**ALASKA STATE LEGISLATURE**
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**
April 25, 2019
3:03 p.m.

**MEMBERS PRESENT**

Representative Ivy Spohnholz, Co-Chair
Representative Tiffany Zulkosky, Co-Chair
Representative Matt Claman
Representative Harriet Drummond
Representative Geran Tarr
Representative Lance Pruitt

**MEMBERS ABSENT**

Representative Sharon Jackson

**COMMITTEE CALENDAR**

HOUSE BILL NO. 133
"An Act relating to care of juveniles and to juvenile justice; relating to employment of juvenile probation officers by the Department of Health and Social Services; relating to terms used in juvenile justice; relating to mandatory reporters of child abuse or neglect; relating to sexual assault in the third degree; relating to sexual assault in the fourth degree; repealing a requirement for administrative revocation of a minor's driver's license, permit, privilege to drive, or privilege to obtain a license for consumption or possession of alcohol or drugs; and providing for an effective date."

- MOVED HB 133 OUT OF COMMITTEE

HOUSE BILL NO. 84
"An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters, emergency medical technicians, paramedics, and peace officers."

- MOVED HB 84 OUT OF COMMITTEE

PRESENTATION(S): SB 74 IMPLEMENTATION UPDATE

- HEARD

HOUSE BILL NO. 89

"An Act relating to the prescription of opioids; relating to the practice of dentistry; relating to the practice of medicine; relating to the practice of podiatry; relating to the practice of osteopathy; relating to the practice of nursing; relating to the practice of optometry; and relating to the practice of pharmacy."

- SCHEDULED BUT NOT HEARD

**PREVIOUS COMMITTEE ACTION**

BILL: HB 133
SHORT TITLE: JUVENILES: JUSTICE,FACILITES,TREATMENT
SPONSOR(s): REPRESENTATIVE(s) SPOHNHOLZ

| | | |
|---|---|---|
| 04/15/19 | (H) | READ THE FIRST TIME - REFERRALS |
| 04/15/19 | (H) | HSS, JUD |
| 04/23/19 | (H) | HSS AT 3:00 PM CAPITOL 106 |
| 04/23/19 | (H) | Heard & Held |
| 04/23/19 | (H) | MINUTE(HSS) |
| 04/25/19 | (H) | HSS AT 3:00 PM CAPITOL 106 |

BILL: HB 84
SHORT TITLE: WORKERS' COMP: POLICE, FIRE, EMT, PARAMED
SPONSOR(s): REPRESENTATIVE(s) JOSEPHSON

| | | |
|---|---|---|
| 03/06/19 | (H) | READ THE FIRST TIME - REFERRALS |
| 03/06/19 | (H) | HSS, L&C |
| 04/04/19 | (H) | HSS AT 3:00 PM CAPITOL 106 |
| 04/04/19 | (H) | Heard & Held |
| 04/04/19 | (H) | MINUTE(HSS) |
| 04/25/19 | (H) | HSS AT 3:00 PM CAPITOL 106 |

**WITNESS REGISTER**

MEGAN HOLLAND, Staff
Representative Ivy Spohnholz
Alaska State Legislature
Juneau, Alaska
**POSITION STATEMENT:** Reviewed HB 133 on behalf of the bill sponsor, Representative Spohnholz.

REPRESENTATIVE ANDY JOSEPHSON
Alaska State Legislature
Juneau, Alaska
**POSITION STATEMENT:** Speaking as the sponsor, testified during the hearing of HB 84.

ELISE SORUM-BIRK, Staff
Representative Andy Josephson
Alaska State Legislature
Juneau, Alaska
**POSITION STATEMENT:** Reviewed HB 84 on behalf of the bill sponsor, Representative Josephson.

HEATHER CARPENTER, Health Care Policy Advisor
Office of the Commissioner
Department of Health and Social Services
Juneau, Alaska
**POSITION STATEMENT:** Introduced and co-provided a PowerPoint presentation entitled, "SB 74 (2016) Implementation Update," dated 4/25/19.

GENNIFER MOREAU-JOHNSON, Acting Director
Division of Behavioral Health
Department of Health and Social Services
Anchorage, Alaska
**POSITION STATEMENT:** Co-provided a PowerPoint presentation entitled, "SB 74 (2016) Implementation Update," dated 4/25/19.

DEB ETHERIDGE, Acting Director
Juneau Office
Division of Senior and Disabilities Services
Department of Health and Social Services
Juneau, Alaska
**POSITION STATEMENT:** Co-provided a PowerPoint presentation entitled, "SB 74 Implementation Update," dated 4/25/19.

BECKY HULTBERG, President/CEO
Alaska State Hospital and Nursing Home Association
Anchorage, Alaska
**POSITION STATEMENT:** Co-provided a PowerPoint presentation entitled, "SB 74 Implementation Update," dated 4/25/19.

SARA CHAMBERS, Acting Director
Division of Corporations, Business, and Professional Licensing
Department of Commerce, Community & Economic Development
Juneau, Alaska
**POSITION STATEMENT:** Co-provided a PowerPoint presentation entitled, "SB 74 Implementation Update," dated 4/25/19.

**ACTION NARRATIVE**

3:03:28 PM

**CO-CHAIR IVY SPOHNHOLZ** called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Zulkosky, Tarr, Drummond, and Spohnholz were present at the call to order. Representatives Pruitt and Claman arrived as the meeting was in progress.

## HB 133-JUVENILES: JUSTICE,FACILITES,TREATMENT

3:04:00 PM

CO-CHAIR SPOHNHOLZ announced the first order of business would be HOUSE BILL NO. 133, "An Act relating to care of juveniles and to juvenile justice; relating to employment of juvenile probation officers by the Department of Health and Social Services; relating to terms used in juvenile justice; relating to mandatory reporters of child abuse or neglect; relating to sexual assault in the third degree; relating to sexual assault in the fourth degree; repealing a requirement for administrative revocation of a minor's driver's license, permit, privilege to drive, or privilege to obtain a license for consumption or possession of alcohol or drugs; and providing for an effective date."

3:04:44 PM

MEGAN HOLLAND, Staff, Representative Ivy Spohnholz, Alaska State Legislature, on behalf of Representative Spohnholz, sponsor of HB 133, reminded the committee HB 133 is a Division of Juvenile Justice (DJJ), Department of Health and Social Services (DHSS), "clean-up" bill which updates the language used to refer to facilities that are operated by DJJ and to the authorities held by the division. The bill also contains several policy clarifications to ensure DJJ can complete its mission and also to ensure relevant state statutes accurately reflect DJJ authorities. She referred to a previous hearing in which the committee discussed section 6 of the bill - which would close a loophole in statutes related to sexual abuse of a minor - and offered to provide invited testimony in this regard.

3:07:17 PM

CO-CHAIR ZULKOSKY moved to report HB 133 out of committee with individual recommendations and the accompanying zero fiscal notes. There being no objection, HB 133 was reported out of the House Health and Social Services Standing Committee.

3:07:35 PM

The committee took an at-ease from 3:07 p.m. to 3:09 p.m.

**HB 84-WORKERS' COMP: POLICE, FIRE, EMT, PARAMED**

3:09:00 PM

CO-CHAIR SPOHNHOLZ announced the next order of business would be HOUSE BILL NO. 84, "An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters, emergency medical technicians, paramedics, and peace officers."

3:09:10 PM

REPRESENTATIVE ANDY JOSEPHSON, Alaska State Legislature, sponsor of HB 84, informed the committee the bill would broaden and further explain the intent of the original presumptive illness bill.

3:09:36 PM

ELISE SORUM-BIRK, Staff, Representative Andy Josephson, Alaska State Legislature, on behalf of Representative Josephson, sponsor of HB 84, stated HB 84 adds new categories of emergency worker to the existing presumptive legislation that provides presumptive coverage for certain diseases; the new categories are emergency medical technicians, paramedics, and peace officers. Further, the bill adds breast cancer to the list of diseases covered by presumptive coverage and also extends coverage to professionals who entered service prior to August 2008, who have gone through all official medical examinations, and who did not show evidence of disease in their first seven years of service.

REPRESENTATIVE JOSEPHSON related the case of a firefighter who developed prostate cancer and who had difficulty establishing "presumption"; he pointed out - if HB 84 had been in effect - the firefighter's presumptive coverage would have been clear because he was working before 2008, and thus he could have been exposed to a toxic substance that later gave him cancer. Further, this example clarified that compliance with the medical examination requirements [within existing statute] was adequate even though there was not an established system for medical examinations. Representative Josephson restated the bill also

expands the categories to other first responders. He further explained:

> [HB 84] is still a very limited benefit in that it can only last for 60 months total following the last day of employment. ... It can only be earned, or one can only qualify if they fought fires, for example, for seven years, and then there's also some burden of proof to say, "This is the thing that I think I was exposed to." So, this doesn't just come flowing in just at one's beck and call. It has, it has some ... sideboards, and those would still exist.

CO-CHAIR SPOHNHOLZ has heard testimony reporting breast cancer rates are approximately six times higher amongst female firefighters; she questioned whether breast cancer victims would still have to demonstrate exposure to a chemical documented to increase the incidence of breast cancer in order to establish presumptive coverage for breast cancer.

REPRESENTATIVE JOSEPHSON indicated yes. He noted the aforementioned testimony was reported from a study limited to the San Francisco [California] Fire Department.

3:13:49 PM

CO-CHAIR ZULKOSKY moved to report HB 84 out of committee with individual recommendations and the accompanying zero fiscal note. There being no objection, HB 84 was reported out of the House Health and Social Services Standing Committee.

3:14:07 PM

The committee took an at-ease from 3:14 p.m. to 3:18 p.m.

## PRESENTATION(S): SB 74 IMPLEMENTATION UPDATE

3:18:41 PM

CO-CHAIR SPOHNHOLZ announced the final order of business would be a presentation updating the implementation of Senate Bill 74, [passed in the Twenty-ninth Alaska State Legislature].

3:19:03 PM

HEATHER CARPENTER, Health Care Policy Advisor, Office of the Commissioner, Department of Health and Social Services (DHSS),

introduced a PowerPoint presentation entitled, "SB 74 (2016) Implementation Update." Ms. Carpenter said Medicaid reform covers the many topics shown on slide 2, and directed attention to slide 3, noting the first topic for discussion, [section 1115 of the Social Security Act Behavioral Health Waiver (1115 waiver)], would be presented by the Division of Behavioral Health, DHSS.

3:20:11 PM

GENNIFER MOREAU-JOHNSON, Acting Director, Division of Behavioral Health (DBH), DHSS, informed the committee DBH submitted its 1115 waiver demonstration project application in January 2018, which was followed by a federal public comment period, and approval was received from the Centers for Medicare and Medicaid Services (CMS). In March 2018, negotiations with CMS began during which CMS offered to "fast track" the Substance Misuse Disorder (SUD) treatment component. In November 2018, approval for the SUD component was received, followed by approval of the DBH implementation plan, which requires DBH to meet six milestones, including: access to critical levels of care for SUD treatment; use of evidence-based criteria; use of nationally-recognized program standards for residential treatment provider qualifications; sufficient provider capacity. Further, DBH will use a phased-in approach focused initially on Anchorage, the Matanuska-Susitna (Mat-Su) area, Southeast, Fairbanks, Nome, and Kodiak (slide 4).

REPRESENTATIVE TARR asked what Nome and Kodiak have done to prepare so they can participate in the initial implementation of the plan.

MS. MOREAU-JOHNSON was unsure. She said DBH has made the plan available to any area that is ready to implement the services, and Kodiak and Nome "voiced their interest." She offered to provide additional information in this regard. In further response to Representative Tarr, she agreed the regions across the state are very different.

3:25:51 PM

MS. MOREAU-JOHNSON directed attention to slide 5 which described the population [affected by SUD]. She clarified the 1115 waiver is not a "level of care" waiver; however, DBH's data has shown SUD [patients] are typically served at the acute end of the behavioral health continuum of care, and thus the division identified certain populations in order to provide early

prevention and intervention services. The division is approved through the 1115 waiver to provide the following services: residential treatment for those with SUD; opioid treatment services for persons experiencing opioid use disorder; intensive outpatient services; partial hospitalization services; medically monitored intensive inpatient services in a hospital setting; medically managed intensive inpatient services in a hospital setting; ambulatory withdrawal management services in an outpatient setting; clinically managed residential withdrawal management; medically monitored inpatient withdrawal management; medically managed intensive inpatient withdrawal management; recovery peer support services. Ms. Moreau-Johnson pointed out DBH has an exemption from the Institute for Mental Diseases (IMD) exclusion and thereby is allowed to provide Medicaid coverage in certain facilities for individuals over the age of 21, or under the of age 64. Continuing to the present status of implementation, she noted DBH has drafted regulations to support the implementation of SUD treatment services and will have Medicaid coverage for services beginning July 1, [2019]; in addition, DBH is working with providers to complete the statewide gap analysis, is holding roundtables, and is working to ensure providers will be ready to access services. Further, DBH noticed its intent to award a contract to an administrative services organization and targets July 1, [2019] for service delivery. Also, DBH continues to negotiate with CMS for federal approval of the remaining components of the 1115 waiver (slide 6).

3:30:27 PM

MS. MOREAU-JOHNSON restated DBH identified the aforementioned component of the 1115 waiver by the population of those needing acute care; the remaining populations that are pending approval are at-risk families and youth, and individuals who experience serious mental illness. Those identified needing acute care require a diagnosis from the Diagnostic and Statistical Manual (DSM) of mental disorders; at-risk families and youth are identified by the Alaska Longitudinal Child Abuse and Neglect study social determinants. She advised CMS has indicated DBH is very close to receiving approval for the components awaiting approval (slide 7). Ms. Moreau-Johnson returned attention to the notice of intent to award an administrative services organization contract and recalled the Senate Bill 74 fiscal note directed DBH to contract with an administrative services organization (ASO). Therefore, DBH issued a request for proposal and is approaching contract negotiations which could take two months. Functions of the administrative services

organization include utilization management, clinical reviews, provider development and support, recipient outreach, quality management, data management, and potentially claims processing (slide 8). In response to Co-Chair Spohnholz, she said the proposal evaluation committee intends to award [the ASO contract] to Optum.

CO-CHAIR ZULKOSKY referred to slide 3 and asked for a further description of the intent and functionality of the 1115 waiver. For example, whether the 1115 waiver intends to streamline access to integrated care services, so Alaskans who are affected by SUD, do not suffer significant impacts to their health.

3:36:22 PM

MS. MOREAU-JOHNSON agreed with Co-Chair Zulkosky's description of the 1115 waiver; she added the 1115 waiver allows the state "to fund, through the 1115 authority, the acute end of care also." Further, the 1115 waiver allows the state the opportunity to innovate and provide Medicaid services in ways that go beyond the constraints of the Medicaid state plan. She noted the state's application achieved budget neutrality by identifying populations that have been served at the acute end of care, thus the state will show a savings in Medicaid expenditures by increasing the availability and access to community-based care, prevention, and early intervention, and at the same time meet the needs of the acute end of care [patients] by "waiving some of the rules that appear in the state plan." For example, in the state plan, Medicaid cannot pay a daily rate outside of a medical facility thus providers are "piece-mealing together" charges that the 1115 waiver will allow.

REPRESENTATIVE TARR returned attention to DBH's award for ASO services as described on slide 8. She asked whether all providers will be required to participate in the ASO structure for behavioral health management, or whether participation will be limited to Medicaid patients.

MS. MOREAU-JOHNSON explained the ASO will be assisting DBH in administering all publicly funded behavioral health services administered by DHSS. She stressed the ASO will not contract with providers - as would a managed care entity - and the state will not delegate authority to the ASO; therefore, providers of Medicaid services will enroll with Medicaid and the ASO will provide support and expertise to DBH.

3:40:47 PM

REPRESENTATIVE CLAMAN remarked:

> As I understand, the substance use disorder approval had come under the 1115 waiver, and we were waiting, I think, for the behavioral health waiver and it sounds like what we've now got is this, is the procedure for the administrative services which will essentially be administering the behavioral health part of the waiver. ... Is there another waiver we're still waiting to receive?

MS. MOREAU-JOHNSON clarified the ASO will assist DBH in administering all behavioral health services that are publicly funded, including SUD services. In fact, the section of the 1115 waiver that was approved was the SUD treatment services; the remainder of the services, such as mental health and behavioral health support, are due to be approved and the ASO will assist DBH in administering all of the [Medicaid] services.

REPRESENTATIVE CLAMAN surmised the behavioral health component waiver is pending, and after approval is received, ASO will help administer all the waivers.

MS. MOREAU-JOHNSON said correct.

REPRESENTATIVE CLAMAN asked when the behavioral health approval is expected and whether there are other outstanding waivers.

MS. MOREAU-JOHNSON related a representative of CMS reported CMS is drafting the approval document for behavioral health services and thus she is confident the approval will be forthcoming within one month. Speaking from her knowledge of the 1115 waiver demonstration project, she said she knows of no other waivers.

CO-CHAIR SPOHNHOLZ clarified the 1115 waiver is the only application currently in process, although there are multiple parts to the 1115 waiver. She pointed out elements of the 1115 waiver include intervention and prevention work, which are new to Medicaid services. She discussed how the collection of data could be used to identify families that are at risk for serious problems and then respond by using the 1115 waiver to provide outreach and support to families. Co-Chair Spohnholz returned attention to the selection of Optum, noting Optum's sister company is UnitedHealthcare, which is administering the [Medicare Coordinated Care Demonstration Project] in

Southcentral, and asked about the possibility of integrating the coordination of care through the structure of the ASO.

3:46:10 PM

MS. MOREAU-JOHNSON said the proposal evaluation committee did not include a reference to the relationship between Optum and UnitedHealthcare in its recommendation; however, one of the performance measures of the ASO is to help integrate behavioral health care, and it is important to identify at-risk families outside of behavioral health settings.

CO-CHAIR SPOHNHOLZ urged for any method to identify at-risk populations and connect individuals to care.

MS. MOREAU-JOHNSON advised DBH works with the Office of Children's Services (OCS), DHSS, staff to "loop-in the social services agencies that work with the child welfare systems because we're really trying to cast the net wide."

MS. CARPENTER directed attention to slide 9, DBH's Comprehensive Integrated Mental Health Program Plan (Comp Plan) entitled, "Strengthening the System," which was developed by DHSS in collaboration with the Alaska Mental Health Trust Authority (AMHTA) and their advisory boards. The Comp Plan seeks to coordinate services across target recipients' lifespans; by law, recipients, also known as trust beneficiaries, are Alaskans who experience mental illness or a developmental disability, chronic alcoholism, Alzheimer's Disease or related dementia, or have experienced a traumatic brain injury (TMI). The target population also includes persons of all ages who are vulnerable to developing beneficiary conditions. The Comp Plan also seeks to prevent the aforementioned conditions, when possible. She advised the plan's public comment period closed [4/12/19]; the previous Comp Plan was completed in 2006 and expired in 2011, thus the Comp Plan should be updated now along with the 1115 waiver and other Medicaid reforms (slide 10). Ms. Carpenter said the next topic, State Plan Options, would be presented by the Division of Senior and Disabilities Services, DHSS.

3:50:08 PM

DEB ETHERIDGE, Acting Director, Juneau Office, Division of Senior and Disabilities Services (DSDS), DHSS, informed the committee Senate Bill 74 engaged DSDS in two initiatives: refinance general fund (GF) dollars, and maintain services to individuals with disabilities. In response to the first

initiative, DSDS utilized the [federal section 1915(c) of the Social Security Act Individualized Supports Waiver (ISW)]. Prior to 2016, DSDS administered the Community and Developmental Disabilities Grant for individuals with developmental disabilities who were waiting on the DSDS registry - also known as the waitlist - for an Individuals with Developmental Disabilities Waiver, which is a 100 percent GF grant program. After a review of the program and its services, DSDS chose to refinance the GF grant program with a new ISW that would serve over 600 individuals, and she described the history of the change. The new program was implemented in October 2018 and can serve up to 620 individuals to a cap amount of $17,500; she stressed DSDS determined the cap amount of $17,500 would serve most individuals. The ISW cap is lower because residential services are not provided.

CO-CHAIR SPOHNHOLZ asked about services for those whose needs are not addressed within the cap amount of $17,500.

MS. ETHERIDGE said DSDS identified eight individuals on the Community and Developmental Disabilities Grant who would be better served by the Individuals with Developmental Disabilities Waiver which allows payment for residential services.

MS. ETHERIDGE explained the implementation of the program was delayed for some individuals, so DSDS used $450,000 to continue their services.

MS. CARPENTER recalled DHSS purposefully used language in [Senate Bill 74] that ensures the state receives maximum benefits from the legislation.

3:55:03 PM

REPRESENTATIVE TARR asked for clarification of "the waitlist."

MS. ETHERIDGE said there are over 700 individuals on the Developmental Disability Registry and Review (DDRR); DSDS drew from the registry to create the ISW waitlist; however, all individuals remain on the waitlist for the Individuals with Developmental Disabilities Waiver. Currently, DSDS is updating the waitlist; of the 700 individuals, 425 have been identified for the ISW and more have opted not to remain on the waitlist for the Individuals with Developmental Disabilities Waiver. She said she expected that next year, there will be a difference in the number of individuals on the DDRR who receive 1115 waiver services. In further response to Representative Tarr, she said

625 individuals were identified for the ISW, and 425 have decided to remain on the waitlist for the Individuals with Developmental Disabilities Waiver.

REPRESENTATIVE TARR surmised a different level of need is met for individuals through the new ISW and there remains a group of people who need to receive more extensive services through the Individuals with Developmental Disabilities Waiver.

MS. ETHERIDGE said the ISW provides services for individuals at service levels that were received through the Community and Developmental Disabilities Grant program. In response to Co-Chair Spohnholz, she clarified the "larger" waiver is the Individuals with Developmental Disabilities (IDD) Waiver, formerly known as the People with Intellectual and Developmental Disabilities Waiver.

3:59:24 PM

MS. ETHERIDGE returned attention to the second DSDS initiative within Senate Bill 74, which directed DSDS to apply for the Community First Choice program, section 1915(k), which is a different type of state plan option through CMS. She remarked:

> The reason I point that out is because once a service becomes a state plan service, it becomes an entitlement. And that is really important for you to know because we are very careful with implementing an entitlement program in Alaska. The Community First Choice program ... offers services very similar to our state plan personal care services for people with, who require nursing, or nursing facility level of care, or an institutional level of care. It also offers the state an opportunity to draw down an additional 6 percent enhanced match.

MS. ETHERIDGE further explained, through the Community First Choice state plan option, DSDS provides personal care services, education and training on how to hire, fire, and train a personal care attendant, personal emergency response, and training to do a task; for all these services the state's enhanced federal medical assistance percentage (FMAP) reimbursement is 56 percent. Further, DSDS auto-enrolled 826 individuals in the Community First Choice program who were receiving state plan personal care services, and Home- and Community-Based Services, for an estimated savings in 2019 of over $2 million (slide 12).

REPRESENTATIVE CLAMAN asked if enrollees are primarily an elderly population or others with significant disabilities.

MS. ETHERIDGE said the population consists of any individual who meets requirements for an institutional level of care, and so may be a person with disabilities, intellectual developmental disabilities, physical disabilities, or a senior.

4:02:38 PM

REPRESENTATIVE TARR asked for clarification of how services are being reorganized through existing and new waivers.

MS. ETHERIDGE explained the existing 1915(c) waivers remain; however, if a service currently offered by a Home- and Community-Based Waiver is now offered through the Community First Choice program, DBH will transition to Community First Choice and save an additional 6 percent. She further explained DBH did not initially transition all services because there are two institutional levels of care: under 21 in a residential treatment facility or over 65 in an institution for mental disease, and DBH was unsure of the number of individuals receiving these two levels of care who may transition. She cautioned DBH expects the number of individuals identified for personal care, personal emergency response, and chore services to be low, but the population of individuals entering respite care is not well understood and therefore creates a higher risk to DBH.

CO-CHAIR SPOHNHOLZ questioned how respite care could carry a higher risk.

MS. ETHERIDGE advised respite care could be expensive because it could be expanded to a population not currently served by DBH.

4:04:54 PM

CO-CHAIR ZULKOSKY asked for a "high level perspective" on the mission of the aforementioned programs and how the waivers reform the Medicaid system.

MS. ETHERIDGE explained Home- and Community-Based Services, including personal care, provide people with assistance so they can remain in their home and community - without risk to their health - and avoid transitioning into a nursing home. The mission of DSDS is to provide services so individuals can remain

safe and secure, and federal waivers allow DSDS to do so. For example, the state plan is a contract with CMS; the waivers provide permission to waive some of the rules of the contract so that DSDS can provide services at lesser levels of care and at lower cost. Another example is that DSDS currently serves 14 individuals out of state at an intermediate care facility for Individuals with Intellectual and Developmental Disabilities; if they could be served in a Home-and Community-Based setting, their care would be less expensive.

CO-CHAIR SPOHNHOLZ recalled at one time the state funded grants to organizations that were then obligated to provide services to a specific group of people; however, the system is now facilitated through the waiver structure. She asked whether the new system comes with tools to help the community develop "the right kinds of services to support ... the population we need to care for?"

MS. ETHERIDGE acknowledged there is a tremendous change from providers having the flexibility of a grant to instead having a reimbursement system such as the Home- and Community-Based Waiver, which is more of a medical model and a more restrictive system. She said DSDS seeks a balance in order to provide services the state can afford; for example, DSDS administers services to seniors and as seniors reach more expensive levels of care, services cannot be managed in a grant but must be leveraged with federal funds. Further, as DSDS increases Medicaid services through the ISW, it seeks to ensure there is the workforce needed to deliver services.

CO-CHAIR SPOHNHOLZ asked about challenges faced by the provider community as the system moves from a grant-based model to a medical billing-based model.

MS. ETHERIDGE advised many providers served the Community and Developmental Disability Grant program and the Home- and Community-Based Waiver thus some issues, such as conflict-free case management, have arisen. In further response to Co-Chair Spohnholz, she acknowledged the change from a grant to a reimbursement system for expenditures is difficult. She remarked:

> Because you do have to have the money up front. Medicaid pays you back for incurred expenditures, so you do have to have the capacity to provide that service up front, where the grants are the opposite.

And so, we've ... definitely gotten feedback about how that's structured ....

4:12:44 PM

MS. CARPENTER pointed out DHSS is moving forward with the ASO to address this issue; the ASO will assist behavioral health providers - who have not participated in Medicaid billings - through the transition.

REPRESENTATIVE TARR related an example of personal services that were cut back for an individual who receives 24-hour care, and an example of an individual whose services through the Developmental Disabilities (DD) Waiver were cut back, both due to budget pressure. She expressed her concern there may be unmet needs due to cost adjustments in personal care assistance (PCA) services.

MS. ETHERIDGE recalled last legislative session DSDS was tasked with completing a data analysis of 2017-2018 data; the division found a significant decrease in spending for personal care and Home- and Community-Based [care], and increased expenditures for long-term care. She said DSDS seeks to "re-balance that."

REPRESENTATIVE TARR observed PCA services are much less costly than institutional-level care.

4:18:24 PM

MS. CARPENTER redirected attention to slide 13 and noted Senate Bill 74 also focused on "superutilizer" reduction. She explained superutilizers are individuals comprising about 5 percent of the Medicaid population who use approximately 95 percent of the services; Senate Bill 74 identified two areas with which to reduce the percentage of superutilizers, the Alaska Emergency Department Coordination Project, facilitated by the Alaska State Hospital and Nursing Home Association (ASHNHA), and Primary Care Case Management. Primary Care Case Management has two components: the Alaska Medicaid Coordinated Care Initiative and the Care Management Program. The Care Management Program identifies superutilizers by reviewing claims that indicate high emergency room (ER) usage and abnormal prescription usage behaviors and refers those claims to case management. The Care Management Program is also known as the Locked-In Program, which covers about 300 participants per month, who are assigned one primary care provider and one pharmacy. She said participants are "locked in" with a provider

with whom they have a relationship, or one is assigned by DBH. The Alaska Medicaid Coordinated Care Initiative is available to all Medicaid recipients who are not otherwise enrolled in a case management program; approximately 30,000-50,000 individuals per month have access to the program, mostly telephonically through MedExpert, and another 55 individuals are served by Qualis Health. She discussed further coordination of care with other agencies such as the Department of Corrections, OCS, and the Division of Public Health, DHSS. Ms. Carpenter concluded, estimating the savings from fewer ER visits, fewer duplicative services, and fewer prescriptions, are approximately $8 million per year. She turned attention to the second area of superutilizer reduction and said the Alaska Emergency Department Coordination Project would be presented by ASHNHA.

4:21:22 PM

BECKY HULTBERG, President/CEO, Alaska State Hospital and Nursing Home Association (ASHNHA), informed the committee ASHNHA brought the Alaska Emergency Department (ED) Coordination Project to the legislature with the goals to improve care in EDs and reduce the inappropriate utilization of ED services (slide 14). The model ASHNHA implemented was the Seven Best Practices Model from Washington State; she said the key elements of the project include implementation of an ED electronic information exchange system that "pushes" complete critical information to a clinician at the point of care, without further research. She said the model was implemented at eleven hospitals in Alaska beginning in February 2017. Ms. Hultberg noted the system provides regional and nationwide records of care; a second key element of the model is the Prescription Drug Monitoring Program (PDMP) which reports patient use of narcotic prescriptions. Other elements of the model are statewide guidelines for prescribing narcotics and care coordination (slide 15). Slide 17 further described the electronic ED information system which provides "flags" in a patient's record that will alert the ED physician of pertinent information. Ms. Hultberg related ED physicians support the system because it improves patient care.

4:25:24 PM

CO-CHAIR SPOHNHOLZ asked whether the Alaska Psychiatric Institute (API) is part of the electronic information system.

MS. HULTBERG advised API is "technically not at a point where they are able ... to join."

REPRESENTATIVE TARR noted the system only provides ER information and asked if this information is only a part of electronic hospital records or is a separate system.

MS. HULTBERG explained one problem with medical records is there is a huge volume of electronic information that must be searched; even if records are interoperable, patients may not volunteer information about their visits to other hospitals, and the system "pulls the information they need to know, at that point in time, and it pushes it to them so they don't have to go hunt for it ...."

REPRESENTATIVE TARR asked whether the system would integrate health records beyond the ER.

MS. HULTBERG advised the system is a separate piece to help in the ER care setting and is not a substitute for interoperability [of medical records].

REPRESENTATIVE CLAMAN questioned whether the system will provide information to the Mat-Su Regional Medical Center ER about a patient's recent visits to "Providence family practice," or only about visits to the Providence Alaska Medical Center ER.

MS. HULTBERG said the system does not provide full records but uses "flags" to alert an ER physician of pertinent information. However, if Providence family practice were connected to the system, and a patient has a care plan, Providence family practice can upload the care plan, which would then be available to the ER physician.

4:29:41 PM

MS. HULTBERG returned attention to slide 17 and said the system is operational at eleven hospitals and at six other entities. Slide 18 listed participating organizations; she noted the system will be expanded to additional hospitals and to include primary care providers.

CO-CHAIR SPOHNHOLZ opined communication between EDs and primary care providers is critical to reducing healthcare costs, and she elaborated.

MS. HULTBERG agreed. She said another element of the project is the ED narcotic prescribing guidelines that were voluntarily developed by ED physicians. The guidelines allow physicians to inform patients that every ED in Alaska is following the

guidelines and thus avoid having patients visiting multiple EDs seeking narcotics. Further, the guidelines have been endorsed by every provider and hospital, have reduced prescriptions issued by EDs, and have connected PDMP information to the exchange system (slides 19 and 20). Slide 21 illustrated a case study conducted by CollectiveMedical with Mat-Su Regional Medical Center to identify the impact of the combination of the narcotics guidelines, the ED information exchange, and case management work. The study reported a 79 percent reduction in opioid scripts written in EDs while maintaining positive patient satisfaction rates. Ms. Hultberg closed, reviewing the project's goals of improving patient care and, thereby, reducing ED costs; although not accompanied by a major data study, ASHNHA believes both goals have been accomplished (slide 23).

4:34:40 PM

MS. CARPENTER recalled during the drafting of Senate Bill 74, DHSS sought language that would allow the state to test for projects and determine value over volume; in fact, discussion of the bill covered managed care organizations, accountable care organizations, and provider-based models. However, DHSS decided upon coordinated care demonstration projects that would be proposed by providers on a regional basis. For example, on 9/1/18, Providence Family Medicine Center began testing a patient-centered medical home model project which provides participating Medicaid patients the services of an interdisciplinary care team: primary care, case management, care coordination, social work, health education, and transitional and follow-up care. The state is paying a partial capitation rate for additional services. She said the project is voluntary, involves approximately 5,000 patients per month, and the state is currently assessing the project's outcomes. The other project is a contract with UnitedHealthcare on a Managed Care Organization that is expected to begin operation [10/1/19]; discussions regarding the project are underway and are related to rates. In addition, provisions of House Bill 176 [passed in the Thirtieth Alaska State Legislature], known as the ground emergency medical transport (GEMT) bill, allow local governments to receive cost-based payments outside of the managed care organization structure, and this provision is also being reviewed by DHSS (slide 24).

REPRESENTATIVE TARR asked whether already existing models were considered.

4:39:01 PM

MS. CARPENTER explained the state issued a request for proposal (RFP) and responded to proposals that were submitted. She turned attention to section 43 of Senate Bill 74 which is the Medicaid Reform Program statute that requires several specific reports. One of the reports required is the Electronic Explanation of Medical Benefits (EOMBs), which intends to encourage Medicaid recipients to review their explanation of benefit (EOB), so that mistakes, fraud, and abuse may be reported, and she described the procedure. Currently, 2,500 of 100,000 adult recipients have registered for the service, which will be expanded to include children (slides 25 and 26). In response to Co-Chair Spohnholz, Ms. Carpenter said she would provide examples of the type of problems that have been reported by recipients.

MS. CARPENTER said another aspect of the Medicaid Reform Program is redesigning the payment process; although DHSS received one proposal to bundle payments, DHSS determined the proposal would not be cost-neutral, and she elaborated. No proposal for global payments was received.

CO-CHAIR SPOHNHOLZ asked for descriptions of health maintenance organization (HMO) capitation, bundled payments, and global payments.

MS. CARPENTER explained bundled payments are charged from a variety of providers related to one service, for example, all the charges related to a surgery, with the exception of diagnoses. A capitated rate is charged by a managed care organization with which DHSS has an agreement for a certain cost. She said she would provide a comparison between bundled and global payments.

4:44:36 PM

REPRESENTATIVE TARR asked whether the aforementioned reforms are intended to reduce the administrative costs of the delivery of services.

MS. CARPENTER said DHSS always seeks to reduce administrative costs; for example, through regulation, DHSS was able to eliminate "the 72-hour rule" in order to remove "an administrative nightmare" for physicians, and she elaborated. She restated DHSS seeks to redesign the payment process in order to pay for value over volume; Alaska Medicaid is a fee for service system, which encourages providers to charge "for

everything, so if [we] change the system in how we're paying - we want to pay for outcomes - we don't want to just pay for sick care ...."

REPRESENTATIVE TARR returned to the topic of bundled payments and questioned how DHSS determined bundled payments were not a good option.

MS. CARPENTER said she would provide copies of a report to explain why bundled payments would not save costs for smaller communities at this time.

CO-CHAIR SPOHNHOLZ observed there is less opportunity for cost savings "the narrower the range of services you're providing ..." Capitated rates are an incentive for providers to change the way they provide care because they wish to raise the level of health for recipients; however, [in small communities] there is less opportunity to find costs savings in administrative reforms such as billing.

MS. CARPENTER returned to the topic of Medicaid reform within Senate Bill 74 and said in 2016, DHSS engaged a stakeholder group that developed 18 quality and cost effectiveness measures to monitor the Medicaid program throughout the reform process. A report released "year 1" results in December [2018] and DHSS will continue to report results in this regard. The annual Medicaid reform report to the legislature is transmitted every November and includes information related to policy and finance related to Medicaid. In addition, Senate Bill 74 required a biannual report on the Alaska Medicaid Management Information System (MMIS), which was certified by CMS on 9/28/18; CMS certification allows Alaska to receive federal funds for 75 percent of operations and maintenance (slide 27).

4:51:10 PM

MS. CARPENTER continued to slide 30 which indicated DHSS has achieved three-quarters of claims for FY 19, totaling $65 million, and is on track to meet or exceed its target of $84 million in savings through efforts such as Tribal reclaiming.

CO-CHAIR ZULKOSKY disclosed she works for the Alaska Native Tribal Health Consortium during interim and acknowledged DHSS's work to ensure Tribal reclaiming is audit-proof and free from abuse or fraud.

MS. CARPENTER continued to the topic of fraud, waste, and abuse and pointed out another annual legislative report is issued jointly by DHSS and the Department of Law every November (slide 31). Also, Senate Bill 74 requires an eligibility verification system conducted by a third party, and CMS requires an Asset Verification System and an Independent Verification and Validation System. There have been three responses to a request of interest issued by the Division of Public Assistance, DHSS, and the systems will be implemented.

4:54:44 PM

The committee took an at-ease from 4:54 p.m. to 4:56 p.m.

MS. CARPENTER added the aforementioned systems will be implemented this fiscal year upon approval by CMS. The Eligibility Verification System will also satisfy federal requirements under the Food and Nutrition Service, U.S. Department of Agriculture (slide 32). She continued to the topic of Pioneer Homes, noting Senate Bill 74 required residents to show proof of Medicaid when applying for payment assistance; the goal of this provision is to have elders first apply for federal [assistance]. She pointed out the provision is a successful strategy to increase Medicaid receipts and reduce cost for elders residing in Pioneer Homes. Although it takes about six months to obtain proof of a Medicaid application due to staffing issues, the strategy has increased the federal match to 50 percent and reduced GF payment assistance to elders living in Pioneer Homes (slide 33).

4:59:20 PM

REPRESENTATIVE TARR asked whether there is a Medicaid waiver to address the issues that arise when an elder, who needs to move to a Pioneer Home, has assets.

MS. CARPENTER advised elders can place assets into a [Miller Trust, also known as a Qualified Income Trust] and said she would provide more information in this regard.

CO-CHAIR ZULKOSKY, in response to Representative Tarr, advised Alaska is not unique in its requirement that elders divest their assets to qualify for Pioneer Home payment assistance.

MS. CARPENTER said the topic of Telehealth would be provided by the Department of Commerce, Community & Economic Development (DCCED).

5:01:40 PM

SARA CHAMBERS, Acting Director, Division of Corporations, Business, and Professional Licensing, DCCED, informed the committee Senate Bill 74 expanded telehealth services - in which physicians provide services while not in the room with a patient - to audiologists, speech language pathologists, marital and family therapists, occupational therapists, and others who may reasonably provide telehealth services through videoconferencing and audioconferencing. In this provision, Senate Bill 74 required the state to create a registry for telemedicine businesses and thus 245 individual and corporate businesses have registered with the Division of Corporations, Business, and Professional Licensing (slide 34). She pointed out the PDMP, under the purview of the Board of Pharmacy, Division of Corporations, Business and Professional Licensing, DCCED, was changed by Senate Bill 74 from an optional report to mandated registration and reporting for pharmacists, physicians, nurse practitioners, optometrists, and dentists. This ensures providers check the PDMP prior to dispensing or issuing a prescription to a patient; mandated registration has increased the number of users; however, a number of affected providers have not yet registered and await further action by the board (slide 35).

CO-CHAIR SPOHNHOLZ asked for the difference in number between providers who are registered with the U. S. Drug Enforcement Administration (DEA), U.S. Department of Justice, and those registered with the PDMP.

MS. CARPENTER explained about 25 percent of each licensing category is not registered.

REPRESENTATIVE PRUITT questioned whether there is a sunset related to the PDMP.

MS. CARPENTER recalled Senate Bill 74 included a sunset on the PDMP provision which was removed in House Bill 159 [passed in the Thirtieth Alaska State Legislature].

5:06:48 PM

CO-CHAIR SPOHNHOLZ shared other uses for the PDMP such as to notify providers of a drug overdose.

MS. CHAMBERS directed attention to slide 36 which illustrated increased use of the PDMP by providers.

REPRESENTATIVE PRUITT questioned whether the division has options if a provider refuses to register or use the PDMP.

MS. CHAMBERS said at this time the division can review the rate of a provider's use of the PDMP and she discussed future options.

REPRESENTATIVE PRUITT urged for a legislative solution to [address providers who do not register or use the PDMP].

MS. CHAMBERS advised Senate Bill 74 was also designed to allow subordinates to access and check the PDMP so as not to overwhelm providers.

CO-CHAIR SPOHNHOLZ added [House Bill 159] expanded the number of people who are allowed to perform data entry [into the PDMP].

MS. CHAMBERS directed attention to slide 37 which illustrated the number of prescriptions reported in 2016 and 2017; there was about a 10 percent decrease in opioid prescriptions in the first year of the PDMP.

5:12:47 PM

CO-CHAIR ZULKOSKY observed some hospitals have strengthened or instituted pain management plans in response to the rise in opioid use and asked whether the division considered the effect of programs, such as pill counts and drug testing, on the decreased availability of opioids.

MS. CHAMBERS acknowledged there may be other elements [affecting drug use] that are outside of the scope of the PDMP. She noted the related boards are encouraging more collaboration to consider how DCCED can help facilitate conversations between pharmacists and prescribers; pharmacies need to be in contact with all licensed providers so they can efficiently question or confirm appropriate drug use. In fact, this is a recent issue that has led to crises for some patients.

CO-CHAIR SPOHNHOLZ related concerns about the PDMP for those with issues of chronic pain who may suffer unintended consequences.

5:18:11 PM

MS. CHAMBERS opined the aforementioned crises are not a negative consequence of Senate Bill 74 but are "growing pains." She directed attention to slide 38 which illustrated the number of patients receiving opioid prescriptions has decreased except for prescriptions greater than 100 milligram (mg) morphine equivalent per day (MME). She pointed out Senate Bill 74 required prescriber boards to submit recommendations about prescriptive guidelines to the legislature; guidelines were completed in 2016 and were primarily based on the Centers for Disease Control (CDC), U.S. Department of Health and Human Services, guidelines. She cautioned there are no "hard and fast rules" in this regard, thus education for patients and prescribers is warranted. Slide 39 provided detailed information about the PDMP annual report delivered to the legislature in March 2019, and available online at: pdmp.alaska.gov.

MS. CARPENTER directed attention to slide 40 which identified savings from Medicaid reform and other adjustments. She noted DHSS has already incorporated the shown savings into its budget.

CO-CHAIR SPOHNHOLZ pointed out DHSS has saved over $139 million by finding ways to better achieve its mission.

CO-CHAIR ZULKOSKY observed many of the reforms were administrative but have also improved access to programs.

MS. CARPENTER said the section 1115 Behavioral Health Waiver will have the most impact to access because some services that were previously not Medicaid billable now are.

CO-CHAIR ZULKOSKY returned attention to slide 40 and asked Ms. Carpenter to differentiate between GF savings and cost avoidance.

5:24:39 PM

MS. CARPENTER said she would provide details in this regard. In further response to Co-Chair Zulkosky, she explained an area that may turn out to be an offset - and not cost avoidance - is telehealth because DHSS did not estimate a specific money value of the savings in telehealth; telehealth savings include DSDS services and have the most potential for offset savings.

CO-CHAIR ZULKOSKY suggested savings and realized investment under Medicaid reform and expansion may approach $250 million.

CO-CHAIR SPOHNHOLZ questioned why savings related to telehealth are not measured.

MS. CARPENTER advised major savings from telehealth fall within DCCED licensing and would not be reflected in Medicaid reform; for example, most telehealth savings are part of "Tribal health" and thus are 100 percent GF. She offered to conduct additional research.

CO-CHAIR SPOHNHOLZ recalled telehealth was identified as a "strategy" as a part of Senate Bill 74; however, no one is tracking how much money the state is saving - or spending on travel that could be avoided - by expanding access to telehealth. She characterized telehealth as a future redesign opportunity.

5:29:49 PM

MS. CARPENTER agreed the cost of travel is significant for Alaska. She continued to slide 41 which was a graph that showed enrollment has grown over the past four years due to the economic recession and Medicaid expansion; however, reforms have allowed DHSS to hold state GF spending per enrollee flat as Medicaid spending has increased. Slide 42 indicated the per enrollee cost curve was held well below DHSS's original forecast. She concluded Medicaid reforms are effective and an accomplishment by DHSS.

CO-CHAIR ZULKOSKY urged DHSS to provide more general information on the focus and mission of its programs and services, and to provide additional information on what percent of Senate Bill 74 has been fully realized and the timeline required to reach 100 percent of implementation.

MS. CARPENTER agreed there are outstanding provisions of Senate Bill 74; for example, one state plan option is the [section 2703/1945 of the Social Security Act] Health Home State Plan, which has been delayed until the results of the Providence Family Medicine Center medical home model project become known, because the state would only receive eight quarters of enhanced 90 percent federal match. Other provisions of Senate Bill 74 have been delayed due to "the right timing as well as just the, the mass amount of work for the department ... [that] would fall on the same, you know, handful of individuals."

CO-CHAIR ZULKOSKY restated her question.

MS. CARPENTER said she would provide a percentage of the reforms within the purview of DHSS that have been implemented.

CO-CHAIR SPOHNHOLZ acknowledged the amount of time and work needed to implement Senate Bill 74 and other reforms.

5:38:31 PM

**ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at [5:38] p.m.