HOUSE FINANCE COMMITTEE
February 14, 2023
1:35 p.m.

1:35:40 PM

CALL TO ORDER

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

MEMBERS PRESENT

Representative Bryce Edgmon, Co-Chair
Representative Neal Foster, Co-Chair
Representative DeLena Johnson, Co-Chair
Representative Julie Coulombe
Representative Mike Cronk
Representative Alyse Galvin
Representative Sara Hannan
Representative Andy Josephson
Representative Dan Ortiz
Representative Will Stapp
Representative Frank Tomaszewski

MEMBERS ABSENT

None

ALSO PRESENT

Heidi Hedberg, Commissioner-Designee, Department of Health; Josie Stern, Assistant Commissioner, Department of Health; Emily Ricci, Deputy Commissioner, Department of Health; Renee Gayhart, Director, Healthcare Services, Department of Health.

PRESENT VIA TELECONFERENCE

Deb Etheridge, Director, Division of Public Assistance, Department of Health; Dr. Anne Zink, Chief Medical Officer, Department of Health.

SUMMARY

HB 39 APPROP: OPERATING BUDGET/LOANS/FUND; SUPP

HB 39 was HEARD and HELD in committee for further consideration.

HB 41 APPROP: MENTAL HEALTH BUDGET

HB 41 was HEARD and HELD in committee for further consideration.

FY 24 BUDGET OVERVIEW: DEPARTMENT OF HEALTH

Co-Chair Johnson reviewed the meeting agenda.

#hb39
#hb41
HOUSE BILL NO. 39

"An Act making appropriations for the operating and loan program expenses of state government and for certain programs; capitalizing funds; amending appropriations; making reappropriations; making supplemental appropriations; making appropriations under art. IX, sec. 17(c), Constitution of the State of Alaska, from the constitutional budget reserve fund; and providing for an effective date."

HOUSE BILL NO. 41

"An Act making appropriations for the operating and capital expenses of the state's integrated comprehensive mental health program; and providing for an effective date."

1:36:44 PM

^FY 24 BUDGET OVERVIEW: DEPARTMENT OF HEALTH

1:37:26 PM

HEIDI HEDBERG, COMMISSIONER-DESIGNEE, DEPARTMENT OF HEALTH, introduced herself and her staff. She provided a PowerPoint presentation titled "State of Alaska Department of Health: House Finance Committee Budget Overview," dated February 14, 2023 (copy on file). She began on slide 2 and highlighted that the Department of Health and Social Services (DHSS) had split into the Department of Health

(DOH) and the Department of Family and Community Services (DFCS) on July 1, 2022. She read from prepared remarks:

> This visual on slide 2 is a helpful reminder of which divisions went to which department. Department of Health retained the prevention systems and payment. The Department of Family and Community Services has the direct care services also commonly referred to as the 24/7 facilities. The department reorganization was good. It provides a smaller span of control and allows the commissioners to focus on divisional work and system operations that support population health and person-centered services. The Department of Health and Department of Family and Community Services continue to coordinate on approving the continuum of care for person-centered care and working together on complex care coordination.
>
> Complex care coordination is defined by a person that utilizes more than one division or department program. These individuals have complex needs and require a lot of resources and supports that can be incredibly costly. Both departments are working on a complex care plan, which will help streamline healthcare services with the desired result of better client care and cost savings. In addition, the two departments also continue to share IT resources and are working on a road map to separate those IT resources. The May 2021 cyberattack highlighted the technology debt, overburdened, and overtaxed IT systems. The roadmap will support both departments identifying the necessary resources to support the HIPAA compliant services for Alaskans.

1:39:57 PM

Commissioner Hedberg moved to DOH's mission on slide 3. She read from prepared remarks:

> Slide 3 is the Department of Health's mission to promote and protect the health and well-being and self-sufficiency of Alaskans with a focus on systems of care to ensure Alaskans receive timely services.
>
> We serve every Alaskan from birth through elders. While not exclusive, but to give context for what the budget supports, a few examples include senior

benefits; Medicaid eligibility; background checks; licensing and oversight of healthcare and childcare facilities; Medicaid services such as physical health, dental care, and behavioral health services; vital records like birth, marriage, and death certificates; and personal care attendants for seniors and Alaskans that have disabilities.

The department has ten appropriations that operate as six divisions and Medicaid. The list of divisions is on the slide.

1:40:57 PM

Commissioner Hedberg moved to an organizational chart on slide 4 and read from prepared remarks:

Slide 4 is just a visual reference; it's a great tool to see which programs are within each division. We also have a handful of boards that are associated with the Department of Health.

JOSIE STERN, ASSISTANT COMMISSIONER, DEPARTMENT OF HEALTH, reviewed slide 5 titled "Department of Health Operating Budget Comparison FY2022-FY2024." She read from prepared remarks:

Looking at this chart you can see that the Department of Health's total FY 2024 requested budget is around $3.1 billion. This slide does not include Departmental Support Services, Human Services Community Matching Grants, and Community Initiative Matching Grants. These items are usually presented as a singular item and are not shown here because the majority of the changes that occurred with the bifurcation of the Department of Health and Social Services occurred within Departmental Support Services. If these items are included, the total requested budget is around $3.14 billion.

This graph presents three budget aspects: Fiscal Year 2022, which represents the total actual spending from July 1, 2021 to June 30, 2022; Fiscal Year 2023 management plan, which is a true-up of implementing the FY 2023 enacted budget; and the Fiscal Year 2023 governor, which is the governor's proposed budget that was released on December 15th. Both Fiscal Year 2023

and 2024 show the budgetary authority of the department.

Looking across these total numbers for the Department of Health, there have been increases in unrestricted general fund, also known as UGF, driven by inflation, increased utilization, as well as federal and state rate increases. As a result, the majority of the increases reside in Medicaid Services.

The department received more federal funding in Fiscal Year 2022 due to an increased enhanced Federal Medical Assistance Percentage, also known as e-FMAP, which accounts for the largest difference in federal authority from FY 2022 to FY 2024. There was also an adjustment in Fiscal Year 2022 to remove a reimbursable services agreement with the Department of Military and Veterans Affairs, Division of Homeland Security and Emergency Management from federal COVID to other COVID.

The department received funding from the Federal Emergency Management Agency, also known as FEMA, for COVID-19 activities by this department.

1:43:27 PM

EMILY RICCI, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH, reviewed slide 6 with prepared remarks:

Medicaid is a joint state/federal program that offers health insurance to low income families, children, and individuals, as well as those with disabilities. The purpose of the Medicaid program is to provide health coverage to Alaskans in need. Medicaid is an entitlement program, meaning those who meet the eligibility criteria are entitled to benefits. These benefits are outlined in state and federal regulation and statute as well as through a state plan. The state plan acts as the agreement between the State of Alaska and the federal government outlining which services will be provided to which individuals under what circumstances.

I would emphasize that because this is a joint program, making changes to the program is challenging, time consuming, and frequently requires state statute

and regulatory changes followed by submission of a state plan amendment to the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid program plays an important role in the lives of many Alaskans with over 262,000 individuals currently enrolled in the program. This represents over 35 percent of Alaskans making this the largest health coverage in the state.

As I stated earlier, this program is a joint program financed by both the federal government and the state. At a minimum, the state shares 50 percent of the cost of eligible services including administrative services with the federal government covering the other 50 percent. In practice, the total cost share between the state and the federal government is higher, averaging between 72 to 73 percent. This is because the federal match, called the FMAP, which was discussed in the last slide, may be higher for certain types of services. For example, the federal government will fund 90 percent of administrative costs for Medicaid systems development, 100 percent of eligible services through the Indian Health Service or our tribal health organizations, 90 percent of cost for Medicaid expansion, and 65 percent of associated with the Children's Health Insurance Program. So, between that blend, you tend to see higher overall federal matches than the 50/50.

You may notice there are no specific positions associated with the Medicaid component in the budget, the work and the positions to administer the program are embedded in the division's budget lines. Any additional funding the divisions are able to leverage or any cost savings they achieve are reflected in the Medicaid budget rather than their division budgets. This is a large program, as you can see, the total spend in state Fiscal Year 2022 was $2.5 billion, the state's share for that was about $610 million with the federal share at $1.8 billion. To put that in context, what this means on an operational basis is that in state Fiscal Year 2022, 6.3 million claims were processed within the Medicaid program and that creates a weekly check write of between $45 million to $50 million. Every week the teams in the Division of Health Care Services and other divisions supporting

the Medicaid program are paying out $45 to $50 million and processing annually 6.3 million claims.

1:46:47 PM

Ms. Ricci turned to slide 7 and spoke about Medicaid cost drivers and cost containment with prepared remarks:

This slide briefly highlights a combination of cost drivers and cost savings or cost containment measures. I'm going to start with the cost drivers and then walk through some of the cost savings or cost containment.

The primary cost driver or cost savings reflects changes in federal regulations that impact the federal match we discussed in the prior slide. Aside from enrollment, the item that has the largest cost impact are changes to the percentage in the federal match. Increases in the federal match like the enhanced 6.2 federal match we have received for the past three years, can result in substantial offset of general fund dollars required to fund the program. Alternatively, reductions in the federal match, which we're going to experience with the reduction of the 6.2 enhanced federal match beginning this spring, can result in increased costs to the state. Other cost drivers include inflationary adjustments in the amount that providers are paid.

The average Medicaid inflationary rate component in Fiscal Year 21 and 22 was 1.8 percent. This inflationary rate is significantly lower than what we've heard providers actually experience and we all see this in our own experiences at the grocery store or purchasing other items. Rates are also routinely adjusted. They are reviewed and reset on a schedule outlined generally in regulation. The timing for these adjustments varies depending on the service. More frequently, rates are redetermined or rebased for the first year of a four-year cycle and then inflated annually for the following three years. The process then repeats.

Another important cost driver is enrollment in the program. In 2020, in response to the pandemic, states across the nation suspended eligibility reviews or what we call redetermination, as part of the federal

government's response to the COVID-19 pandemic. We're going to talk about this in more detail in the future slides, specifically slide 9, but the result was an increase in the overall Medicaid enrollment by around 30,000 Alaskans between 2020 and today. The good news is that there's been some very strong and successful efforts to contain costs within the Medicaid program. The most impactful of these is tribal reclaiming. This is a process where the state is able to receive 100 percent of federal funds for eligible services provided to a tribal member covered by the Medicaid program in certain circumstances.

In FY 22, the state saved $74 million through the tribal reclaiming program. Since this process started in 2017, states have saved nearly $380 million. Other important saving mechanisms include recovering eligible drug rebates, which created $123 million in savings in FY 22 as well as ensuring Medicaid is a payer of last resort, meaning that if there are other health insurance plans or other coverages that should be paying first, those coverages are paying first. This is also called subrogation. This ensures other eligible insurers like Medicaid are picking up the bill. In Fiscal Year 2022, these activities resulted in around $470 million in cost avoidance; however, a portion of that would be experienced by the federal government, not just the state. Other important cost saving measures include program integrity, which focuses on eliminating fraud and abuse as well as case management programs.

Co-Chair Edgmon asked if there was any way to do the presentation without reading verbatim. He wanted to have a back and forth conversation. He appreciated the attention to the detail, but he requested a dialogue.

Co-Chair Johnson was also having a hard time following along. She asked to hear a summary of slide 7.

Ms. Ricci explained there were major cost drivers and cost saving measures the state engaged in regularly. One major cost driver was federal match (whether it increased or decreased it could be a cost driver or cost savings). Another cost driver was enrollment of the number of individuals in the Medicaid program, which could change. There was most recently a change with the response to the

COVID-19 pandemic in 2020, which required that enrollees remain continuously eligible and resulted in about 30,000 additional enrollees. A third cost driver was an increase in rates, particularly in relation to inflationary factors as well as the routine review of rate rebasing undertaken by the department. On the cost saving side, tribal reclaiming had fundamentally changed how the state engaged with the tribal system and how the Medicaid program benefitted from the system.

1:53:03 PM

Representative Hannan shared that she served on the Department of Corrections (DOC) subcommittee and one of DOC's large costs was health and rehabilitative services. She elaborated that when people went into custody, except for 24-hour stays in the hospital, Medicaid was discontinued for those who had previously been covered. She explained it was an element of Medicaid in the state's expansion waiver. She expounded that Representative Justin Ruffridge, who also served on the DOC subcommittee and was a pharmacist by trade, had stated the situation was not supposed to happen under Obamacare expansion. She noted they had been told off the record that it depended on how a state implemented Medicaid expansion. She was curious when Medicaid expansion had been implemented if the state had talked about including coverage for its the corrections population. She stated that without Medicaid or other insurance the funds came straight out of UGF budgeting for DOC. She noted the department had some cost containment measures going but the corrections population was pretty unhealthy.

Ms. Ricci answered that the department would follow up on the question. She explained that the state's [Medicaid] coverage terms were nuanced, particularly regarding more than 24 hours out of a facility, they followed the national standard. She remarked that California had received a waiver in the past several weeks to provide expanded coverage to incarcerated individuals. She noted it was the first of its kind that had been approved nationally.

Representative Stapp asked about tribal reclaiming. He stated his understanding that in FY 22 there had been 159,000 applications for tribal reclaiming and the department had only been able to reclaim 20 percent of the

total. He asked what the state could do to increase tribal reclaiming in the future.

Ms. Ricci deferred to a colleague.

RENEE GAYHART, DIRECTOR, HEALTHCARE SERVICES, DEPARTMENT OF HEALTH, answered that tribal reclaiming started in 2016 after the state health official letter allowed states to reclaim the remaining balance on American Indian and Alaska Native beneficiaries. She explained that in order to enter reclaiming there had to be a care coordination agreement between a tribe and the non-tribal entity when services were referred out to a non-tribal setting. She highlighted an example where a patient went from the ANMC [Alaska Native Medical Center] to Seattle Children's Hospital. There would have to be an agreement between the two entities to enter any kind of reclaiming.

Ms. Gayhart elaborated that the referral validation had to be validated by the tribal health organization for the State of Alaska. She detailed that many referrals were lost because of the way data exchanged or did not exchange. Additionally, the exchange of data had to go back and forth between the two entities. For example, if a patient went from ANMC to Seattle Children's Hospital for a transplant and then came back to Alaska, the records would have to go back and forth. She stated that when all was said and done, it was necessary to have all three of the elements in place. She reasoned it may seem as at though 159,000 claim lines was substantial while only 20 percent was reclaimed; however, it was often because the exchange of information systems were not speaking to each other (i.e., the health records and exchange of the records). She noted the process was manual and administratively burdensome. The department had been working with CMS to see if it could come up with a more streamlined approach. She highlighted the State of Alaska was the most aggressive tribal reclaiming state in the union. She relayed that many other states were following Alaska's lead. The state was pressuring CMS to change the way it looked at the state health official letter.

2:00:10 PM

Representative Tomaszewski asked if the department was using the same dilapidated programming to get Medicaid redeterminations. He asked if the process had started and

whether the department was prepared. He wondered whether the department would be able to process the redeterminations quickly.

Ms. Ricci answered that slide 9 would cover the topic in more detail. She relayed that the systems the department had available to maintain Medicaid eligibility were the same systems the department had. The systems would be used through the redetermination process. She elaborated there was a lot of ongoing work that would continue in the next several months. She stated it was a large challenge for all states. There were certain timeframes and guidelines the state had adhere to in order to communicate with CMS regarding its ability and plan to operationalize the redetermination process. She would elaborate more on slide 9.

Representative Josephson understood that tribal reclaiming had started up under the prior administration. He stated his understanding that additional staff for the effort had been funded. He assumed there were not infinite possibilities to fully reclaim and see savings. He asked if his statements were accurate.

Ms. Gayhart answered that it was not necessarily the case. She clarified that during the pandemic there had been a reduction in services delivery and transportation overall. She explained that the reductions resulted because the services did not happen and there had been nothing to reclaim. There would be an increase in the out-years after the pandemic because the services started to increase again. She elaborated that the state was reclaiming on the backend, but if the tribes started providing more services on the frontend, 100 percent would occur on the frontend, making the work on the backend unnecessary. She explained that the staff that were hired were working on two fronts: they were working with the tribes to expand service on the frontend in order for tribes to take on more services for their beneficiaries and they were increasing the reclaiming on the backend. The current reductions were a result of the pandemic and because the department was working with CMS to try to redefine the terms of the state health official letter.

2:03:46 PM

Representative Josephson asked about inflationary and rate adjustments. He thought they were things that required legislative action; however, he believed Ms. Ricci described it as an administrative adjustment. He asked for clarification.

Ms. Ricci answered it was a bit of both. There were regulations that articulated what increments the department undertook, reviewed, or rebased. There were also certain rates based on national standards called RBRVS [Resource-Based Relative Value Scale] that were updated annually on a national level. She stated that ultimately all of the updates had to be reflected and approved in the budget through the legislative process. She relayed there had been periods of time where rates for certain provider groups had not been updated or rebased in a way that reflected the regulatory schedule. She cited home and community based waiver services as an example. The items received increased funding in FY 23, but the specific rates had not been rebased prior to that since 2011. There were certain services that may not be updated regularly.

2:05:58 PM

Ms. Ricci turned to slide 8 and discussed two Medicaid increments in the budget. The first was $2.6 million to extend the postpartum Medicaid coverage from 60 days to 12 months. She detailed that the coverage had been demonstrated to result in savings. The second increment was $18.1 million UGF associated with cost increases discussed previously. The increment included about $7 million in Medicare Part B changes, which impacted how much the state had to pay on behalf of members who were Medicare age eligible and participated in the program. There was about $3.2 million associated with an increased encounter rate, a rate paid by the department to tribal partners and federally qualified health centers (FQHC). There was a $2.3 million increase associated with RBRVS, the method used to determine payments for professional services. Additionally, there were some increases associated with the home and community based waiver services and some audit findings.

Representative Tomaszewski remarked on increased utilization rates. He thought that redeterminations should result in a decrease in utilization rates in the coming fiscal year.

Ms. Ricci replied that there were currently many unknowns. She explained there was uncertainty at the state and federal level about the number of people who would be ineligible as a result of the redetermination process. She noted that another item to consider was whether individuals who were no longer eligible for coverage under the Medicaid program were individuals who had been or had not been utilizing services. She estimated that about 75 percent of enrollees in the Medicaid program utilized services. She believed the answer to the question depended on how many individuals were disenrolled and whether those individuals were utilizing services.

Representative Tomaszewski asked if a person had to reapply annually for the Medicaid program. Alternatively, he wondered whether an enrollee was carried on year after year until a redetermination occurred.

Ms. Ricci answered that redeterminations typically happened annually. There were some instances and categories where the timeframe was shorter or longer. Beginning in 2020, in response to the pandemic, the review was suspended. During that timeframe there had been only three reasons an individual could be disenrolled: the individual was deceased, moved to another state, or requested to be disenrolled.

2:10:06 PM

Ms. Ricci turned to slide 9 titled "Unwinding of Continuous Enrollment of Medicaid." She noted the unwinding of the continuous enrollment of Medicaid was more frequently referred to as the redetermination process. Beginning in March of 2020, states were required to maintain eligibility status for Medicaid beneficiaries with the exception of the three reasons she had just reviewed (in response to the pandemic). However, beginning on April 1, Alaska and all other states would begin the process of redetermining Medicaid eligibility for those individuals. She explained the continuous enrollment requirement was included as part of the federal legislation passed in response to the pandemic, but it was initially tied to the ending of the federal public health emergency. She elaborated there had been substantial speculation over the past six to 12 months about when the public health emergency would end, how much notice states would be given before the end, and how much time they would have to prepare for the redetermination

process. There was no clear guidance, but there was a lot of speculation.

Ms. Ricci relayed that at the end of December, Congress passed the Consolidated Appropriations Act, 2022, which effectively separated the continuous eligibility requirements from the public health emergency and it gave states some definitive timeframes for when they could expect to begin the redetermination process, what some of the rules would be, in addition to how the phase down of the temporary federal funding match would occur. She shared that states had been working hard to think about what it meant and to plan for it. She pointed to an inset window on the right of slide 9 showing the phase down of the temporary eFMAP over the next four quarters. The first stepdown would occur in April, moving from 6.2 percent to 5 percent. The second stepdown would begin July 1, moving from 5 percent to 2.5 percent. The third stepdown would occur on October 1, moving from 2.5 percent to 1.5 percent. Beginning in January of 2024, the eFMAP was eliminated.

Ms. Ricci continued to discuss slide 9. She relayed that part of the guidance released in January was that states would have 12 months to complete eligibility redeterminations for all active Medicaid cases (beginning on April 1). States would have 14 months to finalize disenrollments. She explained the state had a period of 60 days to work through the process following the date an individual was potentially determined to be disenrolled. The first disenrollments specifically associated with the redetermination effort would start at the end of May. The federal government was aware the changes would be a big lift for many states.

Ms. Ricci relayed that the department had engaged in at least two technical calls to talk through the aging and very challenged enrollment systems: ARIES [Alaska's Resource for Integrated Eligibility Services] and EIS [Eligibility Information System]. She elaborated that EIS was the legacy system and was very challenging to use. She specified that most of the state's Medicaid beneficiaries were enrolled in ARIES, which was good news. She elaborated that programming was already underway to have autorenewals occur. She believed the testing should be finalized by the end of February. To the degree the department would be able to utilize information resources from other databases within the Department of Labor and Workforce Development

(DLWD) and Permanent Fund Dividend Division (PFDD) to complete information for applicants, the systems were in place to automatically review those individuals and put them through the system. The department did not yet know what percentage of the total renewals would occur automatically and what percentage would need to be done manually. She stated it was one of the big questions the department was currently working to address.

2:15:17 PM

Co-Chair Edgmon remarked on the department's estimate that there were around 263,000 Alaskan's enrolled in Medicaid. He observed that the state did not know what the total number would be after the reenrollment process. He found it interesting that with a state of ~740,000 people, one in three were on Medicaid. He asked if it was an inordinate amount compared to other states. He noted that Alaska's population continued to taper off; however, he believed its Medicaid population was increasing. He asked if Alaska was aging as a state and having more people eligible for Medicaid than before.

Ms. Ricci would follow up with exact estimates. In general, around 30 percent was not unusual for other states. She did not believe Alaska was unusual in the proportion of Alaska residents who were eligible and participated in the Medicaid program. She addressed why the number was increasing. She detailed that a large portion of Medicaid enrollment was based on income and eligibility and the state had some changing economic factors over the past eight to ten years. She did not know that an aging population had as much impact on the Medicaid program. She detailed that it did impact portions of the program such as the home and community based waiver system services. The aging population had less of an impact on general adult enrollment, which was more of an issue of rate reimbursement as more individuals were eligible for Medicare. As that occurred, Medicare would become a larger portion of a provider's business, which would have economic impacts.

Co-Chair Edgmon stated that the previous year the legislature had passed a PFD that was three times larger than the prior year. He knew there was a backfill component to the budget. He asked what the backfill figure may be.

Ms. Ricci believed Co-Chair Edgmon was referring to the maintenance of effort. She deferred to Ms. Stern for detail.

Co-Chair Edgmon added that the topic related to income eligibility.

Ms. Stern asked for verification that Co-Chair Edgmon was referring to the PFD hold harmless provision. She reported the PFD hold harmless had been steady over the past several years at about $17.5 million. Historically, the amount spent was about $15 million. She reported the expenditure was about $11 million in FY 22, which was lower than in previous years.

2:19:56 PM

Co-Chair Edgmon wondered why the number would not rise commensurately with the size of the aggregate PFD.

Ms. Stern clarified that the PFD hold harmless was an account for when the PFD was distributed. She explained that sometimes the PFD pushed recipients above the income limit and then they were ineligible for services. She explained it depended on how many individuals were pushed out of services. The fund covered the individuals. Additionally, because people were not allowed to be disenrolled [during the pandemic], the actuals were lower in FY 22 than in previous years.

Representative Stapp asked if administrative or ex parte redeterminations would be used.

Ms. Ricci replied that ex parte redeterminations would be used to the extent possible. She characterized the ex parte redeterminations as automatic renewals where information was used from other sources; however, the method would not be available for all redeterminations.

Representative Stapp believed the income data for ex parte administrative redeterminations generally came from SNAP applications. He referenced the current state of the SNAP program and asked if the state had the ability to use the income verification used for the SNAP program for Medicaid redeterminations.

Ms. Ricci replied it was one means that could be used to inform the ex parte renewals, but there were other means including DLWD and PFDD. She deferred to a colleague for additional detail.

DEB ETHERIDGE, DIRECTOR, DIVISION OF PUBLIC ASSISTANCE, DEPARTMENT OF HEALTH (via teleconference), confirmed that while SNAP approval expedited Medicaid approval, the department also had the ability through the redetermination process to verify income using DLWD data.

2:23:13 PM

Representative Stapp asked how DLWD would have income data for individuals in the state.

Ms. Etheridge answered there was a shared database that included income data on individuals that DOH accessed through DLWD. She would follow up with the details.

Representative Josephson looked at the 12 to 14-month period as a blessing because it was a chunk of time. He understood there were two things going on including the redetermination and that the federal government would provide less FMAP as COVID-19 was winding down. He referenced the SNAP experience and shared he had met with individuals from the Food Bank earlier in the day who had communicated their shelves were empty. He stated it was hard for laypeople to know the problem avoidance to be looking for. He provided a couple of examples. He wondered if it pertained to someone who needed surgery in a year and could not get it at the federal and state government expense or someone who got the surgery, but the doctor went unpaid because the patient was Medicaid ineligible. He wanted DOH to tell him everything it could possibly need in order to avoid the problem. He asked what would happen if no redetermination was done.

Ms. Ricci answered that if the state took no efforts to redetermination eligibility, the state would not receive the eFMAP in quarters two, three, and four in calendar year 2023. There were still certain requirements the state had to undertake in order to receive the stepdown eFMAP. There were also reporting requirements beginning on Aril 8 in order for CMS to monitor how many and what proportion of the population the department was working through applications and how many were being disenrolled. She

explained that if redetermination did not occur or if the division was late in making eligibility redeterminations, an individual may not be eligible for health coverage that they would otherwise be entitled to. She elaborated that hospitals and providers may contact the division to determine why they were not being reimbursed for services. She highlighted that eligibility errors occurred at different points in the system on a regular basis. One of the first indicators in the department's system that an error had occurred was when people tried to fill medications. She explained it was one of the impacts when someone was not properly enrolled in the Medicaid program, but they were eligible for coverage.

Ms. Ricci communicated that the department needed and was exploring partnerships. The department was exploring whether it could benefit from work conducted by other entities or organizations providing care to Medicaid enrollees or collecting the information for other uses. She thought about partnership in a couple of different ways. The first was communication: what needed to be communicated to which groups at what point. She explained the process would be slightly longer than 12 to 14 months. Currently, the department was advising recipients to update their contact information to ensure any letters went to the right address. The Division of Public Assistance had set up a line through its call center for people to call with their updated contact information. The department was also developing a draft communications plan to share with stakeholders in order to receive input on any errors or missing components. The department was also working to determine whether there were ways it could leverage what other entities or groups were already doing to collect the information.

2:29:40 PM

Commissioner Hedberg categorized the department's needs in three separate buckets. The first was updating information. The department needed every individual on Medicaid to call the virtual call line and update their information. Two, when individuals were called up to be redetermined for eligibility, the department needed to collect information. The department was actively engaged in conversation with partner organizations in the healthcare industry to determine what the organizations could do to help it collect the verification information. Third, a DOH employee

had to make the final decision on whether an individual was eligible or ineligible. She expounded that if someone was determined to be ineligible, the department wanted to pivot them to a federally facilitated marketplace to find another appropriate health insurance plan. The department did not want any Alaskan to go without health insurance. The department was looking to leverage its partnerships with the healthcare industry to ensure it was being innovative and maximizing every relationship to prevent anyone from being lost through the system.

Representative Hannan asked if the typical Medicaid redetermination process occurred annually.

Ms. Ricci replied that for most individuals the redetermination process occurred at 12 months. She noted there may be certain categories of individuals where the timeframe was longer.

Representative Hannan asked for circumstances where longer eligibility was granted. She shared that her sister had passed away in January with advancing cognitive decline due to multiple sclerosis. She detailed that her sister had been eligible for Medicaid since the onset of her disability 14 years ago. She explained that that the redeterminations had become more and more difficult because her sister was an independent adult who insisted on doing the eligibility application herself. She detailed that part of her sister's diagnosis was a cognitive decline; therefore, completing the application became more and more cumbersome. She explained there was clear medical evidence her sister's disability would persist and that she would never hold a job or be eligible for other insurance. She could not imagine her sister's circumstance was unique. She considered all of the recipients on Medicaid with complex diagnoses who had to spend a lot of time annually completing the eligibility process and may experience a loss of coverage for a month or two. She asked how to move the individuals into a circumstance where they did not have to take up their time and the department's time to ensure their health insurance was intact.

Ms. Ricci would follow up on the question. She would speak with the director of Senior and Disabilities Services as well.

2:34:11 PM

Ms. Stern moved to slide 10 titled "Medicaid Services Operating Budget Comparison FY2022-FY2024." She highlighted that Medicaid was one of the top budget drivers in the state. She elaborated that to draw approximately $1.8 billion in federal funding, the state leveraged around $670.6 million. She relayed there had been increases in UGF from fiscal year 2022 to 2024 due to the cost drivers discussed earlier in the meeting. The department was also able to collect additional federal funds in FY 22 due to the eFMAP and open-ended federal authority.

Commissioner Hedberg discussed the Division of Public Assistance on slide 11. The division had 18 programs and 459 full-time positions. On average it took about two years to train an employee on all of the 18 programs. She highlighted SNAP as one of the more complicated programs.

2:35:43 PM

Commissioner Hedberg turned to slide 12 and discussed the Division of Public Assistance backlog. She explained the backlog was in reference to SNAP. She reviewed the reason for the backlog. In August of 2022, the department received an influx of 8,000 applications, which was the kickstart to the backlog. She detailed that the federal Food Nutrition Services (FNS) agency had a policy stating it was necessary to reverify a recipient's SNAP eligibility every six months. The policy decision - whether the six-month eligibility verification process was suspended during COVID-19 or not - was held in federal court. She explained that Alaska had been informed in August of 2022 it needed to start the verification process. Additionally, the department used a legacy EIS IT system for SNAP and a portion of the Medicaid program. She expounded that the EIS was built on technology based off of 1959. She relayed that all of the department's IT systems had been impacted by the May 2022 [2021] cyber-attack on DOH. The department had not initially known the depth and breadth of the cyberattack. She explained that all of the department's 181 IT systems were pulled down. The department's IT staff had been redirected to forensics analysis to ensure it could secure and continue to protect the health information of Alaskans. The event was significant and DOH was still working through some systems that had not yet been brought back online.

Commissioner Hedberg continued to review reasons for the SNAP backlog (on slide 12). She referenced the pandemic Electronic Benefit Transfer (EBT) for children who qualified for free lunch. When schools shut down due to COVID-19, funds were transferred to a debit card for families to purchase food. She detailed that the process had been manual. She explained that the manual processes, legacy IT system, cyberattack, and the restart of the SNAP eligibility verification process all culminated in August of 2022. She shared that she had started her position in mid-November and had talked with many Alaskans who were impacted by the backlog. She had visited the Division of Public Assistance offices, talked with staff, met with direct providers and Food Banks to hear what immediate solutions could be implemented.

Commissioner Hedberg discussed immediate actions the department was currently taking [to mitigate the SNAP backlog]. The department was focusing on recruitment and onboarding of its vacant positions. She highlighted that due to media coverage, there had been a significant increase in the number of applications for eligibility technicians. The department had a training team with the capacity to train 14 eligibility technicians at a time. She specified the department's goal was to fill its vacant positions and the team was doing well working towards that goal. Additionally, DOH had requested and received about 45 long-term nonpermanent positions. The positions had been recruited, filled, and were currently in the training process.

Commissioner Hedberg relayed there had been two vacant IT positions that had been filled by individuals with experience coding with the antiquated IT languages on the mainframe. She noted the department was awaiting approval to hire for the two positions that would focus on EIS reprogramming. The department expanded the contract for two contractors to provide IT staff with reprogramming support.

2:42:08 PM

Commissioner Hedberg continued to review slide 12. She highlighted the department's virtual call center with the intended purpose of health equity. She explained there were only 11 offices; therefore, the call center had been created to help individuals with their application process over the phone. She elaborated that the backlog had

resulted in a spike in calls that had peaked at about 2,000 calls per day in October 2022. She detailed that a couple of weeks ago, DOH had engaged in a temporary contract with one of its vendors for staffing support to help answer calls, answer basic questions, collect information, and pass the information on to the department's eligibility technicians. There were around 30 eligibility technicians on the call center and the contracted vendors had enabled the department to pivot trained staff over to processing applications.

Commissioner Hedberg continued to review backlog mitigation efforts on slide 12. She highlighted the department's efforts in crisis communication to ensure DOH was proactive in getting the word out about what caused the issues, what it was doing, and in managing expectations. She shared that unfortunately due to the frustrations, there had been some threats made by some Alaskans. She detailed that the department took every threat very seriously and wanted to ensure its staff felt safe when coming to work. In response, DOH planned an analysis of each of its Division of Public Assistance offices to ensure they were shored up for safety. Additionally, the larger offices in Anchorage, Juneau, Mat-Su, and Fairbanks would have security guards to deescalate situations and respond to emergencies. She stated that much of the feedback came from DOH staff and the public assistance leadership team in addition to input from direct providers and Alaskans. She shared that in 2022, the legislature had provided 20 long-term nonpermanent positions and the department was requesting 10 full-time positions to invest in an IT infrastructure.

2:44:48 PM

Co-Chair Edgmon recalled there had been an executive order in 2021 to split the department in addition to Executive Order 121 that had been successful in 2022. He recalled discussion about the IT systems and the tremendous amount of processing work. He asked why the old mainframe issue had not been included in a strategic outlook in the past to avoid the current situation.

Commissioner Hedberg answered that 10 years earlier the EIS had been slated to migrate to ARIES. She noted that ARIES currently housed Medicaid and several other programs. She explained that the system had only partially migrated over 10 years back. The programs remaining in EIS were SNAP and

a portion of Medicaid. For the past nine years funding put into the capital budget was slowly matched with federal funds to slowly address the reprogramming and changes to get to a point where it was possible to move the two programs off of EIS. The department had been working towards the goal, but it had not had the funding to finish the transition.

Co-Chair Edgmon wondered why the state had not planned for the issue. He highlighted there were a lot of needy families who were suffering the consequence of not having the system modernized and in place. He was not blaming anyone, but he wondered why it had not been planned for. He found the situation hard to comprehend. He remarked that the attempts to separate the Department of Health and Social Services into two departments had been considered before the Dunleavy administration.

2:48:32 PM

Representative Stapp looked at slide 12 and noted that one of the causes for the backlog was listed as open enrollment for federally facilitated marketplace. He stated his understanding that CMS handed off applications to the state when individuals were determined to be Medicaid eligible on its website. He asked about the state's potential liability for not enrolling a person in Medicaid in a timely manner.

Ms. Ricci answered that CMS could ultimately come in and specify that Alaska was not meeting the requirements for completing application and enrollment in a timely manner. She stated CMS could put the state on a performance improvement plan. The consequence was the impact on the providers and the patient trying to receive services. She explained that if an application was submitted in January and it was worked in the beginning of February, it was possible to look back 90 days after that January application was received for services covered. There was the ability to receive coverage for some of the services even if the application was delayed. She remarked that retrospective claims reviews were always administratively complicated and not ideal, but it could be done.

2:50:52 PM

Representative Hannan remarked that Commissioner Hedberg had specified the cyberattack was in May 2022, but slide 12

showed the cyberattack occurring in May 2021. She asked which date was correct.

Commissioner Hedberg replied that the cyber-attack was in 2021.

Representative Hannan remarked that slide 12 showed an explanation of how the problem would be fixed systemically. She had not heard from the administration on how the state was getting food to hungry families. She underscored that many families had been without food support for four to five months. She remarked the state had known coming out of COVID that food banks were already stressed. She was hearing from small community grocery stores that were not certain they could remain open because SNAP beneficiaries had been unable to shop. She noted there were government emergency food stores with the National Guard or the Department of Military and Veterans Affairs (DMVA). She asked if there had been any effort to try to get food to hungry families. She understood it was not something DOH would do, but she wondered if there had been conversations to try to resolve the immediate hunger families were experiencing.

Commissioner Hedberg clarified that mitigation efforts listed on slide 12 were immediate and temporary. There were additional long-term strategies including transitioning from EIS to ARIES. She acknowledged the frustration by Alaskans who were experiencing delayed benefits. She understood there was an impact and she had heard heart wrenching stories. She wanted to ensure the department could do everything possible to make sure families had access to resources. The department had heard from the Food Bank that it was running through food very quickly. The department wanted to be at the table and figure out how it could work with other state agencies and organizations to solve the very complex problem of access to nutritious foods. There was a recognition of and dialogue about how the state could work through the situation. She stated it was an active conversation.

2:54:14 PM

Representative Hannan asked if there had been any administrative executive branch agencies standing up food delivery programs to feed people immediately since the start of the crisis in October. She highlighted emergency

services through DMVA and the National Guard. She recognized it was not the best food, but it was food. She asked if the state was doing anything to ensure the outmigration of Alaskans did not continue because residents could not survive the winter.

Commissioner Hedberg replied she heard Representative Hannan's comments and would take the feedback back to the group in order to look at every resource. She stated that they wanted to get nutritious food out to Alaskans.

Representative Josephson stated the Food Bank had told him two things that could be done immediately. First, 44 states had broad-based category eligibility, which essentially let someone earn more money and step down with food stamps. Second, the state could move to a 12 or 24-month recertification. He thought Commissioner Hedberg had stated the federal government had indicated the opposite. He believed the department had stated the federal government wanted the state to use a six-month determination. He found it to be confusing. He asked why the state did not do broad-based categorical eligibility and why it did not expand certification times.

Commissioner Hedberg answered there had been eight different recommendations from the Food Bank and other direct providers. She explained that the prior federal administration had communicated intent to get rid of the broad-based categorical eligibility; therefore, at that time, DHSS had paused on evaluating the rule. She relayed that the Division of Public Assistance was currently reviewing "what that is and what it would look like." She relayed that currently Alaska had a six-month certificate. She elaborated that the state needed to reverify with the federal Food Nutrition Services agency every six months. The department wanted to move to a 12-month recertification, and it had to reprogram the EIS system in order to make the change. She explained that the reprogramming of the EIS system started in January 2023. The tentative reprogramming timeline was January through March, at which time the system would be tested to ensure there were no errors and staff would be trained. The goal was to roll the updated system out in the spring.

Representative Josephson asked for verification that the department could move to the 12-month determination process

without action being taken by the legislature. He believed the change was within the governor's authority.

Commissioner Hedberg agreed.

2:58:45 PM

Representative Galvin echoed questions asked by Representative Hannan about what was currently being done and whether the state had thought about an emergency order [related to the SNAP program]. She believed the answers had been covered. She asked about hiring. She referenced a statement by the department that two IT positions were on hold awaiting permission. She asked if the positions needed legislative funding or if there was another reason.

Commissioner Hedberg replied that as part of the recruitment process the Department of Administration reviewed the application and concurred with DOH's findings that an individual met the criteria. The department was currently waiting for approval to hire. She noted the approval was expected via email any day.

Representative Galvin thought the two hires sounded paramount for the work ahead. She asked how it was going with the vacancy rate of other positions that would help rectify the situation.

Commissioner Hedberg answered that about one week earlier DOH had four recruitments for the Division of Public Assistance in different job classes. The department was seeing a high application rate in the specific division, which was not always the case in other divisions. The department had a team reviewing the applications. If applicants met the criteria they went through an interview followed by an onboarding process once approval to hire was obtained. The department had a training team that took cohorts of 14 new employees and trained them in the SNAP application process or other public assistance programs.

Representative Galvin appreciated the energy and willingness of individuals to sign on. She highlighted the importance to Alaskan families with the most need. She asked how many staff the department intended to hire. She asked for the current vacancy.

Commissioner Hedberg would follow up. She answered the number was decreasing.

3:01:50 PM

Co-Chair Johnson noted the time and asked to save questions until the end of the presentation.

Ms. Stern reviewed the Division of Public Assistance operating budget on slide 13. The slide included the Senior Benefits Payment Program, which was usually a separate budgetary line item. The program was included because it was operated and managed by the division. The Senior Benefits Payment Program totaled about $20.8 million UGF.

3:02:51 PM

Commissioner Hedberg noted that Dr. Anne Zink would speak to the remaining three slides.

DR. ANNE ZINK, CHIEF MEDICAL OFFICER, DEPARTMENT OF HEALTH (via teleconference), reviewed slide 14 pertaining to the Division of Public Health. She shared that the division served as the center point for thinking about how to improve the health and wellbeing of Alaskans. She stated there had been a robust conversation about the expense of Medicaid and how to start minimizing the costs. She remarked that healthy people were cheaper people. The division housed over 430 employees and brought in $50 million in grant funding into the state. The department worked extensively to respond to disasters, prevent injuries, and ensure quality and accessibility of healthcare, promoting healthy behaviors, and working across the state.

Dr. Zink followed up on an earlier question by Representative Hannan. She relayed that the program was currently working with the Balto Box program [a program implemented the Alaska Women, Infants, and Children (WIC) program] that sent out food to impacted communities including those struggling to get food. The program had been sending the food to one community currently.

Dr. Zink discussed the Healthy Families Initiative on slide 15. She explained the initiative had been introduced by the governor to make Alaska the best state in the country to raise a family. The idea was that strong families were the

foundation of a healthy society and vibrant economy. The initiative was comprised of three primary pillars: healthy beginnings, healthcare access, and healthy communities. She explained it was a four-year statewide initiative that included investments and ongoing programming. She highlighted the Fresh Start campaign that used federal dollars to connect Alaskans with free services to help them manage their chronic health conditions. She referenced the cost of healthcare and one of the major drivers of Medicaid was related to chronic conditions. The program helped Medicaid beneficiaries and any Alaskans to help manage chronic conditions and have a healthier lifestyle. There was a proposed $9.9 million UGF in the FY 24 operating budget for the Healthy Families Initiative. The funding would go to postpartum Medicaid extension and $2.76 million for TB and $4 million for congenital syphilis mitigation. The state was seeing a rapid rise in the diseases that could cause long-term devastating health consequences, which would increase costs to the state as a whole.

3:05:34 PM

Dr. Zinc turned to slide 16 and spoke about the Healthy Families Initiative: Office of Health Savings. The idea was to reduce healthcare costs while improving the health of Alaskans. She addressed the challenges of providing and changing the way Medicaid did its work. The initial focus would be improving the Medicaid program including a focus on subrogation, ensuring Medicaid was the last payer if someone had another type of insurance. She stated that pharmacy continued to be a major driver of the cost of healthcare. The office would work to address pharmacy cost and improved access to critical medications. She elaborated the work had been done through AVAP [Alaska Vaccine Assessment Program] that worked broadly across the state. She stated that it looked at pharmaceuticals and expensive medication such as Paxlovid or other medication like epinephrine and insulin. The office would also look at innovative payment models. She stated that while the Medicaid budget was large, the state spent more money with other insurance types to ensure there were innovative payment models working across payers.

3:06:56 PM

Ms. Stern reviewed slide 17 showing the Division of Public Health operating budget comparison for FY 22 to FY 24. The

majority of the increase in UGF was due to the Health Family Initiative increments discussed by Dr. Zink. There was also a technical adjustment in FY 22 to accurately reflect the reimbursable services agreement the department had with the Department of Military and Veterans Affairs for COVID-19 activities.

Co-Chair Johnson asked if DOH expected the budget to change with the governor's amended or supplemental budget. If so, she requested updated information based on any changes.

Commissioner Hedberg confirmed DOH would send an updated slide deck.

Representative Josephson referred to slide 10 and observed there was an increase under management plan for Medicaid services and a greater increase in the coming fiscal year on slide 10. He asked if the increase reflected the rebasing and inflation adjustment.

Ms. Ricci confirmed the increase was largely the rebasing and inflation adjustment including $18 million and $2 million for postpartum [Medicaid extension]. She deferred to Ms. Stern for additional detail.

Ms. Stern added there were two increments in the FY 23 budget for Medicaid Services associated with increased utilization and inflation, in addition to an item added by the legislature for increased wages for personal care attendants.

3:09:16 PM

Representative Galvin observed that the governor had included funding for TB and congenital syphilis mitigation. She asked if there was any recent data regarding chlamydia mitigation. She believed in the past Alaska had been number one in terms of chlamydia cases. She wondered why it had not been included and asked for the status.

Dr. Zinc responded it had been difficult to choose the area to put the most focus on. She remarked that gonorrhea and chlamydia tended to be very high in Alaska. There was substantial ongoing work and effort in the area. The governor had specified funds for congenital syphilis and TB because of the rapid rise in the diseases and the impacts on families and communities. She relayed that congenital

syphilis could be treated with one shot of penicillin; the disease could leave a child significantly deformed for life and the state needed to bear the responsibility of the cost. She noted that tertiary syphilis could cause significant mental health and health challenges for adults. The state had much higher rates for TB and had seen a rapid rise since the pandemic. She explained that intervening now would make a large difference. She noted it did not mean that ongoing work for other diseases such as chlamydia, gonorrhea, and HIV – that was currently having a cluster outbreak – did not continue. The department had selected the two specific diseases because the spending and focus could have the biggest impact on Alaska's health for the future.

Co-Chair Johnson thanked the presenters for the presentation and reviewed the schedule for the following day.

HB 39 was HEARD and HELD in committee for further consideration.

HB 41 was HEARD and HELD in committee for further consideration.

#
ADJOURNMENT

3:12:58 PM

The meeting was adjourned at 3:12 p.m.