HOUSE FINANCE COMMITTEE
February 16, 2022
1:35 p.m.

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CALL TO ORDER

Co-Chair Merrick called the House Finance Committee meeting to order at 1:35 p.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Kelly Merrick, Co-Chair
Representative Dan Ortiz, Vice-Chair
Representative Ben Carpenter (via teleconference)
Representative Bryce Edgmon
Representative DeLena Johnson
Representative Andy Josephson
Representative Adam Wool (via teleconference)
Representative Bart LeBon
Representative Sara Rasmussen
Representative Steve Thompson

MEMBERS ABSENT

None

ALSO PRESENT

Albert Wall, Deputy Commissioner, Division of Medicaid and Healthcare Services, Department of Health and Social Services; Sylvan Robb, Deputy Commissioner, Department of Health and Social Services; Adam Crum, Commissioner, Department of Health and Social Services; Gennifer Moreau-Johnson, Director, Division of Behavioral Health, Department of Health and Social Services.

PRESENT VIA TELECONFERENCE

Dr. Ted Helvoigh, Vice President, Evergreen Economics; Rich Albertoni, Manager, Public Consulting Group.

SUMMARY

PRESENTATION: MEDICAID UPDATE BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Co-Chair Foster reviewed the agenda for the day.

^PRESENTATION: MEDICAID UPDATE BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

1:36:15 PM

Co-Chair Foster relayed the list of testifiers and invited the testifiers in the room to the table.

1:37:04 PM

ALBERT WALL, DEPUTY COMMISSIONER, DIVISION OF MEDICAID and HEALTHCARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced himself. He would be discussing Medicaid, enrollees of Medicaid, associated costs, and the future of Medicaid. The subject was vast and complex and he would not be able to cover everything about Medicaid in one presentation. He reviewed the list of testifiers from the Department of Health and Social Services (DHSS). He began the PowerPoint Presentation: "Medicaid Services FY 2023 Overview" (copy on file) by reviewing the agenda on slide 2. The topics of the meeting included the following:

- Medicaid Eligibility
- Medicaid Budget
- Medicaid Eligibility and Spending in Alaska (MESA) – Ted Helvoigt, Ph.D.
- Public Consulting Group Recommendations – Rich Albertoni
- 1115 Waiver – Behavioral Health Demonstration Project

1:40:46 PM

Mr. Wall turned to slide 3 to provide an overview of Alaska Medicaid. He explained that Medicaid was the largest health coverage program in Alaska and provided comprehensive coverage for Medicaid-eligible recipients. The coverage amount was dependent on recipient needs. He added that Medicaid was a collaborative effort between multiple divisions. While the process was dependent on the state, Alaska had four divisions that were involved in the

process. He had been doing presentations on the involved divisions at the DHSS subcommittee meetings.

Co-Chair Foster indicated Representative Carpenter had joined the meeting online.

Mr. Wall continued to discuss the divisions involved in the Medicaid process. The divisions were listed on the slide as follows:

- Medicaid Eligibility: Division of Public Assistance (DPA) Medicaid Program Administration: Health Care
- Services (HCS), Division of Behavioral Health (DBH), Senior and Disabilities Services (SDS)
- Service Payment: HCS and DBH, through both fiscal agents – Conduent and Optum

Mr. Wall indicated that the majority of enrollees were seeking primary care, which was usually referring to services performed at hospitals and physician clinics. Many Alaskans needed other services like mental health treatment or substance abuse treatment. The Division of Behavioral Health (DBH) was responsible for such services and was highly involved in the Medicaid process. He also pointed out that Medicaid had two service payments: Optum and Conduent. It was divided into two because there needed to be quick proof that services were medically necessary due to the 1115 waiver. The two service payment methods allowed for a more streamlined process.

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Mr. Wall continued to slide 4 and explained that Medicaid was nuanced and complex. There were a variety of agencies that performed specific and important tasks that were paramount to Medicaid's functionality. He emphasized that Alaska Medicaid could not exist without help provided by the following agencies:

- Federal Reporting, Claiming, and Audits: Finance and Management Services
- Rate Setting: Office of Rate Review
- Program Integrity: Medicaid Program Integrity Unit and Medicaid Fraud Control Unit (Department of Law)
- Medicaid State Plan: Office of the Commissioner
- Health Information Technology

- Coordination and Consultation with Tribal Health Organizations

Mr. Wall noted that the Federal Reporting, Claiming, and Audits: Finance and Management Services unit was responsible for drawing down about $1.7 billion in federal funds every year. The unit had an immense impact despite its small size. Program Integrity performed audits of providers and brought in about $5.5 million per year. He relayed that Medicaid was a contract between the federal government and the state, and the Medicaid State Plan administrator acted as the contract manager for the state.

Mr. Wall continued that each division had a tribal liaison and met with a number of different tribal healthcare groups. Another important element was the tribal reclaiming process which was handled through healthcare services. The tribal reclaiming process involved finding general funds that could have been claimed under federal funds through tribal health. The unclaimed funds would be adjusted to bring the money back to the state. In FY 20, $90 million was brought into the state through the process.

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Representative Rasmussen asked which departments providers would contact if there were issues with Medicaid billing.

Mr. Wall replied that slide 3 represented the four divisions within Medicaid. Behavioral health providers had tools available to them through DBH that provided contact information for Medicaid billing issues. If the provider was anything besides a behavioral health provider, they would go through health services.

Representative Rasmussen asked for the number of medical providers that were assigned to one Medicaid billing contact for questions and problems.

Mr. Wall replied that the number of providers assigned to a single contact depended on provider-type, and there were many different provider-types. He would get back to the committee with the answer in writing.

Vice-Chair Ortiz asked what type of work a fiscal agent would do in relation to Medicaid.

Mr. Wall explained that fiscal agents were responsible for working with providers on the claim filing process. The agents were also responsible for ensuring the accuracy of the claim and handled the money involved in the claim. The department worked with Conduent and Optum to provide the service to providers.

Vice-Chair Ortiz was confused about the term "waiver" in relation to Medicaid. He asked for more information on waivers.

Mr. Wall explained that a waiver gave permission for someone to not adhere to a core set of rules. For example, the 1115 waiver referred to a section in federal code that described the waiver. He agreed that waivers were confusing and that each state had its own 1115 waiver and some had more than one. The numbers referred to Medicaid rules that were waived. He used the 1135 waiver as an example, which Alaska filed in response to the COVID-19 pandemic. An 1135 waiver informed the federal government that there was an emergency and requested that some rules be waived in order to provide better healthcare given the circumstances. He thought there was a testifier later in the presentation that would give more detailed information about waivers.

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Representative Edgmon asked what effects splitting DHSS would have on Medicaid.

Mr. Wall responded that the department would be dividing the administration and processing of claims from 24/7 care. The simplest way was to separate regulation from the actual practicing of care. For instance, Alaska Psychiatric Institute (API) was a licensed hospital and fell under the jurisdiction of healthcare facility licensing. There were divisions within DHSS that were responsible for overseeing other divisions in the same department, which did not seem logical. The split would address the issue and would allow there to be more proactive focus on things like cost containment of Medicaid.

Representative Edgmon noted that he and Representative Thompson were present when the Medicaid legislation was being crafted in 2016 and that it was time intensive.

Mr. Wall understood and noted that he had invested a lot of work into Medicaid as well.

Mr. Wall turned to the slide 5 which discussed Medicaid eligibility. He noted that as demographics in Alaska changed, the impacts on Medicaid changed. He explained that demographics were used to project costs.

Mr. Wall turned to the chart on slide 6. The green bars represented the Medicaid expansion population. Overall, enrollment in Medicaid was growing steadily. The Medicaid enrollment numbers would continue to grow until the changes brought about by the pandemic were controlled. He turned the presentation over to Ms. Sylvan Robb from DHSS.

2:01:25 PM

SYLVAN ROBB, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, began with slide 7 to discuss the Medicaid budget development process. She relayed that the department included a number of variables in order to come up with cost projections. Some of the variables included population changes, utilization changes, actual spending trends, and program changes and special initiatives. She relayed that the department had to submit a report called the CMS 37 to the federal government every year. The department used some additional resources for projections, such as Medicaid program utilization metrics developed using the state's accounting systems as well as long-term forecasts of Medicaid enrollment and spending in Alaska.

Ms. Robb continued to slide 8 and reported that Medicaid had a budget of $2.4 billion. In FY 23, the projected unrestricted general fund (UGF) need was $656 million. She indicated that DHSS was asking for an increment of $45 million and she would discuss how the department arrived at that number later in the presentation. She noted designated general funds (DGF) as well as federal funding had been relatively stagnant as shown in the graph on the slide. Overall, the cost of Medicaid had increased slightly, but UGF spending was down by $20 million.

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Ms. Robb continued to slide 9. She explained that the FY 23 budget assumed that the enhanced Federal Medical Assistance Percentage (FMAP) map would conclude at the end of FY 22.

The assumption was that the state would be back at the original FMAP levels for FY 23. The enhanced FMAP had awarded the state an additional $17.5 million of federal funding for Medicaid each quarter, which equated to nearly $70 million annually. The department anticipated a shortfall of $72 million if the department did nothing to contain the costs. However, the department was only requesting $45 million because it had a number of cost containment strategies that would be implemented. Some of the cost savings strategies were listed on the slide as follows:

- Public Consulting Group cost saving activities to be implemented in FY2023:
- $17.0 million projected to be captured once Medicaid eligibility redetermination resumes (until the Public Health Emergency is over, states receiving the enhanced FMAP must adhere to a continuous enrollment requirement).
- $6.5 million – Implementation of Section 1945 Health Homes
  $3.5 million – Pay for Performance for Hospitals

  Other cost saving activity to be implemented in FY2023:
- $4.6 million – Implementation of Indian Health Service (IHS) reclaiming by the Administrative Services Organization for the Division of Behavioral Health

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Representative Josephson noted that in FY 20, the department had produced a phase 1 cost containment implementation schedule. He wondered if he could get an updated version of the schedule.

Ms. Robb suggested that Representative Josephson speak with her after the meeting to ensure she understood which document he wanted. She would get the updated version to him.

Representative Edgmon noted there had been a previous discussion about projecting annual Medicaid expenses with an increased emphasis on tribal compacting. He asked how tribal compacting impacted Medicaid expenses.

Mr. Wall asked the representative to repeat his question.

Representative Edgmon elaborated that there was a previous meeting during which the need for more tribal compacting was emphasized, particularly by the Office of Children's Services (OCS). He wondered what the relationship was between tribal compacting and Medicaid.

Mr. Wall indicated that tribal compacting would be an OCS issue and would not have a direct impact on Medicaid. There were some services offered through Medicaid that were used by OCS clientele, but the compacting would not have a direct impact.

Representative Edgmon asked if Mr. Wall was speaking strictly to present circumstances. He wondered if there was a possibility that Medicaid would play a more substantial role in OCS in the future.

Mr. Wall reiterated that he did not believe there would be a direct impact on Medicaid due to compacting. However, services provided through Medicaid to OCS clientele would be impacted. He explained that the department was required to consult the tribes on any changes to Medicaid.

Vice-Chair Ortiz asked to return to slide 8. He noted there had been a gradual increase in Medicaid participation and thought the increase did not necessarily correlate to an increase in costs. He wondered if a similar increase could be seen in graphs ranging back to 2005.

Ms. Robb thought the question would be better answered by subsequent testifiers.

2:14:41 PM

Representative Josephson asked about the last item on slide 9 which projected a $4.6 million savings in more aggressive tribal reclaiming. He wondered if the savings was used both in the Administrative Services Organization (ASO) for the DBH and separately in the Division of Medicaid and Healthcare Services (DMHS). He asked if the budget reflected the $4.6 million savings twice.

Ms. Robb responded in the negative. Tribal reclaiming was already done through the claims that were paid through healthcare services. The forthcoming tribal reclaiming

would be for claims related to the 1115 waiver. Tribal reclaiming for 1115 waiver claims had never occurred before.

Mr. Wall added that one of the reasons was because the 1115 waiver was relatively new. The service line for the waiver was introduced in two phases: first, substance abuse was implemented, then mental health was added. The process had been implemented thoughtfully and the reclaiming aspect had not been added until the process had proven to be sound. Other tribal reclaiming was already done through another fiscal agent.

Representative Josephson thought that DMHS indicated that tribal reclaiming opportunities were down due to the pandemic and lower utilization. He asked if the $4.6 million might not be achieved because of a lack of utilization.

Mr. Wall agreed that it was possible. However, he stood by the present projection.

Ms. Robb indicated Dr. Ted Helvoigh from Evergreen Economics would be continuing the presentation.

2:17:36 PM

DR. TED HELVOIGH, VICE PRESIDENT, EVERGREEN ECONOMICS (via teleconference), continued to slide 10 to begin his portion of the presentation. He relayed there was a demand by the legislature in 2005 to compile a long-term spending forecast for Medicaid Enrollment and Spending in Alaska (MESA). The projections were based on Medicaid enrollment as it currently operated and intended to inform the legislature and DHSS on the state of Medicaid.

Dr. Helvoigh turned to slide 11 to review the modeling approach, which relied on published data and statistical modeling to build the forecast in consecutive steps. The steps were ordered as follows: long-term population projections, enrollment in the Medicaid program, utilization of Medicaid services, intensity of Medicaid use, and spending on Medicaid.

Dr. Helvoigh moved to slide 12 which charted weekly spending on Medicaid services during all of FY 20, FY 21, and part of FY 22. The chart took date of service into

account and acknowledged that services might be paid in 30 days, 90 days, or another timeframe. He relayed that Medicaid spending was close to what it was prior to the pandemic. The long-term forecast assumed that the pandemic was a detour and that spending would fully recover.

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Dr. Helvoigh advanced to slide 13 which reflected enrollment and growth in enrollment. He highlighted that enrollment increased due to the pandemic. However, the increase did not mean there was a greater demand for Medicaid but simply that a person would have to "move or die" to get off of Medicaid. He relayed that there were fewer ways to get off of Medicaid than there were in the past and the growth should decline because of the pandemic waning.

Dr. Helvoigh moved to slide 14 which showed substantial growth beginning in 2016. Spending increased rapidly when Medicaid expansion began, slowed in FY 20, and was coming back up again. The blue bars on the graph showed what the state was spending on Medicaid services each year. The state was spending less than it was 10 years ago. The green line in the chart showed Medicaid enrollment and the blue line showed Medicaid recipients. He emphasized that enrollees and recipients were very different. He elaborated that an enrollee was anyone who was enrolled in Medicaid and a recipient was an enrollee who actually used Medicaid services. In recent years, there were many more enrollees than recipients, which was not the situation in 2012 because the reevaluation of Medicaid was done more frequently prior to Affordable Care Act (ACA). He noted that due to ACA, more people could enroll in Medicaid which resulted in a greater separation between enrollees and recipients. In FY 22, approximately 78 percent of Medicaid enrollees were also recipients. Enrollment was not the best indicator of program use; instead, recipient numbers were a more informative benchmark.

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Dr. Helvoigh continued to slide 15 and explained that the population was aging, and growth had slowed. The senior population would experience relatively strong growth through the 20-year projection period. The group that would

experience the slowest growth was children. He emphasized that spending patterns were much different based on age.

Dr. Helvoigh advanced to slide 16 to discuss Medicaid enrollment projections in the long-term. He reported that in 1999, there were fewer than 100,000 enrollees and today, there were about 267,000. Enrollee numbers were projected to reach 300,000 by 2042. Children had historically been the largest enrollee demographic, but that had since shifted and working-age adults were now the main enrollees.

Dr. Helvoigh turned to slide 17 which contained a graph that reflected the growth in Medicaid reimbursement rates. He relayed that Medicaid reimbursement rates would grow at a slower rate than overall healthcare price inflation. The blue line on the graph showed the projected growth in medical price inflation in Alaska, and the red line showed the projected growth in Medicaid reimbursement rates. He thought it was a useful graph to show cost controls.

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Representative Josephson asked if Dr. Helvoigh had recommendations how to close the distance between the blue and red lines. He asked if Dr. Helvoigh was using a 4.2 percent Evergreen economic growth rate.

Dr. Helvoigh responded that he could not provide guidance on how to increase the growth in reimbursement rates. The red line represented historical data and it trended in coordination with national inflation increases. The projections represented by the blue line came about by looking at the historical medical price inflation for Alaska as compared to the overall general price inflation in the United States. He used data from a third party to project what health care inflation would look like in Alaska. He compared the U.S. and Alaska because he needed to use a series that was already forecasted in order to accurately project price inflation in the state.

Representative Josephson asked what Evergreen's projected growth rate was for medical price inflation.

Dr. Helvoigh thought it was close to four percent. On average, it was 3.5 percent to four percent.

Representative Josephson understood that the administration was calling for a one percent growth rate.

Dr. Helvoigh responded that he did not know the rate called for by the administration. His point was that over the past 15 years, medical price inflation had grown at 3.5 to four percent or even faster, yet the overall Medicaid spending has significantly lagged behind. It was clear that Medicaid spending had grown at a much slower rate than general medical price inflation in Alaska. In other words, Medicaid costs appeared to have been strongly contained.

Dr. Helvoigh advanced to slide 18 and explained that general fund spending would grow faster than federal spending. He projected that Medicaid spending would grow by 3.5 percent each year. The state was currently receiving an additional 6.3 percent FMAP that would eventually be discontinued, at which time the state would experience a substantial increase in Medicaid spending. Between state general funds and other matching funds and federal funds, annual Medicaid spending would grow at an average rate of about 3.5 percent.

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Co-Chair Foster noted that administration projected in the 10-year outlook that the cost would increase by about one percent. However, he understood that Dr. Helvoigh thought 3.5 percent should be expected.

Dr. Helvoigh confirmed that 3.5 percent was the expectation. He was not familiar with the forecast by the administration that Co-Chair Foster was referring to.

Co-Chair Foster thought he should have directed his question to Mr. Wall.

Mr. Wall was confused about which projection of cost was being discussed. He asked if the costs on slide 18 were referring to the overall cost of medical or the reimbursement costs for Medicaid.

Co-Chair Foster thought it was the overall cost of medical.

Representative Josephson asked what the department was projecting for Medicaid growth.

Mr. Wall suggested that he get back to the committee with a response in writing.

Dr. Helvoigh continued to slide 19 with a chart that compared projected spending to the current forecast and the first long-term Medicaid forecast. He explained that the red line represented actual spending, the green dashed line represented projected spending, and the blue dot line represented the first long-term forecast from 2006.

Dr. Helvoigh turned to slide 20 which contained a graph that showed that many more Alaskans were receiving Medicaid services. He noted that the number of recipients was similar to the forecasted number for a long stretch of time but expanded significantly in about 2015 due to Medicaid expansion.

Dr. Helvoigh advanced to the third chart on slide 21 which concluded that spending per recipient was much lower in the present day than was projected in 2006. Costs had been flat over the past 10 years.

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Representative Edgmon thought the chart proved that Medicaid expansion helped bend the cost curve down.

Dr. Helvoigh thought that it did provide slight proof on a per recipient basis. By definition, the expansion population was comprised of non-disabled working-age adults. He thought Medicaid expansion probably helped reduce spending per recipient but did not contribute to reducing the overall spending costs.

Mr. Wall added that the real difference was in the general fund spend. There was a tremendous reduction in the general fund spend due to the expansion population, however the overall expenditures were about the same.

Representative Edgmon thought that was intuitive because expansion population was about 90 percent after starting at 100 percent.

Mr. Wall indicated it had stepped down over a couple of years.

Representative Edgmon argued that it would be difficult to bend the curve because of high costs in Alaska.

Mr. Wall responded that he understood the conversation to be centered around the inflation of medical costs, not just the reimbursement of Medicaid. The inflation costs seemed to be the more important costs to address. He thought it was important to isolate Medicaid to be able to look more closely at it and come up with a better plan to reduce costs.

Representative Edgmon was getting confused about the inflation discussion. He thought that if the Medicaid cost inflation was reduced to one percent it would help bend the cost curve.

Mr. Wall wanted to find out more information about the one percent projection before speaking to it.

Representative Josephson commented that the Legislative Finance Division (LFD) in preparing its long-term outlook for the governor's ten-year plan noted that the administration anticipated that agency operations would grow at 1.5 percent and Medicaid at one percent.

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Dr. Helvoigh continued to speak on slide 21. He commented that inflation referred to the price of a service, not the overall spending.

Dr. Helvoigh continued to slide 22. There had been a drive by the department to use data to better understand Medicaid spending in Alaska. The chart on the slide showed Medicaid recipients by age and diagnosis of one or more chronic conditions. As people aged, the likelihood of developing a chronic condition increased.

Dr. Helvoigh moved to slide 23 which included a chart that showed the average and total spending on Medicaid services by number of diagnosed chronic conditions. The orange bar represented total spending on Medicaid Services for recipients with chronic conditions. The blue line represented the average spending per recipient. As the number of chronic conditions increased, spending also increased.

Dr. Helvoigh advanced to slide 24 which included a chart that showed the projected spending on Medicaid services for FY 22 through FY 42. The orange bar represented spending on beneficiaries that were not diagnosed with a chronic condition and the blue bar represented spending on those who were diagnosed with one or more chronic conditions. About 80 percent of spending was dedicated to individuals who had one or more chronic conditions. By 2042, spending would increase to about 84 percent.

Representative Edgmon surmised that the numbers on the slide included the prison population's need for Medicaid.

Dr. Helvoigh answered that incarcerated individuals were included in the data.

Representative Edgmon remarked that Alaska's population continued to get older and not younger. He thought that was something to keep an eye on.

3:03:34 PM

RICH ALBERTONI, MANAGER, PUBLIC CONSULTING GROUP (via teleconference), continued to the second portion of the PowerPoint presentation titled "PCG Medicaid Strategic Advising Project: Summary of Findings and Recommendations Included in DHSS Budget" (copy on file). He began on slide 26 and explained that the Public Consulting Group (PCG) assisted DHSS in creating a global roadmap that redesigned the Medicaid and public assistance system at a lower cost.

Mr. Albertoni moved to slide 27 to show some of the methodology utilized by PCG to shape the Medicaid system redesign proposal. The left column included information on site visits and engagements directly with DHSS, the middle column showed engagement with stakeholders, and the right column showed additional resources used over the course of the project. All of the resources were vital in shaping the recommendations and findings paper that was released by PCG.

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Representative Edgmon asked if all of the stakeholder engagement regarding Medicaid contributed to the decision to split DHSS into two separate departments.

Mr. Wall indicated that the conversations were separate. The conversation with PCG started prior to the pandemic and had been ongoing for a number of years.

Representative Edgmon clarified that the conversation to divide the department happened independently from the conversation about Medicaid system strategies.

Mr. Wall responded that the conversations informed each other, but PCG was not consulted on the decision to split the department.

Representative Edgmon thought the conversations were one and the same and the overall goal was to provide better programmatic representation. He struggled with the fact that conversations were separate.

Mr. Wall reiterated that the conversations informed each other.

Representative Edgmon interjected that was not what he was concerned about. He thought the conversations needed to have happened together in real-time.

Mr. Wall reported that the conversations were held in parallel but that Mr. Albertoni with PCG was not hired to determine whether the department should be split.

ADAM CRUM, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, indicated that Mr. Albertoni specifically worked to determine which items that worked across the country to contain Medicaid costs would also work in Alaska. He explained that Mr. Albertoni's role was to present how strategies used across the country would function in Alaska. At the same time, the department had separate conversations with all of the stakeholders listed on slide 27 to ensure that they understood the DHSS split.

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Mr. Albertoni advanced to slide 28 to discuss the overall reform principles. He explained that paper was organized around the following principles:

- Payment Reform: Move toward value-based purchasing
- Delivery System Reform: Move toward coordinated care
- Cost Containment: Address inflationary pressures

- Program Integrity: Prevent fraud, waste and abuse
- State Financial Stewardship: Assure Alaska claims its fair share of Medicaid matching dollars

He relayed that the principles acted as a roadmap for the Medicaid system to move away from a fee-for-service system and containing costs through program integrity initiatives. He relayed that he would be speaking later in the presentation about why it was difficult to move away from a fee-for-service system in Alaska.

Mr. Albertoni continued to slide 29 and indicated there were three initiatives that the department included in the budget: Medicaid eligibility redeterminations, implementation of section 1945 health homes, and hospital payments including pay for performance. The first was a program integrity initiative, the second was a delivery system reform, and the third was a payment reform.

Mr. Albertoni continued to slide 30. He explained that all Medicaid recipients who had enrolled during the pandemic would remain eligible for the program unless they moved out of state, specifically asked to be removed from the program, or become deceased. There had been discussions about creating a one-time data use hub to gather information about enrollees to determine if there were any changes in circumstances that impacted eligibility. Other states had done similar redeterminations and had saved significant amount of money. Eligibility for Medicaid had remained frozen with the declaration of the Covid Public Health Emergency (PHE) and redeterminations had also remained frozen. When PHE ended in April of 2022, states would have options. States could incrementally evaluate Medicaid enrollees and everyone would be evaluated over a period of 12 months. There would be significant savings with redeterminations coming out of PHE.

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Mr. Albertoni turned to slide 31 to discuss the Alaska delivery system reform baseline. He relayed that Alaska was much more fee-for-service than most states. He explained that most states had implemented some version of commercial managed care. The state had unique characteristics such as the Tribal Health System that made traditional Medicaid managed care challenging on a statewide basis. It was difficult to establish networks within rural areas in the

state, but Alaska was making progress. The state had existing care coordination assets upon which to build, such as the Behavioral Health 1115 Waiver, the Providence Care Coordination Demonstration, and High Utilizers Mat-Su (HUMS). He relayed that PCG aimed to implement changes incrementally in its report.

Mr. Albertoni advanced to slide 32 which discussed health homes, which were authorized in Section 1945 of the ACA. Health homes were providers that became care coordinators and homes within the ACA were primarily targeted at people with chronic health conditions. States had significant latitude in determining health home implementation and eligibility and could utilize state plan amendments instead of waivers. The state could receive 90 percent in matching funds for eight quarters for care coordinating elements of health homes. He indicated there were footnotes in his paper that showed how the process would provide savings to the state.

Representative Josephson thought attaining state plan amendments was an extensive process.

Mr. Albertoni responded that it depended on the amount of detail required, but that it could take at least a few months. If there were disagreements on items like implementation, the process could take longer.

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Mr. Albertoni continued to payment reform on slide 33. He reported that states often focused on hospitals when beginning the process of payment reform. Hospitals represented a large percentage of total spend for the program and included a relatively small number of providers. Currently, the baseline for hospital reimbursement in Alaska was a per diem method, which incorporated hospital cost increases as they accrued. As a result, the state reacted to cost adjustments rather than managing the rates. The outpatient method that was currently in place was based on a percent of charges, which permitted hospitals to control their own prices by adjusting charges. Neither the percent of charges nor the per diem method was acuity-based, meaning reimbursement was not based on the intensity of resource utilization.

Mr. Albertoni moved to slide 34 to the new recommended method for hospital payment reform. He explained that the idea was to take a small portion of the overall hospital budget and put it into a pay per performance fund. He recommended that about $3 million be carved out for the fund, which could be easily achieved by putting a budget adjustment factor into the rate setting that effectively managed cost growth and incentivized hospital efficiency. Most states that implemented similar programs would then pair the budget adjustment factor with quality-based payments to incentivize both resource efficiency and positive patient outcomes. The savings in the proposal were based on reducing preventable readmissions in Alaska by 25 percent.

3:23:31 PM

Mr. Wall turned the presentation over to Ms. Gennifer Moreau-Johnson.

GENNIFER MOREAU-JOHNSON, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, began with slide 36 to discuss the 1115 behavioral health Medicaid waiver. She explained that DHSS was required to apply for a Section 1115 demonstration project waiver and continue cooperation with grant-funded community mental health clinics and drug and alcohol treatment centers.

Ms. Moreau-Johnson moved to slide 37 which included a graph showing the mental health continuum of care. She explained that the 1115 waiver targeted certain populations. The population on the slide represented youth and adolescents with mental health or substance use disorder or those at-risk of developing such disorders. The blue bar on the graph represented the services covered by the 1115 waiver. She emphasized that the inclusion of early intervention under applicable services had been a gamechanger for the state.

Ms. Moreau-Johnson advanced to slide 38 which showed a graph of the mental health continuum of care for individuals aged 18 and older. She noted that the gamechanger in the graph was the emphasis on "step-up, step-down" services, which were services that could either divert from or stabilize an individual when discharged from acute care.

Ms. Moreau-Johnson explained slide 39 which showed the substance abuse disorder continuum of care for individuals aged 12 and older. She relayed that the gamechanger in the category was aligning services with the American Society of Addiction Medicine's (ASAM) levels of care.

Ms. Moreau-Johnson turned to slide 40 which showed an example of a shift from state grant funds to Medicaid. The graph focused on the Institute of Mental Disease (IMD) for substance use disorder, which provided a service not previously billable to Medicaid. The graph showed the transition in costs from the service being funded by state grants to being funded by state Medicaid, to being funded by federal Medicaid. Overall, the 1115 waiver consisted of about 80 percent federal dollars.

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Ms. Moreau-Johnson advanced to slide 41 which included a graph depicting the difference between state and federal spending on Medicaid during FY 21. Behavioral health claims represented approximately ten percent of all Medicaid claims.

Ms. Moreau-Johnson moved to the final slide 42 which showed the number of unique agencies billing Medicaid for 1115 waiver services by state region. She emphasized that the 1115 waiver was authorized in two parts: behavioral health and substance use disorder. The second part was not authorized until May 1, 2021 [note: Ms. Moreau-Johnson made a correction to this date below]. She relayed that grant funded community providers would still remain part of the collaborative process. She concluded her portion of the presentation.

Representative Josephson asked for clarification that the substance abuse portion of the waiver was not authorized until less than a year ago.

Ms. Moreau-Johnson corrected herself and responded that it was the other way around. The substance use disorder component was implemented first in 2018, and the behavioral health component was implemented in 2021.

Representative Josephson reported that Mr. Tom Chard from Alaska Behavioral Health Association (ABHA) told him that the problem with the proposed transition was capacity. He

understood that there needed to be expansion in order to qualify. He asked if he understood Mr. Chard correctly.

Ms. Moreau-Johnson thought the question deserved a longer conversation. She explained that some services were held back through the state plan and other services were then implemented through the 1115 waiver. It was complicated and she did not want to understate that the transition was difficult. The division continued to do things like pre-provision certification opportunities for providers for certain services to ease the transition. She acknowledged again that the process was difficult and there were capacity issues, but the department was doing everything it could to make the transition as smooth as possible.

3:31:40 PM

Representative LeBon referred to slide 30 and noted that he had not been part of the legislature when Medicaid expansion was decided upon. He understood that the goal of expansion was to ease the transition for enrollees who were between jobs but were actively seeking employment or education. However, there had been an increase in the number of individuals unable to find employment due to the pandemic. He asked if it was expected that enrollees who were now able to work would detach from Medicaid and that the Medicaid population would decline. He wondered if the state would see Medicaid savings in the following year or two.

Mr. Wall thought that some of Representative LeBon's concerns were addressed during the cost containment and redetermination eligibility portion of the presentation. He expected that individuals who had found employment with benefits would come off the Medicaid rolls and the population numbers would decline. He added that many individuals had jobs that either paid too little or did not offer health benefits, and therefore they could not afford to disengage from Medicaid. He offered reassurance that the issue was being discussed.

Representative LeBon understood that the state would be entering into a period of redeterminations and that Medicaid populations were expected to decline within a year.

Mr. Wall responded, "Absolutely." He added that redeterminations were federally mandated.

Representative LeBon asked if Mr. Wall thought PHE would be lifted within the next six to nine months.

Mr. Wall responded that he was confident that PHE would end on the expected end date of April 15, 2022.

3:35:49 PM

Representative Josephson relayed that a cable news network reported a 44 percent decrease in COVID-19 cases, but over the past week over 2,300 people died every day.

Co-Chair Foster thanked Ms. Moreau-Johnson for her efficiency in getting through the final slides. He wished he had split up the presentations into multiple meetings. He thanked all of the presenters and reviewed the agenda for the following meeting.

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ADJOURNMENT

3:36:58 PM

The meeting was adjourned at 3:36 p.m.