

**ALASKA STATE LEGISLATURE  
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

January 9, 2020

3:03 p.m.

**MEMBERS PRESENT**

Representative Ivy Spohnholz, Co-Chair  
Representative Matt Claman (via teleconference)  
Representative Harriet Drummond  
Representative Geran Tarr  
Representative Sharon Jackson  
Representative Lance Pruitt

**MEMBERS ABSENT**

Representative Tiffany Zulkosky, Co-Chair

**COMMITTEE CALENDAR**

PRESENTATION: MEDICAID REFORM UPDATE

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

ADAM CRUM, Commissioner  
Office of the Commissioner  
Department of Health and Social Services (DHSS)  
Anchorage, Alaska

**POSITION STATEMENT:** Presented a PowerPoint overview titled "Medicaid Reform Update."

RENEE GAYHART, Director  
Director's Office  
Division of Health Care Services  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Presented during the PowerPoint overview titled "Medicaid Reform Update."

GENNIFER MOREAU-JOHNSON, Director  
Division of Behavioral Health

Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Testified during the PowerPoint presentation on Medicaid Reform Update.

HEATHER CARPENTER, Health Care Policy Advisor  
Office of the Commissioner  
Department of Health and Social Services  
Juneau, Alaska

**POSITION STATEMENT:** Testified during the update on Medicaid Reform.

NANCY MERRIMAN, Executive Director  
Alaska Primary Care Association (APCA)  
Anchorage, Alaska

**POSITION STATEMENT:** Gave a presentation entitled, "Community Health Centers - the Value Opportunity."

APRIL KYLE, President  
Alaska Behavioral Health Association  
Anchorage, Alaska

**POSITION STATEMENT:** Presented, "Update on SB 74 Behavioral Health Reforms."

JARED KOSIN, President  
Alaska State Hospital and Nursing Home Association (ASHNHA)  
Anchorage, Alaska

**POSITION STATEMENT:** Presented a PowerPoint overview titled, "MEDICAID: A Critical Component in Alaska's System of Care."

#### **ACTION NARRATIVE**

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**CO-CHAIR IVY SPOHNHOLZ** called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Spohnholz, Drummond, Jackson, Pruitt, Tarr, and Claman (via teleconference) were present at the call to order.

#### **PRESENTATION(S) : MEDICAID REFORM UPDATE**

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**CO-CHAIR SPOHNHOLZ** announced that the only order of business would be a presentation updating Medicaid reform in Alaska, noting that this consisted of about \$2.4 billion in the budget.

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ADAM CRUM, Commissioner, Office of the Commissioner, Department of Health and Social Services (DHSS), directed attention to the PowerPoint titled "Medicaid Reform Update," noting that Medicaid Reform was ongoing. He discussed slide 2, "Topics," directing attention to Senate Bill 74, which was passed in 2016, and the status of the 2019 cost containment measures. Moving on to slide 3, "Senate Bill 74 (2016)" he explained that this was a bi-partisan, comprehensive, holistic approach to the entire health care system in Alaska, allowing programs to be developed to change health care, make Medicaid better, and put together many plans to give DHSS the authority to move forward. He noted that he would discuss Coordinated Care Projects, Behavioral Health System Reform, Electronic Explanation of Benefits, Tribal Reclaiming, Pharmacy Initiatives, Fraud, Waste & Abuse, and Telehealth. He stated that slide 4, "Coordinated Care Projects," meant working in partnerships with patients and providers to facilitate the appropriate delivery of health care and resulting in improved health and lower costs.

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RENEE GAYHART, Director, Director's Office, Division of Health Care Services, Department of Health and Social Services, directed attention to the coordinated care projects mentioned in Senate Bill 74. She added that DHSS had also been asked to enhance existing efforts, which included case management. She pointed to Medicaid recipients who used services across the Medicaid spectrum and explained that DHSS was now working to assign these recipients to a single primary care and pharmacy provider to allow for efficiencies in the management of care.

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MS. GAYHART moved on to the Alaska coordinated care demonstration projects, slides 4 and 5, and reported that Senate Bill 74 created a mechanism for DHSS to partner and contract with third party outside entities, which included managed care organizations (MCOs) and accountable care organizations. She shared slide 6, "Alaska Coordinated Care Demonstration Projects," and reported that DHSS had negotiated with four respondents to RFPs (Request for Proposal) and gave a notice of intent to award with United Health Care and with Providence Family and Medical Center for a medical home model.

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COMMISSIONER CRUM directed attention to "United Health Care: Managed Care Organization," slide 5, said that, although DHSS had been working on this prior to the current administration, it had been evaluated within the current context of planning and was now determined to be a concern for its impact on beneficiaries. He stated that, as other options were being reviewed for the ability to "mesh together into a global managed care system," it was decided not to proceed with the United Health Care contract.

CO-CHAIR SPOHNHOLZ asked if it was possible to move forward with a managed care project excluding the tribal health population.

COMMISSIONER CRUM replied that United Health did not want to put the decision on hold until the state made its decision for how to move forward with the process in a way to best take care of the tribal health partners.

CO-CHAIR SPOHNHOLZ asked if there could be an integration of a managed care demonstration project as a sister company of United Health Care was now managing the behavioral health.

COMMISSIONER CRUM said that this would be evaluated as the process moved forward.

CO-CHAIR SPOHNHOLZ asked about the timeline for the next steps on managed care.

COMMISSIONER CRUM replied that DHSS was most intrigued with the local and regional aspect for serving the specific population and was reviewing a possible pilot project in conjunction with the Medicaid reform strategist and the stakeholder groups over the upcoming months.

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MS. GAYHART moved on to slide 7, "Alaska Medicaid Coordinated Care Initiative," AMCCI, and also known as the "superutilizer" initiative. She shared some of its history, noting that in 2016 Alaska was one of seven states to receive a national grant for review of this in conjunction with consulting services. She reported that there was a focus on the reduction of emergency room visits by helping people manage chronic conditions and offering case management. She added that telephonic case management was also being reviewed, even though the contract with MedExpert [International] had not been renewed. She noted

that Senate Bill 74 also suggested that the Alaska State Hospital and Nursing Home Association (ASHNHA) work with superutilizers.

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CO-CHAIR SPOHNHOLZ asked whether concern with delivery was the rationale for not renewing the MedExpert contract.

MS. GAYHART replied that, as DHSS was reviewing enhancement of the care management program for additional cost containment, the state had decided to pick up services from existing contracts.

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COMMISSIONER CRUM explained that a large aspect of Senate Bill 74 was to "to address the shortage of psychiatric inpatient beds and residential substance use disorder treatment programs, and the fragmented system of community-based behavioral health providers and insufficient treatment services, particularly in rural areas," slide 8, "Behavioral Health System Reform." He added that Senate Bill 105, passed in 2018, allowed for licensed marital family therapists to independently bill Medicaid and that Senate Bill 169 allowed any physician to operate a mental health physician clinic and supervise the provision of care in the clinic via distance delivery. He added that Senate Bill 74 also removed the requirements that Medicaid behavioral providers be grantees of DHSS, allowing DHSS to move toward the 1115 waiver.

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GENNIFER MOREAU-JOHNSON, Director, Division of Behavioral Health, Department of Health and Social Services, discussed slide 9, "1115 Behavioral Health Waiver." She explained the three components, which read, in part:

Substance Misuse Disorder Treatment Component

- Approved in November 2018
- Became effective January 1, 2019

MS. MOREAU-JOHNSON added that currently there were 38 providers in 108 locations certified to provide 1115 Substance Abuse Services. She reported that the revenue generated from these 1115 waivers was helping the agencies even more than the earlier grants as the predominance were Medicaid expansion recipients

with a 90 - 10 match. She continued with slide 9, which read in part:

Behavioral Health Component

- Approved September 2019
- Will be implemented by June 30, 2020

MS. MOREAU-JOHNSON explained that this was moving more quickly as it was not necessary to do the implementation plan with the federal government. She finished slide 9, which read in part:

Administrative Services Organization

- Contracted with Optum Health in November 2019
- Goes live on February 1, 2020

CO-CHAIR SPOHNHOLZ asked whether claims would be paid by the administrative services.

MS. MOREAU-JOHNSON said that was correct, that claims would be paid out of two systems until July 1 when Optum would begin to pay all the claims, do the utilization review, and offer technical support for providers.

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REPRESENTATIVE TARR asked whether, as the administrative and billing services were currently being handled by state employees, there would be any attrition when these services were transferred.

MS. MOREAU-JOHNSON replied that there were already multiple contracts with Optum performing some of these existing contracts and that state employees would not be replaced.

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MS. GAYHART discussed slide 10, "Electronic Explanation of Medical Benefits (EOMBs)," which read:

Were made available October 2018 - August 2019

- Low participation rates and contract expenses that exceeded overpayments identified and other benefits.
- Division of Health Care Services plans to reintroduce in early FY2021

MS. GAYHART explained that, although DHSS recognized the EOMB portion of Senate Bill 74, it had been temporarily put on hold.

She said that the current contract with MedExpert was expiring at the same time an extension was being negotiated with the fiscal agent contract. As these EOMBs were being developed into the contract with Conduent, a one-time design and build of this EOMB process would cost about \$514,000, which was matched by federal dollars at 90 - 10; whereas, the EOMBs were currently costing between \$1.3 - \$1.5 million annually. She stated that this would be implemented by FY 21. She pointed out that, even with these EOMBs, there were additional extensive fraud controls in place, emphasizing that DHSS took fraud very seriously.

CO-CHAIR SPOHNHOLZ asked if this meant bringing the EOMB process in-house.

MS. GAYHART replied that this would be handled by the fiscal agent, Conduent.

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COMMISSIONER CRUM reminded the committee that this would be built into the system at the 90 - 10 percent match.

CO-CHAIR SPOHNHOLZ expressed concern about Medicaid fraud by providers, noting that it was constructive to educate the utilizers.

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COMMISSIONER CRUM paraphrased slide 11, "Tribal Health Reclaiming Efforts," which read:

Tribal Medicaid beneficiary claims have been reimbursed at 100% federal match for services provided by or through a tribal health facility.

- Dependent on collaboration with Tribes and providers:
- Care Coordination Agreements • Referrals • Exchange of Records

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MS. GAYHART turned attention to slide 12, "Tribal Health Reclaiming Savings," and said they were meeting the targets set forth in Senate Bill 74 by the Centers for Medicare and Medicaid Services, through an official state health letter, to qualify for a 100 percent match. She reported that there were now more than 1700 care coordination agreements and that, even though the

percentage of referral verifications was going up, there were still some issues with health information exchanges as not all the providers had the same electronic health record systems. She pointed out that, as it was not required to designate your race in the Medicaid system, if some Alaska Natives did not designate, the reimbursement was not 100 percent. She declared that the division was currently meeting its targets.

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CO-CHAIR SPOHNHOLZ commended Ms. Gayhart for saving \$200 million to date.

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COMMISSIONER CRUM paraphrased slide 13, "Fraud, Waste & Abuse," which read:

Eligibility Verification system

- Both SB 74 and the Center for Medicare and Medicaid Services have requirements for verification systems for Medicaid recipients.
- The U.S. Food and Nutrition Service also has verification system requirements for its programs (SNAP)
- DHSS is putting out a Request for Proposals for a system that would meet both sets of requirements.

CO-CHAIR SPOHNHOLZ commented that the 2019 Medicaid Reform Report had noted a \$10.2 million savings, the result of curtailing fraud abuse by providers.

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REPRESENTATIVE TARR commented on the issues with implementation of coordination between the two state verification systems and asked if this new system would replace both the existing systems and allow for system wide efficiency.

COMMISSIONER CRUM offered his belief that, over time, this new system would integrate both the existing systems, although it would be a delayed process. He added that, in addition to the Eligibility Verification System (EVS), an electronic document management (EDM) system would be implemented to allow documents to be scanned with a program to collect and organize the data and more easily track recipients. He declared that this unified

process would save staff time and better serve the customers to the Division of Public Assistance.

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HEATHER CARPENTER, Health Care Policy Advisor, Office of the Commissioner, Department of Health and Social Services, in response to Representative Tarr, stated that the current eligibility system was different from the Eligibility Verification System. This new EVS system would work with the current eligibility system and final eligibility determinations had "to be made by actual state employees per CMS rules." She explained that this eligibility system would look at all of an individual's assets, including those in other states, and notice whether there were multiple identifications. She reiterated that this would be linked with contractors.

REPRESENTATIVE TARR expressed her concern for the purported administrative inefficiencies of the current system.

COMMISSIONER CRUM expressed his agreement.

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REPRESENTATIVE TARR noted that there had been a hesitation from the associations regarding the electronic time sheets for personal care attendants and asked if there had been an administrative change to ensure this would happen.

COMMISSIONER CRUM replied that the EVS system had to be implemented to be in compliance with the 21st Century Cares Act, although DHSS had needed to request a good faith extension. He said that DHSS would work closely with the groups to fix any areas limited by technology.

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CO-CHAIR SPOHNHOLZ suggested that there could be an update with the public assistance process from the Division Director.

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COMMISSIONER CRUM introduced slide 14, "Telehealth," a breakdown of the use and expenditures for the telehealth system.

MS. GAYHART continued with slide 14, explaining that Senate Bill 74 dictated an expansion of telehealth to primary care,

behavioral health, and urgent care, which, in Alaska, was used as a mode of service delivery. She declared that the program had been successful since FY 16, and pointing to slide 15, "Telehealth," she listed the top disease categories as tracked by the diagnosis on each claim. She reported that most claims were for mental and behavioral health. She noted that many of the claims indicated youth diseases, which allowed for a transportation savings. She pointed out that Anchorage, Bethel, Nome, and Fairbanks all had high utilization in telehealth. She described both the interactive telehealth method of a patient and a provider on the screen, and the store and forward method which allowed x-rays and other lab work to be put into the system for review. She said it was difficult to do a "one for one" comparison including transportation costs, as sometimes telehealth spurred a need for transportation. She reported that the tribal health organization, as they often had the necessary equipment, was the biggest provider and utilizer of the service.

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CO-CHAIR SPOHNHOLZ asked if there could be an approximation of costs that would include travel costs in all the cases.

MS. GAYHART replied that some of those analyses required a support system and not just a "data pull by a single analyst." She declared that this was "definitely on the radar to work on this year, we're just not there yet." In response to Co-Chair Spohnholz, she explained that a decision support system would allow a comparison of claims by the system instead of manually by an individual.

CO-CHAIR SPOHNHOLZ asked about the elimination of the origination fee for Medicaid to out of state billings.

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MS. MOREAU-JOHNSON, in response to Co-Chair Spohnholz, said that she would research that.

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REPRESENTATIVE CLAMAN asked what could be done to encourage providers, other than tribal health, to increase their use of telehealth especially in the remote areas in Alaska.

MS. GAYHART declared that the cost of the equipment, as well as connectivity, often excluded certain providers.

REPRESENTATIVE CLAMAN declared that it was frustrating as there seemed to be such easy access and lower costs to technology.

MS. GAYHART added that DHSS struggled with security concerns with texting and cellphones. She referenced a telehealth workgroup during Senate Bill 74, noting that the regulations demanded a strong security component.

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COMMISSIONER CRUM reported that DHSS was having internal discussions for ways to proceed.

CO-CHAIR SPOHNHOLZ added that telehealth was one of the ways to increase access to health care and to control costs. She shared the difficulty of recruiting mental health providers in Alaska, especially in small communities, and expressed her support for the increase of telehealth as an appropriate level of care.

COMMISSIONER CRUM stated, "we put forward a lot of stuff this last session in order to meet our budgetary goals" and paraphrased slide 16, "FY 2020 Cost Containment Measures," which read:

DHSS proposed several Medicaid-related cost containment measures during the FY2020 budget preparation process.

Expected savings from several of these were incorporated by the Legislature into the final budget submitted to the Governor.

I will quickly review the status of each.

COMMISSIONER CRUM moved on to paraphrase slide 17, "FY 2020 Cost Containment Measures," which read:

5% Provider Rate Reduction for Medicaid services

Withholding Medicaid Rate Inflation Adjustments

Hospital Diagnostic Related Groups (DRGs)

Long Term Care Rate Reduction

Cost-Based End Stage Renal Disease

## Pharmacy Adjustments

COMMISSIONER CRUM added that, as DRG was a very complicated process, DHSS had hired a contractor to do an analysis working directly with the stakeholder groups to identify where this process could come in. He pointed out that Alaska was a fee for service state, whereas DRGs allowed for bundled payments with a movement toward a value-based payment system. Referring to the long-term care rate reduction, he stated that there was an issue with the upper payment limit, so it was necessary to implement a three percent reduction.

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MS. GAYHART stated that the cost-based end stage renal disease was on track for the expected savings as DHSS had set a lower rate. She declared that there were several efforts with pharmacy adjustments, including Senate Bill 44 which allowed the state to update the Medicaid preferred drug list and do prior authorizations for the medications list. She shared that there was an expected savings for \$6 million.

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COMMISSIONER CRUM mentioned that some of the cost containments would not allow a sufficient level of access to care for the home and community-based services, so these waivers "have been held harmless" from both cost containments and would continue to receive the normal rates.

CO-CHAIR SPOHNHOLZ asked about the process and timeline for the five percent provider rate reduction.

COMMISSIONER CRUM explained that the agreements with Alaska State Hospital and Nursing Home Association (ASHNHA) would delay implementation of the five percent reduction and that the difference for what had been removed since July 1 had now been paid back.

CO-CHAIR SPOHNHOLZ asked if this included hospitals and nursing homes.

COMMISSIONER CRUM explained that the nursing homes were under the long-term care and would include all providers except for the critical access and primary care.

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COMMISSIONER CRUM moved on to paraphrase slide 18, "FY 2020 Cost Containment Measures," which read:

Limit Physical Therapy/Occupational Therapy/Speech  
Therapy to 12 visits per year

Cost of Care Collection Improvements

Medicare Part B Premiums Recovery

Expand Care Management Program

Implement Nurse Hotline

COMMISSIONER CRUM noted that children's physical, speech, and occupational therapies were exempt from these service limits, and added that should a physician determine that an individual required more service, the physician could submit an appeal to DHSS.

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CO-CHAIR SPOHNHOLZ asked for clarification that the limit for the therapies was separate for each therapy.

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MS. GAYHART replied that this would soon be released for regulatory comments. She said that the limit for the amount allowed for an option should the provider determine that additional services were necessary. In response to Co-Chair Spohnholz, she clarified that the limits were per category.

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MS. GAYHART said that individuals in long-term care situations could qualify for Medicaid, although they may have to contribute to their cost of care. She said that DHSS was taking steps to collect these obligations from both the recipient and the representatives. She pointed out that this was a federal regulation, pointing out that there was the potential for a \$1 million savings.

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REPRESENTATIVE JACKSON asked, regarding the five percent provider rate reduction, whether this differed for a Medicaid or private provider, and if so, would it discourage private providers working with Medicaid patients.

COMMISSIONER CRUM explained that rate reductions were mandated by the Centers for Medicare and Medicaid Services to ensure that there was not a loss of providers. He reported that, in Alaska, Medicaid paid higher than Medicare. He stated that DHSS recognized the expense and difficulty of providing services in Alaska.

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MS. GAYHART returned attention to slide 18 and stated that DHSS paid the Medicare Part B premium for those eligible individuals who could not afford the premium. She discussed expansion of the care management program to include 500 additional people this year, with another 1,000 individuals during the next year. She explained that this would be conducted through the quality assurance unit. She said the implementation of a nurse hotline had been delayed along with the delay of United Health Care.

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REPRESENTATIVE DRUMMOND asked how many superutilizers there were in Alaska and what kind of progress had been made toward a reduction to that number.

MS. GAYHART explained that the term superutilizer was also used for high utilizers, and in her division, the care management program was looking to expand its management to include 1,000 people in that program. She noted that many of these people may not be on the program long term, dependent on the types of services needed.

REPRESENTATIVE DRUMMOND asked what percentage of those 1,000 individuals represented superutilizers.

MS. GAYHART offered her understanding that, in the Medicaid population of about 210,000 individuals, about 1,000 were considered superutilizers with an additional 100 people considered to be high utilizers.

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COMMISSIONER CRUM directed attention to slide 19, "FY 2020 Cost Containment Measures," which read:

- Electronic Visit Verification
- Timely filing allowance reduction
- Transportation Efficiencies
- Adult Preventive Dental

COMMISSIONER CRUM explained that the timely filing allowance would shorten the time limit for a provider to file a Medicaid claim from 12 months past service to 6 months. He noted that this would require a change to statute, although DHSS now felt that this would not result in any savings. In response to Representative Claman, he clarified that this option would not be pursued.

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COMMISSIONER CRUM explained that, although the initial transportation efficiencies were projected to save \$8.2 million, the tribal entities had taken on a large part of the savings through management. He stated that the adult preventive dental had originally been considered an optional service, but with the Patient Protection and Affordable Care Act, it was now an essential health benefit. There had been a decision to fully re-instate this program. In response to Co-Chair Spohnholz, he offered his belief that those providers who had been denied compensation since October, could now submit their claims.

CO-CHAIR SPOHNHOLZ stated that for providers, especially with the small profit margin from Medicaid patients, not getting a payment was "a bit of a challenge so every effort that could be made to expedite that, I think, will make a lot of difference."

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REPRESENTATIVE JACKSON asked whether the nurse hotline had been discontinued. She declared that the hotline saved a lot of money in times of concerns or problems. She expressed her desire that there was not abuse from dentists.

COMMISSIONER CRUM replied that DHSS was still exploring the nursing hotline in a cost appropriate manner. He shared that many providers were sharing ways to prevent abuses and continue to offer appropriate care.

COMMISSIONER CRUM reported that the DHSS Medicaid consultant was working to "put forward something that everybody understands is do-able and good for Alaska moving forward." He added that DHSS was actively engaging in partner relationships, noting that DHSS did not deliver health care, but helped to enable the delivery of health care.

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NANCY MERRIMAN, Executive Director, Alaska Primary Care Association (APCA), explained that APCA was "the statewide training and technical assistance provider for community health centers across the state and also their membership associations." She paraphrased slide 2, "We Believe:" which read:

We Believe:

- Primary care is key to healthcare savings and value
- Primary care seeks more opportunities to integrate with other care providers
- Primary care needs more flexible payment structures
- Primary care should be comprehensive and integrated

We also Believe:

- SB 74 was a step in the right direction

MS. MERRIMAN recapped slide 3, "Community Health Centers/Federally Qualified Health Centers," which read:

27 CHC Organizations operating ~170 Clinics in Alaska

- 113,000 Alaskans in more than 500,000 visits
- Less than \$100 Million Medicaid spend
- CHCs provide more high-value and less low-value care
- Nationally, CHCs save Medicaid ~24% over care in non-CHC settings

MS. MERRIMAN discussed slide 4, "SB 74 and Primary Care Missed Opportunities?", which read:

SB 74 had 16 Major Medicaid Redesign Initiatives

Few had direct opportunities for primary care:

- Coordinated Care Demonstration Projects
- Section 2703/1945 Health Homes

Challenges of the Time:

- \$3-4 Billion budget deficit

- No State Dollars were put toward significant system reform
  - A need for short-term savings
- These concerns continue to burden us today.

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MS. MERRIMAN said they were encouraged but there was still a long way to go and it would take meaningful investments. She turned attention to slide 6, "Our Investments and priorities align with SB 74 goals," which read:

CHC Data analytics and population health platform  
(\$1.5 Million)

- o Health information
- o Disease Prevention & Wellness (risk stratification, referral tracking, visit planning)
- o Quality Measures

- Proposal: The Alaska Health Home Pilot
  - o Coordinated Care Demonstration proposal
  - o 1945 Waiver = Health Home
  - o Redesigning the Payment Process

- Patient-Centered Medical Home (PCMH)
  - o 18 of 27 CHCs recognized
  - o Team-Based integrated care

MS. MERRIMAN stated that care coordination services that were required to be provided, and were high value and low cost, were not reimbursed by any payer. She pointed out that these low cost and high value services really made a difference, especially for the highly complex, expensive patients with many health conditions. She noted that although SB 74 provided an opportunity to be innovative with new tactics to improve health outcomes and save on costs, implementation on some of the initiatives had been elusive. She directed attention to the 1945 waiver, which would allow Alaska to establish a health home program and had been included in legislation and the Milliman Report of October 2018. She added that the Centers for Medicare and Medicaid Services still offered financial support to states with development of these health home programs, noting that the 90 percent FMAP (Federal Medical Assistance Percentage) offered for those care coordination services was still available for eight quarters. She noted that the initiative had not moved forward, even though it was an opportunity for meaningful coordinated care demonstration with health center expertise and

high value care delivery. She declared that this was a recognized, proven program to pay for high value, low cost services for highly complex patients, lamenting that this opportunity had been missed, but she expressed the hope that the program possibility would be examined again. She opined that primary care needed to be recognized and supported.

MS. MERRIMAN discussed slide 7, "CHCs continue to be the best deal in healthcare," which read:

Future:

- We're Investing in the exploration of:
  - o A Clinically Integrated Network and
  - o Value-Based Pay
- We're seeking:
  - o Reimbursement for Coordinated Care
  - o An expanded list of reimbursable Provider Types that would enhance integrated services
- We value:
  - o Transparency in Administrative and Legislative Changes
  - o Inclusion of stakeholder voices and perspectives

MS. MERRIMAN shared an anecdote about a practice that, due to a lack of funds, had to decline participation in a valuable project that would have delivered robust information about their patients and their consumption habits. She declared that APCA valued transparency, both in administrative and legislative changes to the Medicaid program moving forward, adding that stakeholder and provider perspectives would inform the process and help with successful reforms. She stated that primary care and preventive health saved Alaska money, was good for patients, and was good for Alaska.

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REPRESENTATIVE TARR asked if the suggestions for the expanded list and reimbursement for coordinated care were allowable within the state plan, hence could be changed at the state level, or would they need to be changed at the state plan amendment level.

MS. MERRIMAN offered her belief that expanding the list of reimbursable providers could be done at the state regulation level. She added that coordinated care services were tougher, and she opined that those had a "really good chance of being covered within the demonstration project" and were included in

the Providence Primary Care Practice demonstration project as a per member per month amount above the cost of the usual visit. She noted that this flexible payment allowed the practice to deliver the services that were not reimbursable and would have been difficult to get reimbursed on a per item basis.

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APRIL KYLE, President, Alaska Behavioral Health Association, contextualized what the behavioral health system in Alaska looks like today. She informed the committee that there are committed, effective, and competent behavioral health providers who are delivering good services and making meaningful improvements in their communities. The problem, she said, is that the supply of behavioral health providers and services doesn't reach the demand, which leaves a lot of Alaskans without the behavioral health care that they need. When Alaskans can't access that behavioral health care because there aren't enough services there becomes an increased demand for law enforcement, criminal justice, and the Office of Children's Services (OCS). The state is in a position where there's not enough behavioral health services and a small group of providers who want to meet that need, which leaves a gap in the system. Next, she addressed reform and the 1115 waiver, calling it "transformational" for behavioral health in Alaska. The idea behind the 1115 waiver was to recognize the gap between the supply and demand and create an environment where new services could be built in the continuum. She further noted that by building out those new services, an argument was made that the state would save money in other parts of its healthcare delivery. The 1115 waiver specifically says that the state will bring online 30 new outpatient treatment programs and 200 new residential treatment beds. She said, "think about all the Alaskans today who need those services right now but aren't able to access them because they don't exist in our continuum." The 1115 waiver ideology is that building up those services will save money by providing less expensive, earlier interventions in real time, "because treatment works, and recovery is possible."

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REPRESENTATIVE TARR sought clarification on the percentage of providers that have joined the 1115 waiver environment thus far.

MS. KYLE explained that the first step in becoming an eligible provider under the 1115 waiver is to apply and seek approval. According to the Division of Behavioral Health (DBH), she said,

there are five or six providers that are being reimbursed in the 1115 [waiver] environment and prepared to meet the regulatory requirements.

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REPRESENTATIVE CLAMAN expressed concern about the discussion coming from the executive branch regarding a withdraw from Medicaid expansion. He asked how that would impact the 1115 waiver.

MS. KYLE stated that the 1115 [waiver] services are largely paid through federal (indisc.) services. The ability to launch new behavioral health services depends on the environment of the (indisc.) continuing. She reported that if Medicaid expansion was in threat, the ability to move forward for behavioral health would be in jeopardy.

REPRESENTATIVE CLAMAN asked Ms. Kyle if she knows the current position of this administration on whether it will continue efforts to potentially roll back [Medicaid].

MS. KYLE said she doesn't want to speak for the administration.

[4:47:45 PM](#)

COMMISSIONER CRUM, in response to Representative Claman, said that at this point in time, [the administration] has not had any discussion about the removal of Medicaid expansion.

REPRESENTATIVE CLAMAN opined that any move to try to roll back the expansion would be devastating to Alaska. He said he is somewhat encouraged that the administration doesn't seem to be pursuing that at this point.

CO-CHAIR SPOHNHOLZ concurred.

[4:48:46 PM](#)

MS. KYLE resumed her presentation, directing attention back to Medicaid reform and the impact on behavioral health (slide 2). She said the Administrative Services Organization (ASO) is in contract and scheduled to launch the first part of its service February 1, 2020. She noted that only a handful of providers will be submitting claims on that day. She continued by saying that SB 74 aims to increase access by allowing any willing provider to participate in the Medicaid behavioral health

continuum. Part of that, she said, includes creating an even playing field regarding the administrative responsibilities and the obligations of behavioral health providers who had previously been delivering Medicaid services. The ASO is cast with decreasing the administrative burden on providers; however, that work hasn't started yet. Finally, she related that SB 74 called for the improved integration of behavioral health and primary care, which the 1115 waiver and behavioral health reform has yet to address.

MS. KYLE turned her attention to the next steps (slide 3). She said the good news is that the Alaska Behavioral Health Association (ABHA) has a solid business case that says they save money by developing more behavioral health services. She reiterated that the 1115 waiver creates the environment for those services to be developed. However, to be successful, reform efforts depend on three things. First, predictable, sustainable operational funding so providers can launch new services. Second, start-up capital to fund the system changes, which means updates to billing systems and medical records for better care, as well as required quality data reporting to transforming outreach and clinical delivery, she said. Third, transparent open conversations and involvement in planning stages for providers.

[4:54:14 PM](#)

REPRESENTATIVE JACKSON expressed her desire for all Alaskans to have the opportunity to be above the poverty level. She said, "I don't want us to, like, neglect that idea in order to receive government funds to provide them to keep them there."

[4:55:48 PM](#)

MS. KYLE responded by addressing addiction services. She indicated that lives are changed by the journey through treatment and into recovery. She indicated that the goals of those in addiction and mental health treatment are about education, employment, housing, and reconnecting with family. She said behavioral health is a stabilizing factor, adding that many success stories are not clinical outcome measures as much as they are functional outcome measures.

[4:57:13 PM](#)

REPRESENTATIVE TARR sought clarification on the start-up capital. She questioned whether the state would be providing grants to individual providers.

[4:58:45 PM](#)

MS. KYLE replied in the past, the legislature has appropriated dollars, which were offered through competitive grant processes for new programs to launch. That, she said, has proven successful. She noted that the behavioral health network of providers is operating on thin margins. She added that she doesn't want to speak for the trust; however, there is a big gap between supply and demand, and everyone will need to think about where the dollars will come from to launch the needed services.

[5:00:08 PM](#)

REPRESENTATIVE TARR, in response to Ms. Kyle, surmised that the state could offer a competitive grant for technology and infrastructure upgrades necessary to participate in the 1115 waiver program.

MS. KYLE cautioned the idea that the dollars would be for technical assistance. She suggested that, "if we can trust that the payment will be in the future what we calculate now, and if we can have the launch dollars then we can really bring those services online."

[5:01:22 PM](#)

CO-CHAIR SPOHNHOLZ emphasized that behavioral health providers as well as other health providers are businesses like any other organization. They need to know what their potential revenue streams can be to provide a service in order to build a business model that is sustainable. If there isn't predictability, she said, it creates an operating environment where risk is not enabled. She reiterated the importance of a stable operating environment.

[5:02:14 PM](#)

JARED KOSIN, President, Alaska State Hospital and Nursing Home Association (ASHNHA), provided a PowerPoint presentation titled, "MEDICAID: A Critical Component in Alaska's System of Care." He explained that to understand SB 74 and the future of reforms it's important to know where Medicaid stands today. He said that Medicaid and health care in general are highly connected in

Alaska, which means that Alaska's system of care has major vulnerabilities: capacity and effect of reimbursement (slide 2). He described health care as a system in the concept of a continuum (slide 3). He stated that Alaska's continuum is not efficient for "good reasons." One of those being capacity challenges, or not enough beds for the population. He argued that this, in turn, drives up health care costs. He explained how system inefficiencies are driving and trapping patient care at the highest cost point because the lack of long-term care facilities or assisted living homes to discharge hospital or emergency department inpatients (slides 4-5). Mr. Kosin continued by describing a chart on slide 6 labeled, "Hypothetical Payor Mix (admissions)." He said that people enrolled in government programs like Medicaid and Medicare often pay less than the actual cost of patient care and consequently, private payers are paying more (slide 7). He then turned to reform. He reiterated that Alaska's system is fragile, adding that it needs to be stabilized before making decisions that will affect it. He discussed making rational changes through data-driven decisions and payment reform, as well as innovative ideas on how to keep patients at a lower cost of care (slide 8).

[5:18:41 PM](#)

CO-CHAIR SPOHNHOLZ commented on an issue related to workforce supply. She reported that two separate University of Alaska programs that provide behavioral health care and physical health care training are on the chopping block as a result of budget cuts. She said this will hinder the ability to have a sufficient workforce to provide the health care that this state needs. She said that it is important to remember that health care operates in a larger system and thanked Mr. Kosin for calling attention to that.

[5:20:56 PM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:20 p.m.