. He believed that was going back to the cost of the adults currently being served through family Medicaid. The department made a slight upward adjustment to reflect that the department knew some of the individuals would be moving over from CAMA and those are individuals with chronic conditions that might be a bit more expensive to serve than the family Medicaid population.

4:02:16 PM

CHAIR SEATON requested Mr. Sherwood to review the sectional analysis for the bill, starting with Section 7.

MR. SHERWOOD explained Sections 7 and 8 are technical amendments to the Medicaid eligibility statute. Certain individuals who receive long term care services, nursing home services, and home and community based waivered services are subject to a transfer of asset penalty if they give away assets without obtaining appropriate fair market value in return for the those assets. There are some exceptions or situations where an individual can give away his/her assets, such as to a minor or a disabled child. The Patient Protection and Affordable Care Act clarified that individuals who are determined eligible for Medicaid under the eligibility categories that use the modified adjusted gross income (MAGI) methodology are exempt from those transfer of asset penalties. [These amendments would] put language in Alaska statute "that clearly shows that [Alaska's] statute around imposing transfer of an asset is consistent with federal law ... on imposing penalties for transfer of asset." Responding to Chair Seaton, he explained that MAGI is the new way [the state] is to determine income for eligibility purposes for its children, pregnant women, and parents and caretaker relatives in the Medicaid expansion group. It is not used for the categories that are specifically for the aged, blind, and disabled.

REPRESENTATIVE TARR understood that in some conditions there are hold harmless provisions, but that in general the asset test applies for Medicaid. She asked whether the aforementioned is more in line with the general provision.

MR. SHERWOOD responded some Medicaid eligibility groups have asset limits in addition to income limits, and some do not. As a result of the Patient Protection and Affordable Care Act, all the eligibility categories that use the MAGI methodology are exempt from the asset test, so there is no asset test for those categories. Hence, the argument that it doesn't make sense to apply a transfer of asset penalty to people who give away their assets when in fact they would have been eligible for Medicaid whether they retained or gave away their assets.

4:05:54 PM

REPRESENTATIVE VAZQUEZ requested the department to provide a table listing all the programs that are dealt with under the MAGI system and those that are not.

MR. SHERWOOD agreed to do so.

REPRESENTATIVE VAZQUEZ inquired why the federal government decided to change to the MAGI and disregard all assets for certain categories of Medicaid recipients.

MR. SHERWOOD offered his belief that it was to provide for a seamless transition between healthcare coverage through Medicaid and healthcare coverage through the health insurance exchange. The tax subsidies that are available to subsidize health insurance for individuals with incomes below 400 percent of the federal poverty level use the same basic MAGI rules and do not have an asset test applied to determine whether people are eligible for those subsidies. He said he thinks the notion was that if the same methodology and same asset requirements weren't used, then some people would get left out if their income increased and they then went through the marketplace, or, worse, if their income decreased they then would have fallen into a Medicaid category but there was a Medicaid requirement that made them ineligible for Medicaid and then they wouldn't have coverage in either place.

REPRESENTATIVE VAZQUEZ understood assets are not considered when a person goes through the health insurance exchange and subsidy is based only on income.

MR. SHERWOOD answered yes, that is what he was trying to say.

CHAIR SEATON understood both would be determined the same way - the MAGI is used either with the exchange or with Medicaid, except for certain special cases.

MR. SHERWOOD agreed there are some special cases, but said that, in general, they would be determined the same way and neither MAGI-based Medicaid nor the health insurance exchange uses an asset test.

MR. SHERWOOD resumed the sectional analysis, saying Sections 9 and 10 of HB 148 outline the cost containment measures to be taken by the department. The department is directed to seek the Section 1115 demonstration waiver to look at ways to develop an innovative service delivery system to improve care and increase efficiencies, reduce costs and expand services for Indian Health Service beneficiaries using services delivered through Indian Health Service and tribal health facilities; apply for a 1915(i) option to obtain the 50 percent federal match for home and community services that are now 100 percent general funded; apply for the 1915(k) option at the enhanced federal match rate [of 56 percent]; evaluate and apply to the Centers for Medicare and Medicaid Services (CMS) to participate in various demonstration projects, including payment reform, care management programs, workforce development and innovation, and other innovative service delivery models; and enhance telemedicine capabilities and reimbursement to incentivize its use for Medicaid recipients.

REPRESENTATIVE TARR pointed out the language directs that the department "shall" do these things, so they would be non-optional and would for sure have to take place.

4:11:37 PM

MR. SHERWOOD returning to the sectional analysis, explained Sections 11 and 12 both make amendments to Alaska Statute 47.07.900, the part of the Medicaid statutes which define the terms. These sections remove the requirement that behavioral health providers be a grantee of the State of Alaska. This language has been in Alaska statute for some time and is not viewed favorably by the Centers for Medicare and Medicaid Services. [These sections] would potentially expand the pool of Medicaid behavioral health providers.

CHAIR SEATON asked whether the grants are perfunctory, relating he has heard that some people receive a $100 grant and then this means they can provide services.

MR. SHERWOOD replied most of the grants are significant and substantial. There may have been times the department has made small grants in the awareness that it would enable somebody to provide Medicaid services. He requested Mr. Wall to elaborate.

MR. WALL confirmed Mr. Sherwood is correct, responding that the majority of those grants are large grants given to the department's community treatment providers. In the past there have been small grants that allowed providers to enroll as Medicaid providers, but removal of this language would allow for broader access to Medicaid and the potential enrollment of more providers in the systems.

CHAIR SEATON inquired whether removal of the grant language could in any way be detrimental to any current behavioral health providers receiving grants.

MR. WALL answered there is a relationship with the providers that the department must maintain carefully. There are some concerns that the licensed care providers who are individual members of the behavioral health agencies that provide services may leave the agencies they are in and go out on their own and provide services in that manner. The department is working with its associations to address that issue. The overall effect on the system of care would be a potential increase in the number of providers and more access for Alaskans for Medicaid.

REPRESENTATIVE STUTES asked whether the department has certain requirements for someone to be a provider and whether removing this grant language could prevent someone such as a licensed physician in mental health from becoming a provider.

MR. SHERWOOD replied all Medicaid providers must meet some kind of provider standard. In some cases the department simply uses an existing standard; for example, for physicians the department would use license to practice in the state. For some provider types that are not essentially licensed as such, the department must put forth its own criteria. For instance, for the two services directly impacted, behavioral health clinic services and behavioral rehabilitation services, the department would still need to establish standards through regulations and, in the department's state plan, submit the standards for approval by the federal government. They could be substantially the same

as the standards that are used currently for behavioral health grantees or they could be somewhat different.

COMMISSIONER DAVIDSON added the department does not require any other provider type in Medicaid to be a grant recipient before the provider can bill Medicaid. For example, a physician providing physician services can bill for Medicaid as long as the physician meets the provider requirements and enrolls as a Medicaid provider. Behavioral health is the only program in which the State of Alaska requires the provider to be a grantee. This is akin to the department saying a doctor cannot bill for Medicaid unless s/he applies for and receives a separate grant from the Department of Health and Social Services. At the time the requirement served some purpose, but the department would like to remove it through this legislation.

REPRESENTATIVE STUTES said she is concerned to hear that the provider clinics are worried about some of their licensees going out and practicing on their own, given she would think that would be a benefit cost-wise to the department.

REPRESENTATIVE TARR commented this might provide better insight into the types of services an individual is receiving and through other opportunities with Medicaid expansion working on the continuum of care and be able to better address someone's health needs if there was more of this data. She asked whether the department agrees with this and thinks this potential exists.

MR. WALL agreed with Representative Tarr's statement, saying that right now data for behavioral health clients is tracked through two separate systems. That will continue, but the services will shift from one source to the other. Both of those systems have some different capacity for reporting, but the department sees that capacity growing in the future.

4:20:09 PM

REPRESENTATIVE VAZQUEZ inquired why providers were originally required to be grantees before they could bill to Medicaid.

MR. SHERWOOD responded the provisions existed prior to his time. A decision was made in the development of these services that this provision would be put in statute and without researching the legislative history and he cannot tell the committee why.

REPRESENTATIVE VAZQUEZ expressed her understanding that a behavioral health provider could get a grant and at the same time bill Medicaid.

MR. SHERWOOD replied that grantees can provide services to individuals. If they are Medicaid eligible they can bill Medicaid. He deferred to Mr. Wall to answer the question, but said he thinks there are provisions in the grant that would prohibit duplicative billing, and that it is generally a requirement of most grants that when a provider is charging Medicaid, the provider cannot also charge it off to the grant.

REPRESENTATIVE VAZQUEZ asked why the provider is first able to get a grant before the provider can bill Medicaid if the provider is not allowed to bill both programs.

MR. SHERWOOD replied that is why the department is trying to eliminate the provision as it does not see the need for it.

REPRESENTATIVE VAZQUEZ inquired whether the Division of Behavior Health has a database that identifies this type of double billing.

MR. WALL responded the Alaska Automated Information Management System (AKAIMS) tracks clients in both systems and the division has a quality assurance (QA) unit that does exactly that.

REPRESENTATIVE VAZQUEZ asked whether the division has caught any providers.

MR. WALL replied he cannot answer that specifically. He believed there have been instances of investigations which were then generally handed over to the Medicaid fraud unit. The Division of Behavioral Health may encounter issues in its QA process and then hand that over to the Medicaid fraud unit.

4:23:11 PM

MR. SHERWOOD turned back to the sectional analysis, stating that Section 13 instructs the department to amend its state Medicaid plan to be consistent [with HB 148] and submit the amended plan to the federal government. The Section 1115 waiver would essentially be an addendum to the department's Medicaid state plan. So, Section 13 is really instructing the department to do what it knows it has to in order to keep itself in federal compliance.

MR. SHERWOOD explained Section 14 authorizes the department to engage in emergency rule making [under the Alaska Administrative Procedure Act]. It allows the department to be clear that it can move fast on some of these provisions and start implementing reforms and obtaining savings. The sooner the department can get these in place, the sooner it can start achieving the savings.

REPRESENTATIVE VAZQUEZ said historically the courts have been strict in allowing administrative agencies to issue emergency regulations. She inquired as to how much time the department expects it will be saving by using this mechanism [for emergency rule making].

MR. SHERWOOD responded he doesn't know that the department has calculated an average. A fairly swift moving regulation process through the normal process would take three to four months to become effective, while emergency regulations are effective immediately. With regard to the courts, while these situations can rise to the level of emergency, having it in statute eliminates one point of contention should a group try to obstruct the department's implementation of regulations or emergency regulations.

REPRESENTATIVE VAZQUEZ offered her understanding that the department plans to implement this immediately if the bill passes. Commenting this may affect thousands of people in Alaska, she asked where the due process is by rushing it so fast.

MR. SHERWOOD answered that the provisions in the Administrative Procedures Act for regulations do provide for a notice and a hearing. In simplistic terms, the normal process for adopting regulations is replicated, but the department is allowed to begin implementing them before that process is complete. So, the department would put the regulations into effect and then would go through that process. That said, that is at the state level; there are still some notice requirements that must be met at the federal level - 30 days' notice to providers for changes in reimbursement, timely notice to recipients if making a change that would result in the elimination or reduction in any of their benefits.

REPRESENTATIVE VAZQUEZ requested the federal regulatory and statutory federal citations that enable the department to immediately implement this bill without needing to first apply for a change to the state plan.

MR. SHERWOOD did not recall the specific cite that allows state plan amendments effective in the quarter in which they are submitted. However, any state plan amendment submitted before the end of March 2015, the end of the first quarter, will have an effective date of January 1, 2015, he said. He offered to provide the citation to the committee. In response to Chair Seaton, he confirmed that any state plan amendment would be retroactive to the first day of the quarter in which it was submitted. For example, if a state plan amendment was submitted on March 31, the state could request an effective date of January 1, 2015.

CHAIR SEATON referred to proposed Section 17 of HB 148 and asked whether the effective date would be July 1, 2015.

MR. SHERWOOD acknowledged that the state's statutory effective date for Section 17 is July 1, 2015, but he was referring to the effective date as it relates to the Medicaid state plan being sent to the federal government for approval, which can be retroactive to the beginning of the quarter in which the amendment was submitted.

CHAIR SEATON asked for further clarification.

MR. SHERWOOD clarified that nothing precludes submitting a state plan amendment prior to that date; however, the effective date per state statute requires the effective date to be on or after July 1, 2015.

CHAIR SEATON related his understanding that the implementation date was in Section 17 and even though federal law allows retroactive provisions, state statutes do not allow an effective date prior to July 1, 2015.

MR. SHERWOOD expressed the dates can be challenging to track.

CHAIR SEATON next directed attention to Section 15.

4:31:19 PM

MR. SHERWOOD stated that Section 15 would provide an instruction to the revisor of statutes to make technical amendments to the title of AS 47.07.036 to conform to the amendments of this act.

MR. SHERWOOD stated that Section 16 would provide immediate effective dates for Sections 13 and 14 of the bill, sections

that allow the state to submit state plan amendments and to begin developing emergency regulations. As just discussed, Section 17 would provide an effective date of July 1, 2015 for the remainder of the bill.

CHAIR SEATON asked for further clarification that the state plan amendment could be submitted and the department can proceed with emergency regulations, but these will not be effective until after the statutory date of July 1, 2015 as per Section 17 of HB 148.

MR. SHERWOOD answered that was correct since the types of things the department would be trying to implement with the aforementioned state plan amendments and regulations would not be effective until July 1, 2015. Thus the effective dates of those provisions would not be prior to July 1.

4:33:11 PM

CHAIR SEATON moved to adopt Amendment 1, labeled 29-GH1055\A.2, Glover, 3/24/15, which read:

> Page 7, following line 15:
> Insert a new bill section to read:
> "*** Sec. 9.** AS 47.07.030(d) is amended to read:
> (d) The department **shall** [MAY] establish [AS OPTIONAL SERVICES] a primary care case management system or a managed care organization contract in which certain eligible individuals**, including super-utilizers as identified by the department,** are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. The department shall establish enrollment criteria and determine eligibility for services consistent with federal and state law."
>
> Renumber the following bill sections accordingly.
>
> Page 9, following line 3:
> Insert a new bill section to read:
> *** Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:
> MEDICAID MANAGED CARE FOR SUPER-UTILIZERS. On or before January 1, 2017, the Department of Health and Social Services shall

(1) establish a primary care case management system or a managed care organization contract under AS 47.07.030(d), as amended by sec. 9 of this Act, for super-utilizers, as identified by the department; and

(2) deliver a report on the system or contract to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available."

Renumber the following bill sections accordingly.

Page 9, line 12:
Delete "sec. 10"
Insert "sec. 11"

Page 9, line 17:
Delete "10"
Insert "11"

Page 9, line 23:
Delete "Sections 13 and 14"
Insert "Sections 15 and 16"

Page 9, line 24:
Delete "by sec. 16"
Insert "in sec. 18"

REPRESENTATIVE TARR objected for the purpose of discussion.

CHAIR SEATON explained that the amended Section 9, related to the establishment of a primary care case management system, or managed care organization for certain individuals, changed from "may" to "shall" and includes the super-utilizers as identified by the department as eligible persons. He reported that the proposed amendment would also add a new Section 14 to the proposed bill, which would add the requirement that the department establish the primary care case management for a managed care contract by January 1, 2017. It would require the department to provide a report, plan, or contract to the legislature. He stated that the genesis of this amendment was to address super-utilizers, as they had been identified for a large potential savings; however, AS 47.07.030(d) has been in statute without action.

CHAIR SEATON explained that the department is committed to seeing action. He recognized the difficulties of travel and

small populations means it is not practical to institute case management for the entire state. The department has been given leeway to select the type of care management and to identify eligible individuals who require attention. He acknowledged that some tweaks may be necessary.

CHAIR SEATON tabled Amendment 1 for further consideration, noting it would be taken up at a later date.

REPRESENTATIVE TARR asked if this was a current reform. She agreed that several million dollars has been saved with expansion of efforts related to "super utilizers." She asked if he could compare whether this amendment will change what is currently being done and whether the department can continue its cost savings efforts without language changes.

MR. SHERWOOD did not think the proposed amendment was necessary to continue the department's efforts to curb costs by addressing "super utilizers," and the aforementioned changes will not interfere with the department's current actions.

CHAIR SEATON noted that the required reporting will provide accountability to inform the legislature on the progress being made.

4:37:49 PM

CHAIR SEATON moved to adopt Amendment 2, labeled 29-GH1055\A.3, Glover, 3/24/15, which read as follows:

> Page 9, following line 3:
> Insert a new bill section to read:
> "*** Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to read:
> MEDICAID REDESIGN; REPORT TO LEGISLATURE. The Department of Health and Social Services shall present to the legislature on or before the 10th day of the Second Regular Session of the Twenty-Ninth Alaska State Legislature the results of the Medicaid Redesign and Expansion Technical Assistance study, advertised under request for proposal number 2015-0600-2986, issued February 25, 2015. The department shall deliver a report describing the results of the study and a program for reforming the medical assistance program to the senate secretary and chief clerk of the house of representatives and notify the legislature that the report is available."

Renumber the following bill sections accordingly.

Page 9, line 23:
Delete "Sections 13 and 14"
Insert "Sections 14 and 15"

Page 9, line 24:
Delete "by sec. 16"
Insert "in sec. 17"

REPRESENTATIVE TARR objected for the purpose of discussion.

CHAIR SEATON explained that Amendment 2 would add a new section to uncodified law requiring the department to report to the legislature the results of the Medicaid Redesign and Expansion Technical Assistance study describing the results of the study and a program for reforming the medical assistance program on or before the 10th day of the second regular session of the legislature.

CHAIR SEATON stated that the department has already committed to moving forward with the third-party consultant on Medicaid reform, but this report ensures that the legislature will be informed of the results of the study and program progress.

4:39:33 PM

MR. SHERWOOD commented that the department has intended on sharing the results of the aforementioned work with the legislature.

REPRESENTATIVE TARR expressed her concern for any additional staff time to produce a report. She asked whether the contractor's report will be repackaged.

MR. SHERWOOD replied that the department would not intend to do substantially more work to prepare the report.

COMMISSIONER DAVIDSON added that the final report could be presented as well as in a condensed PowerPoint to provide information to the legislature and the public in a condensed format in an effort to provide transparency in the process.

REPRESENTATIVE TARR asked whether Amendment 2 would adversely impact the timeline for the contractor.

MR. SHERWOOD answered that it should not impact the timeline.

CHAIR SEATON said that prior reports have not been shared with the legislature in a timely manner. He emphasized that Amendment 2 would clarify the reporting expectation.

REPRESENTATIVE TARR maintained that she did not want to take away any staff time to meet the reporting requirement. She recalled a recent example of the committee waiting on a report relating to Medicaid expansion.

4:42:54 PM

REPRESENTATIVE TARR removed her objection.

REPRESENTATIVE VAZQUEZ asked whether the bill would provide for a pilot project on case management.

CHAIR SEATON answered that [Amendment 2] was limited to the report for the Medicaid Redesign and Expansion Technical Assistance study.

REPRESENTATIVE VAZQUEZ said she had no objection.

4:43:35 PM

There being no further objection, Amendment 2, labeled 29-GH1055\A.3, Glover, 3/24/15, was adopted.

CHAIR SEATON said that further consideration on proposed HB 148 would be set aside. He opened public testimony on HB 148.

4:46:33 PM

ILONA FARR, MD, Alaska Family Medical Care, LLC, stated that she was representing herself and several family practice physicians. She spoke in opposition to HB 148. She explained that she has served on the [MRAG] Medicaid Reform Advisory Group and the group was advised that [Medicaid expansion] would cost the state $6.2 billion by 2032 with the state paying $2.8 billion that year. This cost projection did not take into consideration Medicaid expansion. She asked where this money would come from. She expressed her concern about the provider tax. Other states have implemented some of these taxes, consisting of 19 different categories. She expressed concern, noting she has a copy of the study [Lewin Group study], noting her concern related to the potential impact this would have on small businesses, such as

physical therapy and physicians. Most physicians are paid about 72 percent of the costs, with increased audits, regulations, and other requirements necessary with Medicaid and she feared this will drive small businesses out of business and increase large facilities and corporations. Further, the cost differential could mean some providers will be paid $540 for services while private practice physicians would be paid $50, she said.

DR. FARR stated that some people graduate from medical school with $400,000 - $500,000 in debt so it will be virtually impossible for them to set up as small private practices. She expressed concern about the increasing number of Medicaid patients, noting that currently 140,000 - 160,000 patients are on Medicaid. She said the studies do not tell how many patients will be added with Medicaid expansion. She has seen studies that report that Medicaid expansion will add 40,000, others show it will add 64,000 to the system. She offered her belief that in other states that have adopted Medicaid expansion, it has been triple that number. She expressed concern about the cost and number of audits that will be conducted, since the audits can be costly. She has heard the Medicaid patient costs are high, with an average of $7,500 per patient, although she understood one patient's cost was $65,000. Over 2,000 existing Medicaid patients with hepatitis C were estimated to cost $300,000 per patient, which she has not seen budgeted. Further, some individuals are still on the list to receive Medicaid services that are not being covered. Medicaid was supposed to provide services for the elderly and the disabled, but the program is being increased, which could cause the state to reach a financial crisis.

DR. FARR offered to provide copies of reports she has accumulated. She further asked members to support the WWAMI [Wyoming, Washington, Alaska, Montana and Idaho] program, as well as some of the provisions in HB 74.

4:51:42 PM

BECKY HULTBERG, President, CEO, Alaska State Hospital & Nursing Home Association (ASHNHA), stated that her testimony was previously submitted in written form. The ASHNHA supports HB 148 because it expands Medicaid, but also because the state's health care system must be reformed. She stated that health care reform was real, possible, and attainable and this bill will set the framework for meaningful Medicaid reform. She cautioned that reform should not be considered one point in time but that reform is process that needs to happen each year. She

said that states that have had good experiences with cost containment are ones who analyze their system each year.

MS. HULTBERG characterized the state as being at a crossroad, one in which important choices must be made on Medicaid expansion and reform that will have fiscal and economic impacts and will impact people's lives. The choice to engage in meaningful reform remains one of the most important choices the state can make. The legislature has indicated that Medicaid must be reformed. The ASHNHA agrees and supports these efforts, and would like to partner with the state to achieve that goal.

MS. HULTBERG provided two quick examples of reform. PeaceHealthKetchikan received a CMS innovation grant for care coordination, she said, and the project saved money and improved quality, which sounds good, except that the hospital "spent money to lose money" in order to improve care. She offered her belief that the state's financial incentives are not aligned. The current payment system does not give incentives for efficiency and quality and instead rewards volume. Medicaid reform will help to change that dynamic to align incentives, she said.

MS. HULTBERG said that Central Peninsula Hospital in Soldotna has been considering forming a Coordinated Care Organization (CCO) pilot program. The CCO would be paid a global payment to cover all health care needs for a defined population, with metrics and accountability for quality and outcomes. Within that global budget the CCO is empowered to shift resources where they are needed to ensure optimal cost and quality outcomes. The CCO takes risks and in the event the costs exceed the budget, they must "eat" it. However, if the CCO can manage care more efficiently with better quality outcomes they will be rewarded and incentives will be aligned. She said, "That is the destination."

MS. HULTBERG said Medicaid expansion will provide health care for those who could never afford it, transforming lives, plus it provides the engine of health care transformation, which benefits everyone. Innovation requires investment, she said, and transforming the health care system, the state needs the risk capital to invest in those transformative efforts. She said that Medicaid expansion through reduction in uncompensated care provides the risk capital that will enable the state to continue this journey. Besides risk capital, the state needs health care reform because financial incentives must be aligned and pay for outcomes, not volume. In conclusion, she said that

[health care] reform is real, possible, achievable, and Medicaid expansion is critical to achieving it. Finally, the Alaska State Hospital and Nursing Home Association (ASHNHA) and hospitals are ready to partner on this journey.

4:55:43 PM

JOHN GAGUINE stated that he is a longtime Juneau resident. He offered his belief that people have firmly endorsed Medicaid expansion. During the last election in Alaska, an incumbent Democratic U.S. Senator was voted down and even though the Republicans maintain strong control of both houses of the legislature, an incumbent Republican governor was defeated. One primary issue between Governor Walker and former Governor Parnell was Medicaid expansion. The former governor opposed it vociferously and [as a candidate Mr.] Walker was very strongly in favor of it. Obviously, there were other issues as well; however, he offered his belief that it was the one of the primary issues between the two. The people have spoken and if the legislature does not produce a bill on Medicaid expansion that it will be flouting the will of the electorate.

4:57:20 PM

ALYSON CURREY stated that her education and background are in social work. She offered her belief that is an injustice when a childless adult without any disability in Alaska who earns less than $20,000 per year - just under $10 per hour - cannot afford health care coverage. In her work as a social worker, she has seen individuals work multiple jobs just to make ends meet and forego necessary health care in order to pay utility bills, rent, or groceries. She offered her belief that health care represents a basic human right and no one should have to choose between seeking medical care and paying rent. Access to affordable health care should not depend on who you are, where you live, or on your income level. Medicaid expansion would ensure that all Alaskans have health care coverage for preventative care, which would reduce the number of emergency room visits and allow currently uninsured individuals to remain productive members of the Alaskan economy. Reforms to the state's Medicaid program are necessary to ensure that the state has the most effective and efficient system available, and certainly evaluation and re-evaluation should continually occur. Medicaid expansion does not need to wait for Medicaid reform. Thus the state cannot afford to wait to expand Medicaid and expansion does not need to wait for reform.

4:59:16 PM

MELISSA ENGEL spoke in support of Governor Walker and Commissioner Davidson's tireless efforts on Medicaid expansion. As a United Methodist Church youth pastor she looks to the ethics for guidance and HB 148 is a step in the right direction toward embodying compassion and Christian love. As a youth pastor working with five churches, she often meets low-income families and individuals who will benefit from Medicaid expansion and reform. Although she also sees people reach out to help out others, the church can only do so much. She acknowledged that people can help others financially, but not every faith community can do so. The church family cannot provide health care or act as a "go between" for people and their insurance companies. She urged members to reflect the needs of the people and in the spirit of kindness to give people access to the health care they deserve, which could allow them to get a "leg up" and experience transformation in their lives and in their current low-income bracket. She urged members to be authentic and kind. She concluded by quoting John Lewis, a civil rights activist who said, "If not us, then who? If not now, then when?" She suggested the answer could be "yes" and "now" and urged members to please support HB 148.

5:01:42 PM

KARENZA BOTT stated that she stands before members today because of Medicaid. She stated that she wasn't always poor, but one day in 2006 she was driving home from her job at the Division of Elections and a young woman talking on a cell phone while driving ran into her at 55 miles per hour. Her life changed dramatically with her brain no longer talking to her body. Ultimately she was certified 100 percent disabled by the [U.S.] Social Security Administration (SSA) retroactive to 2009. However, she learned that social security benefits do not cover physical therapy and restorative dental work, but Medicaid does. She described her ordeal, noting she was able to get off pain medication in 2012-2013 and is currently in the SSA's Ticket to Work program, and has successfully completed an internship with U.S. Senator Mark Begich in Juneau. She credited her success due to Medicaid. She said she was enrolled in Alaska Native Studies at the University of Alaska Southeast. She concluded by stating she was proud to be an Alaskan and hoped that members will "put a face to the Medicaid reform." She offered her support for Medicaid reform and HB 148.

5:04:04 PM

VERNE BOERNER, President, CEO, Alaska Native Health Board (ANHB), spoke in support of HB 148. The ANHB serves as the statewide organization for the Alaska Tribal Health System that serves over 145,000 Alaska Natives and American Indians. Although tribal programs are often equated with health insurance for tribal members, the ATHS does not provide health insurance for individuals nor does it guarantee benefits. In fact, the ATHS has been chronically underfunded since its inception and most tribal programs must ration care. Not expanding Medicaid carries opportunity costs that will not only impede economic growth but will result in higher costs to the statewide system and sadly affect mortality, she said.

MS. BOERNER stated that the U.S. Indian Health Service (IHS) sources of funding are below the level of need and are finite. Therefore, tribes have been innovative in designing and developing programs that increase resources that depend on third-party billings to extend the capacity to provide care. Heartbreakingly; however, Alaska Natives suffer the highest rates of uninsured and poverty rates in the program, and so Tribal programs are still forced to direct resources to cover uncompensated care and are not able to apply those resources towards capacity building. Rationing care means that diagnosis and treatments are delayed, diseases progress, treatment is more costly, and outcomes are poorer. She said that Medicaid expansion will alleviate pressure on the health system and allow for more resources to be dedicated to capacity building and innovation. In fiscal year (FY) 2012, Alaska Natives made up nearly 40 percent of Alaska's Medicaid recipients; however, payments to those tribal programs only totaled about 16.4 percent. She said, "If that percentage was pushed up to 20-30 percent, the dollar savings to Alaska's general fund would have been $25.8 million and $97.3 million, respectively." Tribes are ready to work with the state and federal government on developing ways to better utilize the Alaska Tribal health system, noting the system has been impacted by underfunding and fiscal pressure and leaving Medicaid expansion funding on the table costs lives. "That is on your and my shoulders as leaders," she said. It limits the ability to innovate and develop sustainable programs and help improve the health status and quality of life for Alaskans. She strongly urged members to pass HB 148.

5:08:37 PM

MICHAEL DZURISIN stated that he had been a state licensed insurance agent in California and considers himself to be an expert on health insurance. He spoke in favor of Medicaid expansion since it will create 4,000 jobs and $1.2 billion in wages and salaries in Alaska. He said that it will also save $6 million in the budget. It will provide insurance for an estimated 40,000 who do not currently have health insurance. It's not ethical to leave people uninsured, plus the uninsured go to the emergency room for care plus emergency room care costs more and affects hospitals. He predicted the overall effect of passing Medicaid expansion will be to lower health premiums. He applauded the governor for supporting Medicaid expansion since Medicaid expansion is the "right move." In fact, many Republican governors in other states have adopted Medicaid expansion including John Kasich of Ohio, Chris Christie of New Jersey, as well as, he believed, in Kentucky. He appreciated earlier testimony by the physician who testified with her concerns with Medicaid expansion; however, he suggested that issues with Medicaid can be fixed by increasing the payments. Speaking as an expert in the field health insurance, he offered that insurance is a game. He advocated for public insurance, which most industrialized nations have, except for Switzerland, which tightly regulates its insurance industry. He reported that the overhead for Medicaid and Medicare is 2 percent as compared to private insurance with 10-20 percent. He said that insurance companies deny people coverage on claims since insurance companies lose money when they pay out big claims. Lastly, he emphasized his primary reason for supporting Medicaid expansion is because he believes everyone's health care costs will go down. People think that if everyone has Medicaid, taxes will need to be raised, but he offered his belief that everyone's insurance payments represent a second tax.

5:12:01 PM

ROBIN SMITH asked to speak as a business owner in Anchorage. She expressed concern about the Alaska's future. According to Northern Economics, Inc. [a consulting firm], Alaska's economy is heading toward recession. She said that Medicaid expansion was one of the bright spots. With the drop in oil prices, Alaska needs to cut the budget, but if the budget is cut too much it will drive Alaska into a recession. In fact, there was little in sight that will bring money into economy, but Medicaid expansion will do so since it will bring $1 billion to the state in the next five years. If Alaska does go into a recession, businesses will be dramatically impacted and will be forced to increase the "bottom line" for their companies, which will mean

eliminating costs, such as health care insurance for employees. Currently, emergency room fees incurred for the uninsured are passed on to Alaska's businesses and individuals in the form of higher premiums for health care, which also impacts hiring decisions for businesses. Health care costs have dramatically risen in the past 30 years, but Medicaid expansion will reduce health care costs and improve business profits. Further, if for some reason Medicaid expansion did not reduce costs, Medicaid can be cancelled in the future. Still, two years of health care would better than no health care, she said. In closing, she urged members to take Alaska future economy into consideration by supporting Medicaid expansion and passing HB 148.

5:14:51 PM

ANDREW SMALLWOOD stated that he works as a commercial fisherman and he is on Medicare. He urged members to support and pass HB 148. He offered his belief that the state has refused Medicaid expansion in an attempt to hinder implementation of the [Patient Protection and] Affordable Care Act. He stated that Anchorage ranks as the highest in the nation and arguably in the world for most medical procedures. An uninsured patient in Anchorage must pay about double what an insured patient pays. Further, coastal Alaska also has highest percentage of uninsured people in the nation, which he characterized as a "pretty dismal situation." Anything that can be done to improve this situation should be done. During declining revenues in Alaska, it makes absolute sense to adopt Medicaid expansion and members should consider the PPACA in a separate issue. He suggested that if the intention of the majority is to block implementation, he hoped the legislative leadership has an alternative plan in mind since the present system in Alaska is broken for low-income individuals.

5:16:47 PM

JEFF JESSEE, Chief Executive Officer, Alaska Mental Health Trust Authority, Department of Revenue, asked to focus on first line of the legislative intent, which read, "The legislature finds that the current Medicaid program is not sustainable." He said that reform is not optional, noting the Alaska Mental Health Trust Authority (AMHTA) is a long-term thinker. He urged members not to let the Medicaid's "house of cards" continue to get bigger since it will collapse at some point and will take the AMHTA's beneficiaries down with it. As Ms. Hultberg of the Alaska State Hospital and Nursing Home Association (ASHNHA) testified earlier, the AMHTA remains committed to work with the

legislature, the department, and the governor on reform to bring the Medicaid budget into a sustainable level. Certainly from the Alaska Mental Health Trust Authority beneficiaries' standpoint, Medicaid expansion is absolutely critical. First, some beneficiaries are homeless and often suffer from substance abuse disorders or have mental health issues. Secondly, 65 percent of inmates in correctional facilities have a mental health diagnosis and 80 percent have a substance use disorder diagnosis. Thus expanding Medicaid would serve as a means for them to obtain services they need to get off the street or stay out of jail, which not only makes good health sense, but it also makes good economic sense. He pointed out substantial discussion has been taking place in the legislature on recidivism and trying to avoid building another prison; however, the state needs to support recovery in order to keep people out of prison. In closing, he said that financial support can either be paid out of the general fund, which is what currently happens, or by passing Medicaid expansion and getting the federal government to help with that effort.

[HB 148 was held over]

5:20:50 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.