

HOUSE FINANCE COMMITTEE
March 27, 2019
1:32 p.m.

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CALL TO ORDER

Co-Chair Foster called the House Finance Committee meeting to order at 1:32 p.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Tammie Wilson, Co-Chair
Representative Jennifer Johnston, Vice-Chair
Representative Dan Ortiz, Vice-Chair
Representative Ben Carpenter
Representative Andy Josephson
Representative Gary Knopp
Representative Bart LeBon
Representative Kelly Merrick
Representative Colleen Sullivan-Leonard
Representative Cathy Tilton

MEMBERS ABSENT

None

ALSO PRESENT

Adam Crum, Commissioner, Department of Health and Social Services; Sana Efird, Administrative Services Director, Department of Health and Social Services, Office of Management and Budget; Donna Steward, Deputy Commissioner, Department of Health and Social Services; David Teal, Director, Legislative Finance Division.

SUMMARY

MEDICAID PHASE ONE OVERVIEW:

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

OVERVIEW RESPONSE:

DAVID TEAL, DIRECTOR, LEGISLATIVE FINANCE DIVISION

Co-Chair Foster reviewed the meeting agenda.

^MEDICAID PHASE ONE OVERVIEW: DEPARTMENT OF HEALTH AND SOCIAL SERVICES

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Co-Chair Wilson requested to hear from the commissioner on how the [Medicaid] changes impacted Denali KidCare and children's programs. She noted the topic had been prevalent at community meetings and she hoped to take care of some of the misunderstandings.

ADAM CRUM, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that Denali KidCare was not affected by the plan. He clarified that the Department of Health and Social Services (DHSS) would maintain how kids were taken care of throughout the process.

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SANA EFIRD, ADMINISTRATIVE SERVICES DIRECTOR, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, OFFICE OF MANAGEMENT AND BUDGET, provided a PowerPoint presentation titled "FY2020 Operating Budget Overview: Department of Health and Social Services, Medicaid Services" dated March 27, 2019 (copy on file). She began on slide 2 and addressed the Medicaid Services operating budget change summary from the FY 19 management plan to the governor's FY 20 amended budget. The governor's budget would reduce undesignated general funds (UGF) by \$249,216,800 or 38 percent and federal funds by \$465,476,600, for a total reduction of \$714,061,900. The reductions consisted of a \$225,000 UGF decrement in Medicaid Services and a reduction of \$8,273,600 UGF related to the governor's proposal to eliminate the Adult Dental Medicaid benefit. The proposal also included the fourth year of planned UGF reductions of slightly over \$15 million resulting from the SB 74 Medicaid reform legislation [SB 74 passed the legislature in 2016]. The true reductions that had not already been planned totaled approximately \$233 million UGF.

Ms. Efird continued with slide 2. She highlighted that in FY 19 there were four allocations to Medicaid for Health Care Services, Behavioral Health, Senior and Disabilities, and Adult Preventative Dental. The governor's FY 20 proposed collapsing the four allocations into one

appropriation for Medicaid Services. The change was based on the ability to more efficiently manage the program. She explained the change would help with processes related to revising programs as billings came into the program and would minimize an administrative burden. She underscored that all of the department's reporting requirements to the legislature and federal government would remain intact.

Co-Chair Foster recognized that Representative Carpenter had joined the meeting.

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Vice-Chair Johnston had heard a concern from the public about defunding an optional Medicaid service once the allocations were collapsed into one, especially if there was insufficient funding. She elaborated that in the past a supplemental had been needed to fund Medicaid. She explained it had taken time to repay. She asked if there would be an opportunity to defund optional services under the governor's proposal.

Ms. Efird answered that DHSS was bound by its current contract with the Centers for Medicare and Medicaid Services (CMS); any changes to the budget would require state plan amendments or regulation changes. Until there were changes giving DHSS permission to reduce or change the proposals within the budget, DHSS was bound to pay claims for all eligible services.

Vice-Chair Johnston asked for a description of the public process [to make changes to regulation or issue state plan amendments].

Ms. Efird deferred the question to a colleague.

DONNA STEWARD, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that whenever DHSS made an adjustment to services, utilization, or rates, it was required to follow the process outlined in its state plan. She noted if the change involved a regulation, DHSS was also required to follow the regulation change process. She expounded that the regulatory process provided an opportunity for public comment. The governor's proposed FY 20 budget would require the department to go through the regulatory process (including public comment) and the state plan amendment process, which would require CMS approval.

The department would not be able to stop funding in perpetuity for any optional or mandatory services without going through either of the processes.

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Vice-Chair Ortiz asked about the governor's proposal to eliminate the adult dental Medicaid benefit (\$8 million UGF and \$18.7 million in federal funds). He asked for the number of current recipients who would no longer receive the benefit.

Ms. Steward did not have the numbers on hand but would follow up. She added that emergency dental services would still be available.

Representative Josephson reported that he had heard opposition to the governor's proposal to collapse Medicaid into a single allocation from individuals working in the senior and disability services sector. He thought there may be a better Federal Medical Assistance Percentage (FMAP) [under the current system]. He explained the individuals believed the change would prejudice them to be part of one appropriation.

Ms. Efird replied that the change would not prejudice the department against paying any type of claims. She clarified that incoming claims went through the Medicaid Management Information System (MMIS) and had to be adjudicated (checked for accuracy and services coverage). Additionally, the FMAP was determined for each claim. Claims were paid based on which services were covered through the total Medicaid budget. She elaborated that groups covered under Senior and Disability Services also received services in Behavioral Health Medicaid and Health Care Medicaid; the groups were not solely served in the Senior and Disability Services budget. The structure had been a way to collect information and give some reporting to the legislature on groupings.

Ms. Efird stated that DHSS had to pay a claim based on what services were covered and were allowed to be paid under each claim. She explained DHSS would never hit the number exactly. For example, if DHSS designated a number for Senior and Disabilities Services in a separate appropriation and it ran short, if the department did not have the ability to move between appropriations, the budget

could be short. Conversely, the department could overfund Senior and Disabilities Services and have a shortage in another Medicaid appropriation. She explained that a budget was a plan - the department's best estimate and projection; however, claims may not necessarily align to the exact budgeted numbers.

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Ms. Steward highlighted the governor's proposed \$233 million reduction to the Medicaid program. The department had approached the reduction in two phases (slide 3); the presentation would focus on phase I. She highlighted the department's belief that the strategies under phase I were attainable in FY 20. Some of the cost containment strategies were new and others had been utilized in the past. Each of the division directors had been focusing and working together to identify ways to become more economical. Phase II had been identified for the end of FY 20 or the beginning of FY 21.

Vice-Chair Johnston directed attention to the bullet point regarding new flexibilities released in November 2018. She asked if the department had a list of the items.

Ms. Steward agreed to follow up with the list.

Representative Josephson asked whether the timeline for phase II indicated the administration would need to spend from the Statutory Budget Reserve (SBR) to fund Medicaid for FY 20.

Ms. Efird replied the department was on board to realize all of the savings in FY 20 for phases I and II; however, phase II was not within the department's control and would require approval from CMS. Safety net language had been included in case DHSS did not receive the approval through CMS during FY 20 for the phase II initiatives.

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Ms. Steward turned to slide 4 and addressed the four primary cost containment levers within the Medicaid program including, eligibility adjustments, rate adjustments, service/utilization adjustments, and program/administrative adjustments. She underscored that DHSS was not recommending any adjustments to Medicaid program eligibility. The plan

did not impact eligibility for Denali KidCare or Medicaid expansion.

Vice-Chair Johnston asked for verification that Ms. Steward's statement was true for both phases.

Ms. Stewart agreed; phase II would not address specific eligibility items either. She turned to slide 6 and addressed four principles for approaching rate adjustments:

- Protect Primary Care
- Protect Small Hospitals
- Protect Access to Services
- Align Payment with Other Public Payers

Vice-Chair Johnston asked for an example of other public payers (slide 6).

Ms. Stewart replied that the other public payer was the Medicare program.

Co-Chair Johnston asked if the other public payer was limited to Medicare and did not include Tricare.

Ms. Stewart agreed. She explained the payment systems were more aligned between Medicare and Medicaid because they were administered by CMS at the federal level. Other public payers, such as Tricare, were administered differently and had much more complex rate structures.

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Vice-Chair Ortiz pointed to the second bullet point to protect small hospitals. He had heard concern from small hospitals that the proposed budget would put them in jeopardy. He asked if the slide indicated that small hospitals could somehow receive greater rates than large hospitals (for the same services).

Ms. Stewart explained that each hospital received a daily rate based on that hospital's cost; each hospital received a separate rate. For example, the daily rate for an appendectomy at Providence Hospital in Anchorage was very different than the rate in Sitka because the costs within the two facilities were different. She reported DHSS could separate out acute care hospitals from critical access

hospitals; the critical access hospitals, by designation, would be protected from any rate adjustments.

Vice-Chair Ortiz asked Ms. Steward to repeat the term for the hospital that would be protected.

Ms. Steward replied they were critical access hospitals.

Vice-Chair Ortiz asked if critical access meant the hospital was the only hospital accessible to individuals in a given area.

Ms. Steward answered that critical access was a specific designation of hospital; there were criteria a hospital was required to meet in order to receive the designation. She detailed that size was typically the determining factor; the threshold of inpatient beds was 25. She elaborated that the first threshold a critical access hospital had to meet was that they have 25 or fewer beds available for services.

Vice-Chair Ortiz asked if Ms. Steward was saying that even though some hospitals operated on much smaller margins, the adoption of the governor's proposal would not place the hospitals in any added jeopardy.

Ms. Steward answered that the critical access hospitals would not receive a 5 percent reduction to their inpatient daily rates and would not have inflation withheld. She noted that a later slide included a list of hospitals that would not be affected.

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Representative Josephson asked if the plan was to align payments at the Medicare rate even in cases where Medicaid paid more to providers.

Ms. Steward answered the department did not have a specific goal to match Medicaid payments to Medicare payments; however, DHSS had a federal upper payment limit imposed by CMS. The limit established a cap where the state could not pay Medicaid services above what Medicare would have paid in the aggregate. The department had to consistently benchmark against what Medicare was paying in order to avoid exceeding the federal upper payment limit. She elaborated that for every dollar exceeding the cap, the state would be required to pay 100 percent of the dollars

out of the GF (instead of receiving the traditional 50/50 federal match). The penalty imposed by CMS for exceeding the payment threshold was severe; therefore, CMS was constantly monitoring Medicaid rates based against Medicare rates.

Representative Josephson remarked that the information described by Ms. Steward was already in place. He asked if the plan was to pay providers in the Medicaid population less than they were currently receiving in the hopes they would continue to provide at a rate lower than Medicare.

Ms. Steward answered that there were no specific proposals to move "this rate" to the Medicare rate. As the department approached reductions to meet the \$233 million reduction, it applied any rate adjustments as fairly across all providers as possible. The department had set forth the goals to protect primary care and small hospitals.

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Representative LeBon asked where the Fairbanks Memorial Hospital fell within the group of hospitals in the state. He asked if Providence Hospital in Anchorage was baseline, whether that put the Fairbanks hospital in the small to medium or medium to large category. He asked what rate adjustments Fairbanks Memorial Hospital should expect from the proposal.

Ms. Steward answered that the Fairbanks Memorial Hospital was not a critical access hospital - there were only two designations including critical access or not. Fairbanks would see the 5 percent reduction for inpatient and outpatient hospital services and the inflation hold would apply.

Representative LeBon asked for verification the Fairbanks hospital would be treated the same as Providence Hospital in Anchorage.

Ms. Steward agreed.

Representative LeBon asked for verification the difference in location, size, community, and energy cost would not be taken into consideration.

Ms. Steward replied that energy costs, personnel costs, facility size, were all figured into the daily rate established for a facility. The daily rate would see the additional reductions [she had previously mentioned].

Representative LeBon asked if the Fairbanks Memorial Hospital would be at a disadvantage to Providence Hospital in Anchorage.

Ms. Steward was not familiar with whether the two hospitals were in competition for services. She elaborated that the 5 percent reduction would apply for Providence as well, but the dollar amount would be different based on the fact they were paid different daily rates. She pointed out that the reduction for Providence would be higher because of the hospital's greater volume.

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Ms. Steward moved to a list of proposed rate and payment adjustments under phase I on slide 7. The first item was the 5 percent provider rate reduction to inpatient and outpatient services for prospective payment system hospitals. She clarified that critical access hospitals were exempt from the change. Additionally, the change would not apply to any Indian Health Service hospitals receiving the federal encounter rate. The rate adjustment would only apply to specialty physician services and would exclude primary care, obstetrics, and pediatrics. In an attempt to help protect primary care, the rate adjustment would not apply to Federally Qualified Health Centers.

Vice-Chair Johnston asked if the savings would be one-time or ongoing.

Ms. Steward answered the 5 percent reduction would be a one-time savings for FY 20.

Co-Chair Wilson asked for verification the 5 percent reduction would remain in effect beyond FY 20.

Ms. Steward answered that the governor's plan would not reapply the 5 percent reduction in FY 21. The rate would move forward at the 5 percent reduction and inflation would move forward as scheduled for FY 21.

Co-Chair Wilson asked for verification the administration would not impose an additional 5 percent reduction in FY 21 and inflation would be added in.

Ms. Steward agreed.

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Vice-Chair Johnston asked for information on what had happened with the rates over the last four years.

Ms. Steward answered that the information would be covered later in the presentation. She continued with slide 7 and addressed the proposed adjustment to withhold inflation. The adjustment would be applied to all providers that receive an annual inflation increase, with the exception of those excluded under the 5 percent provider rate reduction. The proposal would move the acute care hospital system to diagnosis-related groups (DRG). She explained that DRGs were the first step towards bundling payments. She noted that critical access hospitals would have an option to move to DRGs, but primarily they would be unaffected by the change.

Vice-Chair Johnston stated that the legislature had heard the importance of making sure the issues were dealt with accurately. She pointed to the administration's timetable of January 1. She asked if the department was confident in its ability to get the work right under the stated timeline.

Ms. Steward answered it was the department's goal. She reported DHSS would work with two contractors to help ensure the facility base rates were set to the best of the department's ability. There were national companies that helped set facility base rates. The department's MMIS contractor conduit had a bundling module used in other states that the department could use to ensure DRG packages moved forward. With those approaches, the department believed it would be ready for a January 1, 2020 implementation.

Ms. Steward continued with slide 7 and highlighted the proposal to develop an acuity-based nursing facility rate. The adjustment would allow for differential payments based on the level of care needed per patient in a skilled nursing facility. The governor's proposal would move end

stage renal disease (ESRD) clinic services from a set rate to a cost-based rate based on the clinic costs reported on their Medicare cost reports.

Vice-Chair Ortiz asked about the cost-based end stage renal disease. He asked what would not happen that had happened in the past in relation to the particular category.

Ms. Steward answered that there had been a set rate for the services. She noted that dialysis services could be provided in an outpatient setting in a hospital or in an ESRD clinic. The rates would apply to the ESRD clinics. She detailed that for several years a rate had been set, but there had been no real theory behind it. The proposal was to move to a cost-based rate, which was similar to what was used for hospitals under the prospective payment system. The cost-based rate was determined in a model methodology system, which set a rate based on all of the inputs necessary to deliver services as identified on a clinic's Medicare cost reports.

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Vice-Chair Ortiz asked for verification that end-stage renal disease implied the individual was near renal failure and at the end stages of their life.

Ms. Steward answered that there were four levels of kidney degradation. End-stage renal disease meant a person had reached the point where they need dialysis; however, there were a number of individuals who were on dialysis for many years before having a transplant or passing away.

Vice-Chair Ortiz asked if the proposal meant that people in the end-stage category would receive less benefits than before.

Ms. Steward answered in the negative. She clarified that the service would be exactly the same, but the unit cost would be different. She noted that Medicaid accounted for a small percentage of the payment for the services. The majority of individuals who needed ESRD services were with the Medicaid for about 60 days before transitioning into the Medicare program. Some individuals would never transfer to Medicare and would be with the state under Medicaid for a longer period of time, but in general Medicare was the primary payer for ESRD services.

Vice-Chair Ortiz asked if the payout to providers would be less.

Ms. Steward answered in the affirmative.

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Vice-Chair Johnston referenced a separate chart [titled "State of Alaska Medicaid Program, Phase I: Cost Containment - Implementation Schedule," dated March 21, 2019 (copy on file)] indicating no regulation change was required to make the ESRD change.

Ms. Steward answered that the regulations had already been approved. The change to the [ESRD] payment methodology would happen by the July 1 implementation.

Vice-Chair Johnston asked when the department started the conversation with CMS regarding the state plan amendment.

Ms. Steward replied that the state plan amendment was currently in process. The department believed it would be in time for a July 1 implementation.

Vice-Chair Johnston was trying to understand the timelines for the state plan amendments. She wondered when the department had started the conversation with the federal government. She noted that the regulation process had already occurred. She pointed out that some of the other [rate and payment] adjustments still required regulation changes and a state plan amendment. She asked how long it took to amend the state plan.

Ms. Steward replied she would follow up with specifics on when DHSS had started the [state plan amendment] process [regarding ESRD]. She relayed the payments for ESRD clinics had been putting DHSS in jeopardy of exceeding its federal upper payment limit. As the state plan amendment moved forward, the department would submit a new upper payment limit showing that adjusting the rates would bring DHSS down and in line with the federal payment limit requirements. The department anticipated that the ESRD state plan amendment would potentially move quickly because of the immediate issue with the upper payment limit. She did not want to provide a timeline because the immediate issue with the upper payment limit would affect it.

Vice-Chair Ortiz looked at the reduction in payouts to providers for the acuity based nursing facility rate. He asked how the changes would impact skilled nursing facilities and critical access hospitals.

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Ms. Steward answered that "combo facilities" housed a critical access hospital and a skilled nursing facility. She detailed that rates were set separately for each of the two licensures. The movement to the acuity base would apply to skilled nursing facilities and their patients' level of need (lower or higher intensity) would either drive an overall aggregate increase in their payment, keep them about the same, or reduce their payment (if they only served lower acuity individuals).

Representative Josephson asked if there was a chance the cost-based methodology could result in a higher payment than a set rate.

Ms. Steward asked which provider Representative Josephson was speaking about.

Representative Josephson clarified he was asking about ESRD.

Ms. Steward asked if Representative Josephson was asking whether the cost-based methodology could result in a higher level of payment for ESRD clinics.

Representative Josephson replied in the affirmative.

Ms. Steward answered in the negative. She elaborated that currently ESRD facilities were reimbursed at 233 percent above the Medicare rate. When adjustments were made under the model methodology (based on the costs reported by a facility), the state would only pay 23 percent above Medicare.

Representative Josephson asked if the state would pay 123 percent rather than 233 percent.

Ms. Steward replied in the negative and clarified that the payment would be 23 percent above Medicare.

Representative Josephson asked how to know what the position of the providers was.

Ms. Steward answered that the Office of Rate Review had been working with providers for slightly over one year. The department had notified the providers there was a problem regarding the federal upper payment limit and that DHSS would need to make the adjustments. The department had been working on a dual track with providers: 1) to make adjustments to remain under the federal upper payment limit, and 2) to work collaboratively with providers on a global payment system model (being replicated in eight states) to serve patients with dual eligibility for Medicaid/Medicare. She elaborated there was a dual waiver where Medicare and Medicaid programs came together to provide a dual payment. The change would help improve care coordination between the two programs. She had not followed up with the Office of Rate Review to learn whether additional conversations had occurred [with providers]. She explained that step two of the process was still underway with the providers.

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Ms. Steward addressed the last bullet point related to pharmacy rate and payment adjustments on slide 7. The department would move its preferred drug list to allow DHSS to move more nimbly through changes in order to respond quickly when drug prices went up or down. She explained it would help save a substantial amount of money.

Ms. Steward stated that given the interest in hospitals, DHSS had provided additional slides to the finance subcommittee; the information had been consolidated in the presentation to streamline the timing. She turned to slide 8 and continued to address phase I cost containment. The table highlighted the increases in hospital payments for inpatient and outpatient services. The table also identified federal funds and some of the funds under federal reclaiming that would be General Fund expenditures if they were not being reclaimed. She pointed to a steady increase in payments going to hospitals from FY 15 to FY 18. Some of the increase was due to the expansion population, but there were other elements contributing to the increase as identified with claiming and other. She noted there had also been an increase in the traditional Medicaid program that had contributed to that in the past.

Co-Chair Wilson asked how rates in Alaska compared to rates in Seattle for the same services.

Ms. Steward replied that most hospitals in the Lower 48 were paid on the DRG system that Alaska was in the process of moving to. She explained that a direct comparison was not currently possible due to the bundled rate paid to facilities in the Lower 48. When Alaska moved to DRGs it would allow DHSS to determine whether it was paying above or below some of the Lower 48 facilities. She relayed that the State of Washington's Medicaid program paid all providers and all services below Medicaid rates. She elaborated that no matter what the DRG was, if the DRG set the base rate and total, there would be a discount applied to the payment. The department assumed that Alaska probably greatly exceeded costs of services compared to other states.

Co-Chair Wilson discussed that insurance in Alaska had moved to incentivizing individuals to travel out of state for procedures. She asked if the Medicaid program had looked at the same process. She assumed Medicaid had gone through a process and found certain procedures could be done in the Lower 48 even when including the cost of airfare. She was frustrated that the state's insurance tried to push people out and Medicaid tried to keep people in state. She wondered if the department had researched how much Alaskans had to pay for procedures in state versus out of state.

Ms. Steward replied that DHSS had not looked at whether it would be cheaper to send individuals out of state for certain services; it had not been a consideration as the cost containment process moved forward. There were some specialty services that were not available in Alaska and required sending individuals out of state. She highlighted intermediate care facilities as an example of a service not available in Alaska.

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Co-Chair Wilson asked what it would take to do the review. She guessed that some data must already exist in AlaskaCare. She stated that insurance provided an incentive

to travel out of state and included per diem and airfare. She was curious why the two programs did not share data.

Ms. Steward replied that she was not certain data would be the determining factor in the particular situation. She explained that under the Medicaid program the state "was not a group product" and the state did not have a risk base for its pool. The department accepted claims from providers and paid them. Additionally, DHSS controlled the rates, as required by its state plan amendment agreement with CMS. The department was able to pay providers lower than AlaskaCare because it was able to set the rates. She stated that AlaskaCare, with limited flexibility [to pay lower rates], likely paid higher than the Medicaid program. She noted the topic was outside her purview, but she suspected her explanation was accurate. She did not believe AlaskaCare was able to make rate adjustments like the state.

Co-Chair Wilson believed the state should be looking at all avenues if they were putting everything on the table. She did not necessarily believe sending people out of state was the right avenue. She reasoned that the number of providers in Alaska would decrease if patients were sent out of state for services. She knew there was a balance point. She stated it was one of the fastest growing areas in the state. She wanted to ensure the best care was given, but if services were not available locally and a patient had to fly for care, there may be a bigger cost savings, while receiving excellent care.

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Ms. Steward moved to slide 9 and spoke about Medicaid hospital rate adjustments from FY 15 to FY 19. The slide provided history of some of the rate reductions that occurred under previous administrations. For inpatient services inflation had been withheld in FY 16 and FY 17. In FY 18, in addition to the withholding of inflation, there had been a 5 percent reduction to inpatient and outpatient services in all facilities including critical access hospitals. In FY 19 each of the items had been restored from FY 18 - the 5 percent reduction had been added back, rebasing had moved forward, and inflation was granted for the FY 18 rate and applied for FY 19.

Ms. Steward looked at some of the increases from FY 15 to FY 18. She detailed that if the state continued on trend it would be spending approximately \$496 million (total funds) for hospital services. Slide 10 showed a bit of an increase for utilization. She referenced the idea that the increase was due to [Medicaid] expansion. There had been a 6 percent increase in Medicaid patients seeking hospital services between FY 15 and FY 16 and a drop of 1 percent from FY 16 to FY 17. She reported the department would compute the information for FY 18 in about three months to determine if the trend was continuing down. She summarized that utilization was not up dramatically, yet there had been increases in hospital rates.

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Co-Chair Wilson had received a call from a person on Tricare. She believed the individual had told her that once they were in the hospital or treatment for 30 days, they were switched to Medicaid even though they were still on Tricare.

Ms. Steward answered that she was not familiar with the issue but would be happy to look into it. She noted that Medicare had a benefit limit and only allowed a limited number of inpatient days; once that threshold was exceeded, the individual would transition to Medicaid.

Co-Chair Wilson asked if there was any instance a person on Tricare would be switched to Medicaid.

Ms. Steward was unfamiliar with the issue and would follow up.

Co-Chair Wilson would get back to the department on the issue. She had not known about the Medicare process highlighted by Ms. Steward. She asked how many individuals had reached their benefit limit on Medicare and been switched over to Medicaid, "which is Medicare federally funded into the state program in which we're now 50/50."

Ms. Steward replied she could follow up with the information.

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Vice-Chair Johnston looked at slide 11 asked for verification the FY 19 trend line included the \$37.8 million of the supplemental from FY 18.

Ms. Efird replied in the affirmative.

Vice-Chair Johnston acknowledged the trend line and noted some of the amount was possibly due to underfunding the year before.

Ms. Steward highlighted a list of hospitals that would not be affected by proposed rate adjustments or the withhold of inflation (slide 12). The list primarily included critical access hospitals. Additionally, hospitals paid under the Indian Health Service inpatient encounter rate were also not affected. The department did not control or adjust the federal encounter rate. She turned briefly to slide 13 that showed a recap of the rate and payment adjustments. The slide identified an implementation date for adjustments if it differed from the July 1 date.

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Ms. Steward moved to slide 14 and addressed access and provider rates. She explained that anytime DHSS made a rate adjustment it was required to go through a process with the state plan amendment to identify and make changes in the state plan and to signal to CMS that a change was being made. She elaborated that CMS monitored to ensure rates were sufficient enough to keep an adequate number of providers able to deliver services. The state was bound by federal law to submit an Access Monitoring Review Plan that included information on utilization, location and overall number of providers, and the number individuals served in certain communities. The department provided the information to CMS each time the state made a rate adjustment. She explained that DHSS was required to submit follow up information for the next three years in order for CMS to identify whether utilization had been impacted, whether the state had lost providers, or whether there was a general shift in the way services were delivered in response to the rate reduction.

Vice-Chair Johnston asked if DHSS could simultaneously do a regulation change and state plan amendment.

Ms. Steward answered that in the case where DHSS had used a strategy in the past (e.g. withhold inflation and a 5 percent rate reduction), the regulation package could move at the same time as the state plan amendment. However, if the department had not used the strategy in the past, it would not necessarily take that approach because it would want the public process to help inform what the final regulations and ultimately what the state plan would look like.

Vice-Chair Johnston pointed to slide 13 and asked how implementing the hospital DRG would mesh with the 5 percent inpatient/outpatient rate reduction. She asked if it was figured in with the department's savings.

Ms. Steward answered that once the DRG system was in place, the 5 percent reduction and the withhold of inflation would go away. She noted the same would be true for the acuity based skilled nursing facility rates.

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Vice-Chair Johnston asked if the innovative payment model was part of phase II.

Ms. Steward thought perhaps Vice-Chair Johnston was speaking about the ESRD.

Vice-Chair Johnston agreed.

Ms. Steward answered that discussions with ESRD providers had been to look at a global payment via a CMS demonstration model. She explained it was a partnership between the Medicare and Medicaid worlds. She explained the department would pursue the option if ESRD providers believed it could be viable in Alaska.

Vice-Chair Johnston surmised it was an excellent example of coordination efforts.

Ms. Steward agreed.

Representative Josephson looked at slide 13 regarding implementation dates. He asked if the department's budget requests reflected that it was the middle of the fiscal year.

Ms. Steward answered in the affirmative. She detailed that as the department had looked at the dollar figures, they had been identified for the effective implementation dates.

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Ms. Steward moved to slide 15 and addressed service and utilization adjustments as a way to affect cost containment. The department planned to limit services for physical, occupational, and speech therapy for adults to 12 visits in each category per year. With the caveat that should the individual move their provider, identify that they must move forward with additional services in that category, they would be provided. There would not be a limit on the level of therapy sessions for children. The department would expand the "lock-in" or care management program. She explained that under the program an individual was assigned to a specific primary care provider or pharmacy. The change was an effort to curtail a pattern of behavior where some individuals appeared to be shopping for something. The department intended to implement a 24/7 nurse hotline to connect individuals with the appropriate level of care to avoid unnecessary emergency room or doctor visits. The last change on the slide was the proposal to eliminate adult preventative dental.

Ms. Efird followed up on an earlier question asked by Vice-Chair Ortiz regarding adult preventative dental. She shared that in FY 18 there were 31,947 recipients in the program.

Vice-Chair Ortiz asked for verification that the 31,000-plus individuals currently receiving adult dental care would no longer receive care if the governor's plan was adopted.

Ms. Efird clarified that the number of individuals she had provided reflected individuals who had received preventative dental care in FY 18. She confirmed that under the governor's proposal and with an approved state plan amendment, preventative care for adults would no longer be provided in FY 20. Preventative care included exams, crowns, dentures, and other related services.

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Vice-Chair Ortiz believed Ms. Efird had mentioned that emergency dental care would still be provided.

Ms. Steward agreed. She elaborated that Alaska would join 18 other states in which emergency dental services were still available for their Medicaid population.

Vice-Chair Ortiz asked what the impact would be on the increased need for emergency care if preventative care was no longer provided. He reasoned there would likely be an increase in emergency care.

Ms. Steward answered that the Medicaid population was unique and teasing out what the change may be was difficult. She explained that currently, even with the availability of preventative dental services, emergency services made up a good portion of the treatment adults were receiving.

Representative Josephson asked which states Alaska would be joining that did not provide adult preventative dental services. He asked if the states were regarded as poor (e.g. Mississippi or Arkansas) or affluent.

Ms. Steward agreed to provide the information. She noted there were eight states that did not provide any dental services.

Representative Josephson thought it was a policy call about aspiration and where the state was headed. He believed it was a retreat of some sort.

[2:38:44 PM](#)

Ms. Efird answered that the change was a policy decision. She referenced the governor's tenets for putting the budget together that had been shared with the department. The department's direction was to meet its core services and it was working through its budget numbers. The department was trying to protect the core services for low income Alaskans for their healthcare coverage. She acknowledged that cutting adult preventative dental could increase costs in other areas, but it was currently difficult to project. She explained that the service was optional under the Medicaid program and had been added more recently.

Representative Josephson referenced testimony earlier in session by Becky Hultberg, President and CEO of the Alaska State Hospital and Nursing Home Association (ASHNHA). He

remarked that Ms. Hultberg was a respected former commissioner [of the Department of Administration] and had worked for multiple administrations. He recalled Ms. Hultberg's testimony that the term "optional" with regards to Medicaid services was a misnomer and could not be treated in its typical definition. He asked if the testifiers agreed.

Ms. Steward answered that what Ms. Hultberg had brought forward was certainly true of medical services. When the state expanded and chose to use a benchmark for the state employees benefit program to deliver expansion services to the Medicaid population, it eliminated flexibility for optional services. However, dental was not a requirement under the Affordable Care Act (where the model originated) and was a truly optional service under the Medicaid program.

Vice-Chair Johnston asked if DHSS had started the regulation process and amending the state plan. If not, she wondered how long the process would take.

Ms. Steward replied that DHSS had not started the regulation or state plan amendment change processes. The department would start the process as soon as it received direction the change would move forward; the process was anticipated to take about six months.

Vice-Chair Johnston asked if the regulation change was a 90-day process.

Ms. Steward responded affirmatively.

Vice-Chair Johnston asked for verification that the state amendment plan depended on CMS.

Ms. Steward answered that eliminating an optional service would mean a compressed timeline.

Vice-Chair Johnston asked if the processes could occur simultaneously.

Ms. Steward agreed. She expounded that because the service to be eliminated was optional, the regulation and state plan amendment could move forward at the same time.

Vice-Chair Johnston asked if implementation had been included in the department's cost savings related to the program.

[2:42:49 PM](#)

Ms. Efird answered that the figures on slide 15 reflected the program's total cost.

Vice-Chair Johnston asked for verification that the amounts on slide 15 showed the cost of the adult preventative dental program for the coming year.

Ms. Efird clarified that the figures on slide 15 showed costs for FY 19.

Vice-Chair Johnston asked whether the adjustment [shown on slide 15] should be cut in half, given that the state plan amendment would take six months.

Ms. Steward replied that one of the options through the state plan amendment was for the state to have everything completed within a quarter. She detailed that if everything was completed within a quarter, the effective date started the first day of the quarter; the department had until September 30 for CMS to approve a state plan amendment for a July 1 implementation date.

Vice-Chair Johnston asked for verification that if DHSS started the process after the legislature passed the budget (hopefully by May 15), the elimination of the services could be effective on July 1.

Ms. Steward agreed.

Representative LeBon asked for verification that the 12 hospitals on slide 12 were held harmless from the rate reduction.

Ms. Steward responded affirmatively.

Representative LeBon asked how many hospitals throughout the state were not included in the group (e.g. Providence Hospital and Fairbanks Memorial Hospital).

Ms. Steward replied there were seven.

Representative LeBon asked if the seven hospitals all received the 5 percent rate reduction.

Ms. Steward agreed.

Representative LeBon asked if the department had considered Providence Hospital in Anchorage as the baseline. He wondered if Providence was considered the most efficient hospital in the state in terms of economies of scale.

Ms. Steward stated that she did not feel qualified to answer the question.

Representative LeBon suspected the answer was yes. He considered the size of the seven hospitals and wondered whether the department had contemplated a tiered treatment rather than going from zero to a 5 percent provider rate reduction.

Ms. Steward replied that the rate reduction had been modeled on the 5 percent reduction made in FY 18. In order to protect the critical access hospitals, they were exempt from the reduction.

Representative LeBon asked if there had been no consideration for a sliding scale for the remaining seven hospitals.

Ms. Steward agreed. The department had used the methodology from FY 18.

Vice-Chair Johnston requested the daily reimbursement rates for the seven hospitals.

Ms. Steward agreed.

[2:47:29 PM](#)

Ms. Steward briefly highlighted a recap of proposed service and utilization adjustments on slide 16. She moved to cost containment in administrative and program changes on slide 17. She addressed the proposal to reduce the timely filing allowance for all providers to six months. She explained that currently Medicaid providers had up to one year to submit claims from the date a service was delivered.

Vice-Chair Johnston relayed that legislators were beginning to have people come to their offices regarding the proposal. She noted she had been excited about the proposal when it had been introduced. She explained there seemed to be a processing issue where providers had to wait for insurance or other billing before they could submit a claim to Medicaid. Additionally, there had been some holdups in the past related to service authorization. She noted that some of the responsibility resided in the state's hands. She asked how the state would ensure providers were able to submit claims in a timely manner.

Ms. Steward responded that there would be a number of different exemptions. For example, there would be an exemption if there was third-party coverage and a provider was waiting for the primary payer to process a claim. There would be an exemption any time there was a glitch in the DHSS system that would suppress payments. There would be appropriate ways to augment the six months to ensure the state was not unduly penalizing a provider. Additionally, providers would also have an opportunity to request reconsideration and present arguments as to why they qualified for an exemption, if they submitted a claim beyond the six-month deadline. The department did not want to unduly penalize a provider if there was a problem preventing them from submitting a claim within the six-month window.

[2:50:28 PM](#)

Vice-Chair Johnston asked if the proposal would be a one-time cut.

Ms. Steward replied that the adjustment would be a permanent change in the way DHSS would accept claims. She referenced the associated \$10 million reduction and explained that the majority of the amount was due to aberrant billings. She highlighted cases where a provider retired or left the state, and someone picked up their billing ID to submit false claims. Unless the provider notified DHSS they were no longer working, the department was in a "pay and chase" situation trying to get the funds back once it realized the provider was no longer working. There would be a reduction in the \$10 million figure over the years, but the state would potentially be saving in pay and chase situations annually.

Vice-Chair Ortiz considered the \$714 million in proposed cost reductions or projected savings on slide 2. He pointed to slides 7, 15, and 17 that highlighted different amounts of the savings and calculated savings of \$187 million. He asked where the other \$527-plus million savings were.

Ms. Efird answered that the presentation focused on phase I of the department's proposal. She directed attention to a summary sheet of the proposed phase I reductions on slide 20. She explained that phase II would include the additional reductions the department would address at another time. She believed Ms. Steward would speak about phase II at the end of the current presentation.

[2:53:59 PM](#)

Vice-Chair Ortiz highlighted the title of slide 2 "Medicaid Services FY2020 Operating Budget: Change Summary." Based on the title, he assumed the phase I and II stages would both occur in FY 20.

Ms. Efird answered that DHSS was working towards that goal. She explained that items within phase I were in the department's control, while phase II items required approval from CMS. She detailed that because DHSS could not control the federal timeframe for approval, the operating budget included safety net language in case it could not achieve all of the savings in the governor's FY 20 budget. The budget would enable the department to use SBR funding if it was not able to achieve the reductions.

[2:55:25 PM](#)

Vice-Chair Ortiz asked about the specifics related to the SBR.

Ms. Efird replied that the budget language gave DHSS the approval to use \$172.4 million from the SBR to cover any shortfall that may be created if the department was unable to receive approvals from CMS for phase II of its plan in FY 20.

Vice-Chair Ortiz asked if the \$172 million would act as federal matching funds if the goals of phase II were not achieved.

Ms. Efird answered it would include \$102 million GF, plus whatever portion of the \$172.4 million DHSS may need in order to achieve the \$225 million in the proposed GF reduction that the department may not achieve in FY 20. She detailed the department may not be able to achieve \$123 million of the \$225 million proposed reduction in FY 20. The department was still working towards achieving CMS approval for FY 20; it had met with CMS and was looking at the possibilities it would propose for phase II and approval in FY 20. She reiterated her earlier testimony that CMS was in control of the department's ability to make the total \$225 million reduction in FY 20.

[2:58:09 PM](#)

Co-Chair Wilson believed Vice-Chair Ortiz asking whether any portion of funds used from the \$172 million in the SBR would go towards a federal match if the department had to access the SBR as a fund source. She believed the answer was yes.

Ms. Efird replied in the affirmative. She expounded that the funds would replace UGF associated with the federal match that would continue to be realized if approval for phase II was not achieved.

Vice-Chair Ortiz thought it was safe to say it was the goal of the House Majority to stay away from using savings to balance revenues with expenditures for FY 20. He asked if it was not the administration's goal.

Ms. Efird answered that that the goal of the department, under the direction of the governor, was to achieve the large savings in its Medicaid program in FY 20. The administration realized the savings were not all within the department's control and it had given the go ahead to realize changes to streamline the Medicaid program. The administration believed in the department's ability to achieve the savings, but because changes involved [approval from] other entities, the administration wanted to provide a safety net to ensure claims would not go unpaid. She elaborated the goal was to avoid any short funding issues that had occurred in the past, which had required supplementals, pushing payments into another year, and leaving some providers waiting for payment longer than DHSS would like.

3:00:54 PM

Representative Josephson referenced the department's testimony that the 5 percent rate reduction was a one-time occurrence. He asked what the 5 percent reduction and withhold of inflation applied to for FY 20 (slide 7).

Ms. Steward answered that the 5 percent rate reduction and the withholding of inflation would apply to all providers except critical access hospitals, primary care physicians, pediatrics, obstetrics, and federally qualified health centers.

Representative Josephson asked about the policy behind the one-time 5 percent rate reduction. He understood it had happened before. He was trying to determine the long-term plan.

Ms. Steward replied the question was more complex than it may seem. She detailed that for facilities, in addition to the reduction, the department was moving towards new payment models that it hoped would bring more sustainability for payments received by facilities. She elaborated that the department hoped the move to hospital DRGs and acuity-based payments for skilled nursing facilities would mean a leveling out with more sustainable payments. With regard to other providers, the department had attempted to apply the reduction as fairly as possible across all provider types, while protecting primary care and small hospitals. There would be some adjustments for more sustainable payment models for those two providers; the department would be working through 2020 to potentially identify other payment models for other payment types that may help achieve more sustainability.

3:04:05 PM

Representative Josephson referred to the department's testimony about combo facilities for critical care hospitals and acute nursing facilities. He asked if there was a risk that cutting acute nursing care could have an impact on reimbursement for the critical care hospital. He asked if the issue had been accounted for regarding combination facilities.

Ms. Steward replied that the rubric for setting the payment rates for the critical access hospitals and skilled nursing

facilities was essentially the same. She elaborated that if the hospital and nursing facility were reporting their costs correctly on their Medicare cost reports, one should not interface with the other. However, if the facility was sharing costs among the two sides and they were not appropriately accounting for them in either of the cost reports, there could be an unintended consequence that had nothing to do with the formula. The department took the information at face value from the facilities and did not suspect anything was going on, but the situation she presented was an instance where some problems could arise.

[3:05:57 PM](#)

Representative LeBon looked at slide 20 and remarked that the total adjustment of \$187 million was fairly exact. He asked how much of the "financial hit" the three Fairbanks facilities in his district (Tanana Valley Medical Clinic, Fairbanks Memorial Hospital, and the Denali Center) would take. He asked if the department had broken out the \$187 million by hospitals and variety of Medicaid providers for inpatient and outpatient services.

Ms. Steward returned to slide 7 and answered that the 5 percent provider rate reduction to hospitals total was \$15.2 million. In addition, some portion of the \$26 million under the "withhold inflation" line would also be applied to the hospitals. Somewhere above the \$15.2 million would be the total hit to all of the acute care hospitals, which would include Fairbanks Memorial Hospital. She could check to see if there was a specific projection for Fairbanks. Tanana Valley Medical Clinic and the Denali Center would be part of the larger group of providers with a total adjustment of \$28.6 million. She noted that because the larger group included all other providers, the amount would be much smaller; the other providers would also be a smaller part of the withhold inflation line.

Representative LeBon asked if the \$15.1 million adjustment [5 percent rate reduction to inpatient/outpatient PPS hospital services on slide 7] was spread across seven hospitals.

Ms. Steward agreed.

Representative LeBon asked if the money could be broken out by hospital.

Ms. Steward agreed to follow up with the information.

Representative LeBon asked if the \$28.6 million adjustment [5 percent rate reduction to all other providers on slide 7] could be broken out by provider.

Ms. Steward agreed to provide the information.

[3:09:31 PM](#)

Ms. Steward continued with the presentation on slide 17 regarding proposed administrative program changes. The department planned to streamline the cost of care collection, which would be a change in the way the money would go to the department. Currently, a third-party collected the money from individuals residing in assisted living facilities; the change would mean the department would collect the dollars directly. She moved to the third administrative adjustment on slide 17. The department had federal allowances that would pay 100 percent federal funds for the Medicaid program's payment of Medicare Part B premiums for all enrollees on the Medicare program; the adjustment would mean an increased reclaiming of federal funds for the department. The slide showed a reduction in state funds and an increase in federal funds.

Co-Chair Wilson noted any remaining questions would be taken at the end of the presentation.

Ms. Steward continued with slide 17. The department was using new internal strategies where it was hoping to improve some of the collections under tribal reclaiming, which would hopefully bring in an additional \$20 million in federal funds. The department was also working with CMS on an additional tribal claiming modeled on the flexibilities under Medicare Part B. The department was currently negotiating with CMS to allow DHSS to claim for all tribal health beneficiaries in Medicare Part A and Part B premiums. The department would be taking transportation efficiencies and would no longer pay above posted rates; currently, the department had certain contracts with certain providers that paid above the posted rates. The change would mean DHSS would pay the same as all others. Additionally, more bus passes would be used, and the department would be attempting to coordinate family visits

via air travel much more tightly to avoid flying out different family members for nonemergent needs.

Ms. Steward reported that DHSS would be transitioning behavioral health grants with the implementation of the 1115 waiver for behavioral health services (slide 17); the department would be bringing on new services covered under the waiver. Currently, the services were paid through state GF grants. When the grants moved under the 1115 waiver and paid by Medicaid, the grants would be reduced from \$51 million to \$39 million. The next proposed change included the implementation of electronic visit verification, primarily for PCA services in order to more accurately identify utilization of the services and build charges. The department would be transitioning some additional services from its current 1915(c) waiver to the 1915(k) waiver for services not previously earmarked. The change would move the department's federal match from 50/50 to 56/44.

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Ms. Steward noted slides 18 and 19 contained a recap of the items on slide 17. She pointed out that the reduction to the timely filing period [from 12 months to 6 months] was the one area DHSS would need additional flexibility for timelines. The administrative/program adjustments would take the department a bit beyond the July 1 implementation dates. She turned to a recap of total adjustments on slide 20. She highlighted that DHSS was expecting \$697 million new federal dollars coming in once the netting was done for a change in the reductions along with some additional incoming federal funds.

Ms. Steward moved to slide 21 provided a preview of phase II. The department was evaluating additional federal flexibilities that may be coming, to identify some new ways to potentially transform the Medicaid program. She read the department's goals listed on the slide:

- Ensuring Alaskans have access to affordable health care coverage and health care services
- Exploring synergies between federal waiver opportunities that could reduce coverage instabilities for low income Alaskans
- Shoring up the financial sustainability, affordability and predictability of the Alaska Medicaid program

Vice-Chair Johnston referenced a concern she had heard about a proposed adjustment related to behavioral health grants. She asked about a timeline including when the waiver process had started for behavioral health and going forward. She observed that the adjustments were dependent on obtaining the 1115 waiver.

Ms. Steward answered that discussions on the 1115 behavioral health waiver had begun in FY 16 and had begun in earnest in FY 17. In FY 18, DHSS had continued negotiations with CMS and had received a partial approval of the waiver in November [2018] for substance use disorder services. The department was still in negotiation on the second phase, but it was seeing positive signs from CMS. The process was down to the last details and DHSS was hoping for a decision prior to June 30.

Vice-Chair Johnston asked if the remaining grant money would be prorated to grantees until Medicaid could be billed.

Ms. Steward replied that the Division of Behavioral Health was working diligently with providers. There were a number of different reasons some of the providers were having difficulty becoming Medicaid providers; once they became Medicaid providers they could bill for existing services and some of the new services. There were some challenges in getting some of the providers ready to become Medicaid providers. The division was working with providers to ensure all of the pieces could be in place. There would be a structuring of the remaining \$39 million in grants to ensure services continued to be covered with providers and providers that were still having difficulty getting signed up to transmit the Medicaid claims.

[3:17:37 PM](#)

Vice-Chair Johnston asked if the department did not see any of the services going away due to the cut in grants.

Ms. Steward answered that a number of the services currently delivered and paid with state funds would transition and become Medicaid services. While a reduced number of services that were prohibited from being a Medicaid service, would be paid for with state dollars. She elaborated that those grants would always have a state GF component for funding until there was a change in how the

service was delivered so it became a Medicaid service or until there was no longer a need for the service.

Representative Josephson looked at slide 15 and addressed the proposed elimination of the adult preventative dental services. He assumed the numbers would fluctuate up or down by several percent annually. He asked for verification that if the state rejected or did not apply for the \$8.2 million GF, it would lose \$18.7 million in federal funds that would have gone to adult preventative dental.

Ms. Efird confirmed that if the state did not submit the claims for adult preventative dental, it would not receive the federal matching funds.

Co-Chair Wilson asked for verification the proposal would require legislation as well as CMS approval.

Ms. Steward clarified that the elimination of the optional benefit would not require legislation; it would require a regulation change and a state plan amendment.

[3:21:04 PM](#)

AT EASE

[3:21:43 PM](#)

RECONVENED

^OVERVIEW RESPONSE: DAVID TEAL, DIRECTOR, LEGISLATIVE FINANCE DIVISION

[3:21:43 PM](#)

DAVID TEAL, DIRECTOR, LEGISLATIVE FINANCE DIVISION, addressed a State of Alaska Medicaid Program Phase I handout (copy on file). He backed up to February 13th, when the governor had turned in a proposed savings of \$225 million in cost containment measures to Medicaid. He stated there had not been much indication of what the cuts would be. The Legislative Finance Division (LFD) believed the department's longstanding approach to proposed Medicaid reductions. He elaborated the process included regulations and CMS (the federal agency controlling state plans). He furthered that LFD thought the department's argument held true - that the process would be long and difficult. He remarked that it seemed like the administration was trying to cut the budget first and then decide how to achieve the

plan. He shared that LFD had been concerned the proposed cuts would be unachievable, particularly in FY 20.

Mr. Teal continued that LFD had noted the governor's budget included a \$172 million appropriation from the SBR that was effective in FY 19 and therefore did not count as an FY 20 expenditure, but the funds were available in FY 20. He explained that LFD saw the effective rate as \$225 million minus the \$172 million, for an actual cut of about \$53 million. He added there was a \$15 million supplemental proposed for FY 19. He stated it could be argued the reduction was about \$68 million from FY 19. He discussed that DHSS had unveiled phase I of its cost containment plan the previous week; the department had expressed confidence it could achieve the phase I savings in FY 20.

[3:24:02 PM](#)

Mr. Teal continued that DHSS had testified earlier in the meeting that it was not making any proposed changes to eligibility. He believed that probably made a large group of Alaskans happy because the department was on record saying that Medicaid expansion rules would not be changed. The department had also said that rate payments [adjustments] did not apply to critical access hospitals. He argued that perhaps the adjustments should not apply to skilled nursing facilities as well because the bottom line for some of those facilities was probably tighter than for critical access hospitals. The department had provided the most comprehensive analysis that LFD had seen regarding any of the governor's proposals. He thought the analysis provided was helpful.

[3:25:23 PM](#)

Mr. Teal addressed a document that had been provided to LFD by DHSS titled "State of Alaska Medicaid Program, Phase I: Cost Containment - Implementation Schedule," dated March 21, 2019 (copy on file). The document included a table showing all of the reductions. The total GF reduction was approximately \$103 million. He had been hoping for a ranking on the slide showing how difficult each reduction may be in terms of changes required (i.e. regulation and/or state plan amendment changes). He believed that the department had explained that any of the changes requiring a state plan amendment involved fairly simple and easy state plan amendments; in some cases, like the optional

preventative adult dental services, it was necessary to tell CMS but there was not a long approval process. Other changes were slightly more complicated. There was not a ranking of complexity, but that information was conveyed with the implementation date. He explained that implementation dates of July 1 indicated DHSS thought the change could be made quickly, while other dates were delayed until October. The department had testified it was confident the \$103 million GF reductions could be achieved in FY 20.

Mr. Teal stated the question facing the committee was whether all of the reductions were achievable. He believed the proposal was fairly aggressive. He did not want to say the proposal was not achievable, but he would not be surprised if it was not. He thought it was more important for the committee to consider what it wanted the department to achieve. He asked what if the committee did not support some or all of the proposed changes. He stated, "that train left the station" and the department was in control of the reductions. The committee could take the reductions if it wanted, but the department's direction was already set, and it would try to achieve the reductions. He reasoned that if the legislature gave the department too much money it may end up with a surplus at the end of the year.

Mr. Teal continued that the legislature did not get to select which of the reductions [it wanted] or what each may cost. The legislature could choose to add intent to the budget. For example, the legislature could tell the department it wanted DHSS to retain adult preventative dental or exempt skilled nursing homes from the rate reductions. The legislature could go further and put adult preventative dental in a separate appropriation, which would prevent DHSS from using the money for any other services; however, it would not prevent DHSS from eliminating adult preventative dental and lapsing the money.

Mr. Teal reiterated that the legislature did not have the control over the program that it may like to think it had. He considered the impact of making a smaller reduction. He remarked that he had been expecting a governor's amendment showing reductions of \$103 million instead of \$225 million. He noted it did not appear to be the case; he believed the department was aiming at \$225 million and it was confident

that \$103 million was achievable. The key point was that DHSS would either achieve the target or not.

[3:29:59 PM](#)

Mr. Teal continued that if the committee decided to take the \$103 million reduction and the department achieved it, some committee members may be pleased, and others may be displeased (pleased with cost reductions and displeased with service reductions or vice versa). He stated it made a strong case for accepting the proposed \$103 million reduction. He stated that if the department did not achieve the proposed reductions it ran a risk of being short funded in FY 20. He explained that if DHSS achieved half of the proposed cuts, there would be a \$45 million hole in the Medicaid budget. He continued that \$45 million was an entire year's budget for some agencies, but it accounted for roughly three weeks of the Medicaid budget. The department wrote weekly checks that were between \$12 million and \$15 million.

Mr. Teal elaborated that if the department only achieved half of the \$103 million cut, it meant DHSS would run out of money in the first week in June instead of at the end of June. The department had established procedures for the situation; it simply delayed payments to major hospitals until July. The delay was fairly brief and had taken place in the past. Additionally, the legislature would know of the shortfall well in advance and could address it in the supplemental process. He stated it was an odd situation where the cart was before the horse; however, in the particular situation it did not seem that bad to accept the department's recommendations and see what DHSS could do, knowing that the legislature could not control what DHSS did. The alternative was for the legislature to add intent language or structural changes to the budget.

[3:33:05 PM](#)

Mr. Teal highlighted an LFD handout in members' packets showing Phase I of the FY 20 reductions proposed by DHSS (copy on file). He emphasized that the legislature did not have any control over the individual items or the associated amounts. The legislature would decide what reduction to give the department and the department controlled how much money was saved at each point and in total.

Representative Josephson highlighted changes made by rule making that an administration could say it would reduce rates or not fund things. He stated it gave him the impression that instead of having a strong governor model, Alaska had something more than that.

Mr. Teal replied by referencing a court case tying [an appropriation] to education funding. He and others had told the legislature that the governor could not withhold the \$20 million that was appropriated by the legislature to be spent on schools. The primary reason was that schools could and would spend the money. He returned to the proposed reductions by DHSS and explained that the department was saying the state had an entitlement program where the state was required to pay if people went to a healthcare provider. The legislature had to fund the program either in the operating budget or supplemental budget. The program took what the program cost. The department could control costs of the program. For example, he highlighted the proposal to eliminate the adult preventative dental program. He explained that if the program was gone, it would simply be an eligibility issue and patients would no longer get the services. The department had the ability to change the requirements and costs associated with its programs. There was nothing the legislature could do about savings from tribal claiming. He stated the savings target was aggressive, "but if they achieve it, they achieve it."

[3:36:33 PM](#)

Representative Josephson pointed to slide 5 of the DHSS presentation where the department stated it was not recommending any adjustments to Medicaid program eligibility. He asked if the department could make people ineligible unilaterally by using executive branch authority to have a state plan amendment and remove preventative dental.

Mr. Teal replied it was his interpretation. The department was in charge of the state plan and if it received CMS approval it could move forward.

Representative Josephson was thinking of remedies and political remedies that were slow to take up.

Vice-Chair Johnston thought the legislature could make a difference in the behavioral health grant that was not part of Medicaid.

Mr. Teal replied in the affirmative. He stated that DHSS had explained that the total amount was \$51 million. The department believed it could move grants under Medicaid to receive federal cost sharing in order to reduce the state cost by approximately \$12 million.

Co-Chair Wilson surmised that the act of including the grant in the operating budget would not force the department to distribute the funds. She noted that a budget was the maximum a department could spend.

Mr. Teal replied that it was a tricky question. In Medicaid where it was a state plan, the department followed the state plan. However, behavioral health grants were not in the state plan; therefore, if the legislature funded them, it was limiting the amount that could be spent and telling the department what it should be spending. He explained that if the grants became a part of Medicaid, he was not sure whether it was a CMS approved part of Medicaid. He stated it would be necessary to ask the department.

Co-Chair Wilson reviewed the schedule for the following day.

ADJOURNMENT

[3:39:47 PM](#)

The meeting was adjourned at 3:39 p.m.