ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 11, 2016
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

OTHER LEGISLATORS PRESENT

Representative Dan Ortiz

COMMITTEE CALENDAR

PRESENTATION: MEDICAID REDESIGN AND EXPANSION TECHNICAL ASSISTANCE INITIATIVE

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

THEA AGNEW BEMBEN, Managing Principal
Agnew::Beck Consulting
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint titled "Medicaid Redesign and Expansion Technical Assistance Initiative."

NORA LEIBOWITZ, Principal
Health Management Associates (HMA)
Portland, Oregon
POSITION STATEMENT: Testified and answered questions during the PowerPoint presentation.

SUSAN PANTELY
Milliman, Inc.
San Francisco, California
POSITION STATEMENT: Testified and answered questions during the PowerPoint presentation.

ACTION NARRATIVE

3:04:43 PM

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

Presentation: Medicaid Redesign and Expansion Technical Assistance Initiative

3:05:37 PM

CHAIR SEATON announced that the first order of business would be a presentation on the Medicaid Redesign and Expansion Technical Assistance Initiative. He noted that this presentation was in relationship to proposed HB 227 regarding Medicaid Reform, which had substantial budget implications over the next several years.

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THEA AGNEW BEMBEN, Managing Principal, Agnew::Beck Consulting, offered some background on her company and her consulting history. She shared that that she grew up in the state and she had been working as a consultant in Alaska for 20 years. She said that her company had worked in conjunction with Health Management Associates and Milliman, Inc. on this report.

NORA LEIBOWITZ, Principal, Health Management Associates (HMA), reported that the HMA team were primarily the subject matter experts, working closely in discussions with stake holders and the state, in development for the recommendations.

SUSAN PANTELY, Milliman, Inc., shared that Milliman, Inc. was an actuarial consulting firm, and they had provided actuarial analysis for the report. She noted that Milliman, Inc. had

consulted with more than half the states on Medicaid and the implications of the program.

MS. BEMBEN emphasized that the project timeline had been intense, beginning in July, 2015, and the final reports were published on the Department of Health and Social Services website on January 22, 2016, slide 2. She noted that the Agnew::Beck report included an analysis from Milliman, Inc. although the Milliman report in full had been also published separately.

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MS. BEMBEN directed attention to slide 3, "Project Overview," and reported that the project began with an environmental assessment lead by HMA, which compared the experience of other states with Medicaid Reform, as well as an analysis of the various federal financing mechanisms available. She added that it provided an overview of some of the ongoing reforms in Alaska. She stated that the next step was the most intense part of the process, beginning with a key partner and stakeholder meeting at which the findings of the environmental assessment were reviewed with subsequent discussion for the needs and focus of Medicaid Reform in Alaska. She relayed that this was the beginning of many such meetings for the iterative process which analyzed potential reforms. She stated that the final report included not only an analysis of Medicaid reform initiative options, but also proposals for some alternative coverage models for the expansion population. The final report included recommendations from the various reform initiatives and the action steps necessary for reforms. She shared that the final piece of the contract was an evaluation plan, which would be a set of measures as a companion to the ultimate reform package.

MS. BEMBEN moved on to slide 4, "Broad Stakeholder Engagement," noting that at least 500 people had participated on some level. She stated that there were three key meetings, intended to be joint work sessions, with partners from many different sectors which interacted with the Medicaid program, as well as leadership from the Department of Health and Social Services. She added that some engagement meetings with specific sectors, including hospital administrators, physicians, tribal health, and community health centers, were also convened. She reported that they gave more than 30 public presentations, as well as webinars after each key partner meeting. She pointed to slide 5, "Key Partner Organizations" which listed some of the key partner organizations engaged in the work sessions.

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MS. BEMBEN shared slide 6, "Final Report Outline," which included an executive summary, and an introduction with a roadmap for reform. She explained that the roadmap was an attempt to lay out the recommended package with the necessary sequencing, the groundwork for the reforms that would build over time. She added that the background section was a summary of the environmental assessment document, which she described as similar to a primer for care models and federal financing mechanisms around the U.S. She described the recommended foundational reform initiatives, which included primary care improvement, behavioral health access, and data analytics and IT infrastructure, as necessary to be implemented first before other more comprehensive reforms. She stated that the emergency care initiatives and the accountable care organization pilot initiative were the primary tests for value based payment reform. She declared that other topics had been identified for further discussion in work groups, while some topics were explored but not recommended. She reported that the final section provided information on the three options for coverage of the Medicaid expansion population, as well as an appendix containing the reference material.

MS. BEMBEN described slide 7, "Final Report: Roadmap for Reform," and slide 8, "Goals for Medicaid Redesign + Expansion." She stated that these were the initial goals introduced in the Request for Proposal (RFP), considered the goals for Medicaid redesign and expansion. She shared that the goals were to improve outcomes for enrollees, optimize access to care, drive increased value, and provide cost containment. She allowed that although it was difficult to balance all of these goals, the report had attempted to do just that and not focus on one over another.

MS. BEMBEN addressed slide 9, "Alaska Medicaid Redesign: A Phased Journey to Peak Performance," sharing that the graphic was used throughout the report to communicate the journey and its phased sequence for building capacity for further reform.

MS. BEMBEN described slide 11, "Final Report: Recommended Package of Reforms," stating that its main sections included Foundational System Reforms, Paying for Value, Pilot Projects, and Recommendations around Work Group topics.

MS. PANTELY introduced slide 12, "Final Round of Analysis Included Actuarial Analysis by Milliman, Inc." which was based on claims data from 2014 for the Alaska program. She reported that statistical models were used, and estimates were based on already implemented national programs as well as their knowledge of the health care system. She acknowledged that any characteristics and known limitations of the Alaska marketplace were taken into consideration and weighed against the national programs. Moving on to slide 13, "Summary of Actuarial Results for Reform Initiatives," she said that they would address the savings or increased cost for each of the listed initiatives over the next five fiscal years. She shared that the baseline was the assumption for spending if none of these were implemented; however, this was only for the medical expenses and would not match the DHSS budget. She said that some populations had been excluded, including Medicare Part B, as the target had been on a broader population for ease of the projections. She pointed out that, as each of the initiatives was reviewed separately, the total would not reflect the cost for implementation of all as there could be some overlaps.

MS. BEMBEN added that the actuarial analysis was specific to the Medicaid budget, and did not include any savings that could accrue to other parts of the state budget.

MS. PANTELY explained that behavioral health grants and state taxes were all outside the scope of this analysis.

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MS. BEMBEN shared slide 14, "Analysis of Reform Initiatives," and explained that the RFP had included instructions for what each of the initiatives needed to include. She listed: description and key features of the initiative, considerations for any special populations relevant to that reform, an actuarial analysis of projected costs and savings, relevant experience from other states, potential challenges for implementation, and the proposed timeline and phases with action steps for the department when implementing the reform. She noted that those did not take into account whether it was necessary to secure budgetary authority, add staff, or secure other resources.

MS. BEMBEN described the first of the three foundational initiatives, Primary Care Improvement, slide 15, "Recommended Package of Reforms." Every Medicaid enrollee would be assigned to a primary care provider whose role would be to monitor and

coordinate the care for that enrollee. Each enrollee should have an annual health risk assessment, separate from an annual exam, similar to a questionnaire to identify higher and lower health needs and risks. She reported that care management could be helpful for improving the health of those with high risk and high health needs, although, as it was not a great return on investment for people without complicated health needs, it was important to identify those who would benefit. She stated that health homes were a state plan option for a coordinated whole person care, as well as coordination of home and community based support. It was targeted for those with higher health needs, chronic health conditions or severe and persistent mental illness. She added that it was recommended that the department contract with an Administrative Services Organization (ASO) to provide the additional capacity for help with enrollee education orientation, build a provider network, provide data analytics and IT support, and administer the health risk assessments.

3:26:00 PM

REPRESENTATIVE TARR asked for the reason to contract outside the department, as opposed to utilizing existing or new staff who had the institutional knowledge from working for the state.

CHAIR SEATON asked that the immediate questions be for clarifications only.

MS. PANTELY returned attention to slide 16, "Actuarial Results: Primary Care Improvement Initiative," which reflected an increased cost in the first few years, with a subsequent decrease over the baseline. She shared that there was an assumption that all medical costs, even in the first year, would start to decrease. The savings would increase over time, as it most often took time for the programs to get off the ground, and that providers learned from experience and became more efficient. She pointed out that the health home would start a few years after the other programs, and, as it had a higher federal match, it would also project for a greater savings.

MS. BEMBEN stated that the second initiative, Behavioral Health Access, was a companion to the first initiative, slide 17, "Recommended Package of Reforms." She suggested that DHSS apply for a Section 1115 waiver, an application for a demonstration project to propose an innovative use of Medicaid funding other than that under the traditional program. She noted that this waiver could be approved for a five year demonstration period, with the potential for a three year extension. She reported

that this would allow DHSS to contract with an administrative services organization to bring in national expertise for behavioral health systems management. This would propose a change from program and grant management into contract management. She stated that the waiver would establish standards of care to allow expansion of delivery for substance use and mental health services. She proposed that DHSS remove the requirement that providers be a grantee to bill Medicaid for behavioral health services and the broader range of providers be allowed to bill for Medicaid services, effectively broadening and increasing the available work force for additional services. In the second year of the demonstration period, they recommended to amend the waiver application to include a federal waiver of the exclusion for Medicaid funding of services within institutes for mental disease containing more than 16 beds. She pointed out that the other recommendations addressed gaps in the crisis response system. She stated that the goal of this initiative was to remove the barriers for accessing behavioral health services to allow them to be provided in an integrated fashion, early on in order to prevent the need for so much crisis service.

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MS. PANTELY explained slide 18, "Actuarial Results: Behavioral Health Access Initiative," which reflected an increase in cost for the five years of the program with increased access to the professional component and the associated prescription drugs, although some in-patient care would be avoided by moving the services to a more appropriate level of care.

MS. BEMBEN mentioned that development of the proposed health homes would provide a hub for coordinated and managed care for people with high needs, as a requirement would be for integrated physical and behavioral health services within that home.

MS. BEMBEN moved on to the third initiative, Data Analytics and IT infrastructure, stating that it was absolutely foundational to implementing these and more comprehensive reforms later, slide 19, "Recommended Package of Reforms." She explained that the initiative proposed use of the current health information exchange although it currently lacked the connectivity for full utilization. She stated that the important part of the initiative was to connect hospitals, emergency departments, and providers to the health information exchange and to integrate the prescription drug monitoring state program data base for greater accessibility to providers. She shared that it was also

proposed to contract with a data analytics firm to support value based care in order to extract information from the data repository and provide analytics to the departments for better management of utilization and costs of the program. The data analytics firm would also offer support to the providers for connection, as not all the providers had either a mandate or resources to connect. This information sharing would lead to greater opportunities for improving care and containing costs outside the tribal system, where it was already utilized.

MS. BEMBEN discussed Initiative 4: Emergency Care, slide 20, "Recommended Package of Reforms," which she called a pay for value pilot project. She explained that this was a private-public partnership which could be implemented fairly quickly. She said that a lot of this was also imbedded in the aforementioned Initiative 3, as it was about connection through better IT infrastructures for better information sharing among the different departments, in order to reduce preventable emergency department use and better facilitate follow-up with primary care and behavioral health providers. She stated that this would link to Initiative 1 and the need for assignment of a primary care provider. She reiterated that primary care and behavioral health were the two most needed, most basic, and least expensive forms of care offered. She added that this initiative created the connections to previous initiatives. She pointed out that this initiative also proposed a shared savings model: when emergency room use was reduced, a portion of the savings would be shared with the emergency rooms. She reported that this had been done successfully in the states of Oregon and Washington.

MS. LEIBOWITZ added that there was a reduction of $33 million in emergency room costs in the first year of implementation in the State of Washington. She pointed out that, although there was a much bigger population, this was notable for the savings and the use of the shared savings model.

MS. PANTELY directed attention to slide 21, "Actuarial Results: Emergency Care Initiative," which depicted an increase in savings for every year, including the first year of implementation. She explained that the primary savings resulted from a reduction in the facility outpatient, emergency room visits, 50 percent of these emergency room visits were replaced with an office visit to either primary care, outpatient psychiatric, or a specialist. She noted that, although there were professional charges associated with these office visits, there were also professional charges with emergency room visits,

and therefore, there was still a savings. She addressed the incentive to the emergency facilities to provide a shared savings program.

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MS. LEIBOWITZ described Initiative 5: Accountable Care Organizations Pilot, slide 22, "Recommended Package of Reforms." She stated that the accountable care organizations were a mechanism for providers within an area to come together and agree to share responsibility for the cost and quality of health care for a particular patient population. She said this was different from the more traditional full risk managed care, as what made it unique was less about payment mechanism and more about being provider driven. The provider community were the ones to make the changes in the way care was provided. She explained that the proposal for payment was the establishment of shared savings, with a target based on analysis of prior claims for the relevant population and then, if services could be provided and meet the targets for quality of care and access to care for less than the target amount, then the providers and the state would share in that savings. She suggested that, in a later stage, there could be shared losses between the providers and the state. She reported that this was different, from a financing perspective, than the full risk model of a traditional managed care organization.

MS. PANTELY described slide 23, "Actuarial Results: Accountable Care Organizations Pilot Initiative," which reflected savings in the first year of implementation after the providers formed the organization. The savings were generated from efficient and appropriate services, with an increase in preventative services. She pointed out that, as Alaska had a smaller population, there was not the critical population mass necessary for the larger savings.

MS. BEMBEN addressed slide 24, "Recommended Package of Reforms," and identified some workgroup topics for DHSS to convene and guide: expansion of telemedicine to include the non-tribal health providers; Medicaid business process improvements to bring together DHSS experts and providers to discuss the administrative burden and identify other necessary process improvements with suggested resolutions; and continued work with providers and stakeholders for ongoing Medicaid redesign.

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MS. PANTELY shared slide 25, "Actuarial Results: Potential Savings from a Telemedicine Initiative," and reported that, although there was not a specific telemedicine initiative, the analysis was based on the implementation of robust telemedicine initiatives in other states. She said that this had reduced office and emergency room visits, as well as some in-patient visits, and replaced them with telemedicine visits. She reported that there were immediate savings, which increased over time as telemedicine use became more prevalent. She shared that the initiative did not include any cost changes for non-emergency transportation, as it varied from state to state.

MS. LEIBOWITZ discussed slide 26, "Reform Initiatives Considered but Not Recommended." She spoke first about full risk managed care as an option for the expansion population, reporting that the big difference for accountable care organizations was on the structural side, as more often with full risk managed care the state was contracting with an existing insurance carrier who accepted full risk. She compared factors in Alaska, large land mass and small population with states such as Wyoming in the lower 48 which ad also had discussions for implementing this managed care, but had decided not to move forward with the full risk program. She pointed out that it had not been determined that it would never work in Alaska, but that Alaska, instead, needed to have some key fundamental reforms and changes in order to keep moving.

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MS. BEMBEN continued discussion on slide 26, and talked about a dementia care access initiative that had been brought up by stakeholders. She reported that DHSS currently had a robust process looking at its 1915 I and K options, and that the dementia access analysis should be run concurrent to these options.

MS. LEIBOWITZ spoke about the three other initiatives included on slide 26 as ways to pay for services which were not prioritized for analysis. She described bundled payments, taking a set of services and having a payment for the entire package, and offered maternity care as an example; pre-paid ambulatory and inpatient health plans as a type of managed care for a set of services, but more limited than a full risk managed care; health savings accounts, and how they worked in the Medicaid realm, noting that, although savings were possible from the use of pre-tax money, this was less meaningful for a lower income population. She shared that this had not had a huge

impact to providing incentives relative to the overall goal of getting people to use services to manage care. She reported that often, currently, doctors did not even collect co-pays, as the patients could not afford these.

3:57:23 PM

MS. LEIBOWITZ brought attention to "Alternative Coverage Models for Expansion Population," slide 27. She addressed the options: utilizing the current Medicaid benefit package with no changes; establishing an alternative benefit package based on the benefits provided in a qualified health plan, such as the commercial coverage offered through the federal marketplace; and, the states paying an insurer for private coverage, and paying for the individuals' premiums and some co-payments. After analysis, they decided it made the most sense for everyone to have the same current Medicaid benefit package. She shared that there was a lot of feedback from providers regarding the complexity of multiple packages, as this would add more administrative work. She relayed that the cost for the third option did not make it viable.

MS. PANTELY continued with slide 28, "Actuarial Results for Alternative Expansion Coverage Models," which compared the three models. The first option, the current alternative benefit program, relied on the Evergreen report and updates of more recent claims data. The second option, based on a qualified health plan, removed dental coverage with subsequent decreases in cost, although estimates for emergency room use did increase. The third option, the private option, looked at the individual marketplace on the exchange which had been experiencing very high increases, and, based on knowledge of the market, was determined to be more expensive. She shared that the federal government would pay the same amount in any option, but the State of Alaska would be required to assume the rest of the costs.

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MS. PANTELY discussed slide 29, "Actuarial Results: Expansion Option 1 Current Alternative Benefit Package," reporting that they started with the number of newly eligible adults multiplied by the projected take up rate, and arrived at the number of new enrollees. She acknowledged that, as the take up rate was very hard to predict, it was left constant after the first year. The cost per enrollee was determined from the current annual Medicaid cost for members with the same demographic mix. Moving

on to slide 30, "Actuarial Results: Expansion Option 2 Qualified Health Plan Package," she reported the use of a similar analysis, although this option removed dental services and increased the emergency room visits by a small amount. On slide 31, "Actuarial Results: Expansion Option 3 Private Coverage Option," they reviewed the insurance premiums on the individual market and the cost for adding these individuals. Using the assumption for federal payment capped at Option 1, this option reflected the cost to the State of Alaska.

MS. PANTELY relayed that the caveats on slides 32 and 33 stated that these were estimates, and, if the specifics of the program change, they should be reevaluated.

MS. BEMBEN concluded with slide 34, "Next Steps," and stated that they had made presentations to the Medicaid Reform subcommittee and House Health and Social Services Standing Committee. They would next develop some evaluation measures for the reform package.

4:04:55 PM

REPRESENTATIVE STUTES directed attention to slide 31, and asked if there was a cost evaluation if the state did not include all 27 options currently provided.

MS. BEMBEN asked for clarification that this was for the expansion population, and replied that they had not analyzed that as an option, but instead had used the current Medicaid package.

REPRESENTATIVE STUTES asked if the analysis on slide 26 considered all the infrastructure involved in telemedicine, including broadband.

MS. PANTELY replied that the analysis just considered the medical expenses and did not include any necessary investment.

CHAIR SEATON suggested starting with the beginning of the presentation for questions.

4:08:00 PM

REPRESENTATIVE VAZQUEZ referenced slide 12, and asked if the data analytics, mentioned in the Foundational System Reforms, considered the data in the MMIS system.

MS. BEMBEN said that the purpose of this initiative was to better capture and analyze data from providers, which was beyond the claims data in the MMIS system. She explained that this was seeking to analyze other types of data, not accessible through claims data, to help better measure improvement in health outcomes and manage the program.

MS. LEIBOWITZ added that part of the effort to improve access and control costs involved utilizing data collection and analysis to ensure that providers were providing the necessary services in an efficient manner. She said that these quality measures were not usually included in claims data, but required an additional effort. She explained that the benefits in the analysis included the federal requirement for the ten essential health benefits to be included for Medicaid recipients of an alternative benefit package. There was a limit as to what services could be taken out of any model.

4:11:37 PM

CHAIR SEATON asked if these analytics included the e-health network, and how it corresponded to either Medicaid or other primary care in the health system.

MS. BEMBEN replied that there was not an actuarial analysis on the data analytics initiative because there was not a clear picture of the cost for the necessary improvements. She expressed agreement that an increase for connectivity with the health information exchange would benefit other payers, as well. She stated that the third initiative on slide 11 would lay the groundwork for an all-payers claim data base, as, in Alaska, no provider had a huge market share.

4:13:30 PM

REPRESENTATIVE VAZQUEZ asked if the statewide prescription drug monitoring program would be linked with the information exchange.

MS. BEMBEN explained that the current state prescription drug monitoring program data base was difficult to access, not used by every provider, and not up to date.

CHAIR SEATON relayed that there would be a committee initiative to fix that portion of the data base not serving its purpose.

REPRESENTATIVE VAZQUEZ questioned whether all the providers were using the aforementioned prescription drug monitoring program data base.

MS. BEMBEN opined that she did not believe so, but that she did not have a precise number of users.

4:15:10 PM

REPRESENTATIVE TARR asked if the health information exchange was the same as the e-health network.

MS. BEMBEN said that the health information exchange was the IT infrastructure, and that DHSS currently contracted with the Alaska e-health network to manage it and bring on providers and vendors.

REPRESENTATIVE TARR asked if the public face of the health information exchange was the e-health network.

MS. BEMBEN expressed her agreement that the e-health network was the organization managing it, although the providers would most often be accessing information from other provider platforms through the information exchange.

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CHAIR SEATON opined that the e-health exchange was a voluntary exchange of data, and asked if this would be required with Medicaid.

MS. BEMBEN stated that they did recommend for DHSS to investigate this as a requirement for Medicaid providers. She opined that there needed to be some sort of incentive to join, as it was not simple or cost free.

4:19:43 PM

REPRESENTATIVE TARR referred to slide 15, the idea of contract versus increase of staffing.

MS. BEMBEN, in response to Representative Tarr, said that contracting with an Administrative Services Organization (ASO) offered greater capacity than currently existed. She pointed out that the report discussed the possibility of contracting with an ASO for specific program wide functions, such as data analytics. She noted that tribal health organizations may want

to take on certain functions for their enrollees, as there had been an expressed desire for more regional management of health services. She suggested that an ASO could devolve some of these functions to a regional entity. She expressed agreement with the desire to first use local capacity, although there were things for which national expertise was very useful.

MS. LEIBOWITZ stated that it could be difficult to change the entire structure of a department immediately, so, while that was happening or being considered, an ASO could provide those functions.

CHAIR SEATON asked if a contract with an ASO was a recommended reform, even though the benefits were only for those that were at high risk and high cost. He questioned whether identifying those people for primary care and continuity of care was where the savings originated, and he asked for the projected outcome.

MS. BEMBEN referenced slide 15 and stated that the primary reason, a fundamental assignment, was to connect every Medicaid enrollee with a primary care provider, which she declared to be a critical step. She explained that the health risk assessment was also for every enrollee, but the value of this assessment was for its identification of people with higher health needs or risks. She said those enrollees could be referred to the higher levels of care management, with the possibility for receiving services from a health home, or, if they were identified as a high utilizer of emergency room services, they could be enrolled in the DHSS current care program. She shared that conversations with stakeholders indicated that there were some pilot efforts for this care management, although it was difficult to identify those people who would most benefit. She explained that these assessments would help DHSS identify the higher health needs and risks, and prevent future high utilizers with better care management early on.

4:25:40 PM

REPRESENTATIVE VAZQUEZ offered her belief that the savings from this initiative would be even higher than projected on slide 16. She declared that it was also a humanitarian measure as it lessened suffering while offering support from providers. She stated her support for the primary care initiative.

MS. BEMBEN replied that a difficulty of the health system was for the attempts to create better linkages between clinical settings and community base settings. She acknowledged that,

although there was a very robust network of available home and community based services, the linkages to them were "tricky." The primary care initiative included recommendation for better use of those supportive services at a lower cost.

4:28:41 PM

CHAIR SEATON asked whether the cost savings depicted in FY17 - 19, slide 16, was the savings from individual care prevention catching up to the initial implementation costs.

MS. BEMBEN directed attention to "Total Change in Medical Cost," slide 16, and noted that the medical costs started to decrease in the first year because of assignments to the primary care providers for care management. She said that the first year expenses were for the ASO fees. By FY19, the health home services would be ready, would receive a federal match for the first two years, and would accelerate savings in medical costs from the care management for those with higher health needs. She pointed out that although the ASO services were being purchased, they would help reduce the medical costs and produce a better net savings to the state.

4:30:45 PM

REPRESENTATIVE TARR, referencing global payment schedules, asked if that impact was evaluated in this analysis and whether it could be used as a Medicaid reform tool for cost savings. She offered her understanding that a global payment schedule was value based instead of volume based.

MS. BEMBEN asked if this was a capitated payment, and, after acknowledgement, she relayed that they did look at these, especially when reviewing full risk managed care. In that system, the managed care organization would receive a capitated payment, one payment per member per month and would be required to meet quality outcomes and provide the requisite services. She opined that this was similar to "trying to climb Mt. Everest right out of the gate" as it was assuming a lot of capacity and infrastructure that may not yet exist in Alaska. She recommended a sequence of reforms that will build that capacity. She reminded that accountable care organizations were another means for value based payments as they could be piloted in Alaska. In this model, the providers would come together and form an organization, estimate the total cost of care for the population they would contract to serve, and then, if the care was provided at a lower cost than the state, they would share in

the savings. From this model, there could be a shift to a share in the losses if the cost was exceeded. She stated that providers take on all the risk with capitated payments, and offered her belief that this arrangement "would be best to build up to, and not to jump to right away." She shared that the discussions with stakeholders had not reflected a willingness from providers to join this model right now. She reminded that Medicaid was just a portion of their patient population, so willingness to do this for Medicaid had to be balanced against their efforts for the other payers. She pointed out that it was not prevalent in rural states because the dispersed population did not offer the economy of scale.

REPRESENTATIVE TARR asked if there were instances where capitated payment and global payment schedules were different and not used interchangeably.

MS. LEIBOWITZ replied that they were the same idea. Capitation was the monthly payment per person, states like Oregon had moved its managed care program into this, whereby there was responsibility by the managed care entities for everything, including physical health, behavioral health, and dental. The annual payments were increased by a specified rate, regardless of annual expenses. She added that, for states with coordinated care organizations which utilized the global capitation payment, it often seemed like the payment mechanism and the accountable care were linked in a causal way. She stated that the important thing for driving change was accountability, ensuring the organizations and providers were changing the way they did business, and not given incentives for providing more volume, but only for quality.

4:38:06 PM

REPRESENTATIVE VAZQUEZ addressed slide 16, and asked for an explanation to the acronym, PCCM.

MS. BEMBEN relayed that PCCM was the acronym for primary care case management.

REPRESENTATIVE VAZQUEZ asked how the after share savings would work.

MS. BEMBEN replied that the proposed initiative did not suggest any shared savings, the line was included to allow a standard format for all the initiatives.

CHAIR SEATON explained that there was some confusion about the global payment model as an earlier proposal by the Central Peninsula Hospital had referenced a global payment model. The bills proposed by the House Health and Social Services Standing Committee required the Department of Health and Social Services negotiate for a model but there was not an exact specification for construction. He allowed that he had also been confused by the various definitions for the global payment model.

MS. BEMBEN noted that each initiative had to be specifically designed to allow for an actuarial analysis. She offered an example of the accountable care organization pilot, as part of the recommendation was for a shared savings model. This recommendation was for continuation of the fee for services, but the accountable care organization is paid a bonus of the shared savings payment if costs are reduced for the state. She shared that part of the reasoning was for an easier lift out of the gate, yet specific enough to do an analysis. She allowed that a capitated payment was a viable option. She noted that the recommendation had been as an incentive to accountability, while sharing the risk for the cost, and that there were many ways to do this.

4:41:52 PM

REPRESENTATIVE STUTES asked if there were enough providers in Alaska for assignment to every enrollee or would Alaska need more medical professionals.

MS. BEMBEN replied that they did not have a good number to calculate a ratio. She noted that a broad definition for primary care provider included advance nurse practitioners, physician assistants, family practice and internal medicine physicians, and behavioral health providers among others. The behavioral health initiative recommended that DHSS recognize additional behavioral health provider types who were not currently recognized or able to bill Medicaid, in order to create the necessary workforce. She acknowledged that the analysis still needed to be done.

4:44:20 PM

REPRESENTATIVE STUTES commented that many seniors, Medicare patients, were having a difficult time finding physicians, and expressed her pleasure that the "spectrum is being widened on the providers."

MS. BEMBEN said that an important part of the initiative was the proposal that DHSS pay a per member per month incentive for the case management to the primary care provider, as it takes quite a bit of time to coordinate care.

4:45:38 PM

CHAIR SEATON directed attention to slide 17, and read: "In second year, amend Section 1115 waiver to include a federal waiver of the IMD exclusion for residential substance use treatment." He asked if there was a history for these being generally granted in the second year and if the modification of the waiver was a normal process.

MS. BEMBEN offered her belief that the proposal to amend was fairly new.

MS. LEIBOWITZ shared that the provision in Section 1115 of the Social Security Act to ask for a waiver of a portion of federal law was a "fairly well trod path, which is not to say that it's a simple path." She reported that this took a lot of work and documentation, but that the process was well understood and that the letter from CMS indicating interest should give states the sense that the federal government was interested in approving.

4:47:44 PM

REPRESENTATIVE TARR asked if Section 1115 had an eight year, lifetime limit.

MS. BEMBEN replied that the purpose of the waiver was to test innovative strategies, so, if during the demonstration period, this was shown to be a good way to administer Medicaid services, the state could continue.

MS. LEIBOWITZ expressed her agreement, sharing that it was a way to test something for a period of time.

4:48:50 PM

REPRESENTATIVE VAZQUEZ asked for clarification that although there was not a commitment beyond the requested demonstration period, the ability to change during the demonstration period was very limited.

MS. BEMBEN, in response to Chair Seaton, shared that they had received guidance that Centers for Medicare & Medicaid Services

(CMS) had issued expressing desire to integrate substance use disorder treatment with other mental health services.

MS. LEIBOWITZ, in response to Representative Vazquez, stated that this was intended to be a five year period, and that there were federal and state agreements to ensure that extra money was not being spent than without the waiver. She stated that she was not entirely sure how a smaller change would work as part of a larger process.

REPRESENTATIVE VAZQUEZ asked about possibilities other than the waiver for residential substance use treatment, pointing out that Alaska did not have enough infrastructure.

MS. BEMBEN said that part of the reason for limited treatment capacity was that the number of residential treatment beds were limited in order to be allowed to bill Medicaid. She pointed out that the cost of residential treatment was very difficult at that scale and that Medicaid reimbursement was not available to facilities larger than a specific number of beds. This waiver asked that the bed limit be waived.

REPRESENTATIVE VAZQUEZ asked if this was a waiver for federal regulation or was it a federal statutory limit.

MS. LEIBOWITZ replied that, although it was in statute, the waiver would give permission "to ignore that piece of law."

REPRESENTATIVE TARR asked how the Medicaid payment rates were estimated in out years, slide 18, noting that the payment was often considered to be insufficient.

MS. PANTELY replied that the estimates used were from the Department of Health and Social Services, with the exception of pharmacy which used industry standards of 5 - 7 percent.

4:55:47 PM

REPRESENTATIVE VAZQUEZ noted that there may be an ultimate savings as it was acknowledged that there was a mind body connection.

MS. BEMBEN said that a lot of evidence confirmed this. She stated that the medical costs for people with mental illness or substance use were much higher, and if the behavioral health conditions can be addressed, then the medical cost can be lowered. She pointed out this did not include savings to other

parts of state government, reminding the committee of the connection between behavioral health issues and corrections.

4:57:31 PM

REPRESENTATIVE VAZQUEZ expressed her concern that the initiative analysis did not address the payment error rate of 16 percent, slide 19.

CHAIR SEATON pointed to the fact that this was on the payment side, and that the e-health initiative dealt with the exchange. He asked to confine the questions, acknowledging that these were the recommendations.

CHAIR SEATON asked if Initiative 4 was not considered or recommended as it was outside the range of the RFP, slide 20.

MS. BEMBEN emphasized that they did recommend this initiative, and, in response to Chair Seaton, stated that they did not do an actuarial analysis on Initiative 3.

5:00:05 PM

REPRESENTATIVE VAZQUEZ asked about the Oregon study that showed the expansion of Medicaid brought an increase in emergency room visits.

MS. LEIBOWITZ asked if this was the study of expansion for the program.

REPRESENTATIVE VAZQUEZ said that the study looked at the usage of emergency rooms with Medicaid expansion in Oregon, with findings that the use increased. She stated that there was also some evidence of an increase in New York because of the shortage of Medicaid providers.

CHAIR SEATON pointed out that this was a private public partnership. He declared that Alaska currently had expanded Medicaid and that this was a discussion on reform, not expansion. He asked to confine the questions to this recommended package of reforms.

5:01:38 PM

REPRESENTATIVE WOOL asked if dental was ever part of the package or had it been opted out because of expense.

MS. BEMBEN replied that this was a reference to option 2 of the coverage models for the expansion population. She said that the difference was that option 1 would provide the current Medicaid benefit package to the expansion population, whereas option 2 provided a benefit package modeled on the Alaska qualified health plan which did not include dental benefits. In the analysis, there was a decrease in cost because of the lack of dental benefits, although they estimated an increase in emergency care for dental emergencies. She stated that the report offered quite a bit of evidence that supported the advantages for providing dental care to Medicaid enrollees, especially in low income populations, as it was an important preventative care, and prevented the exacerbation of other chronic conditions. She stated that the recommendation was to go with option 1 and keep dental benefits, even though it was slightly more expensive than option 2.

CHAIR SEATON asked that any further questions to be submitted.

5:04:42 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:04 p.m.