**ALASKA STATE LEGISLATURE**
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**
February 23, 2016
3:17 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 |
| 02/02/16 | (H) | Heard & Held |
| 02/02/16 | (H) | MINUTE(HSS) |
| 02/09/16 | (H) | HSS AT 3:00 PM CAPITOL 106 |

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|---|---|---|
| 02/09/16 | (H) | -- MEETING CANCELED -- |
| 02/16/16 | (H) | HSS AT 3:00 PM CAPITOL 106 |
| 02/16/16 | (H) | Heard & Held |
| 02/16/16 | (H) | MINUTE(HSS) |
| 02/18/16 | (H) | HSS AT 3:00 PM CAPITOL 106 |
| 02/18/16 | (H) | Heard & Held |
| 02/18/16 | (H) | MINUTE(HSS) |
| 02/23/16 | (H) | HSS AT 3:15 PM CAPITOL 106 |

**WITNESS REGISTER**

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.

KATE BURKHART, Executive Director
Alaska Mental Health Board
Advisory Board on Alcoholism & Drug Abuse
Division of Behavioral Health
Department of Health and Social Services
Juneau, Alaska
**POSITION STATEMENT:** Testified during discussion of HB 227.

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:** Answered questions during the discussion of HB 227.

BRUCE RICHARDS, Director
External Affairs
Central Peninsula Hospital
Soldotna, Alaska
**POSITION STATEMENT:** Testified during discussion of HB 227.

**ACTION NARRATIVE**

3:17:28 PM

**CHAIR PAUL SEATON** called the House Health and Social Services Standing Committee meeting to order at 3:17 p.m. Representatives Seaton, Foster, Tarr, Wool, and Vazquez were present at the call to order. Representatives Stutes and Talerico arrived as the meeting was in progress.

**HB 227-MEDICAL ASSISTANCE REFORM**

3:17:51 PM

CHAIR SEATON announced that the only 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 stated that the proposed amendments to HB 227 would be introduced, and not formally adopted, for consideration at this meeting.

3:18:47 PM

REPRESENTATIVE VAZQUEZ introduced proposed Amendment 1, labeled 29-LS1096\H.7, Glover, 2/19/16, which read:

Page 5, line 5:
Delete "**may not be less than 50**"

Page 5, lines 5 - 10:
Delete "[, AS A TOTAL FOR THE MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS SECTION MAY NOT BE LESS THAN 75]"
Insert ", as a total for the medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75 percent of all enrolled providers under the programs,

adjusted annually on July 1, as determined by the department, except that the number of audits under this section may not be less than 75"

REPRESENTATIVE VAZQUEZ explained that the proposed amendment reverted the number of audits to the number previously required. She declared that requiring 75 audits was not an extreme hardship, and she expressed agreement that the providers should not be subjected to a simultaneous federal audit. She said these audits were very important to maintain the integrity of the system, and to minimize fraud, waste, and abuse.

CHAIR SEATON tabled the proposed amendment for later discussions.

3:20:31 PM

REPRESENTATIVE VAZQUEZ introduced proposed Amendment 2, labeled 29-LS1096\H.8, Glover, 2/20/16, which read:

Page 8, lines 2 - 7:
Delete all material.

Page 8, line 8:
Delete "(4)"
Insert "(2)"

Page 8, line 13:
Delete "(5)"
Insert "(3)"

Page 11, line 12:
Delete "applications for waivers and"
Insert "application for a waiver"

Page 11, line 13:
Delete "options under AS 47.07.036(d)(1) - (3)"
Insert "under AS 47.07.036(d)(1)"

Page 11, line 16:
Delete "applications"
Insert "application"

Page 11, lines 17 - 18:
Delete ", a section 1915(i) option under 42 U.S.C. 1396n, and a section 1915(k) option under 42 U.S.C. 1396n were"

Insert "was"

Page 11, line 20:
Delete "programs"
Insert "program"

Page 11, line 21:
Delete "waivers"
Insert "waiver"

Page 11, lines 21 - 22:
Delete "(A)"

Page 11, line 24:
Delete ";"
Insert "."

Page 11, lines 25 - 27:
Delete all material.

REPRESENTATIVE VAZQUEZ explained that this proposed amendment would delete the references and material with regard to the options 1915(i) and 1915(k), as these proposed to further expand the regular Medicaid state plan beyond the newly expanded Medicaid group. She declared that this was "a pure expansion of our existing Medicaid program and the department has yet to provide the legislature with very robust studies or data that support their growth assertions that adding these options will save money." She stated that an addition of these "populations" without careful consideration of all the ramifications could put the Medicaid program in jeopardy, as this included a group of people that were not yet clearly defined by Department of Health and Social Services. She acknowledged that, although the 1915(k) option was paid with a 56 percent federal match, it expanded the number of services provided to beneficiaries and expanded the scope of services beyond what was currently available through waivers. She stated that the 1915 options did not include a cap on services or a wait list for individuals. She expressed agreement that it was necessary to include mental health services, substance abuse, and traumatic brain injuries, although the proposed option could also provide services to those with Alzheimer's and related dementia. She suggested that robust studies were necessary to show the number of eligible individuals and the cost to the state, as, without a cap or a waitlist, this could place an undue fiscal hardship on the state. She noted that it was unclear whether Centers for Medicare and Medicaid Services (CMS) would allow any

modifications or withdrawal from these options. She opined that both these options could become entitlement programs. As there was not withdrawal from these entitlements, she offered her belief that it was unclear whether this could cause Alaska to lose further federal funding for Medicaid.

CHAIR SEATON tabled the amendment for later discussions.

3:24:41 PM

CHAIR SEATON introduced proposed Amendment 3, labelled 29-LS1096\H.5, Glover, 2/19/16, which read:

Page 6, line 3, following "**audit.**":
Insert
"**The department may not assess interest under this subsection if a provider**
**(1) identifies and reports an overpayment to the department independent of an audit conducted under this section; and**
**(2) repays the amount of the overpayment to the department within five months after the date the provider received the overpayment.**"

CHAIR SEATON explained that this proposed amendment added clarification to Section 5 of the proposed bill that DHSS may not assess interest against a provider who self-identified for overpayments received if the provider independently identified the overpayment and repaid this in a timely manner, within five months. He said that Section 5 would encourage timely repayment of overpayments, and would encourage providers to be proactive in self-identifying and repaying the overpayments.

CHAIR SEATON tabled the amendment for later discussions.

3:26:16 PM

CHAIR SEATON offered proposed Amendment 4 labeled 29-LS1096\H.6, Glover, 2/19/16, which read:

Page 9, line 30:
Delete "DEMONSTRATION"
Insert "PILOT"

Page 9, line 31:
Delete "January"
Insert "July"

Page 9, line 31, through page 10, line 1:
Delete "design and implement a demonstration project"
Insert "contract with a third party to establish a care coordination pilot project for approximately 500 voluntary participants who are eligible for medical assistance under AS 47.07.020(b)(14)"

Page 10, lines 2 - 4:
Delete "The demonstration project shall provide for the voluntary enrollment of approximately 500 recipients who are eligible for medical assistance under AS 47.07.020(b)(14). The Department of Health and Social Services shall"
Insert "The care coordination pilot project must focus on nutritional sufficiency and"

Page 10, line 6:
Delete "demonstration"
Insert "care coordination pilot"

Page 10, line 7:
Delete "demonstration"
Insert "care coordination pilot"

Page 10, line 9:
Delete "demonstration"
Insert "care coordination pilot"

Page 10, line 15, following "(July 2013).":
Insert "Two years after the date the Department of Health and Social Services first enrolls recipients in the care coordination pilot project, the Department of Health and Social Services shall deliver a report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available. The report shall describe the results of the care coordination pilot project, any difference in the pre-term birth rate for participants in the pilot project as compared to the pre-term birth rate for the state, and the estimated savings to the state resulting from the pilot project."

CHAIR SEATON explained that this proposed amendment changed the project under Section 15 from a demonstration and research

project designed and implemented by DHSS to a care coordination pilot project contracted with a third party. He stated that, as the department did not normally pursue research projects, it was not well suited to efficiently manage a project. He reported that the focused effort for this was already underway in South Carolina, so that Alaska could see if there could be a reduction in pre-term births and related costs that other states had experienced.

CHAIR SEATON tabled the amendment for later discussions.

3:28:01 PM

CHAIR SEATON offered proposed Amendment 5, labelled 29-LS1096\H.9, Glover, 2/22/16, which read:

Page 7, lines 14 - 26:
Delete all material.

Renumber the following bill sections accordingly.

Page 7, line 31, through page 8, line 1:
Delete "provided to Indian Health Service beneficiaries through the Indian Health Service and tribal health facilities"
Insert "for recipients of behavioral health services, as defined by the department by regulation"

Page 11, line 13:
Delete "sec. 12"
Insert "sec. 11"

Page 11, following line 27:
Insert a new bill section to read:
"*** Sec. 17.** The uncodified law of the State of Alaska is amended by adding a new section to read:
IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT. (a) The Department of Health and Social Services shall collaborate with Alaska tribal health organizations and the United States Department of Health and Human Services to implement changes fully in federal policy that authorize 100 percent federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid.
(b) In this section, "Alaska tribal health organization" means an organization recognized by the

United States Indian Health Service to provide health-related services."

Renumber the following bill sections accordingly.

Page 12, lines 6 - 7:
Delete "and the provisions of secs. 12(e), 12(f), 15, and 16"
Insert "the provisions of AS 47.07.036(e) and (f), added by sec. 11 of this Act, and the provisions of secs. 14 and 15"

Page 12, line 22:
Delete "sec. 16"
Insert "sec. 15"

Page 12, line 23:
Delete "sec. 18"
Insert "sec. 19"

Page 12, line 25:
Delete "sec. 16"
Insert "sec. 15"

Page 12, line 27:
Delete "Section 12(e) of this Act"
Insert "AS 47.07.036(e), added by sec. 11 of this Act,"

Page 12, line 29:
Delete "added by sec. 12(e) of this Act"
Insert "of AS 47.07.036(e), added by sec. 11 of this Act,"

Page 12, line 31:
Delete "Section 12(f) of this Act"
Insert "AS 47.07.036(f), added by sec. 11 of this Act,"

Page 13, line 2:
Delete "added by sec. 12(f) of this Act"
Insert "of AS 47.07.036(f), added by sec. 11 of this Act,"

Page 13, line 4:
Delete "Section 15"
Insert "Section 14"

Page 13, line 6:
Delete "sec. 15"
Insert "sec. 14"

Page 13, line 8:
Delete "sec. 16"
Insert "sec. 15"

Page 13, line 11:
Delete "sec. 12(e) of this Act"
Insert "AS 47.07.036(e), added by sec. 11 of this Act,"

Page 13, line 14:
Delete "sec. 12(f) of this Act"
Insert "AS 47.07.036(f), added by sec. 11 of this Act,"

Page 13, line 17:
Delete "sec. 15"
Insert "sec. 14"

Page 13, line 20:
Delete "17(a)"
Insert "16(a)"

CHAIR SEATON explained that the proposed amendment reflected the CMS policy guidance from October 2015 which indicated the willingness by CMS to re-evaluate the current interpretation for Section 19.05(b) of the Social Security Act to allow 100 percent federal medical assistance percentages (FMAP) for more and expanded services for American Indian and Alaska Native beneficiaries. This would include medical travel and services provided by non-tribal providers with contractual agreements with Indian Health Service facilities.

CHAIR SEATON tabled the amendment for later discussions.

CHAIR SEATON stated his desire for testimony on the effect of these amendments in the current budget.

3:30:37 PM

CHAIR SEATON opened public testimony.

3:31:36 PM

BECKY HULTBERG, President/CEO, Alaska State Hospital and Nursing Home Association, offered some brief, broad comments, which she described as "tweaks to the [proposed] bill." She stated that proposed HB 227 did several important positive things, as it articulated a vision in its intent language for the Medicaid program when it speaks about prevention as a core value, payment reform, public - private partnerships, and general cost reduction in the Medicaid program. It also established payment reform demonstration projects, and would change the health care delivery and payment systems, even as this would take hard, difficult work at all levels. She expressed appreciation for the use of pilot projects to test these new payment and delivery models, and for the inherent flexibility in the proposed bill for allowing for different kinds of pilot projects in different regions. She expressed appreciation for the proposed amendment, labelled 29-LS1096\H.5, Glover, 2/19/16, although she encouraged "some sidebars to be put around the issue of overpayments so that providers who self-report are not penalized in the same way." She declared support for the efforts to reduce redundant audits, noting that it was important for the state to have the tools to address fraud and abuse, but not to add administrative burden to low risk providers. She pointed out that "administrative burden equals cost." She declared that the proposed bill was able to strike an appropriate balance between tools and enforcement and to ensure an efficient health care system. She reported that the proposed bill focused on primary care through development of a primary care case management system, which she labeled as a building block for system change as well as the intent to more fully utilize telemedicine. She declared that reform was a long term endeavor, and that this would probably not be the last year to address it.

3:36:21 PM

CHAIR SEATON asked if the five month window for self-reporting mistakes was reasonable.

MS. HULTBERG replied that she would respond at a later date, although she encouraged the reporting of overpayments. She pointed out that, as the state did not pay interest on underpayments, appropriate sideboards were necessary for whether the providers should pay interest on overpayments.

3:37:43 PM

MS. HULTBERG, in response to Chair Seaton, stated that it was possible that the bill language encompassed the project, and she expressed commitment to the emergency room utilization project and the emergency room physicians. She suggested amending the proposed bill to include the project in statute as the intent of the proposed bill was to better manage cost and utilization of super utilizers.

CHAIR SEATON asked about the inclusion of dental health in the proposed bill.

MS. HULTBERG suggested asking the Alaska Dental Society, and she noted that ASHNA supported more access to dental care as it would decrease emergency room visits that could have been more easily treated in other less expensive settings.

3:41:07 PM

KATE BURKHART, Executive Director, Alaska Mental Health Board, Advisory Board on Alcoholism & Drug Abuse, Division of Behavioral Health, Department of Health and Social Services, declared that her comments were on behalf of these boards only. She shared that the boards had participated in the conversations about Medicaid reform and redesign with the current and previous administrations for more than eight years. She shared that, as an external stakeholder, the board engaged Medicaid recipients, those who relied on the services, in order to learn how to "best reform the system." She echoed the comments from Ms. Hultberg about the emphasis on preventative care as an underpinning philosophy for reform. She reported that these efforts were a focus on improving quality and access to care, as well as cost containment, which she stated were a priority for the boards and the constituents. They supported a sustainable system. She expressed appreciation for the flexibility of the proposed bill to pursue a variety of projects to help ensure that the behavioral health would become a robust system to allow all of the Medicaid reform efforts to be successful. She stated that behavioral health was the lynchpin of reform, as it was "such a cost driver of the system." She explained that the state plan options and the 1115 waiver allowed movement of funding for programs from general funds to Medicaid funding. She referenced Section 9 of the proposed bill, expanded access to the super utilizer program, and reported that the majority of the participants had behavior health disorders, that access and quality of care was improved, and that the cost for service had been decreased. This provided support and guidance for people to receive the necessary services in a timely fashion. Moving

on to Section 12 regarding the state plan options and the 1115 waiver, she offered her belief that this would improve the delivery for home and community based services, and refinance services that currently relied heavily on general funds. She discouraged any amendment to remove the state plan options from the proposed bill. She opined that the 1115 waivers could have the most impact on the behavioral health system, as these were very flexible. She moved on to Sections 13 & 14 of the proposed bill, which were designed to increase access to behavioral health services by removing the requirement that an entity be a Division of Behavioral Health grantee in order to bill behavioral health Medicaid. She declared that this was an effective way to increase access. She cautioned that a statutory change was only the start, as there would also need to be regulatory changes in order to accomplish this goal. She reiterated that administrative burden equaled cost, pointing out that the administrative burden for community behavior health providers billing Medicaid was already "pretty significant." She declared support for the reform efforts.

CHAIR SEATON asked for more details about the 1915(i) & (k) waivers, and the reasons for keeping them in the proposed bill.

3:47:34 PM

MS. BURKHART relayed that the boards had been most focused on the 1915(i) waiver as these were the home and community based services that benefited the most disabled, and she offered her understanding that this state plan option would allow people highly impaired by disability to receive more coordinated and comprehensive home and community based services. She declared that this was not adding people, it was just changing the delivery system as many of these people were currently being served by general fund programs. She relayed that the boards had engaged in the process for the 1915(i) and (k) state plan options as they had recognized that people with serious mental illness and chronic substance use disorders that were highly impaired would be in an institution, whether that was prison, homelessness, or the psychiatric hospital, except for the receipt of home and community based services. This was a mechanism to better serve this group of constituents, while financing in a more sound way. She relayed that it appeared that, to achieve the recommendations in the administrations' report, the 1115 was a more flexible option, although this did not mean that an individual with a serious mental illness, so impaired that they would meet the ultimate functional criteria set in 1915(i), would not be eligible for services. She

reported that, for behavioral health, the focus would be on the 1115 waiver and not the 1915 state plan options. She stated that the commitment by the boards to the state plan option was because they had thought it was the answer until they realized that the answer could be the 1115 waiver.

CHAIR SEATON relayed that the committee was attempting to better understand who would be available and qualify for the services. He stated that it was a complex situation.

3:53:31 PM

VALERIE DAVIDSON, Commissioner, Office of the Commissioner, Department of Health and Social Services (DHSS), echoed the previous comments from Ms. Hultberg that the states which do health reform and do it well, also do it continually, year after year. She expressed appreciation for the flexibility included in the proposed bill, as it allowed more available tools to address concerns. She stated support for maintaining the 1915(i) and (k) options in the proposed bill, as it allowed another way to provide services in a more efficient way, and to ensure the necessary care, while saving general fund dollars for the state. She referenced the 1115 option as another tool available for behavioral services. She declared that behavioral health was the key to make the necessary changes in health reform. She expressed appreciation for the flexibility to DHSS within the proposed bill to allow the tailoring of programs and services for cost effectiveness and efficiency. She stated that it made sense "to have a more comprehensive tool box rather than start removing tools from the tool box that really limit our ability to make meaningful change and meaningful reform."

JON SHERWOOD, Deputy Commissioner, Medicaid and Health Care Policy, Office of the Commissioner, Department of Health and Social Services, acknowledged the correctness of the earlier testimony by Ms. Burkhart regarding the 1915(i) and (k) opportunities.

CHAIR SEATON reiterated his request for more graphics to better understand the services. He directed attention back to Amendment 5 and its reference that the behavioral health 1115 waiver was available to replace tribal waivers.

3:59:08 PM

REPRESENTATIVE STUTES asked Department of Health and Social Services for the amount of dollars cut from the budget versus the transfer of state dollars to federal dollars.

COMMISSIONER DAVIDSON replied that the Medicaid program had been cut about $100 million in the general fund, and she offered to provide the details.

CHAIR SEATON talked about the anticipated savings to the general fund versus the total funding expended in the state. He pointed out that an objective of [Medicaid] expansion was to increase health services provided while cutting the general fund. He acknowledged that it was good to know the economic impact from the increase of federal dollars to the needed health care services.

4:01:13 PM

COMMISSIONER DAVIDSON offered some updated information to the committee, sharing that DHSS posted a graphic on its website that included the Medicaid data for each month. This graphic showed how many people had enrolled in Medicaid Expansion, along with the demographics. There was also regional information for all Medicaid enrollees. Through January, there were an additional 10,416 Alaskans covered by Medicaid Expansion, with $34.29 million paid in new claims, which was 100 percent reimbursable from federal dollars.

REPRESENTATIVE WOOL asked if the 10,000 enrollees was close to the expectations.

COMMISSIONER DAVIDSON replied that the number was probably on track to the projections for the end of FY16. She reported that almost 42,000 Alaskans would be eligible, and it had been projected for about 22,000 Alaskans to enroll in the first year. She noted that a bit of an uptick in enrollment was usually seen at this time of year because of the individual insurance mandate.

COMMISSIONER DAVIDSON, in response to Representative Wool, said that the expectation was for about 22,000 enrollees in the first year. She reported that, should the number be higher, it would mean more federal dollars coming in to Alaska, as it was 100 percent federal match in this first year. She directed attention to the $34.29 million paid in claims in January, and shared that this number would always lag a bit, as providers had a one year timely filing limit. She said that smaller providers

often sent in claims sooner, whereas the larger providers often waited to more easily process the claims in larger batches. She pointed out that 54 percent of the Medicaid enrollees through January were children, with 2 percent of these being children experiencing disabling conditions. She stated that 8 percent of all the Medicaid enrollees were a result of expansion.

4:05:19 PM

CHAIR SEATON noted that a number of people had claimed difficulty with getting enrolled. He asked if there had been a wide distribution of information explaining the mechanism for application.

COMMISSIONER DAVIDSON replied there had been quite a few outreach efforts. She stated that the fastest way to enroll was on healthcare.gov, sharing that DHSS had worked with navigator programs which enrolled individual Alaskans in health care plans, regardless of eligibility for Medicaid or market place plans. She said that hospitals allowed individuals already in the hospital to enroll in Medicaid, which for some individuals could be the fastest means.

CHAIR SEATON emphasized that a focus of the House Health and Social Services Standing Committee was to get people signed up for appropriate health care through primary care. He expressed his desire to get the sign up information out to the public.

4:08:24 PM

COMMISSIONER DAVIDSON suggested that pregnant women call the DHSS fast track hot line, as access to good prenatal care lead to better outcomes for the mother and the baby. She reported that, through the budget process during the last year, DHSS had received $1.3 million through the Alaska Mental Health Trust Authority (AMHTA) to fund a number of positions to "gear up for Medicaid Expansion." She noted that most of the positions were in the Division of Public Assistance, with some additional positions in the Health Care Services to help process the claims. She reported that $1.5 million had been reduced from the DHSS budget in the Division of Public Assistance, for positions which helped enroll beneficiaries. She noted that the justification had been that, since the new enrollment system for public assistance would be automated, those existing positions could go away. She pointed out that the changes in the new enrollment system for public assistance were not due to go into effect until 2017 and 2018. She said that DHSS had anticipated

the funding from AMHTA would add to the positions, but the budget reduction had resulted in an actual loss of funding. She acknowledged that the department had learned to "do with what we have, but it certainly was a challenge to be able to step up to meet those new enrollment projections when we thought we were going to have more positions to be able to meet the demand and actually ended up with a net fewer positions to do that."

CHAIR SEATON asked for more information to ensure that this would not happen again.

MR. SHERWOOD added that the Division of Public Assistance maintained a separate hot line, listed on its website, for people with medical urgencies to help with prompt facilitation of applications.

4:13:25 PM

BRUCE RICHARDS, Director, External Affairs, Central Peninsula Hospital, testified that it was time "to set the stage for changing the payment models." He stated that Alaska was currently in a fee for service model, and that the proposed legislation contained several demonstration programs that would allow for piloting different types of demonstrations. He reported that Central Peninsula Hospital was working toward possibly piloting one of the demonstrations, directing attention to page 8, line 27 of the proposed bill, which authorized the demonstration for coordinated care utilizing a global payment fee structure. He shared that the hospital had been working with Moda Health on a model currently operating in Eastern Oregon, and that the language would allow them to proceed forward. He reported that data released earlier from the Journal of the American Medical Association compared the 2011 baseline data with the 2014 data which showed that in-patient care cost had decreased by 14.8 percent, and that per member per month spending on out-patient care had also decreased by about 2.4 percent. He emphasized that, although out-patient spending trends masked a 19.2 percent increase in spending on primary care services, this was a primary care home based model, with a focus on primary care "to keep people healthy and keep them from becoming ill and spending those resources and mis-utilization of them." He stated that the aforementioned Eastern Oregon model had reduced emergency room utilization by 21 percent. He reported that the hospital was looking at covering the Medicaid population in the entire Kenai Peninsula. He explained that community care organizations (CCOs) differed from the traditional accountable care organizations (ACOs) which were

more closely associated with Medicare, not Medicaid, as they accepted full financial risk, the global payment model. He pointed out that the organizations were both locally governed, were accountable for access, quality and health spending, and both emphasized primary care medical homes. He said that both required robust data systems to support the integrated networks for clinical and business functions. He shared that a CCO would operate on a fixed global budget, reduce medical cost inflation, improve the quality of care and outcomes, and create a healthier population. He offered his belief that the demonstration would put Medicaid on a predictable and sustainable path by reducing the growth trend in the per capita Medicaid expenditures. He stated that the current Alaska trend of growth per capita for Medicaid expenditures average more than 6 percent annually. He suggested that the CCO was the next step beyond traditional managed care, based on the funding structure and the risk bearing nature of the program. He emphasized that providers would no longer be paid for treating illness, but instead, for a "highly coordinated system that prevents illness and the high cost associated with it." He stated that the CCO structure required a great deal of front end work, which the hospital was currently working on with Moda Health. He listed some of the work, which included payment structures, shared savings distribution, metrics for accountability, and development of quality targets. He reported that there was currently an analysis of the entire Medicaid population to better understand the needs, in order to build a program which fit the population. He suggested a minor language change to the proposed bill which would provide the most flexibility for program design. On page 8, line 27, delete "design and" in order to allow maximum flexibility for work with Department of Health and Social Services, and to no longer require the department to design the program.

CHAIR SEATON suggested that Mr. Richards review proposed Amendment 4, labeled 29-LS1096\H.6, Glover, 2/19/16.

4:21:33 PM

REPRESENTATIVE WOOL expressed his understanding for the incentives of fee for service and for its increase in fees. He asked if there was incentive in a global payment system to decrease fees, and whether it was projected for fees to flatten.

MR. RICHARDS replied that the main goal of the Eastern Oregon model was to flatten and bend the cost curve of Medicaid expenditures, and reduce it by a percentage per capita. He

reported that the incentive to providers was to flatten that cost curve.

REPRESENTATIVE WOOL opined that there was not a fee for service in a global system because there was a per month per capita payment.

MR. RICHARDS replied that, although it would continue to be a fee for service model, the CCO would still get a global payment and the payment would be distributed through the fee for service mechanism; however, this would be done through a network comprised and put together by the CCO, which allowed for the potential of shared savings with the providers. He noted that the state would be paying on a global level, and the incentive was to reduce the utilization of the population and the cost per capita for each Medicaid enrollee.

4:24:19 PM

CHAIR SEATON asked if a vertical integration with primary care doctors into the hospital setting was integral to the global payment model or could it include providers not in this vertical integration.

MR. RICHARDS replied that it was both, as the hospital had employed primary care providers, as well as independent medical staff. He stated that the program would be built and negotiated to include the services needed by the enrolled beneficiaries. He opined that the primary care based model would prevent some of the occurrences and save those expenses incurred for a specialist or the emergency room.

4:26:32 PM

[Public testimony was closed.]

[HB 227 was held over.]

4:27:21 PM

**ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:27 p.m.