HOUSE FINANCE COMMITTEE
February 13, 2025
9:02 a.m.

9:02:58 AM

CALL TO ORDER

Co-Chair Josephson called the House Finance Committee meeting to order at 9:02 a.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Andy Josephson, Co-Chair
Representative Jamie Allard
Representative Jeremy Bynum
Representative Alyse Galvin
Representative Sara Hannan
Representative Nellie Unangiq Jimmie
Representative DeLena Johnson
Representative Will Stapp
Representative Frank Tomaszewski

MEMBERS ABSENT

Representative Calvin Schrage, Co-Chair

ALSO PRESENT

Emily Ricci, Deputy Commissioner, Department of Health; Deb Etheridge, Director, Division of Public Assistance, Department of Health; Tony Newman, Director, Division of Senior and Disabilities Services, Department of Health; Tracy Dompeling, Director, Division of Behavioral Health, Department of Health.

SUMMARY

PRESENTATION: MEDICAID 101

Co-Chair Josephson reviewed the meeting agenda.

^PRESENTATION: MEDICAID 101

9:04:07 AM

EMILY RICCI, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH, introduced herself. She noted that she would be joined at other points in the presentation by her colleagues. She introduced the PowerPoint presentation "Medicaid 101: Understanding Alaska's Medicaid Program" dated February 13, 2025 (copy on file).

Ms. Ricci continued on slide 2 and explained that Alaska's Medicaid program was a critical component of both the state's healthcare delivery system and its broader economy. Each year, Alaska Medicaid paid approximately $2.8 billion in combined state and federal funds to support health services throughout the state. The funds were disbursed across the health care system, including hospitals, community clinics, primary care providers, pharmacies, and emergency room physicians. She relayed that Medicaid also supported services that helped seniors remain in their homes and communities, which reduced seniors' reliance on institutional care.

Ms. Ricci stated that the Division of Healthcare Services (DHS) distributed approximately $252 million in provider payments each week, which amounted to roughly $8.5 million in annual claims paid to more than 31,000 providers. She emphasized that Medicaid coverage extended to over 246,000 Alaskans and was a significant contributor to Alaska's economic vitality. In 2023, the state's health care sector generated $3.4 billion in wages and accounted for 11 percent of the workforce. She thanked the committee for spending time on Medicaid and hearing the presentation.

9:06:20 AM

Representative Hannan asked how much of the $2.8 billion in annual Medicaid expenditures was derived from federal funds as compared to state funds.

Ms. Ricci responded that the breakdown would be discussed further on upcoming slides. She stated that approximately $700 million came from the state's general fund, while the remaining amount was covered by federal contributions.

Ms. Ricci continued to slide 3 and relayed that Medicaid was one of the largest public health insurance programs in the country. She shared that nearly 79 million individuals

across the United States were enrolled in Medicaid as of October of 2024, which represented roughly one in four Americans. In Alaska, the figure was closer to one in three.

Ms. Ricci advanced to slide 4 and explained that Medicaid played a particularly essential role in long-term care, accounting for 44 percent of all payments for long-term care services nationwide. The program also represented nearly 18 percent of national health care expenditures. She noted that Medicaid was a joint federal and state health insurance program designed to serve low-income individuals and families. Eligible groups included pregnant women, children, the elderly, individuals with disabilities, and other low-income adults. While Medicaid was federally regulated, states retained flexibility in Medicaid program design including which populations were covered, what services were included, and how the program was administered. She explained that Alaska operated under a fee-for-service model, where providers were reimbursed individually for each service rendered. Many other states used a managed care model, in which the state contracted with insurance companies to administer care through a network of providers.

9:08:54 AM

Representative Tomaszewski asked for clarification regarding the cost comparison between fee-for-service and managed care models. He asked which model was generally less expensive and asked about the pros and cons of each.

Ms. Ricci responded that managed care systems more closely resembled commercial or employer-sponsored insurance. In those models, the states paid a contracted insurance company to establish a provider network and deliver services. In contrast, Alaska's fee-for-service system meant that DHS paid providers directly upon submission of claims. She explained that Alaska was paying physicians and health care systems directly for Medicaid services.

Representative Tomaszewski asked which type of system was generally less expensive.

Ms. Ricci replied that cost comparisons between the two systems were complex due to inherent differences in each state’s population, service availability, and delivery

costs. For instance, Alaska's higher overall health care costs likely influenced per capita expenditures, regardless of the system used. Managed care organizations might cover a different range of services than fee-for-service systems which made direct comparisons difficult. She indicated that there were both advantages and disadvantages to each model and that fee-for-service systems allowed for greater direct control over how services were paid, while managed care organizations could potentially offer better care coordination or more comprehensive service offerings. However, she noted that managed care arrangements included a profit margin that did not exist in fee-for-service models. She reiterated that Alaska did not operate a managed care organization within its state Medicaid program. However, when she spoke with Medicaid directors in other states, she found that many states implemented small-scale managed care components while still maintaining significant fee-for-service elements.

Representative Tomaszewski asked whether medical providers were generally satisfied with the fees paid under the current system. He asked if hospitals and providers were content with the structure in place for the negotiation process.

Ms. Ricci responded that medical providers were not consistently satisfied with the fees established through the Medicaid program. She stated that part of the dissatisfaction was related to the overall design of the health care delivery system and the insurance market. Public payers such as Medicare and Medicaid typically operated on a fee schedule with lower reimbursement rates. In contrast, commercial insurers often negotiated higher rates. The dynamic led to cost-shifting between public programs and private insurers. When providers expressed concern about Medicaid or Medicare rates, it was typically due to the perception that commercial payers offered more favorable reimbursement, which prompted providers to shift costs to those payers to offset financial losses from public reimbursements. The department was aware of the concerns and was working to address them within the limitations of the state budget. She explained that the department was presently engaged in a rate methodology review to assess how Medicaid reimbursement rates were established across service categories and determine whether the rates supported the desired outcomes in the health care delivery system.

9:14:02 AM

Representative Johnson asked for confirmation that Medicaid federal funds were still administered by the state.

Ms. Ricci responded in the affirmative. She indicated that a future slide would explain how the Medicaid funding cycle operated.

Representative Johnson remarked that one of the most common complaints she received from constituents related to delays in Medicaid payments to providers. She explained that the delays negatively impacted both health care businesses and access to care. She asked for more information on how Medicaid's payment timeline compared to that of private insurance. She also wondered whether recent cyberattacks on the state's computer systems had affected Medicaid operations or payment systems.

Ms. Ricci responded that the department received reports from providers who experienced delays in payment or claim processing. She emphasized that it was important to consider the issues in the context of approximately 8.5 million claims that were processed annually. Although the overall system managed a high volume of claims, individual provider concerns remained significant and warranted attention. The department worked to determine whether reported issues were part of broader system-wide trends or were isolated incidents specific to individual providers. She provided an example involving claims clearinghouses, where errors could occur if the clearinghouse failed to transmit provider-submitted information into the Medicaid Management Information System (MMIS). In such cases, it might appear that the issue resided within the state's Medicaid payment system, but the root cause was external. She noted that identifying and resolving these types of issues could be highly complex. She relayed that the department would return to the committee later in the day to present a set of proposed IT changes intended to address some of the known systemic challenges in the Medicaid program. She shared that a Medicaid modernization plan would be built out over the next several years to improve infrastructure, leverage automation, and result in better service for providers.

9:17:29 AM

Representative Hannan understood that based on the earlier explanation of managed care versus fee-for-service, managed care appeared similar to a health maintenance organization. She suggested that such a model would only be feasible in areas with a sufficient number of providers available for network participation. She noted limited provider availability and restricted access were persistent challenges across the state. She asked whether her understanding was correct and whether Alaska's limited provider landscape effectively made the managed care model unworkable considering that many services were offered by a single provider.

Ms. Ricci responded that while managed care organizations could be structured as health maintenance organizations, it was not a requirement. She stated that a managed care organization could be designed in a manner similar to the health insurance plans offered to state employees or retirees, which did not operate as health maintenance organizations. She explained that when pooling risk across a population, it was essential to consider how many providers would participate in the network and whether the size of the population pool would be sufficient to sustain the risk. She acknowledged that participation had historically presented a challenge in Alaska. The legislature had reviewed the feasibility of managed care at several points over the previous ten years and despite the considerations, the state had remained within the fee-for-service model.

Representative Hannan asked whether cost shifting was a factor in making Medicaid services financially viable. She suggested that Medicaid patients became more affordable to treat when providers charged more to private payers such as Aetna and Blue Cross Blue Shield. She stated that while treating Medicaid patients might yield lower profit margins, providers were not obligated to accept the patients unless they voluntarily enrolled in the program.

Ms. Ricci responded that providers that enrolled in the Medicaid program agreed to accept Medicaid patients. She stated that there was typically a mix of reimbursement rates from different payers in any health care business. Even within the commercial insurance market, payers often reimbursed at varying rates. Public payers such as Medicare and Medicaid generally reimbursed at lower rates than commercial insurers. She explained that many Medicaid

reimbursement rates in Alaska were based on cost. The rates were calculated using cost reports submitted to the Centers for Medicare and Medicaid Services (CMS) by providers. The state then applied a set percentage to the reported costs to determine the final Medicaid reimbursement rate. The structure made the relationship between actual service costs and Medicaid fees complex to evaluate.

Ms. Ricci relayed that her colleague would now provide information on Medicaid eligibility.

9:20:29 AM

DEB ETHERIDGE, DIRECTOR, DIVISION OF PUBLIC ASSISTANCE, DEPARTMENT OF HEALTH, continued the presentation on slide 5. She explained that the Division of Public Assistance (DPA) played a critical role in ensuring that eligible Alaskans had access to healthcare. She stated that Alaskans had multiple options for applying for Medicaid and the division aimed to ensure accessibility by offering a variety of application methods. Individuals could apply online through the MyAlaska portal, through the federally facilitated marketplace at healthcare.gov, by contacting the virtual contact center by phone, by visiting a DPA office to meet with an eligibility technician, or by working with a fee agent in rural areas. She explained that fee agents in rural locations could help applicants complete the application process and receive an interview. The division also accepted Medicaid applications submitted by mail or by fax.

Ms. Etheridge explained that once a Medicaid application was submitted, DPA made eligibility determinations based on two specific categories. The first category included individuals who qualified for disability-related Medicaid and included individuals who were age 65 or older, had a disability, or received Supplemental Security Income (SSI). The group also included individuals who received Medicare, lived in a nursing home or assisted living facility, or received home and community-based waiver services. Eligibility for disability-related Medicaid was based on income limits, which varied depending on household size and living situation. Additionally, applicants in the category were subject to a resource test. If an individual with a disability exceeded pre-determined resource limits, the division also evaluated whether the individual could

instead qualify under the second major category of eligibility known as Modified Adjusted Gross Income (MAGI).

Ms. Etheridge explained that MAGI was the larger of the two categories and applied to low-income children, pregnant women, families, and adults aged 19 to 64 who did not have dependent children. Eligibility under MAGI was determined based on household size and income following guidelines established by the Internal Revenue Service (IRS). Unlike disability-related Medicaid, MAGI did not include a resource test.

Ms. Etheridge relayed that DPA played a central role in verifying Medicaid eligibility, regardless of the category. The division used electronic data sources whenever possible to streamline the verification process. However, applicants were still required to meet all eligibility criteria, including financial requirements. The requirements included income and, in some cases, asset tests, along with other program-specific limits. Additional eligibility criteria included proof of citizenship or qualifying immigration status, possession of a valid Social Security number, and assignment of rights, which meant that applicants were required to permit Medicaid to recover costs from other sources such as private insurance. Some Medicaid programs also imposed limits on assets, including savings and property ownership. Once all required documentation was submitted, the division issued a written determination of approval or denial. Adequate notice was provided in cases of denial, and all individuals were entitled to a fair hearing. Approved individuals were required to renew their eligibility annually. She relayed that the division was currently using an ex parte process for renewals.

Ms. Etheridge explained that under the ex parte process, the division initiated a review 60 days before the renewal due date. During the review period, the division checked available electronic resources to verify Alaska residency, income, and other eligibility criteria. If the division was able to verify eligibility, it automatically renewed coverage for an additional year. If verification was not possible, the division sent a shortened renewal form to the applicant to complete and return. The division processed the renewal upon receipt of the form. She stressed that Medicaid benefits continued throughout the renewal process. The division also provided at least ten days' notice prior to taking any negative action. She stated that a well-

structured Medicaid system ensured that eligible individuals could apply for, qualify for, and maintain coverage without unnecessary barriers. She affirmed that the division was working toward a system that effectively served those in need while maintaining accountability and program integrity.

9:26:19 AM

Representative Galvin asked about the difference between Medicaid eligibility for children aged zero to one as compared to children aged zero to six. She understood that the governor had recently made a change allowing for coverage specifically for children in the zero to one age group.

Ms. Ricci responded that the relevant change was in the postpartum extension bill [SB 58 passed into law in 2023] that had been passed by the legislature. She acknowledged and appreciated legislative support for the bill, which extended Medicaid coverage for mothers who had given birth from the previous limit of 60 days after birth to a new coverage period of 12 months.

Representative Galvin asked for clarification on whether the extended coverage applied to both the mother and the child, or only to the mother.

Ms. Ricci replied that the change only affected coverage for the mother. She explained that there had been no changes to Medicaid enrollment eligibility for the child because the child was already eligible for Medicaid coverage for the first year of life.

Representative Galvin asked whether other states offered Medicaid coverage for children beyond age one.

Ms. Ricci responded that children in other states could be eligible for Medicaid beyond age one, depending on income thresholds or other categorical eligibility criteria. She reiterated that the general structure had not changed and that children in other states remained eligible based on other state's policies.

Representative Galvin asked if children from birth to age one were also required to meet a specific eligibility threshold.

Ms. Etheridge responded that coverage for children aged zero to one fell under the category of continuous eligibility. If a mother was receiving Medicaid benefits at the time of the child's birth, the child was automatically eligible for Medicaid. She added that some states operated under Section 1115 demonstration waivers that allowed for the extension of continuous eligibility for children beyond the age of one.

Representative Galvin if whether Alaska was unique in not extending continuous eligibility for children beyond age one. She wondered if other states had adopted such policies and if there was any available information on the outcomes of any similar efforts.

Ms. Ricci responded that several other states had pursued Section 1115 waivers in order to extend continuous Medicaid enrollment for children beyond age one. She understood that fewer than ten states had applied for the waivers. She did not know if the waivers had taken effect yet.

9:30:07 AM

Ms. Ricci continued on slide 6 which addressed Medicaid services in Alaska statute. She reiterated that Medicaid was a joint federal and state program and the services covered by the Medicaid program were guided by federal requirements and outlined in Alaska state statute. She relayed that AS 47.07.030 defined covered Medicaid services and identified two categories of services. The first category consisted of mandatory services, which Alaska was required to cover under Title XIX of the Social Security Act. The second category consisted of optional services, which were listed in state statute but were not required by federal law. However, she noted that referring to these services as "optional" could be misleading. Changes under the Affordable Care Act (ACA), which took effect in 2010, had rendered some services mandatory that were listed as optional in Alaska. Additionally, expectations regarding health insurance coverage and the factors that affected individual health status had evolved since the statute was originally written. She explained that many of the services listed as optional had become mandatory.

Ms. Ricci relayed that some examples of services considered optional under state statute included prescription drugs

and emergency hospital services. She noted that if Alaska's Medicaid program had not covered prescription drugs, the system would likely have experienced significantly higher rates of emergency room visits. She stressed that some services remained technically optional in statute, but were effectively necessary due to both federal regulatory requirements and the realities of the health care delivery system.

Representative Josephson asked for more information about the potential cuts to Medicaid. He understood there were ongoing national discussions about possible reductions of trillions of dollars. He asked whether a federal administration could reduce funding for mandatory services and if DOH had sought a legal opinion. He acknowledged that the topic had also been raised in a subcommittee. He stressed that the funds needed to remain available in order for the state to continue providing services to over 200,000 Alaskans.

Ms. Ricci replied that the department was actively monitoring federal discussions related to Medicaid and other health care programs. She explained that all states routinely tracked the developments because of the direct relationship between federal decisions and state-administered Medicaid programs. She confirmed that no specific federal proposals related to the reduction of funds had been introduced. She relayed that DOH would work with Department of Law (DOL) and other relevant entities to assess potential impacts on Alaska's Medicaid program.

Co-Chair Josephson asked whether the state had experienced any delays or disruptions in the transfer of funds for Medicaid recipients. He asked if there had been any noticeable concerns or slowdowns in the flow of payments through MMIS.

Ms. Ricci confirmed that there had been no delays in the flow of federal Medicaid payments.

9:34:36 AM

Ms. Ricci advanced to slide 7 and reiterated that Medicaid was a joint federal and state program. The joint structure allowed states some flexibility in designing and operating Medicaid systems; however, the designs were first required to be approved by CMS. She directed attention to the

diagram on the slide depicting the process of federal fund flow. She explained that DOH first communicated its projected claims costs for a given period to the federal government. Based on the projections, the federal government authorized the state to expend a corresponding amount. The authorization was not an immediate transfer of funds but rather a preliminary agreement. Once the authorization was in place, the state paid providers on a weekly basis as claims were submitted. She noted that the state's weekly Medicaid expenditures totaled approximately $52 million. After processing the payments, the state submitted a report of the actual expenditures to the federal government and subsequently drew down the corresponding funds to reconcile the payments.

Ms. Ricci clarified that the diagram represented only a portion of the complex and ongoing interactions between DOH and CMS. Providers were permitted to submit claim corrections or adjustments for up to two years following the original claim submission or payment, which added further complexity to Medicaid fiscal management. The states also individually managed Medicaid eligibility and enrollment processes, enrollment of providers, and service delivery. She indicated that the legislature played a vital role by approving the optional services covered by Medicaid, authorizing the use of waiver services for certain programs, and defining the eligibility groups included in Medicaid coverage.

Representative Allard asked for specific documentation outlining what the federal government funded for each program, including descriptions and dollar amounts.

Ms. Ricci responded that she would follow up in writing with a breakdown of federal versus state expenditures by service category.

Representative Allard emphasized that she did not need a comparison, but instead wanted specific details on what federal funds supported which programs, along with program descriptions.

Ms. Ricci confirmed that she would provide the information.

9:37:51 AM

Ms. Ricci continued on slide 8 and explained that a key component of the Medicaid program was the method of financing, which involved joint funding from the federal and state governments. The federal share of costs was determined by the Federal Medical Assistance Percentage (FMAP). She relayed that the federal match was calculated annually for each state and the minimum match was established each year. The chart on the right side of the slide detailed different FMAP rates based on various eligibility categories. She explained that the category labeled as "regular Medicaid" was the lowest federal share provided for services. At a minimum, the federal government funded 50 percent of Medicaid program costs, but the federal match could be higher dependent upon specific economic conditions. The regular Medicaid match rate in Alaska was 51.54 percent, but different types of services received different federal match rates. For example, the 51.54 percent rate was the lowest match for standard Medicaid services, while services provided to tribal members through tribal health organizations qualified for a 100 percent federal match. She emphasized that understanding the differences was important when evaluating the Medicaid budget.

Representative Tomaszewski asked how accurately individuals were categorized to ensure proper federal match rates were applied. He wondered if the department encountered challenges in assigning individuals to the correct match category.

Ms. Ricci responded that enrollment was determined through income-based eligibility or categorical eligibility, which was tracked and linked to claims data. Individuals were categorized based on their enrollment in the Medicaid program. She acknowledged that system errors could occur and DPA was actively addressing the issues. She added that auditors reviewed the accuracy of eligibility and enrollment data on an annual basis. She explained that additional coordination was required for individuals to be eligible for the 100 percent match through Indian Health Services (IHS). She noted that Medicaid services might also be delivered outside the tribal health system, which required careful tracking and verification. If there was a care coordination agreement between the tribal health system and the external provider, the department could attempt to recoup a 100 percent federal match for any Medicaid funds that had been expended. She explained that

the recouping process had been a significant component of the Medicaid system since it became available in 2018 and had saved approximately $138 million in general funds in FY 24.

Representative Tomaszewski commented that the current process seemed to occur after funds had already been expended. He asked if there was any way to be more proactive.

Ms. Ricci responded that for the vast majority of services, the estimated federal match was tied directly to the individual's categorical or income eligibility status at the time of enrollment in the program. She clarified that additional administrative work might be required for certain IHS services to receive the full federal match.

9:43:07 AM

Representative Hannan understood that IHS had been expanded in many communities and IHS facilities were often the only available providers in some areas. She asked whether a non-tribal citizen receiving care at an IHS facility would still result in the state receiving the regular 51 percent federal match under Medicaid, rather than the 100 percent match.

Ms. Ricci responded in the affirmative.

Representative Hannan asked if the expansion of IHS into new areas created complications for Medicaid delivery to non-tribal citizens. She noted that organizations such as SouthEast Alaska Regional Health Consortium (SEARHC) had established new facilities and she wondered if the shift caused challenges due to the change in reimbursement rates between tribal and non-tribal recipients.

Ms. Ricci responded that the reimbursement rate was determined by the state. She explained that there was no change in the billing process for tribal health organizations. She indicated that an organization would submit a claim to Medicaid and the state would then identify whether the individual qualified for a 51 percent match percentage, 90 percent match, or another federal match percentage. She noted that complications could arise due to differences in how tribal and non-tribal health organizations were reimbursed. She explained that the

Medicaid program paid different amounts to tribal providers and to non-tribal providers, which affected the overall funding structure.

Co-Chair Foster asked for more information about the potential impacts to hub hospitals that currently received a 100 percent federal match under FMAP, such as SEARHC in Juneau, Norton Sound Health Corporation in Nome, and Yukon-Kuskokwim Health Corporation in Bethel. He noted that the facilities served a high percentage of tribally enrolled individuals and asked whether a hypothetical cut in the federal match would significantly impact the providers. He thought the possibility of the match being reduced to around 50 percent was alarming.

Ms. Ricci responded that the federal match accrued to the state and the Medicaid program paid the Medicaid rates directly to the provider and the state drew down the appropriate federal match. She explained that the difference between a 100 percent match and a 50 percent federal match reflected the impact on state dollars used to cover the services. The state paid the same amount to providers regardless of the federal match rate. The variation in the federal match simply determined how much federal funding the state could draw down to support the payments.

Co-Chair Foster remarked that if there was a reduction in the federal match rate, the result would either be a reduction in services or a requirement for the state to cover a greater share of costs. He emphasized that the state already faced financial challenges and increased costs was an important issue.

9:47:45 AM

Representative Johnson asked if the 100 percent FMAP match on slide 8 meant that the service was fully covered by the federal government and the state did not contribute through a shared match.

Ms. Ricci responded that under a 100 percent FMAP, the federal government reimbursed the state for 100 percent of the claim amount paid for services. She clarified that a 51.54 percent match meant the federal government reimbursed 51.54 percent of the cost for services provided to eligible individuals.

Ms. Ricci advanced to slide 9 and explained that an important component of the Medicaid program was the Medicaid State Plan. She repeated that Medicaid was a joint federal and state program and that the plan served as the formal agreement between Alaska and CMS. The plan outlined key program elements, including eligibility criteria, covered services, provider reimbursement methods, and program administration processes. The plan was subject to federal guidelines, but states still had some flexibility in how they implemented the program. The plan served as the framework for how the state and federal government structured Medicaid in Alaska and was publicly accessible to ensure transparency.

Ms. Ricci emphasized that any proposed changes to eligibility, covered services, administrative procedures, or reimbursement rates generally required a state plan amendment (SPA). She explained that the SPA process involved submitting a formal amendment request to CMS to authorize a change that the state found to be reasonable and compliant with federal requirements. She noted that the process included public and tribal consultation periods and followed a strict procedural framework. She relayed that it was essential that all Medicaid services be authorized either through the state plan or a federally approved waiver. Services that were not authorized through such channels were not eligible for a federal match.

9:50:55 AM

Co-Chair Josephson relayed that he was alarmed when the administration was proposing removing dental coverage for Medicaid recipients in around 2019. He understood that some legislatures had the authority to act as a check on SPAs. He noted that there was a conference in Anchorage that included participation from the insurance industry, health care providers, and other stakeholders. He asked whether the governor had the full authority to make adjustments to the Medicaid state plan without any input from the legislature.

Ms. Ricci responded that Alaska's legislature had a more substantial role in the Medicaid program than legislatures in many other states. She explained that in Alaska, statutory authorization was required before the department could pursue waivers for Medicaid services, which was a

level of legislative involvement that did not exist in all states. She added that the department routinely updated and adjusted the state plan in the normal course of administering a health insurance program. The updates did not typically require legislative or statutory changes. However, the department could not add new services, expand eligibility, or implement similar changes without first obtaining statutory authority from the legislature. She reiterated that such a high level of legislative oversight was rare.

Co-Chair Josephson asked for clarification on how the state would add a specific benefit. He asked whether the legislature would need to pass a bill to authorize the benefit of adult podiatry care, for example, which he believed was not currently covered in Alaska but was covered in other states.

Ms. Ricci responded that the services that could be covered by Medicaid were specified in state statute, including both mandatory and optional services. She noted that podiatry was not among the optional services currently listed for adults in state statute, meaning that the department would not have the authority to offer coverage without a change in state law.

Co-Chair Josephson asked if the governor could unilaterally request that CMS approve adult podiatry as a covered service without legislative approval.

9:54:31 AM

Ms. Ricci responded that because the department was a state agency, it operated in accordance with state statute. She explained that a statutory change would be required before the state could submit a request to CMS to include adult podiatry care in the Medicaid program. She noted that whenever the state submitted an SPA, corresponding regulatory changes were often required. She emphasized that both federal approval and state regulatory revisions needed to be considered when making any changes to the Medicaid program.

Ms. Ricci continued to slide 10 and relayed that waivers were an additional tool for authorizing Medicaid services. She stated that waivers allowed states to offer services or implement delivery models not typically allowed under

standard Medicaid rules. The Medicaid program included a wide range of waivers that were often referenced by number and letter.

Ms. Ricci stated that the two waivers most relevant to Alaska's Medicaid program were the Section 1115 waiver and Section 1915(c) waiver. She noted that the numbers referred to specific authorizing provisions in federal law. The federal Secretary of Health and Human Services could grant permission for states to implement alternatives to standard Medicaid provisions. She added that each waiver had its own restrictions and the waivers were subject to federal requirements. For example, Section 1115 demonstration waivers had been used in Alaska to expand access to behavioral health and substance use disorder services beginning in 2018. She relayed that the Section 1115 waivers allowed states to test new service delivery models or offer services not typically covered by Medicaid, provided that the efforts met the program's overall goals. She explained that the waivers were required to meet specific conditions and be deemed budgetarily neutral by the federal government. She added that Section 1115 waivers typically operated for a five-year demonstration period and were subject to periodic renewal.

Ms. Ricci highlighted that the Section 1915(c) program waivers were listed on the right side of the slide. She explained that the program waivers were used to help individuals remain in their homes and communities and were commonly known as home and community-based waiver services. She noted that Director Tracy Dompeling from the Division of Behavioral Health (DBH) and Director Tony Newman from the Division of Senior and Disability Services (DSDS) each managed waivers within their respective divisions.

9:57:27 AM

TONY NEWMAN, DIRECTOR, DIVISION OF SENIOR AND DISABILITIES SERVICES, DEPARTMENT OF HEALTH, continued on slide 11. He relayed that DSDS oversaw the administration of Alaska's five 1915(c) waivers. He reiterated that the waivers provided services intended to help Alaskans remain in their homes and communities. He stated that the waivers collectively served approximately 5,500 individuals in the state. The first waiver was the Individuals with Intellectual and Developmental Disabilities (IDD) waiver, which served approximately 2,100 individuals. The second

waiver, Alaskans Living Independently, primarily served seniors who were Medicaid-eligible and experiencing functional challenges. The waiver enabled eligible seniors to live more independently and was the largest waiver of the five, serving around 2,400 individuals. The third waiver, Children with Complex Medical Conditions, served individuals under age 22 who had severe chronic medical conditions requiring care that would otherwise be provided in a hospital or nursing facility. Approximately 240 children and young adults were served under the waiver.

Mr. Newman continued that the fourth waiver, the Individualized Supports waiver, was introduced in 2018 as part of Medicaid reforms. The waiver served individuals with intellectual and developmental disabilities and provided a reduced set of services for eligible participants. Approximately 600 individuals were served through the waiver. The fifth and final waiver, Adults with Physical and Developmental Disabilities, served around 176 adults. The eligible group often included individuals who had aged out of other waivers and met the nursing home level of care requirement. He stressed that the waivers shared common features although each waiver served distinct populations. When an individual was enrolled in a waiver, the individual was granted access to a range of services intended to support independent living. There were approximately 14 types of waiver services available, ranging from habilitative care, which could be delivered at home or in an assisted living setting, to employment services, adult daycare, and environmental modifications such as ramps and roll-in showers. He explained that waiver eligibility required individuals to qualify for a Medicaid category determined by DPA, led by Director Etheridge, and to meet a level of care requirement assessed by DSDS.

Mr. Newman expressed that he appreciated the legislature for appropriating funds beginning in FY 24 through FY 26 to modernize the assessment process. The division planned to implement a new tool called the "NRI" that would support several long-desired systemic improvements advocated by stakeholders. He noted that without the waivers, many individuals would have required institutional care. He reported that the department estimated Alaska would spend over $1 billion on institutional care in the absence of waiver services. The availability of the waivers was projected to save the state approximately $600 million and enabled Alaskans to remain in their homes and communities.

10:01:18 AM

Representative Hannan relayed that constituents often reported that they were on the IDD waitlist. She asked if the waiver and the IDD waitlists were the same. She inquired about what actions needed to be taken in order to help transition individuals from the waitlist into waiver coverage. She understood that such transitions would result in cost savings and stronger communities.

Mr. Newman responded the IDD waiver had a waitlist of approximately 323 individuals since late January of 2025, although the number changed almost daily. He explained that the legislature had asked the department to develop a plan in 2022 estimating the cost of eliminating the waitlist. The resulting report was available on the department's website and included details on the appropriations required. He reiterated that the department proposed a more cost-effective approach that involved introducing a new assessment tool. The overall cost of eliminating the waitlist could be reduced if the new tool was utilized. He clarified that the legislature had only funded the implementation of the assessment tool and that additional appropriations would be required to provide services and remove individuals from the waitlist. The costs were outlined in the report.

Co-Chair Josephson recalled that there was a discussion in a subcommittee that that estimated approximately $30 million would be needed to eliminate the waitlist. He asked whether such an investment would result in immediate savings compared to the cost of institutional care. He asked if immediate cost savings could be realized if the legislature decided to eliminate the waitlist without waiting for the full implementation of the new assessment tool.

Mr. Newman responded that it would be difficult to make such a determination. He explained that the department prioritized individuals on the waitlist based on level of need and the remaining individuals on the list typically had the lowest level of identified needs. He added that many of the individuals on the waitlist were already receiving services, often through the more limited Individualized Supports waiver that had been introduced in 2018.

Representative Galvin requested that the 2022 report be shared again with the committee. She explained that she had not been in the legislature when it was originally published and wanted the opportunity to review it. She acknowledged that the report included significant cost estimates.

Mr. Newman confirmed that the department would provide the report.

Representative Galvin then asked for more detail on more limited services available under the Individualized Supports waiver. She wanted to know what the services included, whether it helped reduce costs elsewhere, and what the differences were between the limited services and the more comprehensive services available under other waivers.

Mr. Newman responded that the key difference was the availability of residential services: the IDD waiver included residential services, while the Individualized Supports waiver did not. He explained that residential services were among the most intensive and expensive offered through the IDD waiver. He noted that the Individualized Supports waiver had been created in part to reduce state spending, which allowed the department to lower general grant funding.

10:06:18 AM

Co-Chair Josephson asked if the state currently had the housing, staff, and facilities necessary to eliminate the waitlist.

Mr. Newman responded that it was a valid concern. He stated that the availability of service providers, particularly direct support professionals (DSP), would be a critical factor in any effort to fully eliminate the waitlist. The waitlist could be eliminated by offering everyone access to services, but without the necessary workforce, there would effectively still be a waitlist.

Representative Stapp asked how many other states had a waitlist.

Mr. Newman responded that several dozen states had a similar waitlist. He mentioned that his own nephew had been on the waitlist in Pennsylvania for many years.

Representative Stapp asked what the average amount of time was that an individual spent on the IDD waitlist in Alaska.

Mr. Newman replied that the department had the information, but he would need to follow up.

Co-Chair Josephson asked whether there were waitlists for the other four waiver programs.

Mr. Newman explained that the department had recently implemented a waitlist for the Individualized Supports waiver. The waitlist was currently small as the program was capped at 600 people. At the moment, about 45 people were on the list.

10:08:06 AM

Representative Tomaszewski stated "waivers are savers." He asked whether the $600 million in cost savings listed on slide 11 consisted of federal dollars, state dollars, general fund dollars, or a mix.

Mr. Newman responded that the amount included both state and federal dollars.

Representative Tomaszewski asked whether the mix of funding depended on the specific program and how the breakdown was determined.

Mr. Newman replied that the number was calculated by determining how many people were on each waiver and comparing the number with the average cost of institutional care. The costs of placing individuals in nursing homes or other institutions for people with disabilities were compared to the costs of receiving home and community-based services through a waiver.

Representative Tomaszewski asked for the specific breakdown between federal and general fund dollars.

Mr. Newman responded that the split was roughly 50 to 51 percent federal dollars.

Representative Tomaszewski asked for confirmation that the funding fell into the lowest federal matching category.

Mr. Newman responded in the affirmative.

10:09:41 AM

TRACY DOMPELING, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH, continued on slide 12 which was an overview of Alaska's behavioral health system and the public funds that supported the system. She explained that the system began undergoing redesign and reform in 2016 following the passage of SB 74, which required the department to pursue an 1115 waiver to improve and modernize the Medicaid behavioral health system in Alaska. The waiver also aimed to increase overall funding in the system and shift it to more sustainable sources, allowing federal contributions to be used to support services. The slide showed the combined funding from Medicaid and grants supporting the behavioral health system from FY 18 through FY 24.

Ms. Dompeling relayed that she would begin by providing an overview of the Medicaid funding categories. The brown sections of the slide represented state plan behavioral health services, with the lighter brown showing the state share and the darker brown showing the federal share. She explained that the blue sections of the slide represented the 1115 services, with the lighter blue sections showing the state portion and the darker blue showing the federal portion. She highlighted that the 1115 services began coming online in late FY 20, starting with the substance use disorder services. Additional mental health-related services were added later in FY 21.

Ms. Dompeling noted that the 1115 waiver had been bifurcated to separate substance use disorder services from mental health services. The separation was a direct response to the emerging opioid epidemic in Alaska, which led to prioritizing substance use disorder services first. She relayed that the green line on the slide represented grant funds that were appropriated by the legislature and distributed by the division to community behavioral health providers throughout the state. The numbers in bold at the top of each column on the slide represented the overall annual spending from FY 18 through FY 24. The spending increased by roughly $120 million during the time frame,

which was a 48 percent increase. She explained that much of the growth was due to the implementation of the 1115 demonstration waiver. She highlighted that demonstration waivers were time-limited and the initial waiver lasted five years. The department had secured a renewal that extended the waiver through December 31, 2028, which offered an opportunity to pursue amendments to expand and finetune the waiver to better suit Alaska.

Representative Galvin asked whether the grant funding represented by the green line included federal or state funds. She asked why the amount had dropped significantly in recent years.

Ms. Dompeling responded that most of the green line funding came from federal sources. She explained that DBH received annual block grants for both substance use and mental health issues and the federal funds made up the majority of the grants. She added that the division could follow up with a breakdown of the state appropriations contributing to the grants. The decline in grant funding was largely due to a shift in the way in which services were funded. For example, children's residential services were previously funded through grants, but over time the services transitioned to being covered under the 1115 waiver, allowing providers to bill Medicaid instead. Total spending in the behavioral health system still increased over the past seven fiscal years despite the reduction in grant funding.

10:14:38 AM

Representative Bynum asked whether the spending shown in the presentation excluded funding from other state agencies, such as the Alaska Mental Health Trust Authority (AMHTA) or the Department of Education and Early Development (DEED), which could also provide behavioral health services.

Ms. Dompeling replied that the data primarily represented DBH funding. She relayed that there were times when AMHTA allocated funds to the division for specific purposes, such as crisis services, and in those cases the funding would be included in the grant portion of the chart.

Representative Bynum asked whether the AMHTA contributions were included in the grant component represented by the green line on the slide.

Ms. Dompeling responded in the affirmative.

Co-Chair Josephson asked what information was reflected in the green line for FY 26.

Ms. Dompeling replied that she did not have the information immediately available. She noted that anticipated reductions were tied to the expiration of COVID-19 supplemental funds. She thought Ms. Ricci could respond in more detail.

Ms. Ricci suggested that the committee discuss the FY 26 funding during the scheduled afternoon meeting, which included a budget overview for DBH.

Co-Chair Josephson recalled that about five years ago, he had offered amendments in the House Finance Committee to increase behavioral health grants, particularly the direct cash grants. He remarked that one of the amendments had failed by a single vote. The committee had heard from groups under the Behavioral Health Association umbrella that some services could not meet the requirements of the 1115 waivers. He recalled that one key barrier mentioned was capacity. For example, startup costs for opening a new behavioral health clinic were not reimbursable under the waiver structure. He asked whether such concerns were still valid or if the system had since evolved. He wondered if there were still people with unmet needs who did not qualify for waiver coverage.

Ms. Ricci responded that gaps continued to exist in Alaska's behavioral health care system. She stated that one of the department's ongoing priorities had been to strengthen the behavioral health care system. There had been some progress due to the implementation of the 1115 wavier, but more work still needed to be done. She relayed that Ms. Dompeling had developed a strategic plan to address the challenges in partnership with stakeholders across the state. She explained that the Youth Behavioral Health Roadmap was finalized the previous year and was an important part of the strategic plan. Another component had been a recent assessment conducted by consultants from Milliman that outlined ways to improve the crisis response

system. The focus continued to be on identifying and closing gaps in the behavioral health continuum.

10:18:13 AM

Representative Jimmie noted that her constituency had a high number of Medicaid participants and asked whether there was a way to bring counselors into schools to better support students' mental health.

Ms. Ricci responded that the department had been working on developing school-based services to help schools provide mental health care. She reported that the department received a $2.5 million grant from CMS in 2024. Additionally, legislation passed in 2024 had removed state-level limitations and allowed school districts more flexibility to access Medicaid funds. She confirmed that the department had been actively building out the program.

Representative Jimmie asked for confirmation that the effort applied statewide.

Ms. Ricci responded in the affirmative.

Ms. Ricci continued to slide 13, which detailed some major developments in Alaska's Medicaid program. She explained that Medicaid had been established at the federal level in 1965 and Alaska had joined the program in 1972. In 2015, the state had expanded Medicaid eligibility under the Affordable Care Act (ACA). In 2018, the federal government had approved Alaska's 1115 waiver for behavioral health services. She noted the federal government had required states to maintain Medicaid enrollment in 2020, except in very specific cases. The federal government had also offered states a temporary 6.2 percent increase in the federal match rate to help offset the costs. The enhanced match had begun phasing out in April of 2023, and at that time, states were required to redetermine eligibility for all Medicaid enrollees. She relayed that it had been a massive administrative undertaking and had posed challenges across the country.

10:20:49 AM

Ms. Ricci moved to slide 14, which displayed Medicaid enrollment and spending trends. She noted that the gold and green lines represented enrollment. The gold line reflected

the total number of individuals who had been enrolled in Medicaid at any point during each fiscal year. In FY 24, the number of enrollees had reached nearly 280,000, but the month-to-month enrollment numbers were lower. For example, the state had counted about 253,000 actively enrolled individuals in April of 2023, which was when the state had begun its process of redetermining eligibility. As of December of 2023, the number had dropped to 246,000. The green line represented the number of individuals who had actually received a service through Medicaid. She clarified that not every enrollee incurred costs or accessed medical care, which was an important distinction when considering the Medicaid budget. The bars at the bottom of the chart showed the funding sources. The dark blue line represented the federal portion of the state Medicaid budget, while the light blue line represented the state portion. Over the past eight years, the federal portion of the Medicaid budget had increased at a faster rate than the state portion.

Representative Bynum noted that there was a difference between the number of enrollees and the number of individuals who had actually received care. He asked whether there was a requirement that Medicaid enrollees receive preventative care.

Ms. Ricci responded that there was no requirement.

Representative Hannan asked whether the department encouraged enrollees with chronic conditions to receive care in order to be proactive. She asked if efforts were made to prevent catastrophic outcomes due to unmanaged chronic illnesses.

Ms. Ricci responded that some programs existed for individuals with severe or acute needs. She stressed that strengthening support for individuals with chronic conditions remained a priority for the department.

Representative Hannan asked if barriers to accessing care contributed to the gap between enrollment and actual service usage, such as travel from remote communities or arranging childcare.

Ms. Ricci responded that there were likely many contributing factors. She added that a gap often existed between individuals enrolled in a plan and those actively

using services. However, the widening of the gap over time was significant and had implications for the Medicaid budget and population health management.

10:24:56 AM

Representative Galvin asked if continuous care costs were lower for emergency postpartum coverage for mothers and infants compared to preventative care.

Ms. Ricci responded that she was not sure how many states had implemented continuous coverage and there was not much information available.

Representative Galvin clarified that she was referring specifically to the zero to one age range.

Ms. Ricci responded that she would follow up with the information.

Representative Stapp asked how much flexibility the state plan had to incorporate incentives to encourage participants to seek out preventative care.

Ms. Ricci responded that there was substantial flexibility. She added that implementation would depend on the division's available bandwidth.

Ms. Ricci proceeded to slide 15, which illustrated various influences on the Medicaid budget. She noted that the budget was complex and could be affected by inflation, federal match rates, enrollment numbers, population health trends, and the methods and rates used to reimburse services.

Ms. Ricci moved to slide 16 and stated that one of the elements the division had been tracking was the number of individuals receiving services, particularly during the redetermination of eligibility over the past two years. She explained that the division had monitored whether there was a decrease in the number of individuals receiving services at any given time. The chart showed that there had been relative stability, with an average monthly difference of approximately 2,000 individuals.

10:27:13 AM

Ms. Ricci advanced to slide 17. She noted that individuals with chronic conditions required more medical services, which resulted in higher associated costs. The slide depicted the correlation between chronic conditions and increased healthcare costs. She emphasized that one of the division's focus areas was supporting individuals in managing their chronic conditions to maintain overall population health.

Ms. Ricci continued to slide 18 and noted that a small portion of the population accounted for a disproportionately large share of total spending, which was typical in many insurance plans. The gold bar on the chart on the slide represented approximately 10 percent of Medicaid recipients who utilized services. She noted that 10 percent of the recipients accounted for approximately 67 percent of total Medicaid spending which equated to roughly $1.8 billion. Conversely, about 60 percent of recipients accounted for only 7 percent of total spending. She remarked that the spending distribution was not unusual for insurance. She explained that the pie chart on the left side of the slide provided a different visual representation of the same dynamic between the high and low utilization groups.

Ms. Ricci proceeded to slide 19 and stated that reimbursement methods significantly influenced the Medicaid budget. She clarified that the left side of the slide listed various types of rates paid to different providers, depending on the services offered. The right side of the slide illustrated typical adjustments made to the rates. The adjustments could occur annually or on a one-time basis and were driven by factors such as inflation, rebasing, legislative appropriations, and federal policy changes.

Co-Chair Josephson asked if inflation and rebasing were connected.

Ms. Ricci responded that inflationary adjustments grew on an annual basis and were generally defined in regulations. She relayed that rebasing involved evaluating the underlying costs incurred by a service provider over a longer period of typically three to five years. Both mechanisms reflected changes in service delivery costs but addressed different aspects of the rate-setting process.

10:29:49 AM

Ms. Ricci continued to slide 20, which included a chart that illustrated cost-saving strategies used within the Medicaid program. She explained that tribal reclaiming leveraged a 100 percent federal match for certain services and generated $138 million in FY 24. She noted that drug rebate recoveries savings were shared between the federal and state governments and had offset Medicaid service costs by approximately $135 million in FY 24. She added that the supplemental drug rebates received by the state totaled approximately $168 million.

Co-Chair Josephson reviewed the agenda for the afternoon meeting. He stated that Ms. Ricci would return in the afternoon to discuss the department's budget in more detail.

#
ADJOURNMENT

10:31:15 AM

The meeting was adjourned at 10:31 a.m.