ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 2, 2016
3:03 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. 227
"An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 227
SHORT TITLE: MEDICAL ASSISTANCE REFORM
SPONSOR(s): REPRESENTATIVE(s) SEATON

01/19/16	(H)	PREFILE RELEASED 1/8/16
01/19/16	(H)	READ THE FIRST TIME - REFERRALS
01/19/16	(H)	HSS, FIN
02/02/16	(H)	HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

TANEEKA HANSEN, Staff
Representative Paul Seaton
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Introduced HB 227 on behalf of the bill sponsor, Representative Seaton.

VALERIE DAVIDSON, Commissioner
Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Testified and answered questions during discussion of HB 227.

JON SHERWOOD, Deputy Commissioner
Medicaid and Health Care Policy
Office of the Commissioner
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Testified and answered questions during discussion of HB 227.

STACIE KRALY, Chief Assistant Attorney General
Statewide Section Supervisor
Human Services Section
Civil Division (Juneau)
Department of Law
Juneau, Alaska
POSITION STATEMENT: Testified and answered questions during presentation of HB 227.

BECKY HULTBERG, President/CEO
Alaska State Hospital and Nursing Home Association
Juneau, Alaska
POSITION STATEMENT: Testified and answered questions during the presentation of HB 227.

ACTION NARRATIVE

3:03:21 PM

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

HB 227-MEDICAL ASSISTANCE REFORM

3:03:50 PM

CHAIR SEATON announced that the first order of business would be HOUSE BILL NO. 227, "An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

CHAIR SEATON explained that these reform efforts had been introduced last year in a bill combined with Medicaid Expansion, and were now being presented separate from Medicaid Expansion.

3:04:42 PM

TANEEKA HANSEN, Staff, Representative Paul Seaton, Alaska State Legislature, explained that the proposed bill was comprised of reform components, with a goal to renew the conversation around Medicaid reform, especially important in the current budget climate for sustainability and efficiency in all the programs. These reforms had all been discussed in the last year, and many of the reforms would require approval by the legislature in order to give Department of Health and Social Services the authority to move forward.

MS. HANSEN stated that proposed HB 227 encompassed three categories: administrative and procedural changes to help the department administer the program, pursue overpayments, and lessen the burden on providers; offer direction to the department in application for waivers to implement cost reform options, pursue demonstration and pilot projects, and execute other system wide reforms for improvement to care and efficiency; require reports which maintain accountability to the Alaska State Legislature. She reported that, based on the quantifiable reforms, the initial estimated savings was more than $300 million, which had since been updated with new information from Department of Health and Social Services. She added that additional savings could be recognized from other reforms in the proposed bill, including the demonstration projects and super utilizer managed care.

3:08:32 PM

CHAIR SEATON clarified that the proposed bill would not be moved today, and would be held over for further consideration.

MS. HANSEN declared that health care reform needed to be a continuous process of ways to improve on the current system and search for better care.

3:09:17 PM

MS. HANSEN paraphrased from the Sectional Analysis, which read:

> **Section 1** Page 1-2 Legislative intent language that asserts that the current Medicaid Program is unsustainable. The department of Health and Social Services should take the steps necessary to capture additional federal revenue, obtain waivers for tribal partnerships and alternative service models, and establish prevention of disease a primary model of health care.
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> **Section 2** Page 2 Adds civil penalties assessed against Medicaid providers to the procedures covered by administrative adjudication under AS 44.62.330.
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> **Section 3** Page 2-4 Directs the Department of Health and Social service to assist Medicaid providers in developing health care models that encourage nutrition and disease prevention by adding to the duties of the department under AS 47.05.010.

MS. HANSEN pointed out that the background information [Included in members' packets] presented a summary of the projected health care savings related to Vitamin D sufficiency, which summarized the findings of two studies reviewing the economic burden of Vitamin D deficiency in Canada and Germany. If Alaska recognized similar results as Canada, there could be a 6.9 percent reduction in economic burden, a savings of $28.5 million in annual savings based on the preceding year costs. She noted that this was one of the aforementioned reforms that would not reflect directly in the fiscal notes.

3:11:55 PM

MS. HANSEN moved on and paraphrased from Section 4, which read:

Section 4 Page 4-5 Amends AS 47.05.200(a) to clarify the minimum number of audits that DHSS should conduct each year and that DHSS should minimize duplicative state and federal audits for Medicaid providers to the extent possible.

Section 5 Page 5-6 Amends AS 47.05.200(b) to allow DHSS to impose interest penalties on identified overpayments using the post judgment statutory rate.

MS. HANSEN shared that the intention was for adequate notification and a grace period, and would provide some incentive for providers once overpayments had been identified, to repay the department in a timely manner.

3:13:19 PM

MS. HANSEN paraphrased from Section 6, which read:

Section 6 Page 6 Adopts AS 47.05.250 which authorizes DHSS to develop provider fines though regulation for violations of AS 47.05, AS 47.07 or regulations adopted under those chapters, in addition to other remedies allowed under the chapter. Allows that Medicaid providers may appeal civil fines through the office of Administrative Hearings.

MS. HANSEN explained that the intent was to create a medium enforcement opportunity, in lieu of an audit. She moved on to the next sections, which read:

Section 7 and 8 Page 6-8 Amends AS 47.07.020(g) and (m) to clarify when DHSS may impose transfer of asset penalties when determining eligibility for Medicaid. Clarifies under (g) that the department may only consider information that is verified through a source other than the claimant.

3:16:20 PM

MS. HANSEN reported on Section 9, which read:

Section 9 Page 7 Amends AS 47.07.030(d) to make the establishment of a primary care case management for identified super-utilizers a mandatory service for the department.

3:17:01 PM

REPRESENTATIVE TARR referenced an earlier pilot program, and asked if this would instead address "anything going forward."

MS. HANSEN, in response, offered her belief that this would not interfere.

3:17:47 PM

MS. HANSEN directed attention back to the Sectional Analysis, which read:

> **Section 10** Page 7 Requires the department to include in an annual report to the legislature a description of state costs for optional and mandatory Medicaid services.

CHAIR SEATON clarified that previously there had been two different ideas: provide optional services as opposed to mandatory services, as the optional services were cheaper; or, we provide a vast array of services more than required, only because these optional services were available. Stating that it was difficult to separate these philosophical approaches without a report, this section of the proposed bill required a report detailing the two sets of proposed services.

REPRESENTATIVE TARR presented an example which she opined was necessary to better understand the optional services, surmising that these were often less expensive as they offered prevention to more costly long term chronic health problems.

CHAIR SEATON suggested that representatives from the Department of Health and Social Services (DHSS) should be questioned for further clarification regarding this section.

3:20:37 PM

MS. HANSEN discussed the next two sections, which read:

> **Section 11 and 12** Page 7 Amends AS 47.07.036(b) to remove conflicting language and adds AS 47.07.036(d) to outline cost reform measures that DHSS shall undertake, including demonstration waivers, applying for the 1915 (i) and (k) options, and improving telemedicine for Medicaid recipient. Directs the

department to implement at least one demonstration project using a global payment project and allows for other similar projects.

MS. HANSEN suggested that discussion could center on the Centers for Medicare & Medicaid Services (CMS) recommendations and how these could bolster the aforementioned waivers. She noted that defining the criteria for the aforementioned options could also shift some costs to federal funds.

REPRESENTATIVE TARR asked to review the global payment fee structure.

MS. HANSEN deferred to DHSS and to Ms. Hultberg during her presentation later in the committee meeting, offering her belief that this was a version of provider coordinated care.

MS. HANSEN pointed out that the definition of telemedicine included visual, and that the committee supported its expansion in appropriate ways.

3:26:55 PM

MS. HANSEN discussed the next sections, which read:

Section 13 and 14 Page 9 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.

MS. HANSEN explained that the intention was to expand access to behavioral health services, which were important to the Medicaid population, by removing the grantee language to allow enrollment for smaller providers and allow for medium level care to help prevent more intensive care needs.

3:28:09 PM

MS. HANSEN reported on the next section, which read:

Section 15 Page 9 Directs the department to design and implement a demonstration project utilizing nutritional counselling and supplementation to reduce preterm birth rates among pregnancies eligible for the Denali Kid Care program.

MS. HANSEN explained that a project currently underway in South Carolina, "Protect our Children Now," was working in collaboration with Select Health, a managed care organization. She pointed out that the educational resources and data systems already existed under this model, and she directed attention to the summary of the model, which included its cost and savings [Included in members' packets]. She reported that $450,000 could be spent for the education, supplementation, and testing of 500 pregnancies under this model, noting that the average cost of a pre-term birth was $55,000. She shared that research studies had shown a decrease of 50 percent in the pre-term birth rate, which would reflect a substantial savings.

REPRESENTATIVE WOOL, noting that the pre-term birth rate in Alaska was 8.5 percent, asked about this rate in South Carolina and its corresponding results.

MS. HANSEN opined that, although the background material did not list the South Carolina pre-term birth rates, it was about 13 percent, higher than that in Alaska. She reported that the two research studies on which the aforementioned project focused found a reduction of more than 50 percent in the pre-term birth rate, with the corresponding substantial savings. She acknowledged that there could be some differences in Alaska.

REPRESENTATIVE TARR asked what components, other than Vitamin D, were included in "Protect our Children Now."

MS. HANSEN offered to share the handout from the South Carolina program, which described the project. She declared that, although the focus was on Vitamin D, there was other nutritional counseling in the program. She noted that the research project was in low income community health centers in ethnic areas which had higher rates of Vitamin D deficiency due to skin pigment, even though the state was in a more southerly latitude.

CHAIR SEATON added that the South Carolina model was being replicated in either Montana or Idaho, and funded by Select Health, the local insurance provider, in order to study the savings. He noted that nutritional counseling and non-smoking counseling were part of this established pre-term birth model. He reported that it included at least one post-partum test on Vitamin D status. He pointed out that there was a $1.5 million savings on a $450,000 investment plus the health benefits. He asked whether the state wanted to contract with an organization or have DHSS "start from scratch and develop something." He declared that there was a pre-term birth problem in Alaska, with

some areas reporting 14 percent pre-term births. He stated that the goal of the pilot project was "to find out if something works for Alaska the way it works for other areas of the United States."

3:35:15 PM

MS. HANSEN moved on to discuss the next section, which read:

> **Section 16** Page 10 Requires the Department of Health and Social Services to establish a primary care case management system for super-utilizers and deliver a report on the project by January 1, 2017.

MS. HANSEN shared that the intention was to make the terms broad enough to include the current DHSS projects addressing the super-utilizer issues, and to require a report to the Alaska State Legislature. She added that this section also required the department to provide a report to the legislature on the Medicaid redesign and expansion technical assistance study, on the current cost sharing measures, and on the progress on cost savings of the waivers under Section 12 of the proposed bill. She stated that the language had been slightly modified relevant to the Medicaid Redesign report. She explained that the intention behind the report summarizing cost sharing measures implemented prior to October 1, 2015, mentioned in subsection (b), was to list the current status of cost sharing, including co-pays, to give a better understanding for any consideration for change.

3:39:22 PM

MS. HANSEN moved on to discuss the remaining sections, dealing with conditional effects, which read:

> **Section 17** Page 10 Requires the Department of Health and Social Services to provide to the legislature reports on the Medicaid Redesign and Expansion Technical Assistance study, current cost-sharing measures in the Medicaid program, and on the progress and cost savings of the waivers and options applied for under section 12 of this legislation.
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> **Section 18** Page 11 Informs the revisor of statutes that the Department of Health and Social Services shall apply for federal approval for the state plan

amendments necessary under section 9, 12, 15, and 16 of this Act.

Section 19 Page 12 Permits the Department of Health and Social Services to adopt the regulations necessary to implement this act, not before the effective date of the relevant provisions.

Section 20 Page 12 Instructs the revisor of statutes to make technical amendments to the title of AS 47.07.036 to conform with the changes in this Act.

Section 21 Page 12 Clarifies that changes enacted in sections 9, 12, 15, and 16 only take effect if the Department of Health and Social Services receives the necessary federal approval by the deadlines created in this Act.

Section 22-25 Page 13-14 States that if AS 47.07.0309(d) as amended by section 9 and section 16, section 12(e), section 12(f), and section 15 receive federal approval, each section will take effect the day after the date the commissioner of health and social services notifies the revisor of statutes in writing, as required by sections 18 and 21.

Section 26 Page 13 Provides that sections 17(a), 18, 19 and 21 take effect immediately.

3:40:52 PM

REPRESENTATIVE VAZQUEZ directed attention to page 11 of the proposed bill, and asked whether there was a report on options 1915(i) and (k).

MS. HANSEN replied that a current requirement under Section 17 required a DHSS report to the legislature on February 1, 2019 regarding these and other waivers.

REPRESENTATIVE VAZQUEZ suggested that there was some information and experience from other states which indicated that some of these actions would increase the number of Medicaid beneficiaries. She asked if there had been any studies for the number of new enrollees as a result of these two options.

MS. HANSEN deferred to DHSS, and she opined that this would depend on the definitions of the eligibility criteria.

3:44:20 PM

VALERIE DAVIDSON, Commissioner, Office of the Commissioner, Department of Health and Social Services (DHSS), offered her general comments on the proposed bill. She reiterated that the administration was very committed to Medicaid reform, that reform was a constant for those states that did it well. She highlighted that, over the last several weeks, numerous reports had been released on reform opportunities. She offered that those reports may provide additional reform opportunities for the committee to consider.

JON SHERWOOD, Deputy Commissioner, Medicaid and Health Care Policy, Office of the Commissioner, Department of Health and Social Services, in response to Representative Vazquez, listed his areas of responsibility, which included the Medicaid program as well as four divisions, the Division of Alaska Pioneer Homes, Division of Public Assistance, Division of Health Care Services, and Division of Senior and Disabilities Services.

CHAIR SEATON asked for discussion on the 11 fiscal notes for proposed HB 227.

MR. SHERWOOD pointed out that the 11 fiscal notes did not necessarily "tie neatly to a section of bill," as there were "a lot of moving parts in each fiscal note." He summarized that the net impact was to reduce costs or shift from state general funds to federal funds or another source of revenue. He reported that the total of all the fiscal notes would result in a net reduction to the general fund of $2,889,000 in FY17. He shared that it would also reflect a change in tribal policy with a projected reduction of $12,350,000. The savings would continue to accrue as other programs were implemented, as not all the programs in the proposed bill would start on Day 1. He shared that these savings would grow and, for FY2022, there was a projected reduction in general funds of $88,431,000. He opined that the cumulative savings were more than $300 million over the next six years.

3:51:14 PM

MR. SHERWOOD directed attention to the first fiscal note which reflected the administrative costs at the Division of Behavioral Health, labelled OMB Component Number 2665, which revolved around implementation of Section 12 of the proposed bill. He reported that this included coverage of behavioral health

services administration under the 1115 demonstration waiver to restructure the services. He explained that this would include the addition of one full time staff person to work on the development and administration of a demonstration waiver, at an annual cost of $127,800 in FY 17, with an additional one time cost of $8100. He pointed out that these were paid with 50 percent each of general funds and federal funds.

REPRESENTATIVE STUTES asked how long the federal funding would last.

MR. SHERWOOD replied that this was a 50 percent federal match funding, a standard administrative activities match for Medicaid, which had existed since the inception of the Medicaid program, and it would require congressional action to change those federal match rates.

REPRESENTATIVE STUTES declared that she was skeptical, and asked if there was any assurance for this reimbursement.

COMMISSIONER DAVIDSON, in response to Representative Stutes, said that the guarantee was that federal law mandated this rate, and it would require a change in federal law and the consent of both bodies of Congress and the president.

REPRESENTATIVE VAZQUEZ said that her research found that Congress had changed the federal match several times, and she offered her belief that it would again be changed in the future. She asked how often that had been changed.

CHAIR SEATON asked for clarification that the request was for any changes to federal match, pointing out that the response had been specifically for the administrative fee.

REPRESENTATIVE VAZQUEZ replied that she wanted to know of any changes, including the administrative fees.

COMMISSIONER DAVIDSON expressed her agreement that Congress had occasionally changed the Federal Medical Assistance Percentages (FMAP), pointing out that most recently there had been enhancements to increase the federal match and decrease the match requirement for states. She acknowledged that there had been a time when the normal calculation for FMAP had indicated a 50 percent match for Alaska, however, then Senator Ted Stevens, Chair of the Appropriations committee, had provided a rider to increase the Alaska FMAP beyond the 50 percent. She reported that it had since been returned to the original rate.

REPRESENTATIVE VAZQUEZ asked if Commissioner Davidson's recent testimony to no change had changed, stating "maybe your memory was jogged."

COMMISSIONER DAVIDSON replied that she had not stated that the FMAP had not changed, and, responding to Representative Vazquez, she asked "was that in this committee?"

REPRESENTATIVE VAZQUEZ replied that either the commissioner or Mr. Sherwood had stated that the FMAP had never changed.

COMMISSIONER DAVIDSON offered her belief that the Deputy Commissioner had stated that the administrative match of 50 percent had not changed.

MR. SHERWOOD, in response to Representative Vazquez, explained that he had stated that, to the best of his knowledge, there had never been a change to the basic administrative match of 50 percent, although some other activities had been identified for enhanced match.

4:01:35 PM

REPRESENTATIVE TALERICO asked if the intention for this section of the proposed bill was to increase the efficiency.

MR. SHERWOOD replied that this was for effectiveness, "to make behavioral health services more effective in how we deliver services." He opined that an expectation would be to gain efficiencies.

REPRESENTATIVE VAZQUEZ asked for the amount of grants issued to date in FY16 to behavioral health providers.

COMMISSIONER DAVIDSON offered to provide the information, pointing out that this was not reflected in the fiscal note being discussed.

REPRESENTATIVE VAZQUEZ requested the same information for FY15. She asked if the department posted the list of grantees on its website.

MR. SHERWOOD replied that he would find out.

REPRESENTATIVE VAZQUEZ, in response to Chair Seaton, asked to receive the list from FY15 and FY16.

4:04:29 PM

MR. SHERWOOD directed attention to the fiscal note for Medical Assistance Administration costs to the Division of Health Care Services, OMB Component Number 242. He said that this would consist of one long term, 24 month, non-permanent position to handle the increased volume of appeals for civil fines, with an annualized cost of $54,000 and an additional one-time cost of $7600. He said that, from Section 12 of the proposed bill, one additional full time position would be needed to oversee the tribal claims, with an annual cost of $86,500 beginning in FY17 and a one-time cost of $7600. He pointed out that the federal match for these administrative positions was 50 percent. He pointed out that this would decline over time as the aforementioned non-permanent position phased out.

CHAIR SEATON asked about the increase in FY18 to $97,300.

MR. SHERWOOD replied that the temporary position would only be necessary for six months in FY17, noting that experience had shown that implementation of a new program brought a spike in the volume of appeals until, as the process was better understood, the volume would decrease.

CHAIR SEATON asked about any anticipated revenue from those fines.

MR. SHERWOOD said there had not been a calculation for recovery to expense, although there was some information for expectations to recovery in an additional fiscal note.

4:08:27 PM

REPRESENTATIVE VAZQUEZ asked if this proposed position was being established to address the corrective action plan necessary to submit to CMS as a result of the recent audit.

MR. SHERWOOD replied that this position was not related to the corrective action plan addressed in the recent audit, but, instead, addressed the provisions in the proposed bill. He stated that the provisions of the proposed bill did not relate to the recent audit.

REPRESENTATIVE VAZQUEZ asked for clarification what in the proposed bill would require this additional resource.

MR. SHERWOOD explained that the implementation of the civil penalties provision, with the authority to impose fines in Section 6, necessitated this. He noted that new federal policy on tribal claiming could lead to expectations for enhanced claiming from tribal health providers, and would need some degree of oversight and monitoring for eligibility.

4:11:32 PM

REPRESENTATIVE VAZQUEZ, referencing page 6, lines 13 - 16, of the proposed bill, which discussed the assessment of civil penalties, asked how this interfaced with the criminal prosecution of Medicaid providers by the Medicaid Fraud Control Unit.

4:13:05 PM

STACIE KRALY, Chief Assistant Attorney General, Statewide Section Supervisor, Human Services Section, Civil Division (Juneau), Department of Law, in response to Representative Vazquez, stated that there were two separate processes contemplated within the proposed bill, whereby DHSS would have the ability to impose civil fines in the context of civil actions related to overpayments or sanctions issued against Medicaid providers. She stated that these would be separate and distinct from Medicaid fraud prosecution, which could also have an associated criminal fine or penalty. She pointed out that criminal conduct was not addressed in the context of this proposed bill.

REPRESENTATIVE VAZQUEZ asked who made the decision for criminal or civil prosecution.

MS. KRALY explained that the decision for a criminal case was determined by the Medicaid Fraud Control Unit. If there was an allegation of improper billing or activity, DHSS would meet with Department of Law and the Medicaid Fraud Control Unit to decide what to do. Even if a criminal action was taken, this did not limit a civil review by DHSS of inappropriate action. She noted that sometimes there were concurrent processes, but that the primary decision for who acted was with the Medicaid Fraud Control Unit.

REPRESENTATIVE VAZQUEZ asked who made the referral to the Medicaid Fraud Control Unit.

MS. KRALY replied that this could be made by anyone to either DHSS or the Medicaid Fraud Control Unit.

REPRESENTATIVE VAZQUEZ stated that she liked Section 6 of the proposed bill.

4:17:24 PM

REPRESENTATIVE VAZQUEZ directed attention to page 5, lines 1 - 31, and page 6, lines 1 -3 of the proposed bill. She pointed to page 5, lines 5 - 10, which statutorily reduced the number of audits, and she opined that reducing the number of audits was not a good idea as it reduced the accountability. She acknowledged that, page 5, lines 18 - 20, explicitly stated that DHSS should "attempt to minimize concurrent state or federal audits," and she expressed her agreement, although she "strenuously" objected to the reduction of audits.

COMMISSIONER DAVIDSON, in response, stated that as the national Medicaid program had further developed, there was an increasing number of federal audits imposed on providers. In order to minimize the concurrent state or federal audits mentioned on page 5, lines 18 - 20, of the proposed bill, it was necessary to reduce the number of audits, as stated on page 5, line 5. She declared that, even with this provision, the number of audits required by the provider community had increased over time.

4:21:38 PM

MR. SHERWOOD, in response to Chair Seaton, asked that, as DHSS counted enrolled providers in different ways, he would respond later to ensure that his answer matched the definition used in the provision.

CHAIR SEATON reflected that the minimum number of audits could be in the hundreds depending on the required 0.75 percent of all providers, and he mused whether there was any relevance to the not less than number.

MR. SHERWOOD relayed that the range of audits was close to 75 during an annual cycle.

REPRESENTATIVE VAZQUEZ pointed out that the auditor used analytics to look at high risk provider profiles. She offered her belief that there were about 3000 Medicaid providers, and that historically, the department had chosen to undertake 75 audits, which she deemed was not "outrageously high."

MR. SHERWOOD replied that he would send the current count to the committee, and he expressed appreciation for the point that DHSS did not have random targeting for audits. He noted that the pool of high risk providers was substantially smaller, and shared that DHSS did not want to burden the low risk, low volume providers simply to make a number.

REPRESENTATIVE VAZQUEZ acknowledged that DHSS worked hand in hand with the audit contractor to help identify the high risk providers.

MR. SHERWOOD, in response to Representative Vazquez, said that MMIS (Medicaid Management Information Systems) was a generic term for the claims processing system under the federal definition. He clarified that Enterprise was what the vendor called its specific product. He explained that "capture the income contingent cost sharing rules set in new federal regulations" on the last line of page 2, fiscal note 2, referenced a federal regulation which limited total cost sharing to 5 percent of household income for some Medicaid recipients.

REPRESENTATIVE VAZQUEZ asked for the citation to that federal regulation.

MR. SHERWOOD said that he would forward that to the committee.

4:28:16 PM

MR. SHERWOOD moved on to fiscal note 3, labelled OMB Component Number 2696, from the Office of Rate Review in the Division of Health Care Services. This office established rates for many of the provider payments. Directing attention to the proposed bill, Section 12, subsections (e) and (f), he pointed out that these outlined the requirement for one or more demonstration projects focused on innovative payments including one that includes a global payment fee structure. He reported that fiscal note 3 included one-time costs for hiring a contractor to analyze and implement a new payment model at a cost of $500,000 in FY17, with the assumption for on-going actuarial work in subsequent years associated with the calculation of those payments, at a cost of $100,000 per year. He noted that as these were general administrative costs, the state would only have to pay 50 percent.

REPRESENTATIVE VAZQUEZ asked if an RFP (request for proposal) for a contractor had been issued.

MR. SHERWOOD replied there had not been any action just yet.

REPRESENTATIVE VAZQUEZ expressed her assumption that the money would be distributed through the Office of Rate Review, and was solely devoted to the 1115 demonstration waiver.

MR. SHERWOOD replied that it was for the global payment demonstration mentioned in the proposed bill.

REPRESENTATIVE VAZQUEZ asked if the global demonstration was also the 1115 demonstration waiver.

MR. SHERWOOD offered his belief that the proposed bill specified the 1115 demonstration waiver.

REPRESENTATIVE VAZQUEZ asked if implementation of this 1115 waiver would add new beneficiaries.

MR. SHERWOOD replied that it was not envisioned for the 1115 waiver for global payment to add new beneficiaries, as it would simply change the method of payment for services delivered to current beneficiaries.

CHAIR SEATON pointed out that this was a change from fee for service for value toward the HMO (health maintenance organization) model.

4:32:55 PM

REPRESENTATIVE VAZQUEZ asked about the FMAP (federal medical assistance percentages) for the 1115 waiver if the beneficiary goes to a non-tribal facility.

COMMISSIONER DAVIDSON explained that U.S. Secretary of Health and Human Services Burwell had announced a policy change that would allow Alaska and 34 other states with significant tribal membership to be reimbursed at 100 percent federal match for medically necessary accommodations and travel, as well as for services referred through an IHS (Indian Health Service) facility to a non-tribal facility. She reported that negotiation for this was ongoing with CMS, as well as with other states, as it was a significant national policy change for IHS beneficiaries.

CHAIR SEATON asked to relate this to the global payment model.

MR. SHERWOOD explained that the 1115 demonstration waiver had to be cost neutral. He explained that the federal match was negotiated based on what you intend to do, and "how far afield it is of regular Medicaid." It would be negotiated to a rate that kept it cost neutral for the federal government, with anticipation that the purpose was for savings across the board, and not to add anything extraordinary that was not typically covered, so that the match rates would be for services provided as they applied. He stated that those eligible for tribal match would be at the 100 percent match rate, family planning would be 90 percent match rate, and the base match rate for services would be 50 percent. He pointed out that signing the 1115 waiver was technically an agreement for just how much the federal government would support the project. He clarified that this was the global payment feature.

REPRESENTATIVE TARR requested further detail on global payment, asking if this negotiated FMAP with tribal partners was one component.

MR. SHERWOOD explained that the change in tribal policy was a separate waiver, and the global payment waiver was not dependent on that change. He stated that global payment was a move away from fee for service, looking, instead, for consolidated payment such as a shared savings agreement to provider groups.

REPRESENTATIVE TARR asked whether provider groups might include the state health coverage through Aetna rather than individual fee for service.

MR. SHERWOOD replied that he did not envision this through an insurance company, although an insurance company could be involved as a third party administrator managing the money and cash flow. He stated that typically these were organizations, and offered an example of a community where the hospital, the primary care doctors, the clinics, the behavioral health providers all get together and agree to certain practices and relationships to deliver care more effectively and share and distribute the savings or assume the risk. He offered an example of an innovative hospital project in Ketchikan to better manage chronic care. Under the previous fee for service system, the benefits did not accrue directly to the hospital, but this innovation would allow for some redistribution of those benefits to offset some of the revenue loss.

REPRESENTATIVE TARR asked if, under this scenario, the state was not the payment manager.

COMMISSIONER DAVIDSON, in response to Representative Tarr, shared that a recommendation from the Agnew::Beck Consulting, LLC report on Medicaid Redesign and Expansion was for an accountable care organization, for example, an insurance company, an administrative services company, or a group of providers who came together. She explained that this was a demonstration that would move away from fee for service. She declared that payment reform established disincentives to repeat occurrences, creating, instead, an incentive for prevention, wellness activities, and providing more effective care.

4:44:32 PM

REPRESENTATIVE WOOL asked to clarify that global payment was managed care, a health cost savings measure, and that Alaska was investigating these programs.

COMMISSIONER DAVIDSON replied that she had described one type of care management. She pointed out that there was also a legal entity called a Managed Care Organization, which was its own special structure. She reported that there were many models for care management opportunities, and that the Agnew::Beck Consulting group had spent considerable time discussing the various options to managing the care for Medicaid beneficiaries, as well as analysis for which models made sense for Alaska.

REPRESENTATIVE TARR asked if this was a demonstration project only for Medicaid recipients.

COMMISSIONER DAVIDSON replied that this particular section of the proposed bill was for Medicaid beneficiaries.

CHAIR SEATON opined that an entity using a global payment model at the same time with other insurers was a separate question, but was not part of the state Medicaid population.

REPRESENTATIVE VAZQUEZ asked for a list of the various FMAPs applicable to this 1115 waiver.

CHAIR SEATON reminded the committee that it was still unknown whether there would be a tribal component. He surmised that it would be very difficult to accurately predict all components, because we could have some FMAP rates but we don't know how big or small each recipient type will be.

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BECKY HULTBERG, President/CEO, Alaska State Hospital and Nursing Home Association, stated that there was no easy button in health care reform, and that, although it was really hard work and was expensive and time consuming, it was worth doing as it concerned both the fiscal impact to the State of Alaska and to the care to every patient. She stated that health care was undergoing a period of rapid transformation. During this time of budget difficulties, it was necessary to look ahead and create a road map for how health care would be transformed from its current system, which needed to change, to something ahead. The transformation needed to make economic sense for the state and for patients and communities, and needed to be sustainable, patient centered, and meet the needs of the communities. She reported that many pieces needed to be reviewed, including short term cost containment to better manage cost for the next few years. She suggested a hospital based emergency room initiative, which was one of the recommendations from both the Agnew::Beck report and the hospitals. She shared that this would almost immediately reduce emergency room utilization, emergency room costs, and opioid prescriptions from the emergency room. She suggested the coordination of care among frequently hospitalized Medicaid recipients. She declared that, although both of these would reduce hospital revenue, managing utilization was the right way to approach cost containment and make the transition from volume based to value based care. She moved on to discuss the foundational elements of long term health care reform, what needed to be done now to set the infrastructure in place. She stated that an enhanced role for primary care was very important, opining that the concept for this was embedded in proposed HB 227. She declared that the Medicaid system needed to focus on primary care as the gatekeeper for services. She moved on to state that data analytics, a robust data system, was necessary to understand where the Medicaid patients were going, how were they using the services and what patterns were observed, and how this could be managed based on these observations. She acknowledged that this could cost money now, but the return was in the long term from better management with better data. Lastly, she addressed payment reform, the move from compensation based on volume to compensation based on outcome. She pointed out that this was a huge change in health care that would not be made overnight. She declared support for proposed HB 227, as it offered pilot programs with provider groups and communities to advance payment reform. She stated that there was not the infrastructure on a global scale to "go all in on one type of payment reform or another." She offered her belief that innovation would emerge

through these pilot programs which could then be broadly adopted. She encouraged a pilot approach for the payment reform projects.

4:55:08 PM

REPRESENTATIVE WOOL asked if this move away from fee for service had to be system wide or just for Medicaid.

MS. HULTBERG replied that her counterparts across the United States had agreed that the entire system needed to move away from fee for service, even though it would take a long time. She stated that, as Medicare was a significant part of a hospital payer mix, and, as Medicare had stated it would move to value, this change could happen more quickly in hospitals.

MS. HULTBERG stated that availability of data for decision making was really important, as was the capacity of the Department of Health and Social Services to manage the change. Although this was a time of fiscal challenge, it would still take time and investment and people to do the work. She suggested that it was necessary to assess what the department could realistically accomplish and in what time frame, and then either resource them to do it, or phase it so it was manageable.

MS. HULTBERG, commenting on Section 9 of the proposed bill, endorsed the concept of coordinated care for primary case management, as it was a foundational building block for health care reform. She expressed concern over the managed care organization (MCO) model as it was predicated on high volume, and Alaska was a low volume state. She suggested that this be an optional aspect, as primary care case management should be the focus. She referenced the Agnew::Beck report which indicated that the MCO model would not bring any savings to Alaska. She declared support for expansion of behavioral health services, Sections 13 and 14 of the proposed bill. She stated that behavioral health needs were equally important to address as medical needs. She pointed to data which supported that behavioral health needs often included high medical needs. She said that ASHNA was still reviewing and evaluating the fraud and abuse sections of the proposed bill. She noted that ASHNA was a low risk provider group, but she pointed out that audits added significant administrative time and cost. She expressed concern with over regulation and applauded the efforts to streamline the audit function. She shared that a significant complaint about audits was for the time and cost of compliance to both federal and state audits.

REPRESENTATIVE TARR relayed that one of her constituents, a small provider, reported spending tens of thousands on audits, and she expressed a desire to align the state and federal audits. She stated that there was already a lot of data, and asked if the need was for more real time data to better evaluate the patterns.

MS. HULTBERG said that it was a need for a more advanced analytics capability, and not for raw data, in order to better target interventions.

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MS. HULTBERG commented that most of the components of the proposed bill were directionally correct, and that it was necessary and important work. She declared that overall the Alaska State Hospital and Nursing Home Association was pleased with the bill, that it was "a really good next step as we go down this journey to reform."

[HB 227 was held over.]

5:02:34 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:02 p.m.