

SENATE FINANCE COMMITTEE  
February 1, 2018  
9:04 a.m.

[9:04:39 AM](#)

CALL TO ORDER

Co-Chair MacKinnon called the Senate Finance Committee meeting to order at 9:04 a.m.

MEMBERS PRESENT

Senator Lyman Hoffman, Co-Chair  
Senator Anna MacKinnon, Co-Chair  
Senator Click Bishop, Vice-Chair  
Senator Peter Micciche  
Senator Donny Olson  
Senator Gary Stevens  
Senator Natasha von Imhof

MEMBERS ABSENT

None

ALSO PRESENT

Monique Martin, Healthcare Policy Advisor, Department of Health and Social Services; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Margaret Brodie, Director, Division of Health Care Services, Department of Health and Social Services; Duane Mayes, Director of Senior and Disability Services, Department of Health and Social Services.

SUMMARY

^PRESENTATION: MEDICAID COST DRIVERS and REFORM UPDATE

[9:05:10 AM](#)

Co-Chair MacKinnon noted that the presentation had concluded on Slide 13 the previous day and would begin on Slide 14.

MONIQUE MARTIN, HEALTHCARE POLICY ADVISOR, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, continued to address the presentation "Senate Finance Committee - Medicaid Cost Drivers and Reform Update" from the previous day's committee meeting.

Ms. Martin looked at Slide 14, "Medicaid Reform":

Primary Care Case Management  
FY17 Fiscal Note (\$93.5)  
FY17 Actuals (\$4,250.0)  
FY18 Fiscal Note (\$800.9)  
FY19 Fiscal Note (\$2,145.1)  
On Track? Yes

- Temporarily expand Alaska Medicaid Coordinated Care Initiative (AMCCI)
- Coordinated Care Demonstration Projects and behavioral health system reform to develop / test new models
  - Transition Medicaid recipients to appropriate program

Ms. Martin explained that SB 74 required the department to provide care management services for Alaskans receiving Medicaid that had multiple hospitalizations. She said that the hope was that these Alaskans could shift to a coordinated care demonstration project or to receive services through the 1115 behavioral health waiver. She stated that the Alaska Medicaid Coordinated Care Initiative (AMCCI) had been ramped up to provide care management for those individuals. She relayed that the department was looking to AMCCI to provide services for those reentering communities from the correctional system. She expressed confidence that savings would be achieved in FY18.

[9:08:51 AM](#)

Ms. Martin presented Slide 15, "Medicaid Reform":

Telehealth  
  
FY17 Fiscal Note -  
FY17 Actuals -  
FY18 Fiscal Note (\$650.0)  
FY19 Fiscal Note (\$1,300.0)  
On Track? Savings indeterminate

- Telehealth Workgroup Report:  
[http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/MCDRE\\_Telehealth\\_Workgroup\\_Report.pdf](http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/MCDRE_Telehealth_Workgroup_Report.pdf)

- SB74 directs the department to identify improvements in telehealth capabilities that would be most effective in reducing Medicaid costs and improving access to health care services

Ms. Martin reminded the committee that SB 74 outlined significant requirements for telehealth. She noted the indeterminate fiscal note and actuals for FY17 as reflected on the green chart. She said that the indeterminate number existed as the department ramped up the telehealth workgroup that the department had facilitated. She emphasized that SB 74 had been very specific that any telehealth programs implemented would also reduce Medicaid cost, and shared that the department was working cautiously around telehealth.

[9:11:10 AM](#)

Ms. Martin discussed Slide 16, "Medicaid Reform":

Health Homes

FY17 Fiscal Note 4.8  
FY17 Actuals 4.8  
FY18 Fiscal Note 42.6  
FY19 Fiscal Note (\$1,672.4)  
On Track? Yes

- Planning for Health Homes: 2018
  - Coordinated Care Demonstration Projects
  - Other reform initiatives
- 90 / 10 Match for eight quarters only

Ms. Martin informed that health homes had a specific definition in the Affordable Care Act (ACA). She believed that the one of the coordinated care demonstration projects would be a good model for the rest of the state and other providers to implement. She relayed that the state received a 90/10 match from the federal government for health home; the federal government paid 90 percent of the cost associated with implementation of a health home model for 8 quarters. She stressed that it was important that when the program was implemented, it could be implemented as far

across the state a possible to maximize savings, rather than for a small group of Medicaid recipients in one part of the state.

Senator Stevens queried the definition of "health home."

Ms. Martin explained that health homes allowed for examination of an individual's surroundings and living conditions and how it might affect a person's health.

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Ms. Martin spoke to Slide 17, "Medicaid Reform":

Pioneer Homes

FY17 Fiscal Note (1,066.7)

FY17 Actuals (217.0)

FY18 Fiscal Note (1,066.7)

FY19 Fiscal Note (1,066.7)

On Track? No

- Requires payment assistance applicants to apply for Medicaid
- Timing
  - Income Qualifying Trust
  - Waiver Application Process
  - Level III Residents require the highest level of care

Ms. Martin detailed that Pioneer Homes were implementing this initiative directly with residents. She noted that there were challenges that were being addressed.

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Senator Olson wondered whether there was an opportunity to speed up the waiver application before elderly individuals passed away.

Ms. Martin stated that the Pioneer Homes were working with the Division of Public Assistance and Seniors and Disability Services to find opportunities for efficiencies and other ways to speed up the process.

Senator Olson wondered what the committee could do to make the process more efficient.

Ms. Martin thought some internal barriers had been identified. She believed that Commissioner Sherwood could offer more information.

Senator Olson expressed frustration with the bureaucracy that the elderly and families had to go through to receive care.

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that the department was looking at how to address the barriers. He lamented that most of the barriers were the result of federal requirements. He continued that people in long-term care are subject to transfer of asset penalties, which required the department to do a five-year look back at the patient's financial records to determine eligibility. He thought there was enough coordination but agreed that improvements could be made. He was not sure what could be done at the legislative level. He appreciated Senator Olson's concern.

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Ms. Martin turned to Slide 18, "Medicaid Reform":

Emergency Department Improvement Initiative

FY17 Fiscal Note 4.8  
FY17 Actuals 4.8  
FY18 Fiscal Note 42.6  
FY19 Fiscal Note (\$1,300.0)  
On Track? Yes

- Alaska State Hospital & Nursing Home Association and Alaska Chapter of the American College of Emergency Physicians
- Emergency Department Information Exchange (EDIE)
  - Nine hospitals are "live"
  - Connecting to the Prescription Drug Monitoring Program (PDMP) in 2018
- Established uniform statewide guidelines for prescribing narcotics
- <http://www.ashnha.com/edcp/>

Ms. Martin informed the committee that one of the key pieces of the Emergency Department Improvement Initiative was the Emergency Department Information Exchange (EDIE).

This system was the real-time information exchange for physicians and providers in emergency room facilities. The system was designed to keep tabs on patients inappropriately seeking prescription pain killers. The system also helped to identify people who were not getting connected with a primary care provider to address their health concerns. She shared that regulations had been recently submitted that would connect the emergency department information exchange with the prescription drug monitoring program, which would allow for further surveillance of prescription drug acquisition by patients.

Senator von Imhof referenced slide 6, which showed that hospital services costs was the largest cost driver for Medicaid. She recalled discussion from the previous day pertaining to coordinated and primary care programs. She wondered whether the department was tracking individuals using the emergency room for non-emergency medical services. She wondered whether people who used the emergency room frequently, and who had been identified as high users, could be cut off from Medicaid.

Ms. Martin stated that there were two programs underway to address the issue.

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Senator von Imhof wanted to see past data that showed identification of high utilizers and what had been done to decrease utilizations of the ER. She asked whether the department flagged such incidents as high-priority, since they contributed as the biggest cost driver.

MARGARET BRODIE, DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, relayed that if an individual was over-utilizing ER services, there was a service utilization review program, used both for recipients and providers. If the individual did not work through the care management program, and continued to over use the emergency room, that person would be put into a care management program, which would lock the patient into one physician and one pharmacy. If the patient continued to utilize the emergency room, Medicaid would not pay for the visit unless it was an emergency.

Vice-Chair Bishop queried the leading cause of return visits to the emergency room.

Ms. Brodie stated that the leading cause was typically behavioral health issues.

Co-Chair MacKinnon asked whether Ms. Brodie could address why care coordination might not be an entry point for determining whether a person should be in a care management program, which would restrict use and could be more closely monitored.

Ms. Brodie stated that both programs were always running, and each referred to the other. The contractor currently handling the care management program had 312 individuals enrolled in the program. She said that the care management program could only manage just over 300 people at any time.

Co-Chair MacKinnon asserted that her constituency was curious why the division had decided not to maximize the return on investment with the care management program by targeting a structured delivery of the services for those that overutilized the hospital and the emergency room.

Ms. Brodie stated that there was a shortcoming in the capacity of the contractor. In June of 2017, the department had signed a contract with a new contractor, which would allow for service for more recipients.

Co-Chair MacKinnon asked whether the department would start to examine over-utilization of emergency room care as a cost driver.

Ms. Brodie stated that the department used data analytics to determine who was an outlier of the use of services. She stated that using the new contractor would result in serving many more recipients, and the threshold for overuse could be changed as appropriate.

Co-Chair MacKinnon thought that if emergency room overuse was the number one cost driver, overutilization should be considered when considering recipients.

Ms. Brodie stated that the department did look at the highest cost drivers. She used the example of opioid abuse, in which a patient could be drug seeking at the emergency room or could legitimately use the emergency room for a drug overdose. She reiterated that the limiting factor was the number of individuals that could be served by the contractor.

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Senator von Imhof asked whether Truven Health Analytics was the name of the new analytics company hired by the state.

Ms. Brodie answered in the affirmative.

Senator von Imhof expressed appreciation for the company's work. She hoped that data could be gathered quickly and that the department could provide the company with diagnostic data so that analysis could begin immediately. She hoped that a report could be produced by February 2019.

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AT EASE

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RECONVENED

Co-Chair MacKinnon stated that there had been an ongoing discussion concerning major cost drivers in Medicaid and healthcare in general. She listed cost drivers had been scrutinized for doctors, pharmaceuticals (companies), insurance and insurance providers, and hospitals.

Ms. Brodie thought that the accurate costs drivers were hospitals, physicians, and pharmacies.

Co-Chair MacKinnon asked whether insurance was driving costs.

Ms. Brodie thought insurance could be driving the cost of healthcare overall, which could impact Medicaid.

Co-Chair MacKinnon thought that there was an argument between doctors and insurance providers as to which was the higher cost driver.

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Ms. Brodie stated that for hospital stays, a contractor determined whether the length of stay was appropriate; the length of the hospital stay was pre-approved. She asserted that a patient did not go to the hospital for 10 days and then Medicaid picked up the bill. She said that if a patient was admitted from the emergency room, they would have three days before they needed to get prior approval.

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Co-Chair MacKinnon rebutted that the weighted average in trying to manage hospital stays was directly linked to emergency room stays. She asserted that individuals that were on the system were using their emergency room privileges to access healthcare. She wondered if studies were being held up in order to control the cost of the system based on what the state and federal government are paying for those hospital stays.

Ms. Brodie stated that the department was identifying individuals on a quarterly basis. The new contractor would include more information which would enable quicker intervention.

Senator Micciche referenced a document entitled "Medicaid Claims and Enrollment," (copy on file). He noted the over \$11 thousand per year cost per recipient. He understood that the figure reflected actual utilization costs.

Ms. Brodie answered in the affirmative.

Senator Micciche asked whether intense case management had been considered for the top 25 percent of users.

[9:43:51 AM](#)

Ms. Brodie replied that some individuals were in a case management program; however, individuals that reached older age sometimes became disabled and required more assistance in their daily activities or they could be institutionalized, which substantially raised the cost.

Senator Micciche suggested leaving individuals 85 years or older out of the equation. He spoke to a "normally healthy range," of people 21 through 30 years of age. He argued that the average costs for that age group was higher for Medicaid than in the private sector. He contended that the pressure that the private sector face to keep average costs down was not a problem for Medicaid. He thought that costs could be driven down if users were taught how to manage their healthcare.

Ms. Brodie believed that under the new contract, the high-cost recipients Senator Micciche referred to would be picked up. She shared that the plan was to serve several

thousand, not just the top 300 users, under the new contract. The new system would be in place by June 2018.

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Senator von Imhof asked whether the cost of the contract was in the FY19 budget.

Ms. Brodie specified that the cost was taken from the Enterprise contract and recalled that there had been a savings of \$200,000 per year with the new contract.

Co-Chair MacKinnon asked whether the transition was a new idea, or an idea that was just now being implemented. She relayed that the Medicaid program had been a point of discussion for quite some time. She wondered whether there were competing interests within the department to address the highest cost drivers or had attention been diverted to other things.

Ms. Brodie stated that the department had wanted to make the change for some time. There was a question of staff capacity when considering taking on new initiatives. The staff had been focused on paying claims accurately and on-time. She explained that everyone within the department was working closely together to prepare the system for every reform laid out in SB 74. She relayed that there was a monthly meeting of all Medicaid directors and other key staff members to discuss ongoing projects and capacity for taking on new actions. She used the example of providing clients with an improved explanation of benefits. She believed that some users focused on their co-pay amount and were unaware of the total cost of their care. The concept had been postponed as the department prioritized other money-saving actions.

[9:52:04 AM](#)

Co-Chair MacKinnon recalled her comments from the previous day. She remembered a discussion about explanation of benefits in previous meetings on SB 74, and thought it was an important piece of the problem. She asked about the organizational structure in place for taking on initiatives inside the Medicaid system. She wondered who had been helping to implement the latest software.

Ms. Brodie explained that a team within Healthcare Services was responsible for the system. She explained that the contractor, Conduent, coded the system and made changes at the direction of the team. She described the process, adding that a federal match of 90 percent was being requested for anything over \$100,000. She relayed that weekly meetings were held with the contractor to discuss all projects. She related many projects were active at one time and that currently there were several SB 74 initiatives that needed changes.

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Co-Chair MacKinnon recalled that Ms. Brodie had discussed interface with the many areas of public health. She thought Ms. Brodie had referenced four different entities that intersected with Medicaid and wondered whether those entities were working with the department on system changes.

Ms. Brodie stated that the public health entities did not help with the system but did help with population health issues. She said that the department worked to align its policies with public health policies.

Senator von Imhof relayed that she also served on the Senate Health and Social Services Committee. She had seen a presentation the previous day pertaining to changing services for autism related care. She was concerned that the state would be saving money in reforms while increasing costs through expanding programs with federal match. She wondered who retained the authority to burden the state financially to increase regulation, expand population, and increase programs.

Mr. Sherwood stated that the addition of the autism regulations that Senator von Imhof referenced was the implementation of federal requirements after clarification of policy. He specified that states are required to provide coverage for autism services for children. He stated that the department implemented policy updates on a regular basis and that the department vetted the regulations before implementation. He added that there was also litigation related to the speed in which the department had implemented certain regulations. He explained that under state statute the department had to operate the Medicaid program in compliance with federal law and regulations.

[10:01:32 AM](#)

Senator von Imhof asked whether there was flexibility on how the state implemented updated federal requirements.

Mr. Sherwood thought that there was some flexibility on how a program was structured. If it was determined to be medically necessary for a child to receive a service, the state was required to provide that service. He relayed that there were provisions around limits before requiring prior authorization.

Mr. Sherwood addressed Senator von Imhof's question about the \$9.8 million. He said that the number of children diagnosed and the number of providers available would be examined to assess the expectation of available services. He thought that the 50 percent match rate applied to some recipients of Medicaid, but there were varying increased match rates for other populations.

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Co-Chair MacKinnon commented that the previous year individuals had called from out of state to indicate they had relocated to Alaska from out of state to participate in the robust healthcare system. She was concerned that the mandates from the federal government had been interpreted to provide better care than other states under Medicaid. She was concerned that the federal government was driving spending in the department.

Mr. Sherwood agreed that the state had a robust Medicaid program, but did not think it had a top ranking in the nation. He stated that Alaska could be more attractive than other states depending on individual needs. He countered that for others, the state was not an attractive state for healthcare; lack of access to certain specialists and availability of support for specialty care had forced other Alaskan families to relocate out-of-state. He spoke about the federal requirements, the department always considered how to meet the requirements in the most efficient ways possible.

Co-Chair MacKinnon asked whether cost was considered when evaluating a program's impact to the state or if only the public health impact was considered.

Mr. Sherwood stated that he certainly considered cost. He stressed that the health of the population was important and that he subscribed to practices that provided good health outcomes. He stated that he was aware that money spent in one area was money that might not be spent in another; resource allocation for optimum benefit was a constant challenge.

10:08:35 AM

Senator Stevens stressed the importance of patients understanding an explanation of benefits. He felt that people could not change their behavior if they were ignorant of the cost of their care.

Ms. Brodie stated that the issue was under repeated discussion and that the department was working diligently to be sure that patients were better informed.

10:10:20 AM

Senator Micciche recommended that the department should not expand in any new area until the state could get a "handle on costs." He asked whether the department had considered bringing on a private sector insurance manager.

Mr. Sherwood stated that the department had considered the option from time to time. He pointed out that the Medicaid program was different from insurance programs in a variety of ways.

10:15:16 AM

Senator von Imhof asked whether the department had considered putting out a request for proposal (RFP) for one component of Medicaid. She thought that while the private sector might not understand the complexities of the Medicaid population, they could bring new tools to the table.

Mr. Sherwood elaborated that one option in the coordinated care project included the proposal of working with a private entity. The department was in negotiations with three different entities, one of which was a managed care organization.

Senator von Imhof understood that the RFP was for eligibility and payment processing.

Mr. Sherwood stated that it was not possible to contract out eligibility determination. He clarified that under federal law eligibility determination could only be done for Medicaid by merit based, government employees or employees of tribally operated TANF programs. He relayed that operation of eligibility systems could be contracted out but that the department was looking at contracting out the coverage side of the issue and not eligibility.

Co-Chair MacKinnon wondered how waivers were driving costs.

[10:19:14 AM](#)

Ms. Martin addressed Slide 19, "Medicaid Reform":

Fraud & Abuse Prevention

FY17 Fiscal Note (401.9)

FY17 Actuals -0-

FY18 Fiscal Note (\$556.2)

FY19 Fiscal Note (\$543.7)

On Track? Delayed

- Alaska Medicaid False Claims and Reporting Act
  - Coordination with the Office of the Inspector General for enhanced FMAP
- Require Medicaid Providers to conduct self-audits and return overpayments along with Interest and penalties
  - Regulations implementing these provisions have been adopted by DHSS and transmitted to Dept. of Law
- Fraud and Abuse prevention efforts for FY17  
[http://dhss.alaska.gov/HealthyAlaska/Documents/Medicaid\\_Fraud\\_Abuse\\_Waste\\_Report\\_SB74\\_Nov15-2017.pdf](http://dhss.alaska.gov/HealthyAlaska/Documents/Medicaid_Fraud_Abuse_Waste_Report_SB74_Nov15-2017.pdf)

Ms. Martin stated that although the initiative was delayed, the department had a robust fraud, abuse, and waste prevention program. She shared that the Department of Law produced an annual report on fraud, waste and abuse prevention efforts in the state, based on fiscal year. She said that the report was transferred to the legislature on November 15th of each year and highlighted the larger fraud cases and the efforts to reclaim state dollars. She said that the provisions in SB 74 had helped the department set

up the Alaska Medicaid False Claims and Reporting Act, which would help to achieve an enhanced Federal Medical Assistance Percentage (FMAP). She said that the department continued coordination with the office of Inspector General on the federal level, through the Department of Health and Social Services. She relayed that efforts continued and that the department would work to keep the legislature abreast of any new information about fraud and abuse. She believed that savings could still be achieved.

[10:22:07 AM](#)

Co-Chair MacKinnon wondered whether a tip line existed that would pay the public a reward for exposing fraud and abuse.

Ms. Martin replied that the department already received calls from the public and had a Program Integrity Unit within the Department of Health and Social Services and the Medicaid Fraud Control Unit within the Department of Law. She shared that the department retained a contractor that helped with utilization reviews that identified "oddities" in billing and a unit that examined how claims matched up with recipient's health conditions.

Senator Stevens thought it was important that the public was aware of Medicaid fraud and wondered how the public could be made more aware of the issue.

Ms. Martin responded that there were often press releases once information could be publicly exposed.

[10:24:48 AM](#)

Senator von Imhof noticed that the fraud use and prevention required Medicaid providers to conduct self-audits. She asked if third-party, surprise audits were ever conducted.

Mr. Sherwood stated that in addition to self-audits, the department did regular audits of providers from a random sample of varied provider types. There were also federal efforts to the same end. He spoke to additional types of audits. He said that providers complained when too many audits were conducted and for random audits the same provider would not be audited more than once every three years. He felt that between the state and the federal government, there were plenty of audits being conducted. He added that anytime something suspicious was noticed, the

department could conduct a separate investigation as appropriate.

Senator von Imhof asked whether the findings of the audits could be summarized.

Mr. Sherwood relayed that the department had found a combination of things; many providers were billing appropriately, with a small degree of error. He stated that inappropriate billing had been identified and had been the result of a lack of education on policy or fraud. All cases found fraudulent were turned over for further criminal investigation.

Senator von Imhof observed that the 'FY Actuals' listed on Slide 19 listed zero.

Mr. Sherwood replied that the numbers on the slide were projections of what would be obtained through the state false claims act, which had yet to receive approval from the Office of Inspector General.

[10:29:36 AM](#)

Ms. Martin informed that if state residents were concerned about potential fraud they could call 1-907-269-6279.

Co-Chair MacKinnon asked whether the department was reaching out to pharmacists in the state in the effort to fight the opioid epidemic.

Ms. Martin stated that one provision of the prescription drug monitoring program was allowing Medicaid pharmacists access to the data in that program, which she said had been helpful in fighting the epidemic.

Ms. Martin showed Slide 20, "Medicaid Reform":

Electronic Verification System  
FY17 Fiscal Note 611.3  
FY17 Actuals -0-  
FY18 Fiscal Note (\$23.0)  
FY19 Fiscal Note (\$23.0)  
On Track? Delayed

- Computerized income, asset and identity verification system

- Third party vendor
- Annual savings must exceed the cost of implementing the system
  - ARIES Release 2 delayed
- January 2017 - Maintenance for ARIES transferred from contractor to DHSS
- Working with CMS and Federal 18F team for agile development process
- RFP for Eligibility Verification System and Asset Verification System by end of April

Ms. Martin relayed that there had been a delay in some of the software system due to the departure of one of the contractors. The Centers for Medicare and Medicaid Services (CMMS) has paid for a significant portion of the system and had offered technical support. She said that the Asset Verification System (AVS) and the Eligibility Verification System (EVS) would be combined, an RFP for both systems will be released in April 2018.

[10:33:55 AM](#)

Co-Chair MacKinnon requested further information conserving the asset portion of the combined systems. She understood that asset value was not currently considered for eligibility for Medicaid.

Mr. Sherwood affirmed that some Medicaid beneficiaries were not subject to an asset test; including, children, low-income parents and caretaker relatives, pregnant women, and Medicaid expansion population. He furthered that the Medicaid categories for the aged, blind, and disabled still had asset tests, due to the long duration of coverage under the program.

Ms. Martin showed Slide 21, "Medicaid Expansion FMAP," which showed a table illustrating Medicaid Expansion matches and the impact of expenditures for Indian Health Service (IHS) recipients. She related that the calendar year FMAP was overlaid with the state fiscal year and combined with the expenditures that qualified regardless of the 100 percent federal match, to reveal the state General Fund match related to Medicaid expansion.

Senator von Imhof asked whether there was a way to overlay dollar values. She wondered what the percentages on the table would equate to in dollars.

Ms. Martin turned to Slide 22, "Medicaid Expansion," which showed a table of the dollar amounts.

Senator von Imhof thought that the slide 22 did not reflect an apples to apples comparison. She requested that the information on the slide be enhanced to reflect the total GF expenditure.

Ms. Martin agreed to provide the additional information.

[10:37:54 AM](#)

Ms. Martin continued discussing Slide 22. She noted that the slide contained the actual and projected GF spend for FY 17, and projections for FY 18 and FY 19. She said that areas had been identified where reductions had been made within the department and in the Department of Corrections.

Ms. Martin looked at Slide 23, "Medicaid Expansion," which showed a line graph entitled "Monthly Enrollment Growth Rate." She stated that growth had leveled out beginning in September of 2017. She said that growth had progressed as anticipated.

Ms. Martin spoke to Slide 24, "Medicaid GF Cost Saving Measures." The slide outlined actual savings for FY 17 and estimates for FY 18. She directed committee attention to the cost saving measures that were new in FY 17 and FY 18.

Ms. Brodie interjected that the department had exceed projected savings by \$3 million, due to the decrease in rates for hospitals and physicians.

Co-Chair MacKinnon asked whether Ms. Brodie could explain why there was \$93 million increase in spending for Medicaid.

Ms. Brodie stated that there had been a large increase in enrollment that had driven up the costs of care for hospital services, doctor services, and pharmacy services. There had been a great deal of growth in needs for hepatitis-C drugs and other specialty drugs. She lamented the new drugs were being offered at unprecedented costs to the Medicaid programs and all health payers. She stated that the department had worked to curb those costs. She opined that though the department had realized significant savings, healthcare costs overall had increased. She

pointed out to the committee that without the savings the department would be requesting twice as much funding.

[10:42:45 AM](#)

Co-Chair MacKinnon asked whether the department could reiterate the growth of recipients for the public. She recalled and estimated 240,000 Medicaid recipients in FY 19.

Ms. Martin replied that 215,000 had been the unduplicated count, potential Alaskans that were receiving Medicaid benefits and services through the program. She said that the average monthly enrollment was used as a toll in averaging and negated some of the seasonal swings in Medicaid enrollment, as well as recipients briefly on the program. She said that in FY 16, the average of monthly total Medicaid enrollment was \$151,409; in FY 17 the average monthly enrollment was 186,748.

Co-Chair MacKinnon asked whether the state was paying out 30,000 claims week or per month.

Ms. Brodie specified that the state paid over 120,000 claims per week, for an average of \$35 million.

[10:45:29 AM](#)

Senator Micciche thought that the program should be designed to assist those that were most in need. He believed that the state could manage healthy individuals on the program in order to prevent overutilization, rather than reducing day habitation services for Alaskans that required more services.

DUANE MAYES, DIRECTOR OF SENIOR AND DISABILITY SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, discussed the definition of day habilitation services, which meant to take an individual that was on the developmental disability waiver out into the community and engaging them in a variety of activities such as banking, or going to a medical appointment. He said that day habilitation centered around active instruction; teaching an individual the skill that they needed to be as independent as possible. He shared that over his time as division director he had noticed a growth in cost for day habilitation services, 40 plus percent over the past 5 years. He said that the day

habilitation cap had been implemented on October 1, 2018, and 744 plans of care had been reviewed, 8 percent of which had been denied because they were above the cap. He stated that that cap was soft but that significant justification for the services had to be presented. He stressed that the division had worked thoughtfully to stabilize the service category.

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Senator Micciche wondered why managing the healthcare of healthy adults was not a priority over managing that of those most in need. He thought that reducing utilization of healthy adults would reduce cost for those who had the greatest need.

Co-Chair MacKinnon expressed appreciation for the department on behalf of the committee. She lamented that the state continued to face declining revenues.

Co-Chair MacKinnon discussed housekeeping.

#

ADJOURNMENT

[10:53:12 AM](#)

The meeting was adjourned at 10:53 a.m.

