

HB

148

(FILE 2)

<TARGET><BILL>HB 148</BILL><SUBJECT>HB 148 (FILE
2)</SUBJECT><COMM>HFIN29</COMM></TARGET>



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of
Health and Social Services**

OFFICE OF THE COMMISSIONER

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Anchorage, Alaska 99503-5923
Main: 907.269.7800
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350 Main Street, Suite 404
Juneau, Alaska 99801-1149
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April 11, 2015

The Honorable Representative Steve Thompson
Co-Chair, House Finance Committee
Alaska State Capitol
Juneau, Alaska

Dear Representative Thompson:

On April 8, 2015, the House Finance Committee took up HB 148. During discussion, a question was asked regarding provider taxes. The question specifically asked for the estimated collections generated if the State were to assess the maximum allowable provider tax under federal law, which is 6 percent, on hospital and skilled nursing facility revenues.

While the question presented seems straightforward, the response must be substantially qualified for several reasons. First, there are different interpretations on what exactly constitutes taxable "revenues." For example, there are different classifications of revenue that could be considered (i.e. total revenue, patient-services revenue, investment revenue, non-operating revenue, etc.).

Provider taxes on hospitals and skilled nursing facilities can be calculated in a variety of ways, many of which do not involve revenues. For example, some provider taxes are based on total bed days, while others are based on number of discharges. If revenues are used to calculate the tax, depending on which revenue streams are used, it may not be practical to use a flat tax.

We would also add that the estimate cannot be viewed as a net increase in revenue to the state because, as in other states, the cost of paying the tax would be factored in to Medicaid rates for those providers. Nor can we say what facilities would have the financial capacity to pay the maximum allowable tax of 6 percent and remain solvent, even if Medicaid rates were adjusted.

Representative Steve Thompson

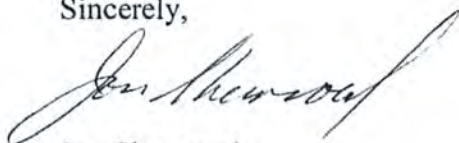
April 11, 2015

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Given these qualifications, we attempted to identify net revenues from patient services, and applied the maximum allowable tax of 6 percent as a hypothetical across all facilities. The result of this calculation is approximately \$100 million. Again, we emphasize that this is not what we would expect this tax to bring into to the state. We are looking forward to a thorough report and recommendations from a subject expert contractor, with input from the provider community, and will report those findings and recommendations to the Legislature in 2016.

Please distribute this response to the other members of the House Finance Committee.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jon Sherwood".

Jon Sherwood
Deputy Commissioner

From: [Barbara Haney](#)
To: [House Finance](#)
Cc: [Sen. Pete Kelly](#); [Sen. Anna MacKinnon](#); [Sen. Click Bishop](#); [Sen. Donny Olson](#); [Sen. Peter Micciche](#); [Sen. Mike Dunleavy](#); [Sen. Lyman Hoffman](#)
Subject: 7 Reasons Why I oppose Medicaid Expansion
Date: Saturday, April 11, 2015 1:08:34 AM

Dear House Finance and Senate Finance Committee Members

I am writing to request you vote no on Medicaid expansion. I have 8 reasons. They are as follows:

1) There is zero evidence that health is improved with Medicaid expansion. However, there is a lot of proof that states have gone deep into the hole over it.

2) Medicaid Expansion is the prerequisite for Obama Care. According to provisions of the PPA (better known as ObamaCare), Medicaid expansion is required to implement Obama Care. (Huffington Post story).

3) The DHSS Estimates Grossly Overstate the Benefits. After looking at the econometric estimates provided here in Juneau, it is pretty clear that there are many factors that have not been considered and that the benefits of Medicaid expansion are grossly overstated. Just for starters, they do not incorporate the impact of new taxes on the supply of providers and cost. Nor do they account for other issues pertinent to service delivery in Alaska. **In the seven other states that have expanded Medicaid, costs on an average rose 88% above forecasted costs.** This will likely be much higher in Alaska. The cost over-runs will do great harm to the Constitutional Budget Reserve-- it will be depleted rapidly.

4) Crowd Out Of Most Vulnerable Populations: Current Medicaid recipients, such as the elderly, disabled, and those with children, will be reimbursed at 50%. The new expanded population will be reimbursed at 90%. If you are a physician, who are you going to take? Clearly the new medicaid patients will crowd out the old ones who are reimbursed at the new rate. Thus, those in most need will go to the end of the line if they are even served at all.

5) Taxes On Providers: House Bill 148 also imposes taxes on providers. For medical providers already operating at the margin (and many in Alaska are barely surviving), this could be the nail that closes their practice.

6) Medicaid is a big source of funding for Planned Parenthood. Early on [Twitchy covered](#) how medicaid expansion and PPA specifically rewarded Planned Parenthood. In addition, Planned Parenthood has a track record of fraudulent claims with Medicaid. [American Life League has a page](#) that details the extensive number fraud of lawsuits in Iowa, Texas, California, and Illinois. The [Alliance Defense Fund's Report to Congress](#) in February 2012 details numerous details of fraud and abuse of Medicaid. Expansion would merely expand those opportunities in Alaska.

7) Doesn't fix any of the current problems: According to Leg Audit in FY 2014, there are serious problems with many of the Medicaid system. The payment system (Enterprise, formerly MMIS) is broken. There are over 451 defects in the payment system documented as of August 2014. The Aries System, used for determining eligibility is also broken. Over half

of the Medicaid providers certification files are incomplete. Nearly 2/3 of the providers lacked of any kind of evidence of rate verification, and important component in addressing costs.

Please vote NO on Medicaid expansion.



April 10, 2015

Hello,

My name is Mary Katasse and I live in Juneau, Alaska. I support Medicaid expansion and reform because I am the mother of two adult sons and the adopted mother of three siblings, Julian who is 7- Christian 4 and Alexia 3 years of age. Julian was diagnosed with FASD in January of 2010. His siblings are in the process of getting a diagnosis.

Our story is a story of success. When Julian first came in to our home, we knew there was a possibility of an FASD, but didn't know exactly what FASD was. With the help of family and local, state and federal agencies, we were able to get the information we needed to get a diagnosis, and to learn how to properly care for a child with an FASD. We are blessed with a wonderful support system which includes our family, friends, our employers, the Juneau School District, their Doctor's office and the local, state and federal agencies. Without early diagnosis and support, my children would not be doing as well as they are.

I am asking you to take Julian, Christian and Alexia in to consideration and support HB 148. All who support these children play a critical role in their lives and the lives of all who are affected by FASD. Thank you for your time and for this great opportunity to share my family with you.

~Mary

Our story can be found here:

<http://juneauempire.com/local/2015-02-05/finding-good-fasd>

<http://www.ccthita.org/info/newsletters/newsletters/2010april.pdf> pg.15

From: [Sarah Isto](#)
To: [House Finance](#)
Subject: A Doctor Supports Medicaid Expansion
Date: Saturday, April 11, 2015 9:05:20 AM

To Members of the Committee:

I am writing this email to testify based on my experience as a physician. During my years of practice here in Juneau I witnessed some of the consequences of a medical insurance system which effectively excludes many responsible, low income working people.

Here is one example (disguised for medical privacy). A young father, whose job did not provide insurance, developed a dark expanding mole. He delayed several months before coming in to have it looked at because he did not want to add to the family's debt. His melanoma story ended well medically. I do not know how it ended for him economically, but I know his loss would have not only caused suffering for his family but would have been a loss to our community and to the state.

Except for a few periods as a young adult, I have always had medical insurance and have never had to face tough decisions about seeking needed non-emergency care. No Alaskan should have to face these decisions.

I urge you to support HB 148.

Sarah Isto, M.D.



ALASKA PHYSICAL THERAPY ASSOCIATION, INC.

A CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
PO BOX 140351 ANCHORAGE, AK 99514-0351
PHONE: (907) 566-3749

April 10, 2015

The Honorable Mark Neuman
The Honorable Steve Thompson
House Finance Committee
Alaska State Capitol
Juneau, AK 99901

Dear Representatives Neuman and Thompson:

The Alaska Physical Therapy Association is in strong support of Medicaid expansion. Access to healthcare is critical for our citizens to stay safe, well, and functioning effectively in their homes and communities. We believe that the proposed expansion in concert with reform measures currently being considered in the Legislature will not only improve the health of Alaskans but will also be good for the Alaskan economy.

Members of our community need to be able to access care at the right place, at the right time, and from the right provider at the right price. When people lack access to health insurance they delay treatment and end up receiving care in the most expensive locations - the emergency room and in hospitals. Early access to health care services will enable Alaskans to stay healthier for longer in their homes and communities. Individuals frequently delay receiving adequate medical care because it is too expensive or too difficult to access. Medicaid expansion will also allow health conditions to be treated at a time when care is relatively less expensive. Early intervention can improve health outcomes, save money and more importantly contribute significantly to quality of life. Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Access to care will improve health outcomes by reducing the number of uninsured Alaskans by half, improve preventive and primary care access, and provide substance abuse treatment and mental health counseling. As you are aware, Alaska has higher incidence of conditions like sexually transmitted infections, diabetes, depression, substance abuse and suicide. All of the above conditions can either be prevented or effectively managed by accessing appropriate primary care. Improved access to affordable healthcare is a critical step if we want to address these serious health concerns in our state.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges. We don't turn down federal money for education, transportation, and the military, and we shouldn't turn it down for health care.

Medicaid expansion is healthy for Alaskans and healthy for the state's budget. Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. Alaska's participation can be contingent on the federal match remaining at 90%. Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Thank you for your leadership in spearheading this critical process for a healthier Alaska.

Respectfully,

LeeAnne Carrothers, PT, PhD
President, Alaska Physical Therapy Association

From: Filymcc@aol.com
To: [House Finance](#)
Subject: April 11 testimony from Partners for Progress
Date: Saturday, April 11, 2015 10:07:38 AM

To: Members of the House Finance Committee

From: Janet McCabe

For: Partners for Progress Board of Directors

Re: House Bill 148

April 11, 2015

Dear House Finance Committee Members,

Our **eleven (11)** member board of directors asked me to express their request that you quickly approve HB 148, to expedite the process of enactment of Medicaid expansion and reform this session. Our reasons for this request are as follows:

1. Action this session would start a flow of new federal dollars into Alaska. The positive ripple effects throughout Alaska's economy would help counter the negative effects of the decline in oil prices. The ratio of benefits over costs of Medicaid expansion is strongly positive.
2. Through the programs operated by Partners for Progress (Therapeutic Court Support and Partners Reentry Center), we have seen firsthand the devastating effects of lack of access to health coverage. Individuals, their families and their employers are all harmed by lack of basic preventive health care. Emergency room care is no substitute, and it costs us all.
3. We are all Alaskans. The people who visited you from Anchorage Faith and Action

Congregations Acting Together, speaking for their collective congregations of 10,000, urged you to consider Medicaid expansion because we must always try to be "our brother's keeper". Our board agrees with them.

Respectfully,

Janet McCabe, on behalf of Partners for Progress Board of Directors

ARCTIC ALLIANCE FOR PEOPLE
A network of Human Service Providers in Interior Alaska

Date: April 7, 2015
To: House Finance Committee
Senate HSS Committee
Interior Delegation
From: Arctic Alliance for People
Re: Support for HB 148 and SB 78

The membership of Arctic Alliance urges the members of the House Finance Committee to pass HB148, the members of the Senate Health and Social Services Committee to pass SB 78, and the members of the Interior Delegation to support the Governor's bills to accept Medicaid Expansion in Alaska, HB 148 and SB 78.

Passage of Medicaid Expansion would provide nearly 42,000 Alaskans with access to health insurance, add 4,000 new jobs and will bring more than \$1 billion federal dollars to Alaska in the first five years. It is also expected to significantly stabilize rising insurance and health care costs by reducing uncompensated care. It will also improve access to both preventative and behavioral health care, helping to build a healthier Alaskan population.

Medicaid Expansion will be good for the Alaska economy – and in this budget environment we can't afford to let an opportunity to stimulate the economy pass us by. To do so would shortchange both current and future generations.

Please support Medicaid Expansion and pass HB 148 or SB 78 THIS legislative session. There are thousands of Alaskans whose quality of life – and even their lives – depend on this wonderful opportunity.

Thank you for your consideration.

Taber Rehbaum and Doug Toelle, Legislative Committee Co-chairs
Pete Pinney, Chair
Arctic Alliance for People

From: [michael mcurdy](#)
To: [House Finance](#)
Subject: Medicaid Expansion....
Date: Friday, April 10, 2015 8:00:46 PM

Because my Social Security Premium for Medicare is over \$100.00 per month, I am unable to afford it. Alaska is Expensive! So I rely on Medicaid. Please consider individuals such as myself..... Michael McCurdy, Homer, AK 99603

From: Deb Sandar
To: House Finance
Subject: Medicaid Expansion
Date: Saturday, April 11, 2015 8:39:49 AM

Good morning -

I am writing in support of Medicaid Expansion for the State of Alaska. I am the Treasurer of the Food Bank of Alaska, and the board and staff of FBA are fully in support of this action. It will improve the lives of many, many Alaskans.

In addition, I belong to a faith community that endorses this action. Leaving fellow Alaskans without access to basic health services doesn't meet the basics of being a good neighbor or a person of faith.

I strongly encourage you to take the right action in this measure, for the good of all of us.

Thank you -

Deborah Sandar
2820 Lexington Circle
Anchorage, Alaska 99502
907-242-4338

From: [Kristi McEwen](#)
To: [House Finance](#)
Subject: Medicaid testimony
Date: Saturday, April 11, 2015 7:44:49 AM

Medicaid expansion is needed now, more than ever. With looming State budget cuts, which will leave thousands of Alaskans without employment and the insurance that comes with it, it would be unwise, unethical, and simply cruel, to deny thousands of Alaskans the opportunity to receive health care, which will be funded by the Federal government. It is not the oil industry that makes Alaska's economy thrive, it is our people – people who work hard every day to make Alaska the place we choose to live. A person with dire health care needs cannot recover the way that oil prices can. With the many ways that Alaska will now have to turn away those in need of services, why also say no to something that we, citizens of the United States, can receive, as so many across this nation do? Medicaid expansion will save lives, create healthy families, make our state stronger, and will be a lifeline in our sinking economy.

Medicaid Expansion now.

Kristi McEwen

321 Miller Hill Road

Fairbanks, AK 99709

Sent from my iPad

From: [Ron Windeler](#)
To: [House Finance](#)
Subject: Medicare expansion
Date: Friday, April 10, 2015 6:53:05 PM

As an Alaskan (native born), I should be in favor of free money from the federal government, but I am also an American, and must oppose criminal, un-Constitutional, un-American spending of my federal taxes on unauthorized and incompetent federal programs such as Medicare and Medicaid. Therefore, I urge you to resist the evil temptation of "free" federal funds for medical care in Alaska. Please, instead, support Americare, the real solution.

From: [Cindy Bettine](#)
To: [House Finance](#)
Subject: I support medicaid expansion.
Date: Friday, April 10, 2015 11:08:33 PM

To the House,

This session, you are faced with a monumental task. The people of Alaska are surely going to face hard times ahead. We've see the state legislature give tax reductions to the oil companies; and possibly a tax credit to Agrium all in the name of increasing jobs.

I'm a small business person and I'm all for increasing jobs. Medicaid expansion will create jobs.

You've proven you are willing to make budget cuts in hard times, so take the Federal money and make the hard cuts in the future if it's necessary. Help the working poor.

Cindy Bettine

Big Lake

From: [Mark Lackey](#)
To: [House Finance](#)
Cc: [Rep. Cathy Tilton](#); [Rep. Mark Neuman](#); [Rep. Wes Keller](#); [Rep. Shelley Hughes](#); [Rep. Lynn Gattis](#); [Rep. Jim Colver](#); [Sen. Mike Dunleavy](#); [Sen. Charlie Huggins](#); [Sen. Bill Stoltze](#)
Subject: Time to Expand Medicaid in Alaska!
Date: Friday, April 10, 2015 8:05:30 PM

I just paid a lot of money in federal taxes.

While I'm thinking a good portion of them could be spent more efficiently, and perhaps I could contribute less...

I certainly would feel better knowing that I was supporting better health and wellness (and providing much cheaper preventive care instead of emergency care) to those without insurance in Alaska. As it stands I'm just supporting those other states to be healthier and and contributing to their cheaper medical bills.

We need to accept the federal funds, increase the percentage of covered individuals, and improve our Alaskan health care system! I'm sure we can continue working on reforms and making Medicaid more expensive, but in the meantime - let's not delay providing more Alaskans with coverage and care.

Thanks for your service to the Mat-Su,

Mark Lackey
Wasilla, Alaska

From: [S.L. Harris](#)
To: [House Finance](#)
Subject: HB 148
Date: Friday, April 10, 2015 8:55:57 PM

Please support HB 148. The bill provides federal funds to pay for basic health care services for uninsured Alaskans. I don't see a down side.

Thank you.

Sandra Harris
424 4 th St
Juneau, AK 99801

From: Tara G
To: House Finance
Subject: Medicaid expansion
Date: Saturday, April 11, 2015 8:20:47 AM

Dear Legislators,

I am writing to oppose expansion of the Medicaid program. Expansion may seem like a good deal for Alaska in the short-term, but I believe that the long-term risks are far too great. There is no guarantee that the federal government will keep its promises or that they will continue to help fund this program, and then where does that leave us? Especially in light of the state's current fiscal crisis, I believe this a risk that we cannot afford to take. Please do not approve Medicaid expansion.

Thank you,

Tara Gallear
Eagle River

From: Familie Veh
To: House Finance
Subject: Expand Medicaid!
Date: Saturday, April 11, 2015 9:03:00 AM

Dear AK State Legislature;

Expand Medicaid! Why? Because it will provide a much needed infusion of money into our health care industry. It's also a life or death situation for the uninsured.

I understand that the members of the AK Legislature already have health care coverage. My recommendation is to strip that healthcare benefit away from lawmakers until they can accept the money for the Medicaid Expansion.

As always, sending respect! Thank you!

Sincerely,
Katharine Veh
Soldotna, Alaska

From: Vince Meurlott
To: House Finance
Subject: Stop HB 148 Please
Date: Saturday, April 11, 2015 8:51:34 AM

Dear Legislators,

Please do not pass HB 148. We do not need an expansion to Medicaid. We believe that we have enough budget problems already and do not need to add to them.

Sincerely,

Vince and Annie Meurlott

596 Arvita Court

Fairbanks, Alaska 99712

Phone (907) 378-4663

Fax (907) 457-4919



"We help adults with mental illness live their own best lives"

Quality Community Behavioral Health Services Since 1985

April 6, 2015

House Finance Committee
Alaska State Legislature
State Capitol Building
Juneau, Alaska 99801

As Executive Director of Juneau Alliance for Mental Health, Inc. (JAMHI), and on behalf of our Board of Directors, I urge your support for the expansion of Medicaid in Alaska. As a state-designated Community Behavioral Health Center, we serve adults with Serious Mental Illness and others experiencing mental illness and multiple co-occurring disorders such as Fetal Alcohol Spectrum Disorder, cognitive impairment, substance use disorders, PTSD, or dementia. In addition to behavioral health issues, many of our clients have chronic medical problems that complicate their mental illness, overall functioning, and ability to live independently. As the population ages, this becomes an increasingly common situation and existing resources don't meet the need. For those without Medicaid or other coverage, options are limited to non-existent.

Medicaid funding is an important revenue stream for JAMHI, accounting for about 50% of our total revenue, and allows us to provide care to those with serious mental illness who have qualified for Medicaid under the existing eligibility criteria. Often, those covered by Medicaid are the Social Security beneficiaries. JAMHI also serves others not currently eligible for Medicaid who have no other payor source. These persons still need treatment to address their disorders and to prevent them from getting worse. Case managers assist clients to help them apply for Social Security benefits. *This assistance is not reimbursable* and even under the speediest of circumstances, using the "SOAR" fast-track Social Security method, it takes on average 40 work-hours to process the paperwork to the point of application. Without this assistance, the process can often take years for a disabled person to become eligible for benefits, often leaving them no means to pay for services.

JAMHI serves between 350-475 adults, providing outpatient clinical and psychiatric assessments, therapy, case management, rehabilitation services, medication management, and care coordination. We coordinate care with primary care providers, the courts, and many other community, regional, and state organizations. In addition to these services, we have a continuum of housing for 52 seriously mentally ill adults, including highly structured Group Living for those in need of a sub-acute setting (just below psychiatric hospitalization) with 24/7 services and monitoring; Supported Living apartments for persons capable of more independent living with staff supports; and Independent Living. Some of the individuals we house used to reside "permanently" at Alaska Psychiatric Hospital until it downsized in the 1980s. Our goal is to assist our clients to live productive lives in the least restrictive, most independent settings in the community. This helps prevent costly hospitalizations, repeated emergency room visits, or incarcerations. Medicaid helps cover the cost of caring for these vulnerable adults.

JAMHI also provides Psychiatric Emergency Services, evaluating persons experiencing suicidality, psychoses, and other psychiatric emergencies which may put them at risk of harm to self or others. The goal is to determine the least restrictive setting that is appropriate for the individual. By working collaboratively with others and tapping into all available resources we have been able to reduce the

3406 Glacier Hwy
Juneau, Alaska 99801

Tel. (907) 463-3303
Fax (907) 463-6858
www.jamhi.org
info@jamhi.org

number of individuals requiring hospitalization. In FY14 we conducted 499 such evaluations in Juneau.

Alaska's present behavioral health treatment system has serious gaps. As a result, there is an imbalance wherein individuals with mild to moderate mental illness and substance use disorders have limited access to treatment services, in contrast with those having severe problems. Medicaid expansion will help remove some of the existing governmental administrative barriers by simplifying the eligibility criteria and process. Individuals will be eligible for Medicaid based on their income (or lack thereof), and this will allow more people with mental health and/or substance use disorders to receive much needed care and treatment.

Some say Medicaid expansion is expensive and something we cannot afford. We believe that we can't afford *not* to take advantage of expansion. Doing nothing, in this instance, costs more than doing something. Medicaid expansion offers us a practical alternative to our current system. It will help create a more holistic and less fragmented approach to healthcare. It will increase the likelihood of successful outcomes, decrease the cost of care, and improve quality. We firmly believe it is the right thing to do. Let's act now!

Thank you for your thoughtful attention to this very important issue. We respectfully ask that you strongly support Medicaid expansion in our state, now.

Respectfully,

Pamela L. Watts
Executive Director
Juneau Alliance for Mental Health, Inc.

From: [Marilyn Holmes](#)
To: [House Finance](#)
Subject: Federal Medicaid Funding
Date: Saturday, April 11, 2015 8:54:30 AM

To the members of the House Finance Committee –

As an Alaskan interested in improving healthy birth outcomes in our state, I am writing to urge you to accept federal Medicaid money in order to provide healthcare to thousands of Alaskans who can't afford health insurance.

According to the World Health Organization, two of the three factors that contribute to healthy birth outcomes for both mothers and infants are 1) universal health care and 2) early and consistent pre-natal care.

These funds will contribute to developing those conditions for Alaska's families.

Thank you,

Marilyn Holmes

Juneau

From: [Kathi Wineman](#)
To: [House Finance](#)
Subject: HB 148
Date: Saturday, April 11, 2015 7:30:39 AM

I strongly urge you to do the right thing and support HB 148 - Alaska's Medicaid. It is the compassionate thing to do.

Thank you,
Kathi Wineman
Juneau

From: [Barry Santana](#)
To: [House Finance](#)
Cc: governor@alaska.gov
Subject: Medicaid Expansion
Date: Saturday, April 11, 2015 8:17:11 AM

Gentlemen and Ladies,

I am an Alaskan voter and typically consider myself socially and fiscally conservative. I am sure there are problems that require fixing in any government program as large as Medicaid...and they need to be fixed. But my Federal tax dollars are being collected this whole Obamacare, Medicaid expansion program and I have NEVER received a dime from Medicaid. With the Alaska Legislature's "head in the sand" approach since this issue became law, fact, reality, you have allowed my money to be spent 100% outside Alaska. The Federal government has been reimbursing states 100 % since the law became effective; there is only 2 years left at best to get in on this Federal freebie; then it will be a 90/10 split. With the potential transfer of medical expenses from other programs to Medicaid and with the economic growth of the Alaskan medical system it seems a no-brainer to me to accept the new Medicaid program and money. Add to that the moral aspects of the issue and it is difficult to understand how the Alaska Legislature has allowed this to happen over the last 2-3 years. We can always opt out if it doesn't work out. We can also attempt to reform Medicaid in a parallel effort...if you have the resolve. You need to resolve this long overdue decision with a yes vote today and get on with budget issues as well as waking up to the damage you are doing to the negotiation process of AKLNG with HB132. Please make a positive decision today!

Barry Santana
Pedro Bay and Wasilla, Alaska

From: Jenny Pursell
To: House Finance
Subject: From Jenny Pursell re the support of Medicaid expansion
Date: Friday, April 10, 2015 8:18:48 AM

Dear Members of the Finance Committee,

I strongly support expanding the Medicaid program in Alaska. I see no downside in doing so. Medicaid coverage will enable Alaskans to get their healthcare needs met so that they can maintain employment or seek employment thusly lending to the health of our economy. It will assist Alaskans being released from prisons to receive substance abuse treatment. These treatment programs benefit all Alaskans as recidivism rates should decline due to those recovery programs. Alaskans having attended recovery programs are more likely to be mainstreamed back into our communities while having the potential to contribute to the strength and health of our communities and state. The expansion of Medicaid programs will reduce the hospital costs for all of us, because those with insurance will not be paying for those folks without insurance..... the Federal government will. The Feds will pay 10% of costs for those eligible for Medicaid through 2016. After 2016 the Feds will pay 90% of those costs. Alaska would then will be responsible for picking up 10% of the costs after 2016. It's important to note that Alaska also picks up 10% of the costs of Federal highway and aviation infrastructure. Surely the medical coverage of Alaskans is JUST as important as transportation infrastructure. As a 13 year resident of Alaska I believe that the health and strength of this state has its foundation in its people. The health and strength of ALL Alaskans MUST be maintained and cultivated for a viable and healthy Alaska!!! I strongly URGE you to expand our Medicaid program!

Jenny Pursell

Sincerely,

P.O. box 33578

Juneau, Alaska, 99803

From: [Jenny Pursell](#)
To: [House Finance](#)
Subject: FW: From Jenny Pursell re the support of Medicaid expansion
Date: Saturday, April 11, 2015 9:58:05 AM

Good Morning and to Whom it may Concern, just want to make sure that you received my email supporting Medicaid expansion which I sent to you April 10 in the morning. Please let me know if you did indeed receive this email. Thank you, Jenny Pursell

From: Jenny Pursell [mailto:mikejen@gci.net]
Sent: Friday, April 10, 2015 8:19 AM
To: 'lhscfin@akleg.gov'
Subject: From Jenny Pursell re the support of Medicaid expansion

Dear Members of the Finance Committee,

I strongly support expanding the Medicaid program in Alaska. I see no downside in doing so. Medicaid coverage will enable Alaskans to get their healthcare needs met so that they can maintain employment or seek employment thusly lending to the health of our economy. It will assist Alaskans being released from prisons to receive substance abuse treatment. These treatment programs benefit all Alaskans as recidivism rates should decline due to those recovery programs. Alaskans having attended recovery programs are more likely to be mainstreamed back into our communities while having the potential to contribute to the strength and health of our communities and state. The expansion of Medicaid programs will reduce the hospital costs for all of us, because those with insurance will not be paying for those folks without insurance.... the Federal government will. The Feds will pay 10% of costs for those eligible for Medicaid through 2016. After 2016 the Feds will pay 90% of those costs. Alaska would then will be responsible for picking up 10% of the costs after 2016. It's important to note that Alaska also picks up 10% of the costs of Federal highway and aviation infrastructure. Surely the medical coverage of Alaskans is JUST as important as transportation infrastructure. As a 13 year resident of Alaska I believe that the health and strength of this state has its foundation in its people. The health and strength of ALL Alaskans MUST be maintained and cultivated for a viable and healthy Alaska!!! I strongly URGE you to expand our Medicaid program!

Jenny Pursell

Sincerely,

P.O. box 33578

Juneau, Alaska, 99803

From: mtaonline.net
To: [House Finance](#)
Subject: Fw: Medicaid expansion
Date: Friday, April 10, 2015 12:20:42 PM

Subject: Re: Medicaid expansion

Please look at the money we are leaving on the table while subsidizing the more enlightened states that have accepted the Medicaid expansion. These are valid studies using empirical timely data,

“The first study, from the Robert Wood Johnson Foundation, examined Kentucky and Arkansas — two states with previously high uninsurance rates that have benefited significantly from Medicaid expansion.

According to the researchers, those states should serve as prime examples of how “expansion can produce savings in tax dollars and generate new revenue for state budgets.” Between state fiscal years 2014 and 2021, Kentucky will save an estimated \$820 million and Arkansas will save an estimated \$370 million after accepting federal funding to extend health coverage to additional low-income residents.

Those savings come from a combination of the additional federal funding allocated for states that accept the expansion and the decline in uninsured residents seeking uncompensated care, which increases revenue for health providers.”

“The second study, from the Kaiser Family Foundation, reported similar findings for Connecticut, New Mexico, and Washington State. Although the researchers acknowledge that it’s difficult to isolate the specific effect of Medicaid expansion on state budgets, they conclude that “early evidence from interviews with budget officials in these case study states shows state savings and revenue gains with limited costs resulting from expansion.”

The three states examined in the Kaiser study are also saving money in programs outside of Medicaid itself, particularly when it comes to their behavioral health programs. With additional federal funding to finance Medicaid, states are able to shift money around to allocate more resources to mental health services, which have suffered big cuts in state budgets over the last several years.

Previous studies projected big savings for Medicaid expansion states — but, now that the policy has been in effect for a full year in many states, researchers are able to start confirming that positive benefit more explicitly. Other states, like New Jersey, have also started factoring the savings stemming from Medicaid expansion into their budgets.

There’s been some other recent evidence that Medicaid expansion can also help spur job growth. According to a recent report from the market research group FitchRatings, the states that expanded their public health programs are creating jobs in the health care field at a more rapid rate, suggesting that “ACA expansion is generally positive for that sector’s employment profile.”

Expanding Medicaid is good for Alaska's working poor and our economy.

From: [Susan Olsen](#)
To: [House Finance](#)
Subject: Fwd: Medicaid Expansion
Date: Friday, April 10, 2015 3:22:23 PM

>

> Dear House Finance Committee members:

>

> I urge you to support expansion of Medicaid: for its very real health benefits to those currently without health insurance; to bring substantial federal dollars into Alaska thus helping to alleviate our current fiscal crisis, and a start to reducing unfunded health costs currently absorbed by hospitals and other facilities but paid by all of with insurance.

>

> Reform of Medicaid does NOT need to be accomplished before accepting federal dollars to expand Medicaid in this state. To so insist is simply a political ploy to thwart the Governor. There is no reason both cannot be initiated at the same time. To argue that we should not expand Medicaid because the Feds might not follow through on providing 90% of the costs in subsequent years (after paying 100% of the initial expansion) is hardly based on experience or principle as evidenced by our long time, complete reliance on, and acceptance of, federal highway dollars.

>

> Your ultimate job is to provide for the security of Alaska's citizens whether through providing for education, food safety, trooper coverage, road building or health. Expansion of Medicaid is fundamentally just the right thing to do.

>

> Susan Olsen

> Anchorage, AK99516

From: [Katherine Hicks](#)
To: [House Finance](#)
Subject: Fwd: Testimony on Medicaid Expansion
Date: Saturday, April 11, 2015 9:38:08 AM

I sent this to Rep. Thompson and Rep Neuman yesterday. I now see that this is the official site I should send this request to NOT FUND MEDICAID EXPANSION. Since I am walking for our Mayoral candidate today, I cannot afford the time to sit and wait to be called upon.

----- Forwarded message -----

From: **Katherine Hicks** <akhix49@gmail.com>
Date: Fri, Apr 10, 2015 at 8:23 PM
Subject: Testimony on Medicaid Expansion
To: Rep.Steve.Thompson@akleg.gov, Rep.Mark.Neuman@akleg.gov

House Finance co-chairs,

I would like this testimony to be put on the record, as I can't afford the time to come down to the LIO and listen to every special interest in Juneau testify while I wait for our turn to testify.

Good morning, members of the committee. My name is Katherine Hicks and I have lived in Anchorage for 41 years. I don't think Alaska should be expanding the Medicaid program. From what I've heard and read, a central claim is that the State will take in more money from this expansion. If you believe that, I have some oceanfront property in Willow to sell you.

The state budget you folks will approve in the next week will include billions of dollars in deficit spending. Who else does that all the time? The federal government. That's the way they do business in Washington, DC, and now they – I should say the Obama Administration – wants to hook us in on the pretext that we will get a short term benefit from expanding Medicaid.

One thing is for sure. Down the road the federal rules will change and guess what, they won't be helpful to, Alaska. And not a one of you on this committee knows if we will have the money when the bills finally come due. By that time, Commissioner Davidson will be long gone, and her pledges that this will all work out fine will be long forgotten. And the citizens of Alaska will be left holding the bag.

My other major concern is that ObamaCare's national Medicaid expansion is being paid for with big cuts to Medicare. In order to pay for the Medicaid expansion and the rest of the things in the federal affordable care act, the government will cut \$716 billion from Medicare overall and \$156 billion from Medicare Advantage over the next ten years.

Much of those cuts will affect doctors who accept Medicare patients. And I am one of many seniors whose own Doctor stopped accepting Medicare. So thank you for that, President Obama. The money the feds are saving on Medicare helps pay for the Medicaid expansion you are considering, a program that will benefit many working age adults, not seniors in poor health with no health care options.

Now, as state legislators, you can ignore this fact by pretending it is not your problem; that it is a federal problem. But by expanding Medicaid in Alaska, you are aiding and abetting the ObamaCare plan to squeeze senior's health care to pay for expanding healthcare for other new groups.

In conclusion, I want to say that I support a safety net for seniors, the disabled, and other people who can't care for themselves. We already do a good job

through the Medicaid program we have today. There may be reforms that would even improve our Medicaid program. But if you believe in the tooth fairy, and think that a few years from now we will find millions and millions of dollars under a pillow then go ahead and expand Medicaid in Alaska.

If you believe there is a limit to what we can afford down the road, then act responsibly and don't commit Alaska to long term Medicaid costs that some experts want you to believe will never come due.

Thank you.

Katherine Hicks

From: [Chris Prussing](#)
To: [House Finance](#)
Subject: Please expand Alaska's Medicaid program.
Date: Friday, April 10, 2015 7:50:35 PM

The hand-wringing and waffling on what should be an open-and-shut "Yes!" decision to expand Medicaid is just ridiculous.

Enough of running this state as if it were the private fiefdom of the Koch, BP and Exxon oligarchy.

Chris Prussing
Juneau

From: [Linda File](#)
To: [House Finance](#)
Cc: governor@akleg.gov; [Rep. Tammie Wilson](#)
Subject: governor's medicaid expansion bill
Date: Saturday, April 11, 2015 9:16:15 AM

To the Chair and Members of House Finance;

Thank you for receiving public testimony on the governor's expansion bill.

If approved, this bill will be the shining legacy of this legislature.

We who support are asking you to open the window of life-saving health care coverage to 40,000 Alaskans. These are people who deserve better. They are our sons and daughters, they are the people who work in our second and third largest industries of tourism and fisheries, often seasonal workers who hold several jobs throughout the year to make ends meet. They are the people who hold the service jobs in the building where you hold session and in the places where you go to lunch or dinners. They are the aides and substitute teachers in our schools. They are the housekeeping staff of the hotels, the clerks at the shops, the homeless you walk by on the street. They are often those without a voice.

The expansion would also bring 4,000 new jobs in medical and related fields, with a return to Alaskans of over \$1 billion dollars in new wages.

It would save the State of Alaska some \$6 million dollars in savings. These are funds we need, now.

Please support the governor's bill for Medicaid Expansion. Do not deny to the most vulnerable Alaskans health care you receive as a person elected by the people of Alaska. We are counting on you.

Linda File
Alaskan resident since 1965
2350 Mission Road
North Pole, Alaska

From: [Teresa](#)
To: [House Finance](#)
Subject: HB 148
Date: Friday, April 10, 2015 5:32:03 PM

I am writing in support of HB 148 to expand Medicaid in Alaska. Helping Alaskans in this tough economy is the right thing to do! People with disabilities would benefit as well. Savings to our State is a no brainer when looking at the cost savings and helping Alaskans without is where we as a people should be!

Please, support and pass this bill!

Thank you,
Teresa Sarabia

Sent from my iPad

From: [Lisa Harbo](#)
To: [House Finance](#); bill.walker@alaska.gov; byron.mallott@alaska.gov
Subject: HB 148 Medical Assistance Coverage; Reform
Date: Saturday, April 11, 2015 9:09:51 AM

Dear House Finance Committee, Governor Walker, and Lieutenant Governor Mallott:

I support Medicaid expansion in Alaska. Because so many people in Alaska already are covered by government-subsidized insurance and/or government-sponsored health care in one form or another, there is absolutely no "free market" for health care in Alaska, and because of this the cost of medical care for those without insurance coverage (and even for many with this coverage, when the coverage includes very high insurance deductibles) is absolutely not affordable, even for many Alaskans with jobs. Alaskans need a medical care safety net where they can get access to needed medical care even when they do not have high paying jobs that include employer-sponsored health insurance. The Constitution of the State of Alaska, Article 7 Section 4 states that "The legislature shall provide for the promotion and protection of public health." Access to medical care is one essential component of the promotion and protection of public health.

Sincerely,

Lisa Harbo
820 Capricorn Street
Fairbanks, AK 99709

- Lifelong Alaskan and over 50 year resident of Interior Alaska -

From: [Cathleen Teich](#)
To: [House Finance](#)
Subject: HB 148
Date: Friday, April 10, 2015 1:29:33 PM

I am in support of House Bill 148 that would give Alaska federal funds (Medicaid expansion) to provide for Alaskans who need health care coverage.

Sincerely,

Cathy Teich

From: [Steve and Heidi Frost](#)
To: [House Finance](#)
Subject: HB148
Date: Friday, April 10, 2015 1:30:47 PM

Hello and Happy Friday,

My husband and I feel strongly that HB148 should be passed by the legislature.

It will make healthcare affordable and accessible to the majority of Alaskans. It will increase the number of people employed in the healthcare industry. Lower the rates I pay (because currently I'm paying for the uninsured - and so are you!). And, reduce the amount the state pays for these services.

It is a win-win-win!

Please pass HB148 - for all Alaskans!

With Regards,
Heidi and Steve Frost

POB 243705
Anchorage, Alaska 99524

From: [Heidi James Frost](#)
To: [House Finance](#)
Subject: HB148
Date: Friday, April 10, 2015 1:24:31 PM

Greetings,

I'm writing on behalf of many individuals with disabilities who would benefit from the passage of HB148. Many people want, but can't get or can't afford, health insurance - at least that was the situation a few years ago. But, now, we can make it affordable to all Alaskans.

By making health insurance affordable, we will be doing much more than just ensuring equal access to all Alaskans, we will also be increasing the number of health-care jobs available. And those jobs are across the spectrum in terms of educational needed to fill them and where the jobs are located. There will be jobs that only require on the job learning as well as paraprofessional jobs and professional level jobs. These jobs will be available in urban, rural, and remote Alaska. It is a great opportunity.

It will also lower the rates I pay the doctors and hospitals. Right now, even nonprofit hospitals are charging patients with health insurance more money to cover the costs of the noninsured. When the majority of people have health insurance, this will become a non-issue.

Finally, in these tough economic times, this is an opportunity to lower the amount that the State of Alaska is paying for health and social service care. Imagine!

Thanks for listening!

Enthusiastically,
heidi

Heidi James Frost
Executive Director
Statewide Independent Living Council of Alaska
(907) 263-2092
www.alaskasilc.org

From: [Lisa J. Seifert](#)
To: [House Finance](#)
Subject: Health Care testimony
Date: Friday, April 10, 2015 1:33:41 PM

Dear House Finance Committee,

I am writing to you to testify on the **behalf** of "**Medicaid Expansion**"

I am a hard working self employed individual. A photographer and Vacation rental proprietor.

I work over 40 hours per week and my income after cost of doing business, Taxes and living expenses hardly leaves me enough to buy Gas.

I have not been able to afford health insurance since October 2009, when my premiums went up to \$575.00 per month.

I had to choose between heating & health insurance.

So after paying Blue Cross & Blue Shield well over \$150,000.00 in the course of about 30 years I was left uninsured just like that.

Medicaid expansion would allow me to have preventative medical Care. This not only guards me from a possible catastrophe and bankruptcy. But it would save everybody money in the long run.

Please Vote "**For Medicaid Expansion**" to help keep "All" Alaskans Healthy.

Thank You,

Lisa J. Seifert
age 53

From: [Fred Nelius](#)
To: [House Finance](#)
Cc: governor@alaska.gov
Subject: Bill 148
Date: Friday, April 10, 2015 7:16:24 PM

Dear House Finance Committee Member,

I am unable to testify in person at your hearing on Bill 148 tomorrow, but I certainly want to let you know my thoughts have not changed since December 25, 2013 when my Letter to the Editor was published in the Alaska Dispatch News.

Here is how that letter appeared:

Palin erred on "death panels"

December 25, 2013

Sarah Palin's death panels do exist, but they were not caused by the Affordable Care Act. That act provides financial assistance on a sliding scale to Americans with incomes above a certain level. People below that level were to be provided health care by Medicaid. In many states that is working.

Palin claimed that the Affordable Care Act would create panels that would, in some situations, deny health care to certain people.

In some states, Republican governors and legislatures have refused to accept federal money to expand Medicaid. That expanded Medicaid would provide health care to people whose income is between the cutoff level of existing Medicaid and the income level that would allow them to get financial assistance to help them afford private health insurance.

Therefore, Republican governors and legislators are, according to Palin's description, denying health care to certain people. They are the death panels.

— *Fred Nelius*

See: <http://www.adn.com/article/20131225/letter-palin-erred-death-panels>

Alaskans have replaced the selfish governor that opposed Medicaid Expansion, but it appears that we still have some heartless legislators who are willing to let people die needlessly because they can not afford medical help.

DO NOY BE ONE OF THEM.

Sincerely,
Fred Nelius
12861 W King Arthur Drive
Houston, AK 99623-1978

(907) 347-9203

From: [Richard Smith](#)
To: [House Finance](#)
Subject: House Bill 148.
Date: Friday, April 10, 2015 12:23:43 PM

I strongly support this Bill.

dick smith

--

Richard H. Smith, PE
HerringbayPE - Consulting Civil Engineer
7866 South Tongass Highway Ketchikan, Alaska 99901
907.225.8605 cell 617.1121
Branch Offices in Sitka & Valdez
Box 912 Valdez, Alaska 99686
907.835.9120 cell 617.1121
herringbaype@gmail.com & herringbaype.com
Alaska Ombudsman Director, EMPLOYER SUPPORT of the GUARD and RESERVE
[ESGR]

From: [Marilyn Pierce-Bulger](#)
To: [House Finance](#)
Subject: I support MEDICAID EXPANSION- FASD perspective
Date: Saturday, April 11, 2015 9:08:40 AM

Hello,

I have been doing FASD diagnosis for the past 5 years. The Anchorage FASD diagnostic team receives referrals from foster/adoptive parents, OCS, agencies, pediatricians, AND birth mothers.

One aspect of this story that is untold and important is that of the adults with FASD who have not been diagnosed, who are out there in the world struggling, and who are **costing taxpayers money** as they are overrepresented in OCS, DJJ, other criminal justice, and health care systems.

When I helped to create Nutaqsiivik (a high social risk family support program) at ANMC/Southcentral Foundation 20 years ago we were capturing data about who we were serving and 28% of the high social risk Alaska Native women giving birth at ANMC either had an FASD or were behaving in a cognitively impaired manner and it was impacting their ability to parent, follow through on OCS case plans, follow parole or DJJ discharge plans, etc.

When some of these undiagnosed women got a diagnosis for their "hidden disability", they became eligible for services they needed and, therefore, might be able to raise a child with assistance. (We documented a longer interval between pregnancies...the revolving door of having a baby, OCS taking a baby began to shift/stop...)

Fast forward to the recent 5 years. I have had adult women in recovery (in their 50's) seeking an FASD evaluation for their adult children (in their 30's) who are doing poorly in the world (i.e. incarceration, can't keep a job, substance use, etc) These adults have no insurance to pay for an FASD evaluation (average cost is calculated to be about \$6,000 because it involves 4 health professionals and a coordination hub.)

The nurse-midwife in me believes that getting their child (even an adult child) an evaluation for FASD (because she knows she drank during that pregnancy) **would be part of the healing process for two generations. Helping the adult child would help her recovery process as well.**

Medicaid expansion would cover these vulnerable adults who are living with "hidden disabilities" so that they **may be able to get the services they should have been receiving since childhood...**

Please support HB 148. Thank you.

Marilyn Pierce-Bulger, ANP

FASDx Services LLC

741 Sesame Street Suite 1B

Anchorage, AK 99503-6657

907/865-3279 phone 907/865-7979 fax

marilynpb@fasdxservices.com



This email has been checked for viruses by Avast antivirus software.
www.avast.com

From: [Penney Benson](#)
To: [House Finance](#)
Subject: I Support Medicaid Expansion.
Date: Friday, April 10, 2015 5:03:37 PM

I urge you to support Medicaid Expansion. Please accept federal Medicaid money to provide healthcare to thousands of Alaskans who can't afford health insurance, In addition to providing health care to Alaskans, federal Medicaid money will boost the state's economy. Data from states that have accepted federally funded Medicaid expansion show those states experienced, greater healthcare job growth, savings to state spending, and lower rates of uninsured patients – which ultimately translates to lower health care costs for the rest of us.

Sincerely,
Penney Benson
PO Box 1124
Cordova, AK 99574
907-424-7540

From: [Felix Favorite](#)
To: [House Finance](#)
Subject: I support Medicaid expansion
Date: Friday, April 10, 2015 9:22:45 PM

Sent from Windows Mail

From: [Conrad Muller](#)
To: [House Finance](#)
Subject: Please support HB 148
Date: Friday, April 10, 2015 7:58:54 PM
Attachments: [conrad.vcf](#)

All Alaskans deserve health care.

Conrad

--

Conrad E. Muller
326 4th St 509
Juneau, AK 99801

206 388-6053

<http://www.databasezone.com>

From: Charles Bingham
To: House Finance
Subject: Medicade
Date: Friday, April 10, 2015 2:26:34 PM

If this were "highway money" you would be all over it. If the Feds should back out, then put a provision in the bill to kill it. We are all ready paying for this, why not take the handout while we can.

Charles Bingham
4005 Borland Drive
Anchorage, AK 99517
907-947-2679

From: [Twyla Hartsock](#)
To: [House Finance](#)
Subject: Medicaid
Date: Friday, April 10, 2015 2:32:17 PM

Please pass the bill to gain medicaid money for Alaska. Thank you. Twyla Hartsock, 2551 Vista Drive, Douglas, AK 99824

From: nomad@spitwspots.com
To: [House Finance](#)
Subject: Medicaid
Date: Friday, April 10, 2015 12:48:30 PM

Please pass House Bill 148 so that all Alaskans can get health insurance! I feel that it is morally right and sound financially.

Thanks for your time, sincerely Doug Meeker, Homer, Alaska.

From: [Aron Wolf](#)
To: [House Finance](#)
Subject: Medicaid
Date: Friday, April 10, 2015 1:14:46 PM

Sent from my iPhone

The expanded Medicaid is essential to the healthcare for a vulnerable sector of Alaskan society it will also substantially help with our present financial state

We should accept it now

Dr. Aron Wolf

From: Dolly
To: House Finance
Subject: Medicaid bill.....
Date: Friday, April 10, 2015 1:28:17 PM

Alaska Legislature:

We, your constituents, want to see the Medicaid expansion bill signed. We hope that you who are still holding back progress on this will see your way clear to stop fighting this and pass it. There are many Alaskans who need this coverage and it will be an advantage for everyone to get it passed. Please do your duty for Alaskans who have voted for you and move this forward.

Thank you,

Dolly and Mike Jens
Anchorage, AK

From: [Sherry Eckrich](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 4:38:58 PM

Expanding Medicaid is very important to thousands of Alaskans. It is short-sighted to not become part of this federal program. Healthcare costs will be borne in the long run by those who have insurance if people who do not have private insurance are not helped to receive care they can afford. Alaska cannot afford to not expand out coverage.

Sherry Eckrich
18514 Olivia Drive
Eagle River, AK 99577

From: Susan Smalley
To: House Finance
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 3:46:01 PM

Thank you for taking this testimony.

I support the expansion of Medicaid. To use a cliché, Alaska's refusal to insure this group of people is pennywise and pound foolish.

When I hear those who are in elected office and who have amazing medical insurance thanks to the state, say things like, "They (the uninsured) can just go to the Emergency Room," or "They (the ERs) have to treat them," I am confounded. This statement in that context seems to say that we have solved the issue of health care for our friends and neighbors. And on to the next issue ...

For example, I, as a taxpayer in the Central Kenai Peninsula Borough, am a co-owner of a valuable piece of land in Soldotna and the hospital on it. I pay attention to the financial numbers in the quarterly reports of the Central Peninsula Hospital — the hospital that sits on my property. People whose only viable access to health care is via the ER, and very often ultimately the hospital stays that follow, are creating financial havoc — both for patients and for us as a borough/community and it affects even those of us who are fortunate enough to have insurance.

More than a decade ago, I was treated for breast cancer. Obviously, I am a survivor. I had access to preventative care in the form of mammograms, and that itself led to the detection of cancer at Stage 1. We had wonderful insurance, much like you as elected officials have now. Even at that, the out of pocket costs were in excess of \$20,000, with my early diagnosis. That's my story.

I can safely say, because of my time spent as a volunteer with cancer patients, that without access to preventative care, many people are not diagnosed until their cancers become symptomatic. In most cases that would be far beyond Stage 1. Ending up in the ER for one's first glimpse of their cancer is a nightmare for the person, as well as for the rest of us who share the burden in some way. The sad and horrific news is that often the later stage diagnosis is followed by much more drastic (i.e. expensive) treatment and the chance of death is greater. If you subtract the human suffering aspect, we, as a society/community are paying the cost of ER visits, surgeries, treatments, hospital stays ... with death as a more likely result, and with much more financial output. Someone lives. Someone dies. Someone pays.

It's magical thinking to envision the ER as a place where one goes with an emergency and emerges whole on the other side. Its function is as a critical stopgap place that should be framed with care on the preventive side and care on the follow-up side. For those we are excluding, it often becomes the only choice. It is expensive for people's health and certainly a financial drain on the rest of us, like you and me and our hospitals. It's the most expensive and least effective method of administering health care.

I admit that my level of concern is about the human beings in my community. Healthy people can be better workers, parents, volunteers etc. The shared reality is that people without appropriate access are costing us a fortune and I trust that for whatever reason, my state

government will respond. And you know what? Those federal dollars are mine too and I want them used this way. I have no conflict of interest and nothing to gain except healthier people and communities.

Sincerely, Susan Smalley

105 Linwood Lane, Kenai, AK 99611


From: [Karol Libbey](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 3:56:38 PM

To the House Finance Committee Members:

I urge you to act now to accept Medicaid Expansion to get the full benefit of federal funding. It will provide greater healthcare job growth, while bringing savings to state spending and lower the rates of the uninsured.

Thank you for your hard work on this matter.

Sincerely,
Karol Libbey
14901 Wildien Dr.
Anchorage, AK 99516

 This email is free from viruses and malware because [avast! Antivirus](#) protection is active.

From: [Sharon Stockard](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 1:23:14 PM

Senate Finance members,

I support expansion of Medicaid for Alaskans, and urge you to support the governor's proposal. There is an effort to enact Medicaid "reform" now but that would be putting the cart before the horse. We should pass Medicaid expansion first, then amend it afterward if needed.

Thousands of deserving Alaskans would benefit from expansion of Medicaid, which would be funded 100 percent by the federal government this year and next. We have already lost 100 percent funding by doing nothing. Plus the state economy would benefit from this expansion. Please pass Medicaid expansion to help out our fellow Alaskans, help stimulate the Alaska economy and receive 100 percent federal funding. It is the right thing to do.

Thank you.
Sharon stockard

From: Julie.Taylor@hcahealthcare.com
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 2:35:23 PM

I am writing in support of Medicaid Expansion. It's good for the economy and good for Alaskan's.

Understandably, there is a fair amount of concern about expanding Medicaid on a "broken" system and a hesitancy to support expansion until it is "fixed". While I agree there are numerous opportunities to improve the program, delaying expansion until better structures are in place has negative implications as well – both from a financial perspective and related to the well-being of many Alaskans.

The patients I am most concerned about are those who are not receiving care for chronic conditions, or those who delay treatment and end up requiring more resources to treat their condition. The "cost" differential between treating a simple sore throat in the ER versus the financial impact of a patient that ends up in renal failure as a result of unmanaged diabetes is staggering. Below you will find two actual patients examples that illustrate the problem with delaying access to care.

Patient A

A 58 year old male has been hobbling on the same bad hip for years. Underemployed and uninsured, he cannot afford to have his hip replaced. He eventually loses his job and is now unemployable – at least until he gets his hip fixed. He takes Advil by the handful to cut the pain, but with limited mobility, he begins to gain weight and is depressed. Months go by and his weight gain continues – and now he has hypertension and is pre-diabetic. He has no money to see a physician so this cycle continues until he begins to experience chest pain one evening and his wife calls 911. The ambulance picks him up and brings him to ARH where he is diagnosed as having an acute MI and is taken to the cath lab. Three stents later, he is in ICU recovering with an additional diagnosis of diabetes to go with his hypertension and obesity. He also has stress ulcers from eating Advil like candy. Hundreds of thousands of healthcare resources have been utilized by this one patient...and he still hasn't had his hip fixed. Fortunately, he didn't have a stroke requiring nursing home placement, because that is a very likely scenario with patients like this. The nursing home stay would have been on our dime as well.

Patient B

A 26 year old female has been suffering with a horrible toothache. She doesn't have dental insurance so she manages the pain as best as she can, figuring it would resolve itself eventually. A month goes by and she is unable to stand the pain any longer and has noticed an odor and experiences purulent drainage from her mouth. She presents to the emergency department looking for pain relief. On assessment, she is determined to have a temperature of 103 and a rapid, thready pulse, indicative of a potential sepsis. She is admitted to the hospital and doesn't respond well to the initial treatment and ends staying inpatient for an extended period of time fighting a super-infection with expensive IV antibiotics. Once again... tens of thousands of dollars are spent because of a condition that could have been treated – and quite possibly prevented – if she had access to dental care.

These are the patients you need to consider when deciding whether or not to support the immediate implementation of Medicaid expansion. They are already in our system – and we are all paying for them in higher costs of care. Imagine how many patients could be treated if we spent those same dollars on the front end instead of the back. If we are ever going to move from reactive to proactive approaches to healthcare, financial support for access to primary care services is a must – which is exactly what Medicaid expansion will provide.

Yes, we want to redirect patients into a primary care setting as much as possible and not pay for ER visits at 10x the cost. This is why the Medicaid clinic Alaska Regional Hospital is proposing in Mountain View makes sense. We are willing to consider foregoing the revenue we receive in the ER treating these patients in the spirit of demonstrating cost improvement opportunities available with Medicaid expansion. The savings in this strategy are large – but not near as substantial as you would find with the examples cited above.

I am hopeful you will keep this information in mind as you make this very important decision. Opponents are using terminology such as "covering able bodied people" as if it is a bad thing, which to me reflects their lack of understanding of the cost conundrum we face as a state. Some of our hardest working Alaskan's fall into the pay ranges that this program could help.

You have a difficult decision to make. If you are interested, I would be happy to provide you with a tour of our emergency department during peak hours - or set up a lunch with our case managers who can tell you what it is really like on the front lines and the patients this decision will impact. I think what you would see would be enlightening.

The clock is ticking on our dollars - and on the health and wellness of Alaskans across the state. I hope you see the value of moving on this in 2015. We cannot afford to wait. Thank you for listening.

Sincerely,

Julie Taylor, CEO

Alaska Regional Hospital



Arctic Slope Native Association, Limited

P.O. Box 1232 • Barrow, Alaska 99723 • 907.852.2762 • fax 907.852.2763

Mr. Chairman-

My name is Luke Welles and I am the Vice President of Finance and Chief Financial Officer for Arctic Slope Native Association, a tribal health organization in Barrow-home to the newest hospital facility in the state of Alaska. We support Medicaid for many reasons, but the primary reason is because of the insurance coverage it will bring to the 43,316 individuals in the state of Alaska by 2020 per the Lewin Report completed in 2013. Both the short and long term benefits are in the state's best interest.

Short term economic benefits include increased federal financial assistance to the state for both non-native and native individuals. Depending on the details of implementation the state could receive up to \$1.12 billion of federal funds while only spending an additional \$61m over the course of the first five years. Given the significant decreases in other areas of the state budget at this current time the additional funds would be significant economic boost in the coming years.

Long term economic benefits include enrolling as many as 20,000+ additional Alaska natives over the next 5 years in Medicaid which will significantly decrease health care expenses to the state of Alaska. When an Alaska native who is a member of a federally recognized tribe receives their health care services from one of the 25 tribal health organizations in the state of Alaska, and Medicaid is the primary coverage, the state receives 101% reimbursement for their care from the federal government. With a current population of over 150,000, Alaska natives will always be a large percentage of the population and it would be short sided of the state to not recognize the fact that the federal government is responsible for the cost of this population's healthcare into perpetuity.

As a long time Alaskan I truly believe this is in the best interest of both the State of Alaska and many of its residents. As you are aware both the Urban Institute and Lewin studies provide detailed social economic facts/figures and the empirical data demonstrating that Medicaid Expansion is a win/win solution for all involved.

Thank you,

Luke Welles
VP Finance/CFO

From: Sandy
To: House Finance
Subject: Medicaid expansion
Date: Friday, April 10, 2015 9:42:05 AM

I favor Medicaid expansion in Alaska. I was fortunate to have worked for 40 years at jobs that provided health insurance, and can only imagine the fear and anger that those without insurance must feel. Every member of the Legislature and their families have access to medical insurance; my friends who work jobs without this benefit should be no different.

Expanding Medicaid as proposed will save money, will improve your constituents' lives and ability to work, and will lessen the burden on hospitals and clinics that must now absorb enormous write-offs.

Please treat Alaska residents as you would want to be treated. Expand Medicaid.

Sandy Dauenhauer PO Box 418 Ester, AK 99725

From: lura.white@att.net
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 6:40:15 AM

Please expand Medicaid. We cannot afford to ignore our less fortunate.

Thank you.

Lura Elverson-White
500 M St, #304
Anchorage AK 99501

Sent from my iPad

From: [Latesia Guinn](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 11:46:34 AM

I would like to encourage and support the expansion of Medicaid for Alaskans. Many of these people who could qualify for the expansion live in rural Alaska and health care is a premium. In our efforts with the Outreach and Enrollment this was discovered that there are alot of people who fall into this gap. Please do all you can to get this passed through ASAP, for the people of Alaska who need this most.

--

LaTesia Guinn
Executive Director
Bethel Family Clinic
Box 1908
Bethel, AK 99559
907-543-3773

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From: [Don](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 12:20:39 PM

Please expand medicaid. It will provide access to more efficient health care to many Alaskans and save the State money. Another strong argument in favor of medicaid expansion is that it will provide coverage for people with alcohol-use disorder to get treatment.

Best Regards,

Don Crandall

From: [Iniakuk Lake Wilderness Lodge](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 12:37:41 PM

I support Governor Walker's position on expanding Medicaid in Alaska.

In addition to providing health care to Alaskans, federal Medicaid funds will boost the state's economy (which could certainly use a boost due to low oil prices and other factors). Data from states that have accepted federally funded Medicaid expansion show those states experienced greater healthcare job growth, savings to state spending, lower rates of uninsured patients, fewer trips to ER because insurance provided a range of options before the need for emergency care.

I urge you to vote for Medicaid Expansion. Alaskans have spoken 2 to 1 in favor of Medicaid Expansion. It's the right thing to do. Being responsive to your constituents is the right thing to do.

Patricia Gaedeke, Owner
Iniakuk Lake Wilderness Lodge, LLC
Of all the paths you take in life, make sure a few of them are dirt. -John Muir
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Remote. Exceptional. Unforgettable. Since 1974

[Trip Advisor](#)
[Facebook](#)
[Iniakuk Blog](#)

From: [Jane Demmert](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 12:47:49 PM

It's time that Alaskans benefit from the expansion of Medicaid as proposed by Governor Walker. By now you know the reasons this makes sense and cents. Health care costs unexpectedly overwhelm Alaskans on meager incomes who now fall above the maximum earnings allowable under Alaska's current income guidelines for Medicaid eligibility. Their fragile financial stability is lost. Health care providers absorb the loss incurred when patients are truly unable to pay their bills.

So what's to be done? Clean up the log jam causing delays in current Medicaid payments
AND go forward with increasing Medicaid access as so many others states have successfully.

Sincerely,

Jane and Dennis Demmert
PO Box 66
Klawock 99925

From: [Loretta Bullard](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 12:49:22 PM

I encourage the house finance committee and the state legislature to support Medicaid expansion. The expansion will:

- provide coverage to those who are without insurance;
- help insure that those of us with insurance, don't foot the cost of uninsured patients through higher medical payments;
- create additional well paying jobs in Alaska; and
- help protect families from the crippling expense of major illnesses. One of the leading reasons families enter into bankruptcy and lose their homes... Is because of medical expenses. Please help Alaskans receive the medical care and financial protection they need.

Sincerely,

Loretta Bullard
Nome, AK

Sent from my iPhone

From: [Emily Kane](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 5:47:12 PM

Dear Legislators

The old adage "an ounce of prevention is worth a pound of cure" applies now more than ever. Unless everyone can have early access to health care, acute problems become chronic and appropriate early intervention never has a chance to work. As a primary care provider in Juneau for 22 years I can assure you that I've saved the State hundreds of thousands of dollars from early intervention. If everyone has access to healthcare we can prevent diabetes and reduce the burden of multiple conditions from irritable bowel syndrome to auto-immune diseases and even cancer. We have no problem accepting federal money for roads. Why should we shun federal money to help PEOPLE?

Sincerely
Dr. Emily A. Kane
Natural Healthcare
Juneau AK 99801

www.DrEmilyKane.com
www.AKANP.org
www.naturopathic.org

From: [Chriss Homan](#)
To: [House Finance](#)
Cc: [Sen. Pete Kelly](#); [Sen. Anna MacKinnon](#); [Sen. Click Bishop](#); [Sen. Donny Olson](#); [Sen. Peter Micciche](#); [Sen. Mike Dunleavy](#); [Sen. Lyman Hoffman](#); [Sen. Kevin Meyer](#); [Rep. Bob Lynn](#)
Subject: Medicaid expansion and budget
Date: Saturday, April 11, 2015 8:31:02 AM

In this time of a fiscal crisis the state of Alaska can not afford Medicaid expansion. In states that have enrollment and costs have been substantially higher than forecast. The Alaska Republican party passed a resolution against Medicaid expansion, aren't you supposed to be republicans? I'm still waiting for Governor Walker's 16% cut in the budget that he promised during the campaign. We need to at least cut by 10%. Every special program is going to scream at even the slightest cut, but we the voters voted you in, not them. Their side lost. We have jobs and families to attend to and do not have the time to always be in your face about our 'special' issue. Please stand strong and represent the basic principles of the republican party; smaller government, lower taxes.

Thank you,
Chriss Homan

From: [Dave Kuiper](#)
To: [House Finance](#)
Subject: Medicaid Expansion and Reform
Date: Friday, April 10, 2015 2:01:42 PM

Dear Members of the House Finance Committee,

Thank you for your service to all Alaskans. I support the Governor's efforts to expand and reform Medicaid NOW. I have heard it said that churches should be able to pick up the slack where healthcare is not affordable. I am a pastor and our congregation is grateful and willing to serve the needs of people as we can BUT healthcare is simply beyond the capacity of our community and I believe so many others. Please do all you can to ensure that the current gap in healthcare coverage for the most vulnerable of our citizens is bridged by supporting the Governor's bill. I believe is the right thing to do!

Thank you,

David L. Kuiper

4920 Car Lynn Circle

Anchorage, AK 99507

From: [Patrick Linton](#)
To: [House Finance](#)
Cc: [Rep. Mike Chenault](#); [Sen. Peter Micciche](#); [Jean Bardarson](#); [Dick Cruse \(skywatcheradvertising@yahoo.com\)](#); [Nancy Merriman](#); [David D'Amato](#); [Kris Erchinger](#)
Subject: Medicaid Expansion and Reform
Date: Friday, April 10, 2015 4:26:42 PM

Dear House Finance Committee Members:

As the Executive Director of Seward Community Health Center, a newly funded federally qualified community health center (FQHC) that opened last year, I am very much aware of the proposed legislation to expand and reform the State Medicaid Program. I do not know all the issues and factors that must be considered from the perspective of managing a large state program such as this. I must respectfully defer to your collective good judgment to do what you think is best for the State and the citizens of Alaska. What I can lend testimony to is what this means as a safety net primary care provider serving the majority of people in the Seward Service Area.

From my professional perspective, I am very much in favor of expanding Medicaid to eligible individuals. We see every day the challenges and frustrations faced by many of our patients and fellow citizens who fall between the eligibility cracks. They fall just above the cut off of the current Medicaid eligibility thresholds and they do not qualify for our own sliding fee discount program. And yet most of them are responsible working members of society who have no other form of insurance. Our trained outreach and enrollment staff do everything they can to assist our patients to find and enroll in some form of coverage, but so many fall into this dreadful "gap" category and have to bear the costs themselves.

So yes, I simply must advocate for these patients that we care for in hopes that many of them will be covered under the expanded program.

I also need to advocate for our community health center; a community project that has been in the works for five years. We represent the best hope to provide sustainable primary health care for our community. We have done well so far in being able to recruit qualified family medicine physicians and practitioners to the health center to serve the community. But sustainability includes being financially sustainable so that we can continue to provide these services in the years ahead. Medicaid expansion will most definitely enhance the financial viability of the health center and support the continued employment of our 20 provider and support staff members. Under expansion, many of our patients will move from the self-pay category to the Medicaid category resulting in increased revenues and reduced write-offs. Because we are non-profit and exist only to serve the primary care needs of the community, these enhanced revenues go directly towards supporting our critical mission.

But I also am a strong proponent of significantly reforming the Medicaid program to control costs, better coordinate care and improve patient outcomes. Simply expanding Medicaid without reform is not sustainable for the State. We must all work together and take responsibility to transform the program and realize these goals. As you consider what reform means and how reform will be developed, primary care will naturally assume an even greater role and responsibility within the Medicaid Program. We know this. We understand this clearly. We are already planning and preparing ourselves to assume this role and carry out our responsibilities at both the local and statewide levels. We are at the table and ready to do our part as the largest primary care network covering the entire state with 28 centers and over 150 sites.

In closing, here are the key takeaways for you to consider and hopefully support:

- Please expand Medicaid for our patients, our health centers and our communities
- Please reform Medicaid to better control costs, coordinate care and improve patient care outcomes
- Please understand the important role that primary care will play in a reformed program
- Please acknowledge our statewide network of FQHC's and welcome us at the table
- Please continue to hold us accountable for our performance individually and collectively

Respectfully and with kind regards,

Patrick Linton

Executive Director

Seward Community Health Center

907-224-8505

From: [Stephanie Stanley-Harrell](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 1:51:30 PM

To Whom It May Concern,

I am an employee of a small clinic in Talkeetna and therefore, I understand the importance of the services needed for rural Alaskans. Medicaid Expansion will provide opportunities for those who may have none. Please consider how important it is for those who need this. Say "yes" to Medicaid Expansion!

Sincerely,

Stephanie Stanley-Harrell, PHR

Human Resources Manager

Sunshine Community Health Center

HC 89 Box 8190

Talkeetna, AK 99676

(907)733-9236 Direct

(907)733-1735 Fax

www.sunshineclinic.org



Sunshine Community
Health Center

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necessarily represent those of the organization.

From: Cici Schoenberger
To: House Finance
Subject: Medicaid expansion
Date: Friday, April 10, 2015 2:15:12 PM

As you can see I am a Behavioral Health Provider at a Community Health Center. I have firsthand information as to how the gap between qualifying for Medicaid and qualifying for subsidies under the Affordable Healthcare Act affects a significant number of people in my community. Many people remain uninsured and therefore cannot afford appropriate health care. Although SCHC offers a sliding fee scale to patients, many still do not have the money to afford basic primary healthcare, including behavioral and dental health. The expansion of Medicaid to this group of people would substantially reduce the number of people without health insurance. A healthier population reduces costs for the state. As the studies that have been completed show, the expense of Medicaid expansion would be outweighed by the savings to the state from uninsured health needs that are either met in a very expensive setting or go unmet until it costs a great deal of money to treat an illness that could have been averted through affordable health care. Many of the patients of SCHC do receive primary health care and are able to afford this, however if they are referred to a specialist or for a diagnostic test that cannot be done in a clinic setting, they are unable to access the treatment that has been recommended because of the cost. I write to urge you to vote for Medicaid expansion both because it appears to be cost saving, and certainly Alaska's budget needs all the cost savings measured that it can get, but also because it is the right thing to do for all your neighbors and friends who could become eligible for basic health insurance and therefore good healthcare. It is the right thing to do.

Sincerely,

Cici Conti Schoenberger, LCSW, CAS

Behavior Health Provider

Talkeetna 733-9229

Willow 495-9425

Fax 733-1735

From: [Shawn Hansen](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 2:40:36 PM

to: House Finance Committee

from : Shawn Hansen, Homer AK.

Re: Medicaid Expansion

Honestly I find it hard to understand why or how any Alaskan can oppose this Medicaid expansion.

We actually have real world hard data from the other states, which have had this program in place, which shows the cost savings to the state and our medical system that translate to reduced cost for all Alaskans; The health improvements for the citizens covered by the expansion, the Job expansion in the health system. More specifically think of the savings in the cost to the currently state-funded CAMA program, the cost to the schools of the children whose parents currently cannot afford the school lunch or adequate supplies because they are paying for their healthcare out of pocket, or the cost of state substance abuse or corrections for someone who did not receive early mental health treatment. Plus all the other inmate health cost.

These are not just claims and projections but real world results. Even in good economic times for our state this seems like a no brainer! In our present budget situation expanding Medicaid is a completely obvious thing to do.

Certainly this is not any panacea for our dysfunctional overall health care system. It does, however, offer an opportunity to begin making some improvements on the system. HB 148 makes a good start on rationalizing and improving the system and starting the move toward keeping people healthy instead of paying much more to try to cure them after they have become sick.

As I said I can't imagine any reason to oppose doing this expansion. I have seen some adds in various media, making vague and misleading claims that the expansion would take money away from things like schools, and other state programs: The sole argument that has a shred of logic so far as I can see is that when, years from now, the Fed's begin to reduce the subsidy from the 100% now in place, that some how that 10% cost in 2020 will cause state budget dislocations.

Given the demonstrated economic positives that is a doubtful situation. But even if it's true then at that time cut the program. Everyone in Juneau has lot's of practice cutting this year. So besides this, future and dubious possible drawback what could be the reason for opposition?

Please inform me if there are real reasons to oppose expansion:

Does anyone remember Ted Stevens? He is no doubt spinning in his grave at the thought of state legislators considering turning down a huge Federal pile of money.

Thank you

Shawn Hansen

Homer AK

From: [Jeffrey Merkel](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Saturday, April 11, 2015 9:34:34 AM

Dear Senators and Representatives,

It staggers the imagination

That you lawmakers are on the cusp of

Turning down millions of federal dollars

Which would create thousands of Alaskan jobs,

If the legislature accepts the Medicaid program

Proposed by Governor Walker.

Have any of you noticed how your popularity has plunged

As you have turned into tea-party tightwads and cheapskates

Toward the concerns of people,

While being wastrels when it comes to oil-patch and corporate giveaways.

May your stock continue to plunge,

As you serve your own ideologies and political gain,

And ignore the needs and concerns of the people.

Which is why we elected Governor Walker,

And sent Sean Parnell packing – to his oil patch golden parachute.

Parnell was always in the pocket of big oil.

What a disgrace he was to our state.

If you can't pull it together in this time of fiscal crisis,

I and many other Alaskans will take the energy
Generated by your dumbfounding recalcitrance,
And turn you out of office.

Your actions resisting the Medicaid Expansion
Will be remembered far and wide
As the best evidence of incompetence and arrogance
In the time of Alaska's greatest need.

Sorry for the fury, but it's real.
There's nothing wrong with the Affordable Care Act.
There's a lot wrong with the Alaska Legislature right now.

Thank you

Jeff Merkel

J e f f M e r k e l

P O B o x 8 0 3 4 3

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*'Hope has two beautiful daughters;
their names are Anger and Courage.
Anger at the way things are,
and Courage to see that they do not remain as they are.'*
Saint Augustine of Hippo

Rev. Lawrence L Rorem

Laura E Rorem

2800-D Peters Lane
Juneau, Alaska 99801
(907) 586-6452
rorem@gci.net

April 11, 2015

House Finance Committee
Alaska State Legislature
State Capitol Building
Juneau, Alaska 99801

We write this letter in strong support for the Expansion of Medicaid in Alaska.

As parents and caregivers of two adult children and grandchildren severely disabled with Fetal Alcohol Spectrum Disorder, Autism and Mental Illness, we are living examples of how important Medicaid is in their lives and ours. Without Medicaid (Denali Kid Care for the grandchildren), they would not survive, or would be an even greater burden on the state as they would be using the hospital as a stop-gap measure. They would be living on the streets or in jail, at an even greater cost to the state. Medicaid provides preventative care that saves the state from much more costly care!

As a 17 year member of the Board of Directors for Juneau Alliance for Mental Health, the local Community Behavioral Health Center serving adults with mental illness, Laura knows that these services provide a LIFELINE for those in desperate need. Many adults with serious mental illness use Medicaid to receive these LIFE SAVING services. Our board, struggles to scrape money together to provide the best services we can to treat mental illness and help our clients to live as independently as possible.

As an ordained Lutheran Pastor for 42 years, Larry's ministry focuses on "the Least of These", those who most vulnerable in society. Laura and Larry together ran food pantry's for many years in the congregations they served. Larry was the Chair of the Glory Hole Board of Directors for 6 years in the early 2000's. Many of these clients would have benefited greatly from Medicaid Expansion.

Our medical support for people who cannot afford adequate insurance to meet their basic health needs is filled with POTHOLES, ROADBLOCKS and DEAD ENDS that harm them and society. As a state we gladly accept Federal Government financial assistance for roads, runways and other needs related to the wellbeing of our state. HUMAN needs for equitable health care are a fundamental NEED FOR OUR MOST VITAL RESOURCE—OUR PEOPLE.

We urge you to lead us toward a **compassionate human based decision** to expand Medicaid so that more of our people can live under the umbrella of health safety.

Respectfully,

Lawrence L Rorem

Laura E Rorem

Rev. Lawrence L Rorem

Laura E. Rorem

From: [Judith Burtner](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 5:08:33 PM

This is Judith W. Burtner. I have never needed Medicaid, and I am thankful for that. I believe that in order to have a healthier climate for all of us in Alaska, we need to expand Medicaid. I think it is the smart thing to do. Thank you.

Sent from my iPad

From: RHEES BURKET
To: House Finance
Subject: Medicaid expansion
Date: Friday, April 10, 2015 2:29:49 PM

I offer the following in support of Governor Walker's proposal to accept increases in Medicaid funding available under the Affordable Care Act, which should and I believe will always be known as Obamacare.

For far too long the poor and near-poor among us have been forced to make ugly choices between receiving adequate medical care and feeding, clothing, and providing shelter for themselves. As a result of this cruel choice which is not forced on many other people in the developed world, the cost of medical care for everyone has been steadily pushed upward, making it still harder for those needing assistance to get enough care when they need it.

The record is beginning to show costs will increase at a slower rate with those in need offered reasonable healthcare options. This helps all of us in Alaska and the Nation as a whole. Refusing to accept the Medicare expansion is unjust, cruel and places Alaska at a disadvantage. We see this in most of the states which refuse to participate in Obamacare. Those states which are refusing can usually be found near the bottom of any list showing success in education, healthcare, or any other measure of the quality of life. We should not be competing for a place with the least but striving to be at the top.

I have personal knowledge of people who are suffering from mental illness. Due to the low funding and poorly managed system of mental healthcare in Alaska, they have added barriers to face in the battle for normalcy and usually end up receiving sub-standard care, and they face huge bills which often go unpaid. The added burden of poor credit does them no good and only shifts many of the bills to the rest of us.

I read of many legislators who complain that we can't expect the federal government to continue to provide the Medicare funding, which is a ridiculous argument and should be rejected without consideration. Do these same legislators refuse highway funding, increases in military expenditures in Alaska, or any of the other funding options those who oppose Obamacare want so badly?

In closing, I want to let those who oppose expansion know we voted for Governor Walker in large numbers and we will be watching, listening and reading of the actions of those of you who oppose helping our fellow Alaskans. We will be back at the polls and we will be working harder than ever to support those candidates who support all Alaskans.

Mr. Rhees E. Burket
Fairbanks, Alaska

From: [Linda](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 4:27:03 PM

I urge you to support the expansion of Medicaid. This program will not only help thousands do Alaskans who cannot afford medical insurance, but will be a boon to local public hospitals that currently are providing services to those without insurance through their charity care programs. This costs each of us since these losses are made up for through higher prices for those of us who pay our own way and through higher insurance premiums for those of us who are insured.

Please do the right thing and approve the expansion of Medicaid.

Sent from my iPad
Linda Murphy
Soldotna, Alaska

From: [Luke Welles](#)
To: [House Finance](#)
Subject: Medicaid Expansion testimony
Date: Saturday, April 11, 2015 9:26:55 AM
Attachments: [Medicaid Expansion.docx](#)

Please let me know if you have any questions!
thanks,

Luke Welles
VP of Finance
Arctic Slope Native Assoc
PO Box 1232
Barrow, AK 99723
907-852-9352 Office
907-399-3029 Cell
907-852-2763 Fax

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From: [Michele Galla](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 4:55:30 PM

Dear Legislators,

I don't care about national political squabbles: I care about the wellbeing of people here and the economic fitness our state. I don't want to see Alaskans suffer while state legislators by proxy play Washington D.C.'s destructive games. Since the majority of Alaska's voters are Nonpartisan and Undeclared, I know I'm not alone in this. Partisan politics about "Obamacare" have no place here.

I'd like to see my federal taxes help people here in Alaska get the medical care they need. Even though this expansion would not directly add services for me or my family, medical bills are a factor in more than half of all bankruptcies, and one foreclosure in our neighborhood affects all our property values. Additionally, it is a matter of morality and compassion: we should ensure our fellow Alaskans have access to affordable, quality medical care. Expanding Medicaid also makes fiscal sense as it helps Alaska's economy by providing and supporting hundreds of well-paying, skilled positions for our workforce. The majority of Alaskans voted for this platform in November and continue to support Medicaid expansion in every poll I've seen.

So, this is a no-brainer: help our economy, while saving the state money; help Alaskans' health and wellbeing, while supporting what the majority of Alaskans want. For all these reasons, let's use available federal resources to help Alaskans. Expand Medicaid.

Thank you,
Michele Galla
Wrangell



April 10, 2015


29th Legislature of the State of Alaska
State Capitol
Juneau, AK 99801

RE: Medicaid Expansion

Dear Legislators,

Please accept this letter as support for SB 78 and HB 148 regarding the Governors' efforts to expand Medicaid. While it is acknowledged that there are many facets to this issue, with some aspects perhaps not completely known at this time; the preponderance of information available does still clearly make this initiative worth pursuing. Being able to serve more Alaskans, while simultaneously having the potential to reduce pressure on the State budget, is an opportunity that deserves to garner our attention, especially in our current environment. Therefore please make every effort to work with the Governor to move this important legislation forward. Thank you for your consideration.

Respectfully,


John Hozey
Valdez City Manager

From: info@alaskara.com
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Wednesday, April 08, 2015 8:14:04 AM
Attachments: [SERIOUS MISGIVINGS - Medicaid Expansion and House Bill 148.pdf](#)
[ATT00001.htm](#)

Hello,

I am hearing that some of you are wavering on Medicaid Expansion. I simply cannot urge you strongly enough to say NO to Medicaid Expansion. There are many reasons why.

There is one that stands out among all others to me... We are moving toward socialism in this country. Medicaid Expansion via Obamacare is one big step in that direction. Are you Republican or Socialist/Democrat? Please do not even consider losing our identity as a free nation by putting this burden on us.

There are also pragmatic reasons to say NO to Medicaid Expansion...

Of 730,000 people in our state, 165,000 already are on assistance. That is a huge financial burden already. Expansion will cost us far more than you think, as demonstrated by what happened in other states already.

The ones who truly need it, have it already. Why would you add to the rolls of assistance those (single, with no children) who are already employed and have employer provided health insurance just to bolster Obamacare's rolls? This expansion is nothing more than another trap to make us dependent upon Obamacare.

Other states who have allowed Medicaid expansion say the enrollment is much, much higher than you will expect and causes financial burdens that their states never expected, nor can they handle. Don't think that people will happily give up their permanent fund to bolster the rolls of Obamacare.

Medicaid will pay for these new single adults far better than Medicare does for seniors. I experienced first hand how doctors refused to take my mother because she was on Medicare. I don't look forward to being forced onto it myself in a few short years because I know doctors will be hard to find. These young single adults will force many seniors right out of the doctor's office because doctors will take more of them due to their benefits paying better.

Regardless, because of the doctor shortage you will create by adding this to our financial burden, more will be using hospital emergency rooms for care because they cannot find a doctor. Hospitals will not be reimbursed very well for their care, so they will also suffer financially. This is an ongoing problem in the states who have already expanded Medicare.

I know you have seen presentations on the dangers of Medicaid Expansion. I'll add a couple of links and one presentation below to refresh your memory. We are trusting you to act like a good parent and keep us from the harm that program will bring to our state. Please don't fall for the 'sympathy' trap brought to you by the left.

<http://alaskapolicyforum.org/2014/10/alaska-makes-right-decision-on-medicaid-expansion/>
<https://docs.google.com/file/d/0B8C9VR9ScGtgOS1TZ25KVlk3cUU/edit>

From: [Emily Kane](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Friday, April 10, 2015 5:47:12 PM

Dear Legislators

The old adage "an ounce of prevention is worth a pound of cure" applies now more than ever. Unless everyone can have early access to health care, acute problems become chronic and appropriate early intervention never has a chance to work. As a primary care provider in Juneau for 22 years I can assure you that I've saved the State hundreds of thousands of dollars from early intervention. If everyone has access to healthcare we can prevent diabetes and reduce the burden of multiple conditions from irritable bowel syndrome to auto-immune diseases and even cancer. We have no problem accepting federal money for roads. Why should we shun federal money to help PEOPLE?

Sincerely
Dr. Emily A. Kane
Natural Healthcare
Juneau AK 99801

www.DrEmilyKane.com
www.AKANP.org
www.naturopathic.org

From: [Anne Fuller](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Saturday, April 11, 2015 8:30:50 AM

Please act to expand Medicaid - our health providers benefit (more routine care, fewer urgent trips, better support for wellness).

Thank you

Anne Fuller
7943 N Douglas Hwy, Juneau AK 99801
fernleafgt@yahoo.com

From: [Kathleen Nyssen](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Saturday, April 11, 2015 9:13:21 AM

Dear Committee Members,

Please support HB 148 and Governor Walker's efforts to expand Medicaid.

In light of the proposed budget, it's clear that **Alaska cannot afford to pass this opportunity up**. To do so would be negligent to the Alaskans who fall through the cracks of the current system. It would be negligent to all Alaskans, fiscally speaking.

As it is, the cost of living in Alaska is prohibitive. Affording health insurance is extremely strenuous for many Alaskans.

I, for example, am a single-parent who falls into the "low-income" bracket. I have three sons, ages 22, 12 and 10-years-old. My younger sons receive Denali Kid Care; however, my eldest is not eligible for DKC, nor is he eligible for subsidies under the Affordable Care Act.

He is not on my insurance because I simply can't afford it.

Expanding Medicaid will help close these kinds of gaps.

Again, I urge you to support HB 148 and help serve all Alaskans.

Thank you,
Kathleen Nyssen

Sent from my iPhone

From: [Andrew Reimherr](#)
To: [House Finance](#)
Subject: Medicaid expansion
Date: Saturday, April 11, 2015 9:42:21 AM

Please do not expand Medicaid. It is Obamacare. It is Federal over reach. Let the medical professionals take care of patients not bureaucrats. Elderly and disabled will be pushed to the back of the line. the State and the Federal governments do not have the money for this.

Andrew Reimherr

From: [Linda Green](#)
To: [House Finance](#)
Subject: Medicaid
Date: Saturday, April 11, 2015 9:16:27 AM

Dear sirs and madams,

Please pass gov. Walker bill which would provide Medicaid coverage to thousands of Alaskans. They sorely need it and it is good for all in the long run.

It is the responsible thing to do for your constituents!

Thank you,
Linda s green

Sent from my iPhone

From: keclark@gci.net
To: [House Finance](#)
Subject: Medicaid participation
Date: Friday, April 10, 2015 3:05:05 PM

We strongly urge the committee to accept the Governor's Bill 148.
We feel sure the Medicaid program will help many Alaskans that need medical assistance.
Further we believe the end result will help Alaska's economic situation.
Please support Governor Walkers Bill 148.

Thank you.

Kenneth & Marie Clark
961 W. Gail Drive
Wasilla, AK 99654
Telephone 907-373-0666
E-mail keclark@gci.net

We request your full support for Medicaid Expansion. This system may have some problems but it is better than not expanding coverage. We appreciate your understanding and full support.

Respectfully submitted,
The Alaskans who have signed below

Signature	Print	Address
1. <u>Cathy Stingley</u>	Cathy Stingley	Homer.
2. <u>Gert Seekins</u>	GERT SEEKINS	HOMER
3. <u>Harvey</u>	J + F P	
4. <u>A. M. Converse</u>	A. CONVERSE	Hunter
5. <u>Brandon M. Glean</u>	Brandon M Glean	Homer
6. <u>Lee Warkworth</u>	Lee Warkworth	Homer
7. <u>Rosemarie Faust</u>	Rosemarie Faust	Homer
8. <u>Louise Lush</u>	Louise Lush	Homer, AK.
9. <u>Tim Quinn</u>	Tim Quinn	Homer AK
10. <u>Frank A. Dropp</u>	FRANK A DROPP	HOMER -
11. <u>Claudia Caffee</u>	CLAUDIA CAFFEE	Homer
12. <u>Elizabeth A. Hunter</u>	ELIZABETH A. HUNTER	PO Box 1128 HOMER, AK
13. <u>Floyd Seekins</u>	Floyd Seekins	PO Box 53 - Homer, AK 99603
14. <u>Bob Moore</u>	BOB MOORE	PO Box 492 Homer, AK
15. <u>Vance Price</u>	Vance Price	184 - W DANVILLE RD.
16. <u>Helen S. Mester</u>	Helen S. Mester	1425 Bay Av. Homer AK
17. <u>Phil Klobertanz</u>	Phil Klobertanz	5140 Kachemak Dr, Homer AK
18. <u>Kearne Craft</u>	Kearne Craft	PO Box 392 Kaslo 99610
19. <u>Karen Cauble</u>	KAREN CAUBLE	Homer
20. <u>Nancy Martin</u>	Nancy Martin	Homer
21. <u>Carol Coleman</u>	CAROL COLEMAN	Homer
22. <u>Megan Gault</u>	Megan Gault	HOMER
23. <u>Daniel Weisser</u>	Daniel Weisser	PO Box 211 Homer AK 99603
24. <u>Chizuko Watay</u>	Chizuko WATAY	HOMER AK 99603

We request your full support for Medicaid Expansion. This system may have some problems but it is better than not expanding coverage. We appreciate your understanding and full support.

Respectfully submitted,
The Alaskans who have signed below

Signature	Print	Address
1. <u>Helen Josefsen</u>	<u>HELEN JOSEFSEN</u>	
2. <u>Carol J. Reich</u>	<u>Carol J. Reich</u>	<u>Soundview Assisted Living</u> <u>980 SOUNDVIEW AVE. HOMER AK 99603</u>
3. <u>Joan Graves</u>	<u>JOAN GRAVES</u>	
4. <u>Althea Clymer</u>	<u>Althea Clymer</u>	
5. <u>Amy Gay Fraker</u>	<u>Amy Gay Fraker</u>	<u>P.O. Box 2867 Homer 2160 Sprucewood</u>
6. <u>Elizabeth Melenthin</u>	<u>ELIZABETH MELENTHIN</u>	<u>P.O. BOX 9501 HOMER, AK</u> <u>99603</u>
7. <u>Marfa Molodtch</u>	<u>Marfa Molodtch</u>	<u>P.O. Box 1185 Anchor Point</u>
8. <u>Jane V. O'Meara</u>	<u>JANE V. O'MEARA</u>	<u>PO Box 1125, Homer AK 99603</u> <u>399551</u>
9. <u>Elmer Erzmainger</u>	<u>ELMER ERZMAINGER</u>	<u>PO Box 153 HOMER, AK. 99603</u>
10. <u>Jeanette Price</u>	<u>JEANETTE PRICE</u>	<u>184 W. Danview Ave. Homer 99603</u>
11. <u>Goniweker</u>	<u>GONIWEKER</u>	<u>184 W. DANVIEW AVE. HOMER 99603</u>
12. <u>Teri Van Dyke</u>	<u>Teri Van Dyke</u>	<u>59295 Park Lane Homer,</u> <u>AK 99603</u>
13. <u>Deronda Somers</u>	<u>Deronda Somers</u>	<u>3953 Main Ave</u>
14. <u>MARGARET ABLON</u>	<u>Margaret Ablon</u>	<u>2158 ASPEN LN HOMER AK 99603</u>
15. <u>Larry N. James</u>	<u>Larry N. James</u>	<u>4048 Bartlett #6</u>
16. <u>LaRene Rogers</u>	<u>LaRene Rogers</u>	<u>Box 849 Homer</u>
17. <u>Barb Brodowski</u>	<u>BARB BRODOWSKI</u>	<u>4048 BARTLETT ST HOMER, AK</u>
18. <u>Katharine</u>	<u>369 KATHARINE</u>	<u>FL FL. 2695 Poppy Ct</u>
19. <u>Alan S. Ches</u>	<u>Alan S. Ches</u>	<u>167 W. Cityview Ave Homer, AK</u>
20. <u>Martha Krahn</u>	<u>Martha Krahn</u>	<u>PO Box 15275 Fritz Creek AK</u>
21. <u>Virginia Stanchio</u>	<u>Virginia Stanchio</u>	<u>Homer AK Bear Creek</u>
22. <u>Micaela Bruyelle</u>	<u>Micaela Bruyelle</u>	<u>Homer AK</u>
23. <u>Mary So Gates</u>	<u>Mary So Gates</u>	<u>PO Box 1107, Homer, AK 99603</u>
24. <u>Alize Lind</u>	<u>Alize Lind</u>	<u>Homer, Alaska</u>
25. <u>Sarah McBride</u>	<u>Sarah McBride</u>	<u>53965 McBride Ave Homer AK</u>

From: [David G Lewis](#)
To: [House Finance](#)
Subject: Medicaid
Date: Friday, April 10, 2015 12:48:30 PM

Dear Sirs,& Madams,

Please support the expansion of Medicaid, it is good for the AK economy and people.

Thank You,

Dave Lewis

Homer

From: [Gerald Brookman](#)
To: [House Finance](#)
Subject: Medicare expansion
Date: Saturday, April 11, 2015 9:22:13 AM

I urge that you support Governor Walker's Medicare expansion proposal. I, personally, would not benefit from this legislation but I understand that an estimated 40,0000 needy Alaskans would. I understand that it would bring jobs and substantial economic benefits to Alaska as well, but I believe the most important reason for supporting it is that it would bring medical benefits to many Alaskans who are presently uncovered, at very little cost to the State.

Thank you for considering my comments.

Gerald Brookman

715 Muir Avenue

Kenai, Alaska 99611-8816

From: [Queen Parker](#)
To: [House Finance](#)
Subject: Support House Bill 148
Date: Friday, April 10, 2015 8:05:37 PM

Please support House Bill 148.

From: [Elyce Santerre](#)
To: [House Finance](#)
Cc: [Sen. Pete Kelly](#); [Sen. Anna MacKinnon](#); [Sen. Click Bishop](#); [Sen. Donny Olson](#); [Sen. Peter Micciche](#); [Sen. Mike Dunleavy](#); [Sen. Donny Olson](#); [Sen. Lyman Hoffman](#)
Subject: Oppose Medicaid Expansion
Date: Saturday, April 11, 2015 9:17:37 AM

Be sure to pay attention to the comments from Barbara Haney, especially the ones I've copied below. She appears to have nailed the problems with Medicaid expansion.

My personal opinion is that we need to fix the current Medicaid program, not expand it in ways that are likely to hurt the current recipients. We need to look at making sure people get care, not "coverage" that doesn't work. — Lisa Santerre

2) The DHSS Estimates Grossly Overstate the Benefits. After looking at the econometric estimates provided here in Juneau, it is pretty clear that there are many factors that have not been considered and that the benefits of Medicaid expansion are grossly overstated. Just for starters, they do not incorporate the impact of new taxes on the supply of providers and cost. Nor do they account for other issues pertinent to service delivery in Alaska. **In the seven other states that have expanded Medicaid, costs on an average rose 88% above forecasted costs--some as high as 123%.** This will likely be much higher in Alaska. The cost over-runs will do great harm to the Constitutional Budget Reserve-- it will be depleted rapidly.

3) Crowd Out Of Most Vulnerable Populations: Current Medicaid recipients, such as the elderly, disabled, and children, will be reimbursed at 50%. The new expanded population will be reimbursed at 90%. If you are a physician, who are you going to take? Clearly the new medicaid patients will crowd out the old ones who are reimbursed at the new rate. Thus, those in most need will go to the end of the line if they are even served at all. This is counter to the original intent of Medicaid... to give aid to those in need.

4) Taxes On Providers: House Bill 148 also imposes taxes on providers. For medical providers already operating at the margin (and many in Alaska are barely surviving), this could be the nail that closes their practice.

5) Medicaid is a big source of funding for Planned Parenthood. Early on [Twitchy covered](#) how medicaid expansion and PPA specifically rewarded Planned Parenthood. In addition, Planned Parenthood has a track record of fraudulent claims with Medicaid.

[American Life League](#) has a page that details the extensive number fraud of lawsuits in Iowa, Texas, California, and Illinois. The [Alliance Defense Fund's Report to Congress](#) in February 2012 details numerous details of fraud and abuse of Medicaid. Expansion would merely expand those opportunities in Alaska.

6) Doesn't fix any of the current problems: According to Leg Audit in FY 2014, there are serious problems with many of the Medicaid system. The payment system (Enterprise, formerly MMIS) is doesn't work efficiently or expeditiously. There are over 451 defects in the payment system documented as of August 2014. The Aries System, used for determining eligibility is also problematic and often provides incorrect results. Over half of the Medicaid providers certification files are incomplete. Nearly 2/3 of the providers lacked of any kind of evidence of rate verification, and important component in addressing costs. If these are not fixed pre-expansion, you can believe they won't be addressed in any new rapid expansion. All

that will happen is an expansion in the problems, and on a much larger scale.

From: [Paul Oliva](#)
To: [House Finance](#)
Subject: Please Accept Medicaid Expansion
Date: Saturday, April 11, 2015 7:28:19 AM

Hi,

I am an anchorage resident and a former AmeriCorps VISTA volunteer. When I was doing my year of service with VISTA, I fell in the gap as a result of the lack of expanded Medicaid here. What kind of message does that send to potential volunteers thinking about doing a year of service in Alaska? Please expand Medicaid and allow VISTA volunteers doing a year of service access to adequate healthcare. It's the right thing to do.

Paul Oliva

Sent from my iPhone

From: Scott
To: House Finance
Subject: Please expand Medicaid in Alaska
Date: Friday, April 10, 2015 3:11:00 PM

Dear Members of the House Finance Committee,

I am writing to request Medicaid expansion in Alaska. Besides the humane fact of what having health care would mean to thousands of our Alaskan neighbors, families, and children, the Alaskan economy is in dire need of this diversification and energy input. As an owner of several small businesses considering our own expansion, I have to say that having the 4,000 newly created- high paying jobs in the Alaskan economy that Medicaid Expansion would provide would make the business community allot more comfortable to continue to invest here at home. This new influx of federal dollars, our tax dollars, are already going to many 'other' states for this purpose. It is time for those dollars to come back home.

Myself, and both of my business partners were able to branch out on our own and create brand new businesses in Alaska. And what made this possible? Healthcare coverage, provided by all three of our wives for our families allowed us this ability to do this. What will healthcare coverage mean to the tens of thousands of newly covered Alaskans? It could be an incalculable myriad of benefits for thousands of families in Alaska. PLUS expansion has the added benefit of reducing the financial burden on the rest of us who already pay for these uninsured folks emergency room visits.

In these low oil price times, it is more important than ever that we continue to push to diversify our economy in whatever ways we can. Ways like Medicaid expansion, Film Tax Credits, and fully funding our education system will pay dividends far greater than our costs now and in ways we can't even calculate. Because right now, the banter in public I hear at my business is a public whose concern is not really the low price of oil, but rather the short-sighted governments response to it.

Thank you for opportunity to offer my views.

Scott Anaya
owner/manager
CRUSH Wine Bistro & CeLLar
www.crushak.com

Sent from my iPad. Please forgive typos.

From: [Leila Wise](#)
To: [House Finance](#)
Subject: please expand Medicaid
Date: Thursday, April 09, 2015 6:55:47 PM

Hi, I'm lucky. I have great health insurance, which means I have great health care. But I also have a chronic condition that first reared its ugly head during a time when I didn't have health insurance. So I ignored the signs and am now struggling.

That makes me extremely sympathetic to low income Alaskans who would be served by expanding Medicaid. Taking care of health issues early prevents long term, more expensive, more destructive problems. Ultimately we do for health care for low income people, whether it's when their lives and bodies are devastated by untreated conditions or whether it's that we pay higher fees and premiums to cover costs for those who can't pay.

Please expand Medicaid. It's a wise investment in Alaska.

Thank you,

Leila Wise
PO Box 244034
Anchorage 99524
277-1330

From: [Mary Sullivan](#)
To: [House Finance](#)
Cc: [Michael Miller](#); [Karla Jutzi](#); [Cara Durr](#)
Subject: Please support Medicaid Expansion
Date: Friday, April 10, 2015 4:22:50 PM
Importance: High

Dear House Finance Committee,

Food Bank of Alaska would like to express its support of Medicaid Expansion. We know that hunger and health are intrinsically connected. Furthermore, we know that having access to health insurance greatly increases the likelihood that individuals will seek medical help before their condition worsens and/or becomes more costly for them, and ultimately for us.

Food Bank of Alaska's network of over 300 statewide partners serves the 1 in 7 Alaskans struggling to find their next meal, this includes 1 in 5 children. And we know from the 2014 Hunger in America, Alaska study that hungry people are faced with difficult decisions every day about whether to pay for food or housing (53%), food or utilities (59%), or food and transportation (64%).

But did you know that hungry Alaskans are also facing serious health problems? 26% have a family member with diabetes. 47% have a family member with high blood pressure. A whopping 56% have unpaid medical bills, and **34% report having no health insurance at all, including Medicaid.**

Having access to Medicaid means that our most vulnerable will have access to the health care they need to thrive and be productive in the workforce. The working poor, in fact, is one of the fastest growing demographics of folks seeking food assistance. We know already that about 60% of those served by Alaska's anti-hunger network were employed in the last year.

For our struggling neighbors, every little bit of help they can receive to stretch their monthly budgets allows them to take steps further and further into independence. Passing Medicaid expansion is good for Alaska's economy not only because of the health care job growth it will create, but also because it will lower the rate of the uninsured and translate to lower health care costs for the rest of us. And, most importantly, lower health care costs for those most struggling, means they won't be faced with some of those heart breaking decisions, like whether to feed their children, or have dinner themselves tonight. It means that for the 56% of Alaska's hungry who are currently making the choice between food and medical care, life will be a little bit easier. It will mean they may finally be able to create the financial and wellness stability they need to change their difficult situation and attain full independence and economic prosperity.

Please support Medicaid expansion. Thank you.

.....
Mary Sullivan, MSW

Director of Advocacy & Agency Relations

Food Bank of Alaska

2121 Spar Avenue

Anchorage, AK 99501

Phone 907.272.3663

Direct 907. 222.3113

Cell 907.727.8773

Fax 907.277.7368

Web FoodBankofAlaska.org



Love Alaska with a gift to end hunger. Please add Food Bank of Alaska when you Pick.Click.Give. at <http://pfd.alaska.gov> – Help us earn a \$25,000 match from Shoreside Petroleum and Petro 49.

From: Keren Kelley
To: House Finance
Subject: Please Support Medicaid Expansion
Date: Friday, April 10, 2015 10:19:01 AM

We respectfully request your full support for Medicaid Expansion. This system may have some “hiccups” but the reality of no system presents far greater problems. We appreciate your understanding and full support.

Respectfully submitted, Keren L. Kelley

From: [badpublicity](#)
To: [House Finance](#)
Subject: Please vote for Medicaid expansion
Date: Friday, April 10, 2015 12:30:16 PM

Please vote for Medicaid expansion.

Barbara Derr
6509 Chevigny
Anchorage ak 99502

Sent from Samsung Mobile

From: [Cindy Smith](#)
To: [House Finance](#)
Subject: Pls pass Medicaid expansion
Date: Friday, April 10, 2015 5:02:30 PM

Please support Medicaid expansion.

Thanks,

Cindy Smith
Juneau AK

From: mcewen.kristi@gmail.com on behalf of [Kristi McEwen](#)
To: [House Finance](#)
Subject: Medicaid testimony
Date: Saturday, April 11, 2015 7:28:02 AM

Medicaid expansion is needed now, more than ever. With looming State budget cuts, which will leave thousands of Alaskans without employment and the insurance that comes with it, it would be unwise, unethical, and simply cruel, to deny thousands of Alaskans the opportunity to receive health care, which will be funded by the Federal government. It is not the oil industry that makes Alaska's economy thrive, it is our people – people who work hard every day to make Alaska the place we choose to live. A person with dire health care needs cannot recover the way that oil prices can. With the many ways that Alaska will now have to turn away those in need of services, why also say no to something that we, citizens of the United States, can receive, as so many across this nation do? Medicaid expansion will save lives, create healthy families, make our state stronger, and will be a lifeline in our sinking economy.

Medicaid Expansion now.

From: [Paula Terrel](#)
To: [House Finance](#)
Subject: Support HB148
Date: Friday, April 10, 2015 10:23:57 PM

I urge the House. Finance Committee to support Governor Walker's legislation to accept the federally funded expansion of Medicaid. I know of several individuals who are about to fall through the cracks and unable to get subsidies for health care. This will not only help them but also be of economic benefit to Alaska.

Thank you.
Paula Terrel
Juneau

From: [Laura Rorem](#)
To: [House Finance](#)
Subject: RE: Medicaid Expansion
Date: Saturday, April 11, 2015 10:03:09 AM
Attachments: [Medicaid Expansion Letter April 2015.doc](#)

Please find attached our letter concerning Medicaid Expansion.

Thank you,

Laura and Larry Rorem

From: mtaonline.net
To: [House Finance](#)
Subject: RE: Medicaid expansion
Date: Saturday, April 11, 2015 10:02:43 AM

Breaking News

4/11/15 11:16 AM EDT

The Montana Legislature has backed expansion of the state's Medicaid program under Obamacare, a startling turnaround after supporters' repeated setbacks during the current session.

More governors in red states have noted the economic advantages of expanding Medicaid. It is also the right thing to do for Alaskans that are struggling to just put food on the table. Even at \$15/hour and a part time \$10/hr job, an Alaskan family of two adults and three children make too much for Medicaid. That was \$34K last year five. Could you live on that? They would be better off to quit working and collect benefits. No one wants that!

Thank you

From: [Karen Grussendorf](#)
To: [House Finance](#)
Subject: medicaid expansion
Date: Friday, April 10, 2015 6:40:20 PM

Sitka Community Hospital borrowed 1 million dollars from the City and Borough of Sitka to cover costs. Much of the overrun was from uncovered charity costs, which could be covered under medicaid. Our new CEO, Rob Allen, has the situation under control, but the problem will continue without the expansion.



City

of

Pelican

BOX 737 - PELICAN, ALASKA 99832 - PHONE: 735-2202/2203 - FAX: 735-2258 - EMAIL: cityhall@pelicanacity.org - WEBSITE: www.pelican.net

**CITY OF PELICAN
RESOLUTION 2015-14**

**A RESOLUTION OF THE CITY OF PELICAN IN SUPPORT OF GOVERNOR BILL WALKER'S
LEGISLATION RELATING TO MEDICAID EXPANSION AND REFORM**

WHEREAS, Governor Walker introduced legislation (SB78/HB148) to expand Medicaid; and

WHEREAS, Medicaid expansion takes advantage of available federal resources by accepting an estimated \$146 million in federal Medicaid expansion money; and

WHEREAS, SB78/HB148 lays out the Governor's plan to reform the State of Alaska's Medicaid system to ensure the program is affordable over the long term; and

WHEREAS, the legislation makes healthcare coverage available through Medicaid to adults who earn \$20,314 or less (\$9.76 per hour) or married couples who earn \$27,490 or less; and

WHEREAS, access to healthcare improves health outcomes and increased productivity and independence; and

WHEREAS, more Alaskans will get preventive and primary healthcare, including behavioral health services and help in managing costly chronic diseases.

NOW THEREFORE BE IT RESOLVED THAT the City of Pelican supports passage of Governor Walker's (SB78/HB148) legislation relating to Medicaid Expansion and Reform.

PASSED, APPROVED AND ADOPTED THIS 8th DAY OF APRIL, 2015.

Signed: Patricia Phillips
Patricia Phillips, Mayor

Attest: Kelly L. Chapman
Kelly L. Chapman, City Clerk



Resolution in Support of Medicaid Expansion

by Anchorage Human and Social Services Executive Directors

February, 2015

Whereas, the health and wellness of Alaskans is a Constitutional priority and is vital to each individual, family, community and our entire State;

Whereas, Alaskans have identified 25 Leading Health Priorities providing a science-based framework to guide efforts toward improving health and ensuring health equity for all Alaskans which includes access to health care;

Whereas, an estimated 40,000 of the most vulnerable Alaskans are uninsured and potentially eligible for Medicaid (*Source: Alaska Native Tribal Health Consortium. Healthier Alaskans Create a Healthier State Economy. Anchorage, AK, 2013.*);

Whereas, the State of Alaska budget deficit, due to significantly lower oil prices and declining oil production, calls for all Alaskans to work together to achieve consensus on priorities, long term financial sustainability, program performance and leveraging revenue sources;

Whereas, routine preventive care contributes to life time good health; early treatment of illness and injury make it more likely for an individual to regain their health; and, treatment in an Emergency Room is most expensive;

Whereas, access to primary care and medication is particularly significant for individuals with chronic disease such as cancer, diabetes and cardiovascular disease; and Medicaid patient are 15% more likely to be tested than uninsured. Medicaid beneficiaries with heart disease are twice as likely to take their medication appropriately, compared to those who are uninsured, and are also more likely to have their blood pressure controlled and to have been checked for high cholesterol compared to the uninsured. [*Cancer Action Network, American Diabetes Association, American Heart Association, American Stroke Association, Medicaid: An Important Source of Health Care Coverage for Patients with Chronic Disease.*];

Whereas, lack of health insurance contributes to family stress and financial instability including 154,900 Alaskans served annually by the Food Bank of Alaska network of over 300 partners:

- 56% making choices between medications/meals
- 26% of households report at least one member with diabetes
- 47% of households report at least one member with high blood pressure
- 34% have no health insurance of any kind, including Medicaid
- 56% of households report having unpaid medical bills
- 53% of clients served have incomes that are at or below the federal poverty level (\$15,510 or less for household of two)
- 27% have incomes between \$1-\$10,000 annually; 29% have incomes of \$10,001-\$20,000 annually

Whereas, good health and wellness are supporting factors in children staying and succeeding in school; adults getting and keeping a job; and, in healthy, competitive communities;

Whereas, the State of Alaska has an opportunity now to develop an Alaska Medicaid Expansion Program which meets the needs of vulnerable Alaskans, communities and Alaska as well as being an effective component of the Alaska health care system and is funded by the Federal government at least at 90% and has the potential to provide additional offsets to program expansion administration;

Whereas, Medicaid Expansion would provide a revenue stream covering a portion of the health care costs of vulnerable Alaskans and in doing so support financial stability and organization sustainability of the Alaska health safety net: community health centers, community mental health centers, tribal clinics, rural hospitals, urban hospitals;

Whereas, in FY2014, as partners in caring for vulnerable Alaskans, coalition members contributed directly to customer health or provided supports to increase the likelihood of short term and lifelong health and wellness. We

- provided 18,805 customers health care services 26,529 customers health screenings; 68,841 customers health education; \$17,690,505 donated logistical or financial assistance; 14,848 with a patient centered medical home; and, 31,793 or 84% of customers surveyed demonstrated/reported healthy behaviors and 8,073 or 84% met the terms of their health treatment plan; and,
- Served 994,312 meals/snacks/ box lunches; sheltered 17,103 homeless individuals/families; provided 24,695 households prevention services and/or income boosts; distributed 540,037 pounds of food; and 1,484 or 64% of participating customers demonstrating improved coping skills, better ability to return to daily life, *ability to return to work and/or home after completing crime or violence prevention and/or stabilization programs* and 1,532 or 70% of participating customers had increased self-sufficiency levels after exiting a program operating in the community; and,
- 1,037 children 0-5 screenings; 1,684 children provided with quality care and education services; 109,165 free books distributed to children 0-5; and, 2,167 or 89% of participating parents/families had increased knowledge of parenting and child development
- 20,948 of youth participating in activities that promote youth development; 196 or 67% participating youth decreasing substance use; 6,000 or 69% youth more engaged with education, learning and school; and, 10,860 or 74% youth with conflict resolution skills (*Note: the information above is a sample based on data provided is based on annual reporting by partner agencies to United Way of Anchorage.*); and,
- We, our partners, business people, teachers, students and parents have been working together to increase the Anchorage School District graduation to 90% by the year 2020, and have together increased graduation rates from 59% in 2005 to 74% in 2014 which contributes as a positive determinant in lifelong health.

Therefore, we the undersigned non-profits support the following Medicaid Expansion strategies:

- Approve Medicaid Expansion
- Fix and clear backlogs for
 - the State of Alaska Medicaid eligibility determination system, Alaska's Resource for Integrated Eligibility Services (ARIES), and;
 - the payment system, Medicaid Management Information System (MMIS) prior to Medicaid Expansion
- Accept federal money for Medicaid Expansion
- Approve supplemental funding for Medicaid Expansion administration

And;

Commit to being partners in this effort by continuing to care for vulnerable Alaskans and by working with the Governor, State of Alaska Legislature, the State of Alaska Department of Health and Social Services, the business community and other stakeholders to develop a sustainable Alaska Medicaid Expansion Program.

Hilary A. Morgan, Co-Chair

hmorgan@ywcaak.org

Signatories

Abused Women's Aid in Crisis, Inc. (AWAIC)

AK Child & Family

Alison Kear, Chief Executive Officer, Covenant House Alaska

American Diabetes Association

Anchorage Neighborhood Health Center

Anchorage Youth Development Coalition (AYDC)

Barbara Dubovich, Chief Executive Officer, Camp Fire USA Alaska Council

CCS Early Learning

Food Bank of Alaska

Jerry A. Jenkins, Chief Executive Officer, Anchorage Community Mental Health Services (and Fairbanks Community Mental Health Services)

Lisa Aquino, Executive Director, Catholic Social Services

Nine Star Education and Employment Services

Pauline P. Smith, Executive Director, Alaska Literacy Program

RurAL CAP

Stephanie Berglund, CEO, thread

Volunteers of America Alaska

YWCA

From: [Devin Swanson](#)
To: [House Finance](#)
Subject: Medicaid
Date: Friday, April 10, 2015 6:58:20 PM

To refuse the federal Medicaid by law makers, is denying our Seniors the best available care, over a political statement. Ridiculous. Don't build three new fighter jets, or a new ship! Why are the old or young the ones to suffer from this?

Sent from my iPhone

From: [Carl Brodersen](#)
To: [House Finance](#)
Subject: I support Medicaid expansion.
Date: Friday, April 10, 2015 11:21:04 PM

-A majority of Alaskans do. I'm most certainly one of them. Please do the right thing.
-Carl Brodersen, Juneau.

From: [Martin Zeller](#)
To: [House Finance](#)
Subject: HB 148
Date: Friday, April 10, 2015 8:27:24 PM

Dear members of the House Finance Committee,
My name is Martin Zeller and I am and have been a resident of the Homer area since 1972. I support HB 148 for many reasons and they all are underscored by their benefit to the citizens of Alaska and the economic and health welfare of all Alaskans irrespective of their eligibility or disability. I am also impressed by the time deadlines for the reform elements of the bill.

My understanding is that the passage of this bill will benefit the State of Alaska by the potential for receiving \$1.1 billion in federal dollars to support the Expansion; 3-4000 new jobs can occur; and about 40,000 uninsured Alaskans will be eligible for basic health coverage.

Ultimately it is the right thing to do and the payoff will be a healthier and more inclusive statewide community.

Thank you for your attention to this mail.

Sincerely,
Martin Zeller
509-294-0451
martinzeller10@gmail.com

From: [David Cheezem](#)
To: [House Finance](#)
Subject: HB 148
Date: Saturday, April 11, 2015 7:34:12 AM

Please support HB 148. The talking points chatter about so-called "reform" is just excuses for inaction. The moral case for expanding Medicaid and the economic case are both aligned.

-- David Cheezem
720 S Alaska St.
Palmer, AK 99645

From: [Barbara Doty](#)
To: [House Finance](#)
Subject: Medicaid Reform
Date: Friday, April 10, 2015 10:16:37 PM

Thank you for hosting the statewide opportunity for public testimony on Medicaid Reform. This is Barb Doty M.D., newly appointed Mat Su Borough Assembly member and practicing family physician in Mat Su for 28 years.

Regarding Medicaid Reform:

Alaska currently has an unsustainable health care system, arguably the most expensive in the nation, and is not in line with efforts to improve and refocus health care toward prevention and optimal health of Alaskans. We have the resources to provide the best health care in the country, but to do so we must invest in infrastructure and insist on good health status data, reasoned principles of operations, and clinician payment based upon health outcomes and patient-informed choice.

I support Medicaid Reform and Expansion that includes the following:

1. Blended payment for Patient Centered Medical Home care models where health status data is collected, analyzed, and acted upon for optimal continuity care
2. Accountability for medical travel costs, including holding patients accountable when appointments are not kept.
3. Expanded use of telemedicine and conference call consultation with appropriate payment streams.
4. Standardized primary pharmaceutical formulary across all payers
5. Active streamlining of administrative burden for clinicians
6. Incentives for development of Independent Physician Association Associations and Primary Care-lead Accountable Care Organizations for coordinated comprehensive care
7. Cost transparency across all levels
8. Primary care coordination of ER Utilization and post-hospital care that is payment incentivized
9. Regulatory reform for Behavioral Health payment to allow all qualified licensed Mental Health Professionals at masters or above bill for services when practicing in conjunction with a licensed primary care clinician
10. Emphasis on the triple aim of Higher Quality, Lower Cost and Better Patient Satisfaction

Thanks for accepting my input.

Barbara Doty M.D.
District 6 representative, Mat Su Assembly

From: Frank & Donita Duncklee
To: House Finance; Sen. Pete Kelly; Sen. Click Bishop; Sen. Mike Dunleavy
Subject: Stop HB 148
Date: Saturday, April 11, 2015 9:21:13 AM

Representatives and Senators,

This isn't good. Thou this is a House Bill it will be coming to you in the Senate soon. This bill should never see the light of day on the floor of the House or the Senate. Please say NO to Medicaid Expansion. The bill has passed the Senate HSS committee and is now headed to Senate Finance. How did this thing even get out of the HHS committee? Medicaid expansion specifically rewards Planned Parenthood, do we really want to support that organization even more?

Alaska **can not** afford this additional drain on the Constitutional Reserve.

Thank you,

Frank and Donita Duncklee

From: [Mary McDowell](#)
To: [House Finance](#)
Subject: Support for HB148 - MEDICAL ASSISTANCE COVERAGE; REFORM
Date: Saturday, April 11, 2015 8:19:54 AM

Dear Members of the House Finance Committee,

I am writing to ask for your support and passage of the Medicaid expansion and reform bill. I believe that taking advantage of the opportunity currently available to Alaska to expand medical coverage to more Alaskans, at so little cost to the state, is the fiscally and morally responsible thing to do.

The expansion would provide so many short and long-term benefits to the individuals who could access better medical care and their families, and to the overall state economy, that it seems inconceivable that we would pass up this opportunity. It is my understanding that Alaska can opt to bow out in future years if the federal government fails to provide at least 90% of the funding. I doubt that that will happen, but even if it does and the expansion to cover the bigger pool of people does not continue far into the future, it only makes sense to take this opportunity to provide better access to health care for so many Alaskans in the meantime. Even a few years of better health care for more Alaskans will pay dividends to the state and its citizens into the future.

With both the state and federal governments struggling with budget shortfalls, and the costs of medical care and medical assistance programs constantly rising, I don't believe that Alaska taking advantage of the opportunity to expand Medicaid eligibility now will diminish the motivation and pressure to continue making needed reforms to medical assistance programs.

Please move HB148 out of the Finance Committee and do all you can to ensure its passage by the full legislature before the session adjourns.

Thank you.

Sincerely,

Mary McDowell
Box 7
Angoon, AK 99820

From: [Monica Adams - CEO \(PCHSAK\)](#)
To: [House Finance](#)
Subject: support HB148
Date: Thursday, April 09, 2015 4:21:02 PM
Attachments: [supportHB148.docx](#)

April 9th, 2015

Dear House Finance Committee

My name is Monica Adams. I am the CEO of Peninsula Community Health Services of Alaska. I am urging you to please support Medicaid Expansion (HB 148). PCHS is a Federally Qualified Health Center and Community Mental Health not for profit health care agency serving 7,500 Under and Uninsured Alaskans living in Central Kenai Peninsula. Over the past two years, the number of uninsured patients we have cared for has risen from 13% of our total patients to 17%. In that same time we have provided over \$3,000,000 in charity care or other losses due to the inability to pay. Many of these people who struggle to pay medical bills are uninsured who may otherwise qualify for Medicaid. The health care industry that cares for the uninsured patients including hospitals and Community Health Centers cannot continue to care for a rising uninsured population. The more Alaskans that continue to remain uninsured the less available health care resources are for all. As it is today, without Medicaid Expansion, PCHS and other agencies like ours will have to eliminate vital health services which will impact the health and safety of our communities. Some may think that this will save the State overall and look only at dollars, but what they do not take into consideration is that these are our community members remain in our community, will access care as emergencies rather than through preventative primary care, thus costing the State and all of its citizens. Community Health Centers provide efficient and effective care for those who are on Medicaid, Medicare, and the Uninsured. Supporting Medicaid Expansion allows patients to receive LOW COST, efficient, effective preventative care which otherwise is delayed resulting in expensive chronic conditions that burden our society and nation as a whole.

People who have health care access are more likely to be employed and contributing members of society; working, paying taxes, and contributing to social and economic growth. As an employer, those who are insured either through our agency or through other plans are healthier are more likely to engage in preventative health care service allowing them to be more participatory members of our workforce. All of us want a healthy and vibrant workforce and community, and Medicaid Expansion is a step toward that end. There are thousands of Alaskans who do not make a living wage, many of whom are uninsured and who could qualify for Medicaid. These hard working Alaskans are likely to experience the struggles of limited access to care resulting in greater sick days and the subsequent financial and health impacts. Medicaid Expansion makes sense for Alaska so that we can have a healthy economy and healthy citizens.



We appreciate the time and attention you have given this important decision and respectfully urge you to expand Medicaid in Alaska.

Thank You,

Monica Adams

From: [Kathleen Menke](#)
To: [House Finance](#)
Subject: Support of Expanding Medicaid
Date: Friday, April 10, 2015 1:21:58 PM

I am on Medicare, so don't need expanded Medicaid.

However, I lived in Alaska for 18 years without medical insurance before reaching the age at which I could buy into Medicare. I know the insecurity that such lack of insurance brings.

I have worked multiple jobs, but few paid me more than \$14,000/year. Couldn't have afforded health insurance. Wouldn't have qualified me for subsidies under #ACA.

Yet, I paid all my bills and built my own house out-of-pocket. Worked wage jobs and ran my own part-time business as photographer/book publisher.

I was lucky and didn't have any major medical emergencies.

Thousands of Alaskans work hard at either low-paying wage jobs and/or as small business owners, contributing to Alaska's economy and well-being. Bankruptcy and bake sales should not be their only option if they need medical care.

Furthermore, care for all of us in Alaska will be improved if federal dollars can be used to expand Medicaid and reimburse providers as needed.

Regards, Kathleen Menke, Haines

From: Diane K King
To: House Finance
Subject: Support of Medicaid expansion and reform
Date: Thursday, April 09, 2015 12:16:39 PM
Attachments: Diane K King PhD.vcf

To the House Finance Committee,

I live in Anchorage and am a Research Assistant Professor at UAA. My area of research is focused on preventing chronic disease, substance use/abuse, and FASDs.

I am writing to ask you to support HB 148.

In addition to the many fiscal arguments in favor of the expansion (including potential for stimulating Alaska's economy and reducing uncompensated care provided by our already overburdened community health and public health care systems), assuring all Alaskans have adequate coverage to access primary care services is a cost-effective way to reduce health disparities and *prevent* many of the costliest diseases and causes of death.

Thank you for all of your work for Alaskans and for listening to both sides of this issue.

Sincerely,

Diane King



I could not at any age be content to take my place in a corner by the fireside and simply look on. –Eleanor Roosevelt

From: [Gail Heineman](#)
To: [House Finance](#)
Subject: This Alaskan supports HB 148, Medicaid expansion
Date: Friday, April 10, 2015 2:16:33 PM

House Finance Committee members,

I am a 34-year Alaska resident. As do a majority of Alaskans, I support Medicaid expansion. I urge you to pass HB 148.

I know that some of you demand reform of DHHS first. I hope you will agree that the reform may be done during and after acceptance of the money.

Besides the near certainty that it will save our State money, we should support expansion so that more of our residents will have access to medical care.

I know that some of you are concerned that there are not enough providers for Medicaid patients. I hope you will see that as reason to work with providers on this issue. We all know that there is already more access for Medicare recipients in Anchorage than just five years ago, because it was seen as a problem and addressed, not just ignored.

Sincerely,

Gail Heineman
2732 W 67th Ave
Anchorage AK 99502

907-243-1602

From: [Chris Prussing](#)
To: [House Finance](#)
Subject: This chart seems to make pretty clear why the Republican objection to Medicaid expansion
Date: Saturday, April 11, 2015 7:38:51 AM

It made me wonder if perhaps more than a little racism is involved.

<http://equitablegrowth.org/interactive/aca-beneficiaries/#>

From: [Jesse Carlstrom](#)
To: [House Finance](#)
Subject: Please Support House Bill 148
Date: Saturday, April 11, 2015 1:10:58 AM

Dear House Finance Committee:

Please support House Bill 148.

I'm a 32 year old lifelong Alaskan. I grew up in Fairbanks. I currently reside in Anchorage. I intend to raise my family in the Last Frontier.

It's critical to expand medicaid in Alaska. It will be good for the people of Alaska. It will be good for the businesses of Alaska. Supporting House Bill 148 is both the morally and fiscally right thing to do; it's an investment that will provide social and financial returns to the state for years to come.

Please support House Bill 148.

Thank you for your consideration,
Jesse Carlstrom

From: [Susan Amundson](#)
To: [House Finance](#)
Subject: Medicaid Expansion
Date: Friday, April 10, 2015 8:04:20 PM

Dear Members of the House Finance Committee:

I am writing to request that you move the Medicaid Expansion Bill forward in order to provide health care coverage for low-income Alaskans. As you are probably aware, the State of Alaska currently spends millions of dollars each year for uninsured, low-income, and disabled citizens using emergency levels of care. Without less costly preventative health services as with Medicaid Expansion, these stakeholders use exorbitantly-priced health portals such as emergency rooms and psychiatric hospitals costing the state so much more.

Thank you for your commitment and work for the State of Alaska.

Regards,
Susan Amundson, PhD
1060 East End Road
Homer, AK 99603

From: [Jenise McGraw](#)
To: [House Finance](#)
Subject: VOTE YES ON MEDICAID EXPANSION
Date: Friday, April 10, 2015 1:47:43 PM
Attachments: [image002.png](#)

Thank you again for the opportunity to

SUPPORT MEDICAID EXPANSION FOR ALASKANS!

The residents of Alaska need and deserve the Medicaid Expansion.

As an employee of a community health center, we see a variety of patients who have Medicaid.

Some of our elders, as well as our children, would not be able to have good health care without

their Medicaid benefits. Please make your YES for MEDICAID EXPANSION for Alaskans!

Jenise McGraw

Executive Administrative Assistant to the ED

Sunshine Community Health Center

Talkeetna, Alaska 99676

Telephone: 907-733-9230

E-mail: jmcgraw@sunshineclinic.org



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From: Gail Roust
To: House Finance
Subject: Medicaid Expansion/Reform
Date: Saturday, April 11, 2015 12:23:52 AM

Alaska Legislators--

I strongly urge you to approve Governor Walker's plan for Medicaid expansion and reform!!!

It will help many fellow Alaskans who cannot otherwise afford health insurance to gain access to health care, while virtually eliminating their use of very expensive emergency room services for nonemergency healthcare. This will save the State big money, as it is much less expensive to pay the State's share for Medicaid insurance than to pay for preventable emergency room services for these folks. (Certainly, by now, you are aware that Medicaid covers preventive health services that eliminate much of need for costly emergency room services.)

Additionally, the generous Federal share of such Medicaid expansion will provide Alaska a nice chunk of matching revenue into the future!!!!

Accepting these Medicaid expansion funds for Alaska should, indeed, be a no brainer--especially since State funds are presently so short.

Gail Roust

Sent from my iPad

Sent from my iPad

From: [Megan Irene Behnke](#)
To: [House Finance](#)
Subject: please support HB 148
Date: Saturday, April 11, 2015 7:54:03 AM

Greetings:

Please support HB 148. This issue is close to home for me--a dear friend who is about to turn 23 is going to lose her health insurance, since her parents are retirees from the state, and their dependents are only covered to 23, not 26.

Under the current rules, she cannot receive subsidies. Please help everyone who, like her, is slipping through the system and suffering for it. It will not cost our state, but will help so many.

Thank you for listening.

Megan

--

Megan Behnke
Chemistry
St. Olaf College
behnke@stolaf.edu

From: [Crystal Hudak](#)
To: [House Finance](#)
Subject: Written testimony for HB148
Date: Friday, April 10, 2015 10:42:27 AM

Good morning,

I'm a graduate from the Coast Guard Academy and served 6 years active duty. I have a Masters degree I earned while in the Service. I'm currently working on my MBA on my GI Bill, I play volleyball on a community team, and I'm one of the fastest lady marathoners in Alaska. I also work over 40 hours a week in a fast-paced environment where I'm considered the expert in my field. I'm a private citizen. I volunteer at my Church, I love to bake, and I love step aerobics, even though I'm often tripping over the bench and on the wrong foot.

I've been diagnosed bipolar and have periods of severe depression where I often think about suicide. I suffered from depression starting in high school, and in my late 20's I began hearing noises that weren't there and suffered from extremely scary and unstable mood swings. I was terrified for myself, and certainly terrified what others would think if I told them. Many people here will judge me for that statement or say I don't look like THOSE people and some will stigmatize me, impacting occupations and relationships. I don't do drugs, I'm not a heavy drinker, I'm someone who's brain chemistry failed her and she was brave enough to seek help. It wasn't easy, and I'm thankful for good friends and community resources that gave me this opportunity. I'm not alone either. According to an article Newsweek released in 2014, one in five adults struggles with mental illness annually. That's depression, bipolar disorder, schizophrenia and other very treatable illnesses. I'm lucky in that I have health insurance through my employer that covers my medication, but if I had to choose between groceries and medication, most likely I wouldn't be here. Medicaid would expand basic health insurance to individuals who earn up to \$20, 314.00 per year, giving approximately 40,000 Alaskans the opportunity to seek and receive medical care. Won't it be wonderful for those to not have to choose between groceries and medical care, but to receive the care they need to work.

IF it wasn't for JAHMI, I do not exaggerate when I say I'd be dead right now. Expanding Medicaid gives other fellow Alaskans the opportunity to have a normal life and contribute. By expanding Medicaid, fellow Alaskans won't have to choose between groceries and medication and our population will be healthier overall. I'm a success story – but only because I have health insurance and access to JAHMI. At my first appointment at JAHMI I broke down in tears - not because of pain, but because of the support and hope I felt from such a caring staff. Now, when I go to follow-up appointments, they ask about my activities, my family, and information I told them three months prior. I'm not the 3PM appointment to JAHMI - I'm Crystal, a unique individual, and my recovery plan is especially tailored to me. How do you determine how much someone's functionality and safety is worth?

This is a tough budget environment and I do not envy the decisions you're making. I ask you to think hard about Medicaid and this opportunity to save Alaska's future and people like me. I contribute so much to my community, but only if there are people and resources like JAHMI around to help me stay healthy.

Thank you. I am available for questions.

- Crystal

From: [Larri Spengler](#)
To: [House Finance](#)
Subject: yes on HB 148
Date: Friday, April 10, 2015 4:11:03 PM

Greetings:

I urge you to support HB 148, joining with Governor Walker's effort to accept the federally funded Medicaid expansion for those Alaskans who are otherwise likely to fall through the health care cracks.

A real example is a young woman I know who is going to turn 23, and thus go off her parents' health insurance; they are state retirees, and for that group, the coverage of dependents does not go to age 26, but rather to age 23.

In the coming year she won't be making enough money to qualify for a subsidy under the basic Affordable Care Act format -- oddly, if a individual makes less than \$11,670 a year, they are required to buy health insurance, but they don't get the subsidies that a low income individual who makes more than that amount may obtain to offset the costs.

Please help correct this unreasonable result, at no cost to state for now (and little cost later), by accepting the federally funded Medicaid expansion. To do so will improve the health of Alaskans, and of our state's overall economy.

Thank you.

Larri Sepngler

Larri Irene Spengler
4545 Thane Road
Juneau, Alaska 99801
907-586-9768 (phone/fax)
lspengler@ak.net

From: [Art Peterson](#)
To: [House Finance](#)
Subject: SUPPORT Medicaid expansion
Date: Friday, April 10, 2015 10:49:47 PM

Hello,

Please **support** Governor Walker's efforts to expand Medicaid – **HB 148**. This expansion would be economically advantageous to the state **AND** provide medical-insurance coverage to thousands of Alaskans who cannot afford to get other health insurance.

As a 48-year Alaskan, I know that we want and need health coverage for the people of our state.

Sincerely,

Art Peterson

Juneau



ALASKA STATE LEGISLATURE HOUSE FINANCE COMMITTEE

State Capitol, Room 519

Rep. Mark Neuman, Co-Chair

Rep. Steve Thompson, Co-Chair

Thursday, April 9, 2015

8:30AM

Agenda:

HB 148 - MEDICAL ASSISTANCE COVERAGE; REFORM

Gov - Department of Health and Social Services

Discussion of Fiscal Notes

Presenting in Person:

- VD - Valerie Davidson, Commissioner, Dept. of Health and Social Services
- SH - Jon Sherwood, Deputy Commissioner, Dept. of Health and Social Services
- HU - Becky Hultberg, ~~Senior Vice President~~, Alaska State Hospital & Nursing Home Association
+ CEO
- o **Available as lifelines for these two:**
 - § Ree Sailors, Deputy Commissioner for Family, Community & Integrated Services
 - § Margaret Brodie, Health Care Services Division Director (on phone)
 - § Jared Kosin, Executive Director, Office of Rate Review (on phone)
 - § Ron Kreher, Director Public Assistance,
 - § Duane Mayes, Director Senior & Disabilities Services
 - § Albert Wall, Director Division of Behavioral Health (on phone)

Other Invited Testimony or questions:

- DT → David Teal, Director, Legislative Finance Division
- Li - Arnold Liebelt, Policy Analyst, Office of Management & Budget

Available for Questions in person from DHSS:

Monique Martin, Health Care Policy Advisor
Ron Kreher, Director Public Assistance,
Albert Wall, Director Division of Behavioral Health
Chris Ashenbrenner, Medicaid Expansion Program Director

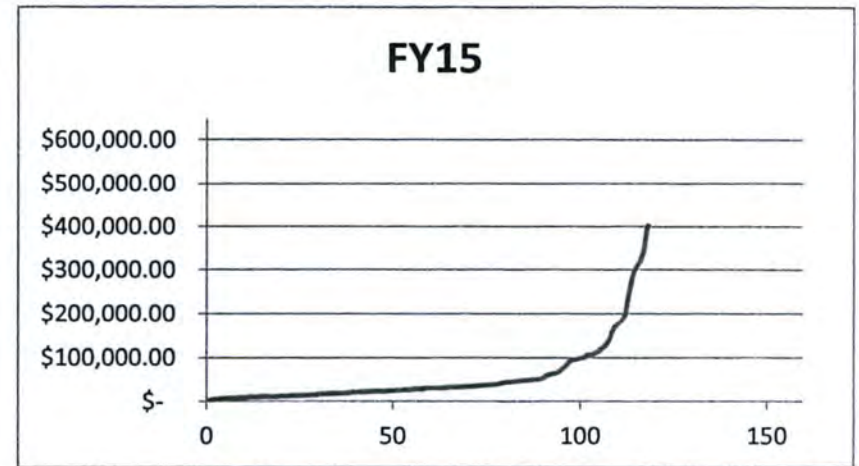
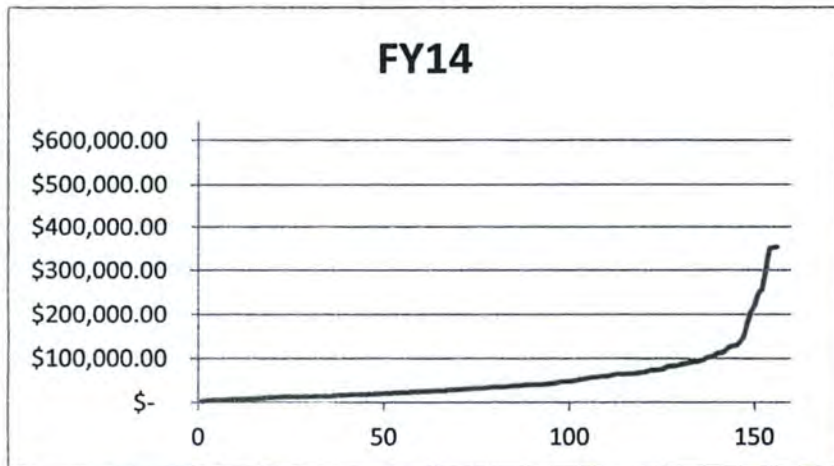
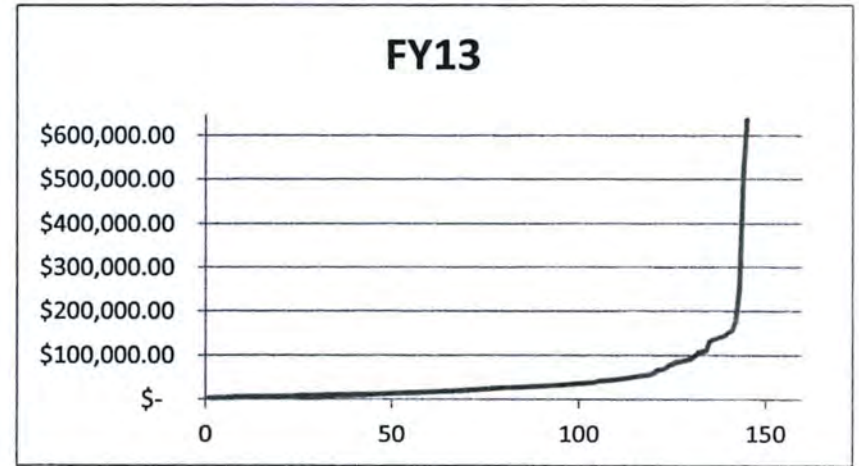
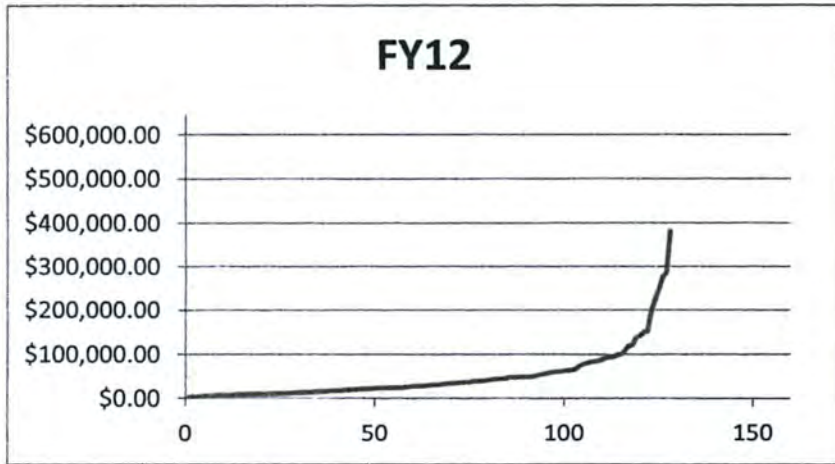
Available for Questions in person:

- RHE Remond Henderson, Deputy Commissioner, Department of Corrections

Yesterday's Invited Testimony:

- EI → Matt Eisenhower, Executive Director of Foundation and Community Health Development, Peace Health, Ketchikan Medical Center
- RI — Bruce Richards, External Affairs/Marketing, Central Peninsula Hospital
- PA — Rick Davis, CEO Central Peninsula Hospital

Alaska Inmate Hospitalization Costs FY 12-15



FY	Lowest	Average	Highest	Total Cost	Inmate Count
2012	\$ 3,367.64	\$ 49,300.70	\$ 381,355.31	\$ 6,310,489.69	128
2013	\$ 2,186.05	\$ 42,906.27	\$ 637,778.69	\$ 6,221,409.00	146
2014	\$ 2,502.74	\$ 54,543.42	\$ 354,661.24	\$ 8,508,773.43	156
2015	\$ 2,786.68	\$ 54,945.10	\$ 403,734.86	\$ 6,483,521.91	118

*FY15 data only covers to March 25th.

Compiled by Dept of Corrections & Dept. of Health & Social Services
DISTRIBUTED BY ALASKA MENTAL HEALTH TRUST




THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of
Health and Social Services

FINANCE AND MANAGEMENT SERVICES
Juneau Office

P.O. Box 110650
Juneau, Alaska 99811-0650
Main: 907.465.3082
Fax: 907.465.2499

MEMORANDUM

DATE: April 9, 2015
TO: Representative Newman
FROM: Sana Efird 
Assistant Commissioner
SUBJECT: Medicaid 101 Presentation

On March 31, 2015, the Department of Health and Social Services received the following questions. The division response is as follows:

- **Rep. Wilson – are there any lawsuits pending regarding the use of waivers?**
At this time there are no lawsuits only fair hearings from recipients whose service level has been reduced or eliminated.

- **Rep. Munoz – How many seniors on Medicare only and how many have dual coverage (Medicaid & Medicare)? What is the income cutoff for eligibility?**
We don't have the numbers of individuals on Medicare who are elderly versus disabled. We do know that there are 69,301 individuals in Alaska that are on Medicare and of those 14,961 are dual eligible (on both Medicare and Medicaid).

- **Rep. Wilson – Can I see a service-by-service comparison between what Medicare and Medicaid pay?**
Here are where the Alaska Medicaid Fee Schedules are located: (There is a different fee schedule for the different types of services over 7,000 codes)
<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Here is where the Medicare Fee Schedules can be found: (There is a Physician Fee Schedule Look-Up Tool on the left hand side that will let them compare.)
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>

- *Rep. Thompson – Is it possible to get a sense of how much Medicare pays versus how much providers charge patients?*

Our Department would have to pull crossover claims and get the billed charges and how much Medicare paid. There is no way of knowing if the billed charges are what they charge the general public or not.

- *Rep. Wilson – what is the cost to the state for the mandatory & optional services, and what are the numbers of recipients for each?*

Please see attached document “Mandatory Optional Services Summary 2011-2014”.

Please note the disclaimer on the FY2014 activity.

- *Rep. Edgmon – Where is Alaska in comparison with other states in terms of growth of the children’s population?*

State of Alaska			
Area	Population Estimates ages		
Region	SFY 14 Population	SFY 13 Population	SFY 12 Population
Anchorage	82,742	83,847	83,561
Northern	39,968	41,033	41,578
Southcentral	55,167	54,826	54,251
Southeast	18,304	18,490	18,635
Western	10,501	10,502	10,340
Total	206,682	208,698	208,365

Source: Population data based on estimates from AK

For data in other states please use this link to the US Department of Commerce:

<http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

- *Rep. Saddler – Has AK considered contracting with MCO? If this has been studied, when was the study conducted?*

Please see the three attached reports from studies completed by PCG (Public Consulting Group).

- *Rep. Edgmon – If chart was representing AK Medicaid expenditures, what portion would be for travel?*

Transportation would be 8%

- *Rep. Edgmon – What number of participants does the top 5% of spenders (slide 36) represent? What types of services are used the most in AK?*

The 5% represents 4 million. Please see attached document “Mandatory Optional Services Summary 2011-2014” for the type of services used the most in Alaska.

- *Rep. Munoz – Do those 5% of top spenders participate in waiver programs?*

Yes. The elderly and disabled make up the majority of the top spenders.

If you have any additional questions regarding this issue, please contact me at 465-1630.

cc: Amanda Ryder, Fiscal Analyst, Legislative Finance
Adam Bryan, Capital Budget Coordinator, Office of Management and Budget
Valerie Davidson, Commissioner
Jay Butler, Chief Medical Officer
Jon Sherwood, Deputy Commissioner
Ree Sailors, Deputy Commissioner
Sarah Woods, Deputy Director
Melissa Ordner, Budget Manager
Anthony Newman, Legislative Liaison
Wilda Laughlin, Deputy Legislative Liaison

Log 3028/2015

FY11 MMIS Medicaid Claim Activity

MMIS Category of Service	Medicaid Waiver Services Only							
	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client
ADULT DAY CARE	O	\$2,707,010	492	\$5,502	O			
CARE COORDINATION	O	\$9,995,146	4,421	\$2,261	O	\$1,816,390	1,311	\$1,385
CHORE SERVICES	O	\$5,231,307	909	\$5,755	O	\$11,071	3	\$3,690
DAY HABILITATION	O	\$20,112,402	963	\$20,885	O	\$6,898,376	484	\$14,253
ENVIRONMENTAL MODIFICATIONS	O	\$757,854	144	\$5,263	O	\$60,337	10	
INTENSIVE ACTIVE TREATMENT/THERAPY	O	\$767,493	143	\$5,367	O	\$1,428,309	272	\$5,251
MEALS	O	\$2,463,939	917	\$2,687	O			
RESIDENTIAL HABILITATION	O	\$70,302,339	1,021	\$68,856	O	\$12,371,839	461	\$26,837
RESIDENTIAL SUPPORTED LIVING	O	\$40,874,397	1,212	\$33,725	O			
RESPIRE CARE	O	\$8,879,392	1,296	\$6,851	O	\$2,593,018	470	\$5,517
SPECIALIZED EQUIPMENT AND SUPPLIES	O	\$636,824	1,123	\$567	O	\$37,317	19	\$1,964
SPECIALIZED PRIVATE DUTY NURSING	O	\$968,377	11	\$88,034	O			
SUPPORTED EMPLOYMENT	O	\$5,381,790	390	\$13,799	O	\$102,941	14	\$7,353
TRANSPORTATION	O	\$4,726,476	1,613	\$2,930	O	\$6,602	9	\$734
ALL Waiver Services **	O	\$173,804,744	4,599	\$37,792	O	\$25,326,200	1,343	\$18,858

MMIS Category of Service	Medicaid Services, excluding Waivers and CAMA							
	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client
ADVANCED NURSE PRACTITIONER	M	\$5,979,406	10,842	\$552	M	\$5,310,087	17,646	\$301
DENTAL SERVICES	M	\$8,831,182	13,429	\$658	M	\$34,708,193	41,870	\$829
FAMILY PLANNING SERVICES	M	\$71,612	119	\$602	M	\$42,657	76	\$561
FOHC	M	\$3,664,921	5,591	\$656	M	\$2,519,915	4,457	\$565
HOME HEALTH SERVICES	M	\$1,028,741	253	\$4,066	M	\$88,685	33	\$2,687
ICF SERVICES	M	\$72,956,063	612	\$119,209	M			
INPATIENT HOSPITAL SERVICES	M	\$84,778,066	9,954	\$8,517	M	\$93,512,602	8,456	\$11,059
LABORATORY SERVICES	M	\$1,727,122	11,343	\$152	M	\$436,580	4,605	\$95
MIDWIFERY SERVICES	M	\$1,102,075	1,167	\$944	M	\$346,589	607	\$571
OUTPATIENT SURGERY SERVICE	M	\$2,459,476	2,520	\$976	M	\$2,790,658	2,726	\$1,024
PHYSICIAN IHS CLINIC	M	\$17,133,699	10,276	\$1,667	M	\$25,009,754	18,858	\$1,326
PHYSICIAN SERVICES	M	\$60,493,636	39,562	\$1,529	M	\$47,711,549	60,827	\$784
SHORT TERM LTC SERVICES	M	\$1,045,059	97	\$10,774	M	\$10,455	1	\$10,455
SNF SERVICES	M	\$16,673,397	507	\$32,886	M			
X-RAY SERVICES	M	\$10,173	95	\$107	M			
ACCOMMODATION SERVICES	O	\$5,878,907	5,741	\$1,024	M	\$4,585,079	7,323	\$626
CARE COORDINATION	O	\$407	5	\$81	M	\$425	1	\$425
CASE MANAGEMENT SERVICES	O	\$66,113	52	\$1,271	M	\$1,234,163	946	\$1,305
CHIROPRACTIC SERVICES	O	\$45,315	386	\$117	M	\$250,411	1,035	\$242
DME SERVICES	O	\$4,721,418	6,280	\$752	M	\$1,912,206	1,687	\$1,133
DRUG ABUSE CENTER	O	\$3,679,037	1,294	\$2,843	M	\$2,242,333	644	\$3,482
EPSDT SCREENING					M	\$3,214	24	\$134
ESRD SERVICES	O	\$15,554,444	269	\$57,823	M	\$26,435	1	\$26,435
HEARING SERVICES	O	\$1,667,289	1,236	\$1,349	M	\$624,190	1,039	\$601
HOSPICE CARE	O	\$241,504	36	\$6,708	M			
ICF/MR SERVICES	O	\$1,048,198	7	\$149,743	M	\$1,277,716	9	\$141,968
INPATIENT PSYCHIATRIC SERVICES	O	\$278,899	111	\$2,513	M	\$53,855,557	1,245	\$43,257
MEDICAL SUPPLIES SERVICES	O	\$5,785,032	6,589	\$878	M	\$3,778,568	3,033	\$1,246
MENTAL HEALTH SERVICES	O	\$22,415,322	4,750	\$4,719	M	\$69,612,981	6,146	\$11,327
NUTRITION SERVICES	O	\$6,746	65	\$104	M	\$950	10	\$95
OCCUPATIONAL THERAPY	O	\$165,335	135	\$1,225	M	\$3,352,096	955	\$3,510
OUTPATIENT HOSPITAL SERVICES	O	\$63,653,592	32,256	\$1,973	M	\$44,470,135	39,091	\$1,138
PERSONAL CARE SERVICES	O	\$104,196,592	4,515	\$23,078	M	\$3,910,256	131	\$29,849
PODIATRY	O	\$54,918	745	\$74	M	\$145,087	312	\$465
PRESCRIBED DRUGS	O	\$61,123,598	30,660	\$1,994	M	\$26,346,806	46,884	\$562
PRIVATE DUTY NURSING	O	\$1,525	1	\$1,525	M	\$2,299,964	13	\$176,920
PROSTHETICS AND ORTHOTICS	O	\$687,408	690	\$996	M	\$429,485	405	\$1,060
PSYCHOLOGY SERVICES	O	\$261,039	345	\$757	M	\$1,811,941	1,003	\$1,807
REHABILITATIVE SERVICES	O	\$1,824,827	1,686	\$1,082	M	\$16,099,331	3,755	\$4,287
RURAL HEALTH SERVICES	O	\$5,056	28	\$181	M	\$1,902	7	\$272
TRANSPORTATION SERVICES	O	\$24,665,618	13,484	\$1,829	M	\$28,659,545	15,567	\$1,841
VISION SERVICES	O	\$2,341,060	13,610	\$172	M	\$3,024,864	16,284	\$186
Mandatory Services **	M	\$277,954,627	45,304	\$6,135	M	\$482,467,338	85,859	\$5,619
Optional Services (excluding waivers) **	O	\$320,369,199	45,932	\$6,975	O			
ALL Non-Waivers Services **	M + O	\$598,323,825	49,648	\$12,051	M + O	\$482,467,338	85,859	\$5,619

** (net total payments, unduplicated annual recipients, and average annual cost per client)

MMIS coding for categories of service approximates the types of required and optional services offered under Alaska Medicaid.

Most clients use both required and optional services over the course of a year. The cost per client for combined Medicaid services was calculated as net claim payments/unduplicated annual recipients.

FY12 MMIS Medicaid Claim Activity 1-Jul-2011 to 31-Jun-2012

MMIS Category of Service	Medicaid Waiver Services Only							
	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client
ADULT DAY CARE	O	\$ 3,330,338	502	\$6,634	O	\$ -	-	
CARE COORDINATION	O	\$ 10,315,755	4,573	\$2,256	O	\$ 2,063,405	1,383	\$1,492
CHORE SERVICES	O	\$ 6,742,944	936	\$7,204	O	\$ 17,500	5	\$3,500
DAY HABILITATION	O	\$ 24,587,088	1,048	\$23,461	O	\$ 8,476,538	564	\$15,029
ENVIRONMENTAL MODIFICATIONS	O	\$ 842,294	159	\$5,297	O	\$ 86,787	16	
INTENSIVE ACTIVE TREATMENT/THERAPY	O	\$ 775,402	146	\$5,311	O	\$ 1,363,251	269	\$5,068
MEALS	O	\$ 3,614,096	946	\$3,820	O			
RESIDENTIAL HABILITATION	O	\$ 80,520,702	1,058	\$76,107	O	\$ 14,458,253	507	\$28,517
RESIDENTIAL SUPPORTED LIVING	O	\$ 45,314,244	1,280	\$35,402	O	\$ -	-	
RESPIRE CARE	O	\$ 10,512,956	1,445	\$7,275	O	\$ 2,811,624	626	\$5,345
SPECIALIZED EQUIPMENT AND SUPPLIES	O	\$ 651,243	1,188	\$548	O	\$ 21,328	25	\$853
SPECIALIZED PRIVATE DUTY NURSING	O	\$ 1,128,068	20	\$56,403	O	\$ -	-	
SUPPORTED EMPLOYMENT	O	\$ 5,911,501	383	\$15,435	O	\$ 114,722	14	\$8,194
TRANSPORTATION	O	\$ 5,269,214	1,711	\$3,080	O	\$ 21,248	8	\$2,656
ALL Waiver Services **	O	\$ 199,515,845	4,797	\$41,592	O	\$29,434,654	1,481	\$19,875

MMIS Category of Service	Medicaid Services, excluding Waivers and CAMA							
	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client
ADVANCED NURSE PRACTITIONER	M	\$ 6,519,067	12,029	\$542	M	\$ 5,807,167	20,119	\$289
DENTAL SERVICES	M	\$ 9,563,560	13,606	\$703	M	\$ 35,089,338	42,390	\$828
FAMILY PLANNING SERVICES	M	\$ 107,010	174	\$615	M	\$ 71,743	101	\$710
FQHC	M	\$ 3,906,317	5,717	\$683	M	\$ 2,439,994	4,156	\$587
HOME HEALTH SERVICES	M	\$ 1,148,793	300	\$3,829	M	\$ 36,589	22	\$1,663
ICF SERVICES	M	\$ 76,779,555	593	\$129,476	M	\$ -	-	
INPATIENT HOSPITAL SERVICES	M	\$ 77,267,654	9,896	\$7,808	M	\$ 95,690,317	8,377	\$11,423
LABORATORY SERVICES	M	\$ 1,844,498	11,212	\$165	M	\$ 370,040	4,535	\$82
MIDWIFERY SERVICES	M	\$ 959,629	883	\$1,087	M	\$ 253,577	458	\$554
OUTPATIENT SURGERY SERVICE	M	\$ 3,181,720	2,899	\$1,098	M	\$ 3,251,111	3,082	\$1,055
PHYSICIAN IHS CLINIC	M	\$ 20,577,130	12,007	\$1,714	M	\$ 28,504,683	22,526	\$1,265
PHYSICIAN SERVICES	M	\$ 61,391,108	40,758	\$1,506	M	\$ 48,086,216	61,139	\$787
SHORT TERM LTC SERVICES	M	\$ 1,811,605	73	\$24,817	M	\$ -	-	
SNF SERVICES	M	\$ 13,008,863	399	\$32,604	M	\$ -	-	
X-RAY SERVICES	M	\$ 8,437	45	\$187	M	\$ 208	1	\$208
ACCOMMODATION SERVICES	O	\$ 6,690,288	6,073	\$1,102	M	\$ 4,997,485	7,455	\$670
ADULT PREVENTATIVE DENTAL	O	\$ 10,855,997	15,419	\$704	M			
CARE COORDINATION	O	\$ 785	4	\$191	M	\$ 84,275	133	\$634
CASE MANGEMENT SERVICES	O	\$ 60,709	73	\$832	M	\$ 1,422,529	1,105	\$1,287
CHIROPRACTIC SERVICES	O	\$ 34,772	349	\$100	M	\$ 213,685	912	\$234
DME SERVICES	O	\$ 4,972,108	6,819	\$729	M	\$ 2,102,861	1,772	\$1,187
DRUG ABUSE CENTER	O	\$ 3,111,805	1,165	\$2,671	M	\$ 2,063,239	532	\$3,859
EPSDT SCREENING					M	\$ 1,740	13	\$134
ESRD SERVICES	O	\$ 12,857,119	282	\$45,593	M	\$ 247,929	3	\$82,643
HEARING SERVICES	O	\$ 1,648,347	1,363	\$1,209	M	\$ 478,646	1,047	\$457
HOSPICE CARE	O	\$ 241,581	42	\$5,752	M			
ICF/MR SERVICES	O	\$ 1,025,464	8	\$128,183	M	\$ 1,255,458	12	\$104,621
INPATIENT PSYCHIATRIC SERVICES	O	\$ 173,231	155	\$1,118	M	\$ 55,713,448	1,246	\$44,714
MEDICAL SUPPLIES SERVICES	O	\$ 7,232,779	7,222	\$1,001	M	\$ 4,331,025	2,939	\$1,474
MENTAL HEALTH SERVICES	O	\$ 21,416,691	5,210	\$4,111	M	\$ 65,122,252	6,303	\$10,332
NUTRITION SERVICES	O	\$ 11,409	159	\$72	M	\$ 43,141	747	\$ 130
OCCUPATIONAL THERAPY	O	\$ 132,603	125	\$1,061	M	\$ 3,345,741	1,023	\$3,271
OUTPATIENT HOSPITAL SERVICES	O	\$ 65,971,506	33,535	\$1,967	M	\$ 45,334,875	39,780	\$1,140
PERSONAL CARE SERVICES	O	\$ 114,034,397	5,074	\$22,474	M	\$ 3,856,140	145	\$26,594
PODIATRY	O	\$ 56,326	831	\$68	M	\$ 157,279	333	\$472
PRESCRIBED DRUGS	O	\$ 52,944,884	31,322	\$1,690	M	\$ 23,346,882	47,529	\$491
PRIVATE DUTY NURSING	O	\$ -	-	\$0	M	\$ 3,114,603	21	\$148,314
PROSTHETICS AND ORTHOTICS	O	\$ 842,354	623	\$1,352	M	\$ 489,210	418	\$1,170
PSYCHOLOGY SERVICES	O	\$ 356,270	421	\$846	M	\$ 2,117,899	1,136	\$1,864
REHABILITATIVE SERVICES	O	\$ 2,011,909	1,843	\$1,092	M	\$ 18,891,315	3,865	\$4,260
RESIDENTIAL HABILITATION					M	\$ 1,001,400	51	\$19,635
RESPIRE CARE					M	\$ 33,778	12	\$2,815
RURAL HEALTH SERVICES	O	\$ 4,180	35	\$119	M	\$ 378	2	\$189
TRANSPORTATION SERVICES	O	\$ 25,253,184	13,717	\$1,841	M	\$ 29,940,351	14,612	\$2,049
VISION SERVICES	O	\$ 2,534,807	14,250	\$178	M	\$ 3,270,193	16,769	\$195
Mandatory Services **	M	\$278,074,945	48,217	\$5,767	M	\$490,568,740	87,879	\$5,582
Optional Services (excluding waivers) **	O	\$334,475,485	47,276	\$6,845	O	\$0	-	\$0
ALL Non-Waivers Services **	M + O	\$612,550,430	52,100	\$11,549	M + O	\$490,568,740	87,879	\$5,582

** (net total payments, unduplicated annual recipients, and average annual cost per client,

MMIS coding for categories of service approximates the types of required and optional services offered under Alaska Medicaid).

Most clients use both required and optional services over the course of a year. The cost per client for combined Medicaid services was calculated as net claim payments/unduplicated annual recipients.

FY13 MMIS Medicaid Claim Activity

MMIS Category of Service	Medicaid Waiver Services Only				Medicaid Waiver Services Only			
	Mandatory / Optional	Adults (21 or older)			Mandatory / Optional	Children (under age 21)		
		Net Claim Payments	Recipients	Cost per Client		Net Claim Payments	Recipients	Cost per Client
ADULT DAY CARE	O	\$ 3,802,121.64	481	\$7,905	O	\$ -	-	\$0
CARE COORDINATION	O	\$ 11,013,435.69	4,742	\$2,323	O	\$ 2,147,172.42	1,271	\$1,689
CHORE SERVICES	O	\$ 7,398,325.26	956	\$7,739	O	\$ 18,155.33	4	\$4,539
DAY HABILITATION	O	\$ 30,284,846.76	1,164	\$26,018	O	\$ 10,006,649.91	626	\$15,985
ENVIRONMENTAL MODIFICATIONS	O	\$ 735,664.97	145	\$5,074	O	\$ 72,743.00	12	\$6,062
INTENSIVE ACTIVE TREATMENT/THERAPY	O	\$ 613,085.56	141	\$4,348	O	\$ 703,466.04	267	\$2,635
MEALS	O	\$ 4,454,096.95	977	\$4,559	O	\$ 2,765.28	1	\$2,765
RESIDENTIAL HABILITATION	O	\$ 86,942,775.67	1,148	\$75,734	O	\$ 15,488,645.95	552	\$28,059
RESIDENTIAL SUPPORTED LIVING	O	\$ 47,710,803.33	1,308	\$36,476	O	\$ -	-	\$0
RESPITE CARE	O	\$ 12,222,623.26	1,554	\$7,865	O	\$ 3,027,175.60	543	\$5,575
SPECIALIZED EQUIPMENT AND SUPPLIES	O	\$ 618,094.72	1,136	\$544	O	\$ 19,525.97	17	\$1,149
SPECIALIZED PRIVATE DUTY NURSING	O	\$ 1,077,376.65	11	\$97,943	O	\$ -	-	\$0
SUPPORTED EMPLOYMENT	O	\$ 7,013,298.92	418	\$16,778	O	\$ 134,890.78	10	\$13,489
TRANSPORTATION	O	\$ 6,546,502.60	1,787	\$3,663	O	\$ 29,602.34	13	\$2,277
ALL Waiver Services **	O	\$220,433,052	5,000	\$44,087	O	\$31,650,793	1,337	\$23,673

MMIS Category of Service	Medicaid Services, excluding Waivers and CAMA							
	Mandatory / Optional	Adults (21 or older)			Mandatory / Optional	Children (under age 21)		
		Net Claim Payments	Recipients	Cost per Client		Net Claim Payments	Recipients	Cost per Client
ADVANCED NURSE PRACTITIONER	M	\$ 6,577,883	11,140	590.47419	M	\$ 6,560,750	19,067	344.08925
FAMILY PLANNING SERVICES	M	\$ 79,236	125	633.88944	M	\$ 45,197	71	636.57746
FQHC	M	\$ 4,391,756	6,959	631.09005	M	\$ 2,576,267	4,669	551.78132
HOME HEALTH SERVICES	M	\$ 1,024,714	301	3404.3667	M	\$ 15,850	7	2264.2571
ICF SERVICES	M	\$ 84,201,996	606	138947.19	M	\$ -	1	0
INPATIENT HOSPITAL SERVICES	M	\$ 88,970,754	11,991	7419.7944	M	\$ 92,904,693	10,383	8947.7697
LABORATORY SERVICES	M	\$ 2,706,109	11,283	239.83948	M	\$ 389,580	4,265	91.343479
MIDWIFERY SERVICES	M	\$ 905,124	798	1134.241	M	\$ 240,639	403	597.11883
OUTPATIENT SURGERY SERVICE	M	\$ 3,654,081	3,229	1131.6449	M	\$ 3,877,525	3,343	1159.8939
PHYSICIAN IHS CLINIC	M	\$ 18,501,732	12,313	1502.6177	M	\$ 26,102,241	22,326	1169.1409
PHYSICIAN SERVICES	M	\$ 66,490,404	42,049	1581.2601	M	\$ 50,051,148	61,048	819.86548
SHORT TERM LTC SERVICES	M	\$ 2,294,872	84	27319.901	M	\$ -	-	0
SNF SERVICES	M	\$ 9,428,727	374	25210.499	M	\$ 3,730	1	3730.4
X-RAY SERVICES	M	\$ 8,224	40	205.598	M	\$ 223	1	223.26
RURAL HEALTH SERVICES	M	\$ 7,142	45	158.70267	M	\$ 947	6	157.80333
TRANSPORTATION SERVICES	M	\$ 27,457,949	14,185	1935.7031	M	\$ 31,541,459	14,942	2110.9262
EPSDT SCREENING	M	\$ -	-	0	M	\$ 774	5	154.842
OUTPATIENT HOSPITAL SERVICES	M	\$ 68,040,581	38,508	1766.9207	M	\$ 47,491,942	47,266	1004.7802
ACCOMMODATION SERVICES	O	\$ 6,608,178	6,075	1,088	M	\$ 5,044,061	7,444	\$678
CARE COORDINATION	O	\$ 228	1	228	M	\$ 128,827	639	\$202
CASE MANAGEMENT SERVICES	O	\$ 46,458	57	815	M	\$ 1,370,918	1,141	\$1,202
CHIROPRACTIC SERVICES	O	\$ 40,678	375	108	M	\$ 213,003	925	\$230
DENTAL SERVICES	O	\$ 21,816,257	19,183	1,137	M	\$ 35,627,346	43,398	\$821
DME SERVICES	O	\$ 5,088,173	6,877	740	M	\$ 1,824,462	1,645	\$1,109
DRUG ABUSE CENTER	O	\$ 3,387,701	807	4,198	M	\$ 2,079,919	391	\$5,319
ESRD SERVICES	O	\$ 2,987,815	304	9,828	M	\$ (23,980)	3	-\$7,993
HEARING SERVICES	O	\$ 1,723,467	1,455	1,185	M	\$ 575,272	1,193	\$482
HOSPICE CARE	O	\$ 351,637	48	7,326	M	\$ 10,765	1	\$10,765
ICF/MR SERVICES	O	\$ 1,582,073	8	197,759	M	\$ 1,831,252	12	\$152,604
INPATIENT PSYCHIATRIC SERVICES	O	\$ 332,686	159	2,092	M	\$ 53,897,956	2,996	\$17,990
MEDICAL SUPPLIES SERVICES	O	\$ 7,547,539	7,473	1,010	M	\$ 4,513,167	2,949	\$1,530
MENTAL HEALTH SERVICES	O	\$ 25,856,093	5,838	4,429	M	\$ 86,494,673	6,493	\$10,241
NUTRITION SERVICES	O	\$ 10,176	163	62	M	\$ 44,437	1,282	\$75
OCCUPATIONAL THERAPY	O	\$ 115,945	135	859	M	\$ 3,808,036	1,081	\$3,523
PERSONAL CARE SERVICES	O	\$ 123,004,302	5,250	23,429	M	\$ 3,781,921	137	\$27,605
PODIATRY	O	\$ 81,479	963	85	M	\$ 143,892	323	\$445
PRESCRIBED DRUGS	O	\$ 43,338,211	31,397	1,380	M	\$ 23,075,312	48,193	\$479
PRIVATE DUTY NURSING	O	\$ (550)	1	(550)	M	\$ 3,541,766	23	\$153,990
PROSTHETICS AND ORTHOTICS	O	\$ 781,620	505	1,548	M	\$ 546,571	397	\$1,377
PSYCHOLOGY SERVICES	O	\$ 474,611	540	879	M	\$ 2,224,831	1,172	\$1,898
REHABILITATIVE SERVICES	O	\$ 2,084,746	1,816	1,148	M	\$ 17,477,033	3,959	\$4,415
RESIDENTIAL HABILITATION	O	\$ -	-	-	M	\$ 381,000	39	\$9,769
RESPITE CARE	O	\$ -	-	-	M	\$ 4,047	4	\$1,012
VISION SERVICES	O	\$ 2,901,844	14,809	196	M	\$ 3,614,750	17,119	\$211
Mandatory Services **	M	\$384,741,283	53,738	\$7,160	M	\$494,034,201	92,013	\$5,369
Optional Services (excluding waivers) **	O	\$250,161,366	42,433	\$5,895	O	\$0	-	-
ALL Non-Waivers Services **	M + O	\$634,902,649	55,695	\$11,400	M + O	\$494,034,201	92,013	\$5,369

** (net total payments, unduplicated annual recipients, and average annual cost per client)
 MMIS coding for categories of service approximates the types of required and optional services offered under Alaska Medicaid.
 Most clients use both required and optional services over the course of a year. The cost per client for combined Medicaid services was calculated as net claim payments/unduplicated annual recipients.

FY14 MMIS Medicaid Claim Activity

Medicaid Waiver Services Only								
MMIS Category of Service	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client	Mandatory / Optional	Net Claim Payments ***	Recipients ***	Cost per Client
ADULT DAY CARE	O	\$ 3,384,434	432	\$ 7,834	O	\$ -	-	\$ -
CARE COORDINATION	O	\$ 9,894,948	4,443	\$ 2,182	O	\$ 1,607,908	861	\$ 1,867
CHORE SERVICES	O	\$ 4,603,549	698	\$ 6,595	O	\$ 2,038	1	\$ 2,038
DAY HABILITATION	O	\$ 25,980,195	1,329	\$ 19,549	O	\$ 5,348,845	448	\$ 11,935
ENVIRONMENTAL MODIFICATIONS	O	\$ 492,428	105	\$ 4,690	O	\$ 93,075	11	\$ 8,461
INTENSIVE ACTIVE TREATMENT/THERAPY	O	\$ 376,949	152	\$ 2,480	O	\$ 679,917	222	\$ 3,063
MEALS	O	\$ 3,567,421	798	\$ 4,470	O	\$ -	-	\$ -
PROFESSIONAL CI	O	\$ 26,683	12	\$ 2,222	O	\$ 7,923	5	\$ 1,585
RESIDENTIAL HABILITATION	O	\$ 85,307,946	1,271	\$ 67,119	O	\$ 9,418,754	426	\$ 22,110
RESIDENTIAL SUPPORTED LIVING	O	\$ 40,431,077	1,182	\$ 34,206	O	\$ -	-	\$ -
RESPIRE CARE	O	\$ 9,551,882	1,495	\$ 6,389	O	\$ 1,875,264	398	\$ 4,712
SPECIALIZED EQUIPMENT AND SUPPLIES	O	\$ 282,228	809	\$ 349	O	\$ 970	4	\$ 243
SPECIALIZED PRIVATE DUTY NURSING	O	\$ 991,529	9	\$ 110,170	O	\$ -	-	\$ -
SUPPORTED EMPLOYMENT	O	\$ 4,846,148	428	\$ 11,323	O	\$ -	-	\$ -
TRANSPORTATION	O	\$ 3,173,765	1,494	\$ 2,124	O	\$ 16,687	5	\$ 4,476
ALL Waiver Services **	O	\$192,710,963	4,709	\$40,924	O	\$19,049,380	898	\$21,213

Medicaid Services, excluding Waivers and CAMA								
MMIS Category of Service	Adults (21 or older)				Children (under age 21)			
	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client	Mandatory / Optional	Net Claim Payments	Recipients	Cost per Client
ADVANCED NURSE PRACTITIONER	M	\$ 5,080,373	12,893	\$ 394	M	\$ 4,621,055	14,498	\$ 319
EPSDT SCREENING	M	\$ -	-	\$ -	M	\$ 5,618,883	15,160	\$ 371
FAMILY PLANNING SERVICES	M	\$ 1,239,224	2,376	\$ 522	M	\$ 202,110	469	\$ 431
FOHC	M	\$ 3,477,329	6,304	\$ 552	M	\$ 1,617,090	2,908	\$ 556
HOME HEALTH SERVICES	M	\$ 569,602	213	\$ 2,674	M	\$ 8,049	5	\$ 1,610
ICF SERVICES	M	\$ 23,544,968	501	\$ 46,996	M	\$ 20,159	1	\$ 20,159
INPATIENT HOSPITAL SERVICES	M	\$ 17,959,096	3,684	\$ 4,875	M	\$ 19,635,117	2,192	\$ 8,958
LABORATORY SERVICES	M	\$ 1,907,603	11,637	\$ 164	M	\$ 149,557	2,990	\$ 50
MIDWIFERY SERVICES	M	\$ 2,148,240	2,933	\$ 732	M	\$ 239,428	573	\$ 418
OUTPATIENT HOSPITAL SERVICES	M	\$ 58,179,652	35,531	\$ 1,637	M	\$ 35,484,366	33,175	\$ 1,070
OUTPATIENT SURGERY SERVICE	M	\$ 2,071,816	2,036	\$ 1,018	M	\$ 1,919,847	1,839	\$ 1,044
PHYSICIAN IHS CLINIC	M	\$ 18,390,626	10,441	\$ 1,761	M	\$ 18,408,672	14,765	\$ 1,247
PHYSICIAN SERVICES	M	\$ 57,038,585	42,589	\$ 1,339	M	\$ 39,576,206	52,227	\$ 758
RURAL HEALTH SERVICES	M	\$ 2,661	27	\$ 99	M	\$ 30	1	\$ 30
SHORT TERM LTC SERVICES	M	\$ 876,532	46	\$ 19,055	M	\$ -	-	\$ -
SNF SERVICES	M	\$ 64,967,259	690	\$ 94,155	M	\$ 888	1	\$ 888
TRANSPORTATION SERVICES	M	\$ 25,609,235	14,430	\$ 1,775	M	\$ 26,965,138	12,106	\$ 2,227
X-RAY SERVICES	M	\$ 9,788	49	\$ 200	M	\$ -	-	\$ -
ACCOMMODATION SERVICES	O	\$ 4,899,404	5,870	\$ 835	M	\$ 3,309,769	6,024	\$ 549
CARE COORDINATION	O	\$ -	-	\$ -	M	\$ -	-	\$ -
CASE MANAGEMENT SERVICES	O	\$ 183,513	164	\$ 1,119	M	\$ 1,624,243	1,234	\$ 1,316
CHIROPRACTIC SERVICES	O	\$ 90,561	580	\$ 156	M	\$ 159,751	682	\$ 234
DENTAL SERVICES	O	\$ 21,994,901	19,628	\$ 1,121	M	\$ 34,718,643	39,327	\$ 883
DME SERVICES	O	\$ 2,999,914	6,077	\$ 494	M	\$ 884,664	1,274	\$ 694
DRUG ABUSE CENTER	O	\$ 2,934,857	570	\$ 5,149	M	\$ 1,430,763	154	\$ 9,291
ESRD SERVICES	O	\$ 3,303,456	289	\$ 11,431	M	\$ 20,394	3	\$ 6,798
HEARING SERVICES	O	\$ 1,210,815	1,422	\$ 851	M	\$ 299,540	1,057	\$ 283
HOSPICE CARE	O	\$ 140,856	22	\$ 6,403	M	\$ -	-	\$ -
ICF/MR SERVICES	O	\$ 1,606,003	11	\$ 146,000	M	\$ 761,839	6	\$ 126,973
INPATIENT PSYCHIATRIC SERVICES	O	\$ 145,435	51	\$ 2,852	M	\$ 29,813,904	654	\$ 45,587
MEDICAL SUPPLIES SERVICES	O	\$ 6,183,557	5,975	\$ 1,035	M	\$ 2,946,921	2,283	\$ 1,291
MENTAL HEALTH SERVICES	O	\$ 32,056,497	6,142	\$ 5,219	M	\$ 63,860,489	5,532	\$ 11,544
NUTRITION SERVICES	O	\$ 12,509	160	\$ 78	M	\$ 133	2	\$ 67
OCCUPATIONAL THERAPY	O	\$ 229,995	219	\$ 1,050	M	\$ 4,280,693	1,261	\$ 3,395
PERSONAL CARE SERVICES	O	\$ 94,684,489	4,895	\$ 19,343	M	\$ 1,808,259	81	\$ 22,324
PODIATRY	O	\$ 81,421	890	\$ 91	M	\$ 90,499	220	\$ 411
PRESCRIBED DRUGS	O	\$ 44,005,476	43,848	\$ 1,004	M	\$ 23,430,596	67,290	\$ 348
PRIVATE DUTY NURSING	O	\$ 136,628	1	\$ 136,628	M	\$ 4,499,831	32	\$ 140,620
PROSTHETICS AND ORTHOTICS	O	\$ 399,951	421	\$ 950	M	\$ 422,063	316	\$ 1,336
PSYCHOLOGY SERVICES	O	\$ 508,118	467	\$ 1,088	M	\$ 2,497,417	1,333	\$ 1,874
REHABILITATIVE SERVICES	O	\$ 2,112,895	2,443	\$ 865	M	\$ 10,924,760	3,395	\$ 3,218
RESIDENTIAL HABILITATION	O	\$ -	-	\$ -	M	\$ -	-	\$ -
RESPIRE CARE	O	\$ -	-	\$ -	M	\$ -	-	\$ -
VISION SERVICES	O	\$ 2,582,438	15,020	\$ 172	M	\$ 3,226,681	14,552	\$ 222
Mandatory Services **	M	\$ 283,072,589	52,435	\$ 5,399	M	\$ 345,478,446	77,684	\$ 4,447
Optional Services (excluding waivers) **	O	\$ 222,503,688	38,002	\$ 5,855	O	\$ -	-	\$ -
ALL Non-Waivers Services **	M + O	\$ 505,576,277	56,520	\$ 8,945	M + O	\$ 345,478,446	77,684	\$ 4,447

** (net total payments, unduplicated annual recipients, and average annual cost per client)

MMIS coding for categories of service approximates the types of required and optional services offered under Alaska Medicaid.

Most clients use both required and optional

*** MMIS COGNOS has a large amounts of back log claims for SFY2014, since this report and the Mandatory VS Optional Report is based on number recipients and claims paid, the dollar amounts spent and number of recipients in SFY2014 will lower than SFY2013.

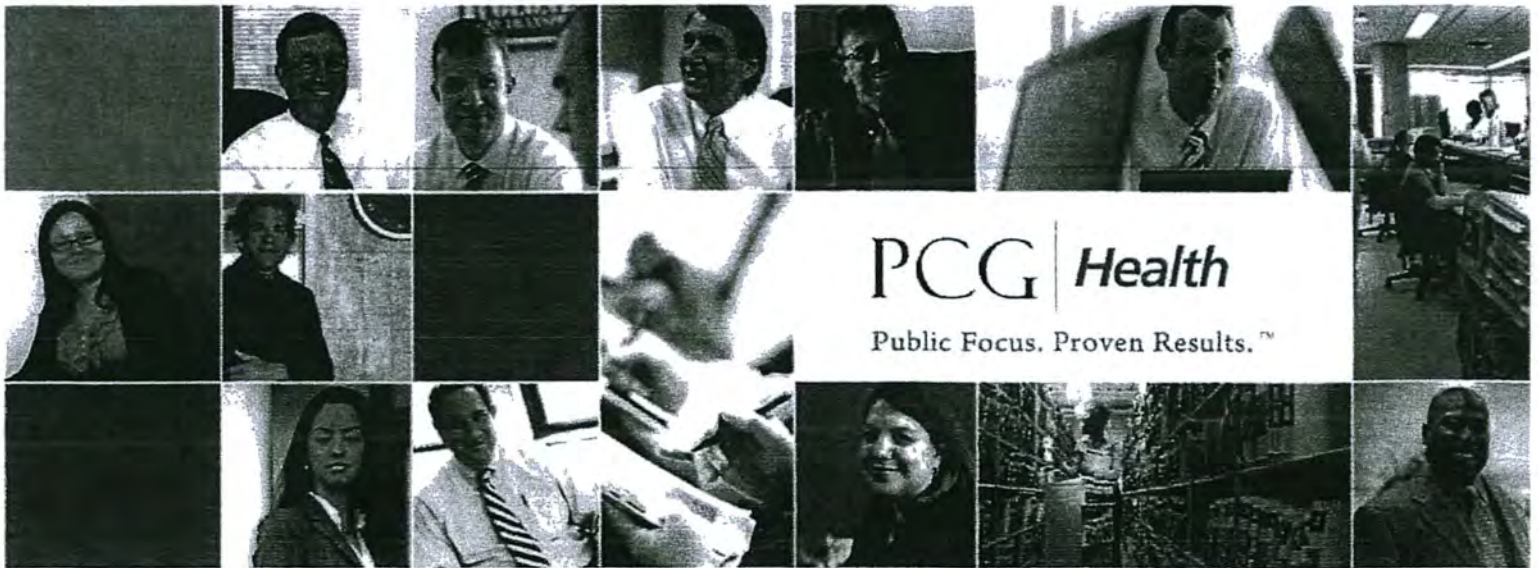
As back logged claims are processed, number of recipients and dollar amounts spent will increase.



Alaska Department of Health and Social Services
Infrastructure Payment Memo

Alaska Department of Health and Social Services *Infrastructure Payment Memo*

September 2012





I. Introduction

This memo examines Alaska DHSS's need to define how and what the Patient Centered Medical Home (PCMH) initiative will be funded. The memo provides an inventory of peer program experiences and how they funded the "start-up infrastructure" cost. PCG then provides observations, recommendations, and next steps. This memo is meant to provide context and experiences for DHSS staff to consider when defining how the PCMH will fund the pilot. Upon feedback from DHSS, PCG will develop a final budget methodology for the PCMH grant process and prescribed set amounts of infrastructure payments based on participation in the pilot.

II. Peer Program Infrastructure Payments

An environmental scan of peer program PCMH infrastructure payments to adopt a Medical Home initiative reveals multiple methods. In most cases fees are being covered through prospective payments or infrastructure grants. However, how they are being covered varies. In many of the projects, a prospective "care coordination" fee paid upon achievement of PCMH recognition is expected to cover the cost of recognition. This means that the practice will pay for the recognition and training up front, but will then be reimbursed upon implementation, once they achieve that recognition. This is usually paid through a PMPM fee. Other projects are asking the payers to provide a separate up-front infrastructure payment prior to PCMH recognition. This includes the recognition fee in addition to other items, such as technology and staff. Still others are paying the recognition fee up-front for the participating practices through a means other than the payers, such as by a grant or another participating stakeholder. The section that follows summarizes 4 PCMH pilots operating in New York, North Carolina, and Pennsylvania.

Adirondack Medical Home Pilot (AMHP)

The Adirondack Medical Home Pilot (AMHP) has brought together payors across the NY region to participate in the Medical Home initiative. The pilot term is over a five-year period from 2010 to 2014. Currently, the AMHP has completed a Readiness Assessment & Work Plan (January 2010), an E-Prescribing initiative (July 2010), and NCQA Recognition project (February 2011). The initial development investment for the initiative was broken down as follows:

- Project Development - (\$500,000) Health Resources and Services Administration (HRSA) grant
- Regional Pod Capacities - (\$3,000,000) MSSNY grant funds
- Electronic Connectivity - (\$7,000,000) HEAL 10 grant funds
- Matching Commitments - (\$8,000,000) Providers



Southwest Pennsylvania (SEPA) Chronic Care Management Reimbursement and Cost Reduction Commission (CCM)

In May 2007 the Chronic Care Management Reimbursement and Cost Reduction Commission (CCM) was established in Pennsylvania. The goal of the commission was to reduce the cost of chronic care conditions through a medical home model. The SEPA CCM was established through six payer organizations that agreed to support the initiative. The SEPA collaborative provides supplemental compensation defined by the terms of the participation agreement drafted by the Governor's Office of Health Care Reform. In addition to traditional service reimbursement from insurers and any ongoing pay-for-performance program administered by the individual insurer, the practices received the following from the SEPA collaborative; 1) "Infrastructure" payments in Year 1 to cover the cost of time away at the learning collaborative sessions, miscellaneous administrative expenses such as those related to registry implementation, and the costs of the NCQA application and submission fee, and 2) Supplemental payments based on level of NCQA recognition. Annualized payments were based on provider full-time equivalents, prorated by carrier and based on each carrier's proportional contribution to the practice's overall revenue. The payments are detailed in Table below¹.

The Joint Commission Journal on Quality and Patient Safety

Table 1. Southwest Pennsylvania (SEPA) Rollout Practice Payments¹

Year 1 Infrastructure ²	Total			
NCQA Survey Tool (one per practice)	\$80			
Registry Assistance (.25 FTE per practice)	\$8,000			
NCQA Application Fee (for clinician champion only)	\$360			
Recognition of Clinician Champion Participation in Learning Collaborative Sessions (7 days) ³	\$11,655			
	\$20,095			

NCQA PPC-PCMH Recognition ⁴ Per FTE Physician or NP ⁵	Practice Size: 1 FTE MD/NP	Practice Size: 2-4 FTE MD/NP	Practice Size: 5-9 FTE MD/NP	Practice Size: 10-30 FTE MD/NP
Level 1 Recognition	\$40,000	\$36,000	\$32,000	\$28,000
Level 2 Recognition	\$60,000	\$54,000	\$48,000	\$42,000
Level 3 Recognition	\$85,000	\$85,500	\$76,000	\$66,500

¹ NCQA, National Committee for Quality Assurance; FTE, full-time equivalent; PPC-PCMH, Physician Practice Connections Patient-Centered Medical Home; NP, nurse practitioner; MD, physician.

² Prorated by carrier and based on each carrier's proportional contribution to the practice's overall revenue. On average, 70% of practice revenue was paid by one of the six participating payers (that is, on average, practices received 70% of these funds). This 70% average includes the seven pediatric practices that focused on pediatric asthma in the SEPA rollout. The pediatric practices generally had higher covered revenues than the practices focused initially on diabetes, which care for large Medicare populations. Traditional Medicare was not one of the participating payers.

³ Paid following each quarterly learning session in Year 1, pending attendance at the learning session by the clinical champion. The other Year 1 infrastructure payments were included in the first quarterly payment.

⁴ Paid annually but prorated for recognition obtained after May each year. Fifteen of the 25 practices did not obtain NCQA PPC-PCMH recognition until the end of Year 1 (April 2008-May 2008) and thus received little or no recognition payments in Year 1. No practice obtained NCQA PPC-PCMH before September 2008.

⁵ Recognition payments were based on FTE clinicians in each practice, excluding residents in residency practices. Mid-level providers (NPs, physician assistants) were not included in the FTE clinician count in physician practices. FTE NPs were counted for the nurse-managed community health centers.



New York Hudson Valley P4P/Medical Home Project

The New York Hudson Valley P4P/Medical Home Project provided an opportunity to receive up to \$3M in payments through a NYSDOH P4P grant and matching Taconic Health Information Network and Community (THINC) RHIO payment. The THINC facilitates EHR implementation in offices practices of the Hudson Valley that interface with regional HIE. They use standardized measures to provide performance incentives from multiple payers. Financial incentives for private practice physicians who reach Level II of NCQA's PPC-PCMH standards are provided. The funding from THINC supplements physician EMR subscription fees to cover basic EMR costs (e.g., software, maintenance, implementation, training, etc.). The maximum bonus amount for the total pool of participating physicians was \$3 million dollars. Incentive payments include two components; 1) process and outcomes measures derived from aggregated administrative data received from all health plans participating in the project (20%) and, 2) structural component determined by achieving Level 2 Medical Home recognition using the NCQA PPC-PCMH assessment tool (80%).

Community Care of North Carolina (CCNC)

The Community Care of North Carolina (CCNC) initiative helps patients link to a primary care medical homes in 1,500 PCP's available to 1.2 million individuals in all 100 North Carolina counties. The PCP's receive PMPM payments and additional resources to better manage populations. This includes local community partners (health systems, hospitals, health departments, DSS, LMEs, community organizations and service providers) engaged in network governance and collaborative initiatives. Payer and providers/networks identify opportunities and priority initiatives, pilot initiatives and spread best practices. CCNC pays a \$3 PMPM and has been established since 2007. It is unclear if start-up costs were paid separately or baked into future PMPM payments.

III. Alaska PCMH Infrastructure Observations

Alaska DHSS must decide how to get the best value for the limited dollars available for the PCMH pilot. The state has indicated that up to \$50,000 will be available for approximately 10 applicants. This funding will go to support a variety of activities including but not limited to training, service expansion, clinical time, electronic health records/information systems, and certification costs. Below is some detail on each of these items identified:

- Provider Training/Clinical Time Away from Patients – The cost of training will be dictated by the intensity and frequency. Pennsylvania's SEPA collaborative referenced a fee of \$11,655 per 7 day training session with the Learning Collaborative Sessions. This accounted for the time lost of clinical leaders participating in PCMH training. Alaska

must define what training module the Alaska providers will be attending, how they will implement, when they will attend, and how they will document the results.

- New Services (not currently covered by Medicaid) – This is a policy issue that the Medicaid agency must grapple with. This will require benefit design and budget authority to add “new” services. Alaska will need to identify the expected utilization effects of adding services and cost out the impact.
- Electronic Health Records (EHR)/Information Systems (IS) Investment – Funding practice level EHR/IS improvements with no central strategy would create a disparate system of EHR/IS resources with little coordination. Alaska should develop a comprehensive strategy for utilizing health information and data analytics to support the PCMH initiatives. The Adirondack Medical Home Pilot (AMHP), Community Care of North Carolina, and New York Hudson Valley P4P/Medical Home Project all made significant investment in a centralized data strategy to support their PCMH initiatives and Alaska should consider the same.
- Certification Reward– Pennsylvania’s SEPA collaborative practices were awarded over \$8,000 each for NCQA certification support for year one infrastructure payments. A similar certification support payment should be made to the selected Alaska providers.

IV. Next Steps

Alaska DHSS should focus the available funding to a select group of providers for training and certification. A more comprehensive EHR strategy should be adopted that becomes the backbone of a successful PCMH project. Additional commitment and funding from payors is critical to the success of the pilot. Every successful PCMH initiative has identified significant support from both government and private payors. The addition of new services is a terrific policy goal to the extent that more funding becomes available, but it is an unlikely first step in designing and developing a successful medical home pilot in Alaska. The items below provide action items for each recommendation provided.

- Define the actual cost of provider training in Alaska. The published reasonable cost equivalents (RCEs) and Bureau of Labor Statistics data can help us develop a reasonable estimate of compensation for “time” spent training.
- Identify the cost of certification for potential PCMH grant recipients.
- Outline a strategy and funding sources to support an Electronic Health Record/Information System investments that support PCMH programs. Alaska can learn from experiences of pilots in NY, NC, and PA.
- Discuss future service additions that support improved prevention, wellness, and overall health improvement.

¹ Gabbay, Robert, Michael H. Bailit, David T. Mauger, Edward H. Wagner, and Linda Siminerio. "Multipayer Patient-Centered Medical Home Implementation Guided by the Chronic Care Model." *The Joint Commission Journal on Quality and Patient Safety*. N.p., June 2011. Web. 19 Sept. 2012.

Alaska Patient Centered Medical Home Status Report July, 2012 through September, 2012

Project Name	Patient Centered Medical Home
To	Josh Applebee, Deputy Director, Health Care Policy, DHSS
cc	Sean Huse, James Waldinger, Garrett Abrahamson, Joe Griffin
From	Brenda McCormick, PCG
Report Period	7/1/2012 – 9/30/12

Project Summary

The Alaska Health Care Commission recommended that the State initiate a patient-centric health care delivery model as part of a larger set of recommendations to restructure the health care system in Alaska. The Department contracted with PCG to assist the Alaska DHSS in implementing a Patient Centered Medical Home Pilot Project. A number of decisions need to be made in order to implement the PCMH program. These are the **operational decisions needed to begin the program:**

1. Assess current environment,
2. Select practice standards,
3. Engage the provider community,
4. Determine patient attribution methodology,
5. Determine pilot metrics and goals,
6. Determine pilot reimbursement strategy,
7. Determine the extent of participation from other payers.
8. Engage recipient involvement to affect behavior change in the way that services are accessed and promote healthy behaviors,

Post selection operational pieces:

- Gap analysis of providers selected against the standards through a practice self assessment,
- Reporting - prepare baseline data and utilization dashboard to share with participating providers, aggregate as well as prepare individually for participating providers, determine control group, and monitor success.
- Preparation about how the standards support health home requirements to prepare for the later possibility of health homes adoption,
- Provider workgroup consisting of participating practices and other interested parties,
- Education strategy to achieve practice transformation throughout the pilot and beyond as the program grows,
- Longer term reimbursement strategies post pilot.

Project Highlights for Reporting Period

July through September was a very busy quarter for the planning process. In order to inform decision making for the DHSS, PCG completed the following reports for the Department including:

- National Standards Comparison and customized standards recommendations for Alaska,
- Data Analysis from Medicaid claims,
- Other State Strategies for Medical Home Models,
- Reimbursement Options Memorandum.

Project Highlights for Reporting Period

PCG held a stakeholder meeting and webinar as well as initiated contact with many provider practices to answer questions and generate interest in pilot participation. PCG also met with the Family Practice Association, the Hospital and Nursing Home Association, and the Alaska Primary Care Association to discuss the project and garner support. In addition, PCG and DHSS had conversations with Premera Blue Cross and Blue Shield to recruit their participation in the pilot. Premera has expressed their interest and we believe at this time they will be joining DHSS in the pilot. The primary open question now is the extent to which behavioral health integration will be required of participating practices. PCG is currently researching the extent to which other states have required integration at the Department's request and will be updating the other state strategies report to incorporate the information gathered.

Next Steps:

- Resolve open questions regarding behavioral health integration,
- Develop the provider application,
- Determine performance metrics,
- Develop utilization report design,
- Solidify Premera's involvement,
- Release the provider application for participation.

KEY PROJECT TASKS COMPLETED

Deliverables	Description	Next Steps	Est. Complete Date
National Standards Comparison and standards recommendations for Alaska.	PCG provided the Department with a draft comparison report of the most commonly used national standards for PCMH projects. The report describes the elements of each national standard and the comparisons of each.	PCG provided and discussed the report with DHSS and determined that without management of any kind in Alaska currently it would be difficult to require that any national standard be met by practices in the pilot. With that in mind, PCG provided recommendations for a paired back set of standards that providers would be asked to meet.	Initial Report provided – August 6. Paired back set of standards provided- August 17

Deliverables	Description	Next Steps	Est. Complete Date
<p>Data Analysis from Medicaid claims</p>	<p>PCG submitted a data request to DHSS to collect Medicaid recipient data for FY 2011. The data request was submitted to the DHSS on May 2, 2012 and included the following elements.</p> <ol style="list-style-type: none"> 1. Unduplicated recipient count by geographic unit, age/gender, eligibility category, race/ethnicity, and institutionalized status 2. Recipient count by primary diagnosis 3. Expenditures by service categories, primary diagnosis, and provider type 4. Unduplicated Hospital admissions, readmissions, and emergency department visits 5. Unduplicated recipients with at least 1 primary care encounter 6. Unduplicated recipients receiving prevention services 7. Prevention Quality Indicators (PQI) Admission Rates for Diabetes, Cardiac, and Other Measures <p>Data was provided back to PCG by the state on June 25, 2012. Additionally, the state forwarded a readmission analysis by the Agency for Healthcare Research and Quality (AHRQ) on July 11, 2012. Subsequently, the state provided additional ER visit documentation on September 7, 2012. Collectively, the information provided from the state has allowed PCG to define benchmark spending, diagnosis, readmissions, ER utilization, prevention services, and provider network adequacy by borough.</p>	<p>Use data to develop baseline data to the extent possible for the pilot implementation. Request additional data from DHSS IT as necessary and with consideration for decisions regarding metric use. Share with providers to set goals for year 1 post implementation..</p>	<p>Initial report provided 8-13.</p> <p>After concerns were expressed by the state about the validity of ED data, the data was rerun by DHSS IT. PCG amended the report and resubmitted with the corrected data on September 30.</p>

Deliverables	Description	Next Steps	Est. Complete Date
Other State Strategies	PCG provided DHSS with a report on what other states are doing in country to transition to a PCMH model. Feedback was received in mid September. PCG was asked at that time to expand the information provided with respect to behavioral health integration. PCG is currently researching the topic in more depth and will be amending the report for the state in the next week.	Document and incorporate additional information with respect to behavioral health integration as requested. Provide an amended report to DHSS.	Submitted to DHSS on September 7. New draft amended with additional behavioral integration information October 16.
Reimbursement Options Memorandum	PCG provided a memorandum regarding payment strategies that the state can employ to reimburse providers, using three other states as examples for how the state may structure their payment. PCG was informed that Alaska will be providing an infrastructure payment during the pilot phase but will transition to a longer term reimbursement strategy supporting health care reform principles once the pilot is completed.	PCG is awaiting the state's feedback and next steps regarding the memorandum contents.	Submitted to DHSS on Sept. 21.
Engage Other Payers	PCG and DHSS has had three conversations with Premera Blue Cross and Blue Shield regarding their interest in supporting the pilot as a payer. Premera has indicated a willingness to participate in the pilot and has made a decision to provide reimbursement using health care reform strategies at the onset of the pilot.	Provide additional information to Premera regarding performance goals and metrics.	Conversations held: Aug. 7 Aug. 30 Sept.10

Deliverables	Description	Next Steps	Est. Complete Date
Held Large Stakeholder Meeting in person on-site in Anchorage and also made available through a conference line and webinar to achieve maximum participation.	<p>A stakeholder session was conducted in August to present standards recommendations and introduce possible short and long term reimbursement strategies.</p> <p>The session was well attended and discussion revealed barriers to consider as well as reactions to the standards. Follow up is ongoing with the provider community. Commitments for participation were held back due to the undetermined dollar amount that practices will receive for participation but PCG has now learned the approximate dollar amount that practices will receive and is sharing that information when requested.</p>	Use feedback obtained to customize standards.	Aug 21
Outreach to Provider Community	<p>PCG has been performing outreach to individual practices who attended the stakeholder session with the goal of providing information and answering questions to gauge and engage interest in pilot participation. In addition, PCG had separate meetings with the Family Practice Association and some of its members, the nursing home and hospital association and the Alaska Primary Care Association. All of whom have expressed support for the pilot and have assisted us in engaging their members.</p>	Continue to reach out to providers to garner support and possible participation. Four practices to date have expressed a strong desire to participate. PCG will continue outreach efforts in order to maximize participation to the extent possible.	Throughout August and September and ongoing.

30 Day Outlook			
Determine pilot metrics and goals.	Submit a report with recommendations to DHSS with respect to metrics to determine the success of the pilot with consideration to measures already being collected by practices for other purposes.	Submit report and discuss with the DHSS a recommended set of measures.	Friday, October 19.
Submit draft application to DHSS	PCG is currently preparing a draft application and process for consideration by DHSS.	Submit draft and obtain feedback from DHSS.	October 18

30 Day Outlook			
Update Other State Strategies Report	Provide updated report for other state strategies with the inclusion of additional behavioral health information.	Submit draft and obtain feedback from DHSS.	October 16
Solidify Premera's involvement.	Provide additional information to Premera as needed to obtain final decision to participate.	Schedule another conference call.	October.
Develop utilization report design.	Determine metrics based on DHSS decisions, recommend a report design, and request additional data from DHSS IT to develop baseline data.		November
Determine attribution methodology.	Determine attribution methodology to identify patients for selected practices.		November

Considerations, Comments and Concerns Raised to Date	
Current Projects Underway in Alaska	<p>Known initiatives:</p> <ul style="list-style-type: none"> • NUKA project • CHIPRA project • Alaska Primary Care Association project • Medicare demonstration recently awarded to Neighborhood health center in Anchorage
Concerns/comments (quotes) raised by some provider practices to date.	Transforming a practice to a certified PCMH is a huge undertaking and very time consuming. In particular rural clinics are doing their best to keep their clinics staffed with PCPs which is only projected to get worse. Commitment to waste reduction is difficult to show especially early on that it makes a difference in decreased hospitalizations/ER usage/etc. I do see a lot of cost in human resources as far as case management/data collection/etc. that would be an added cost for most of us rural clinics.
	This looks unrealistic to get done within a year. We do have to continue seeing patients as well. We first need to get a decent EMR so that is already a huge undertaking for our small clinic. We don't have a case manager and could use one. We do have behavioral health integration. It would be good to know what kind of financial and other assistance it involves.
	This PCMH project is something I am very interested in. Help/assistance and input of many sorts would be welcomed as I am a solo doc with a busy practice.
	I feel my practice is enough of a "home" to my patients and I don't really see a benefit in this program. There are enough outside experts telling FPs how to treat their patients, how to structure pay for hospital work, not to mention federal and insurance experts telling me how to practice.
	I have a lot of PCMH experience from my previous university job as associate medical director for QI and work in QI now in my community hospital. Let me know how I can help/participate...
	What is being suggested here is already in place in many if not most family



	medicine facilities. This program has no added value except to employ more administrative personnel and add to the cost of delivering medical care.
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Project Resources Utilized in Reporting Period
Brenda McCormick – PCG Project Manager, Senior Advisor James Waldinger, PCG Associate Manager Sean Huse, PCG Manager Garrett Abrahamson, PCG Consultant Joseph Griffin, PCG Business Analyst Julia Sun, PCG, Business Analyst

Respectfully Submitted,

Brenda McCormick
Project Manager, Public Consulting Group

Alaska Department of Health and Social Services

Patient-Centered Medical Home Performance Metrics Report

October 2012

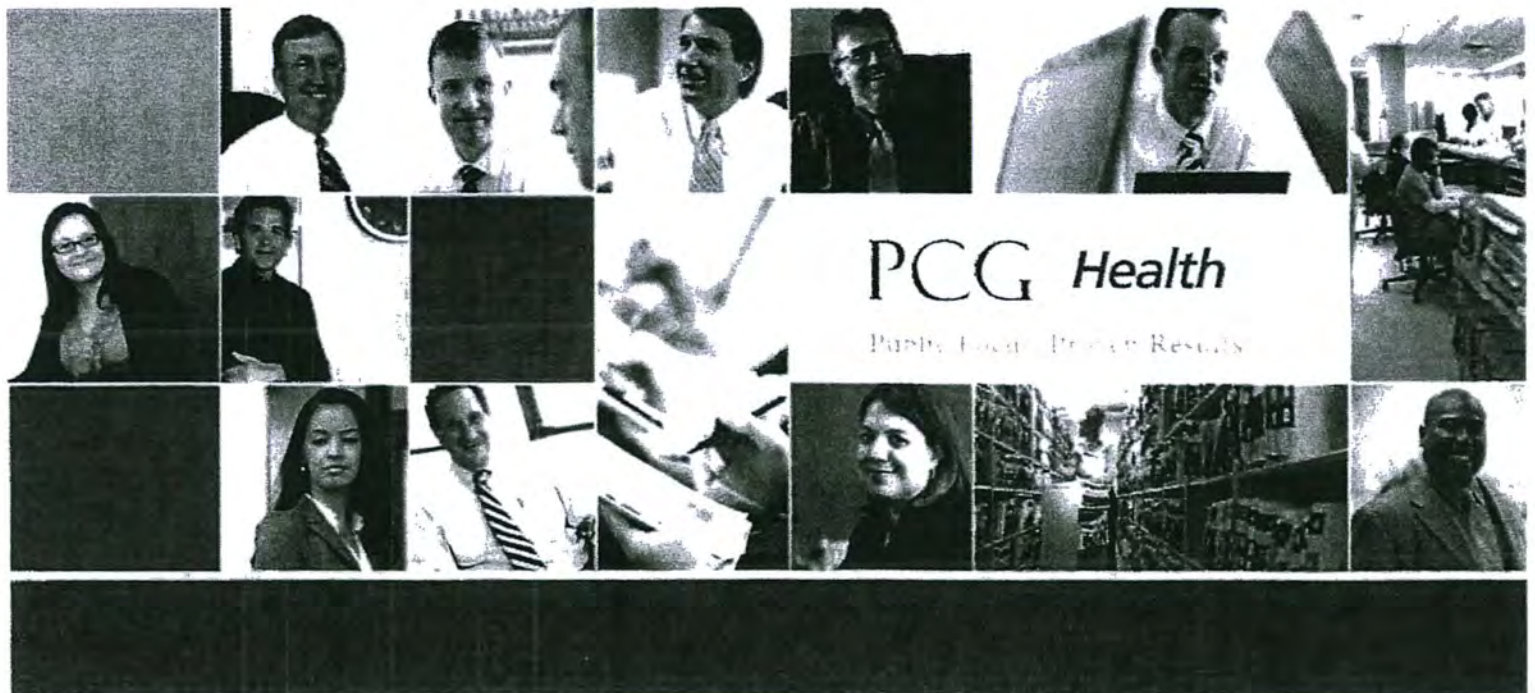




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Introduction

The patient-centered medical home (PCMH) is an emerging care delivery model in the healthcare marketplace. According to the National Academy for State Health Policy (NASHP), all 50 states have initiated some level of medical home/patient-centered care model. The State of Alaska's Department of Health and Social Services (DHSS) is in the process of implementing a PCMH system for Alaskans, which will begin in 2012.

An important aspect that DHSS must consider is how and what to measure in determining the success of their PCMH system. ~~Goals and standards of the program must first be identified~~

Based on the goals and standards, data driven performance metrics can be developed that will gauge the success of the PCMH system. DHSS must also determine the data and reporting capabilities within their state and their healthcare system in establishing metrics along with an analytical infrastructure.

This report's purpose is to identify potential performance metrics for Alaska's PCMH program by taking a look at existing metrics to provide DHSS with options for determining and demonstrating the success of their PCMH pilot program.

Existing Performance Metrics

There are numerous different performance metrics for Alaska DHSS to consider in evaluating their PCMH program. The Centers for Medicare and Medicaid Services (CMS) issued Electronic Health Record (EHR) Incentive Programs that provide financial incentives for the "meaningful use" of certified EHR technology to improve patient care. In order to receive an EHR incentive payment, providers have to show that they are "meaningfully using" their EHRs by meeting thresholds for a number of objectives. CMS has established the objectives for meaningful use that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to receive an incentive payment.¹ EHRs are an important feature of the PCMH model in terms of coordinating and providing comprehensive care and therefore these EHR Meaningful Use Measures are an option for Alaska to consider as possible objectives and metrics for their PCMH program.

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by

¹ Meaningful Use: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

eligible professionals. The program provides an incentive payment to practices with eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.² The 2012 PQRS Measures List consists of over 200 measures that can be reported to CMS by practices. The PQRS measures are another set of existing metrics for DHSS to consider.

The Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA) are used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.³ HEDIS measures address a broad range of important health issues and can be especially effective for measuring chronic care disease states. NCQA issues HEDIS core measures specifically for Accountable Care Organizations (ACOs), which are similar to the PCMH model, in terms of patient-centered, coordinated care. These care models have like goals around quality and cost of care.

Section 2703 of the Affordable Care Act (ACA) gives states the option to establish a health home for enrollees with chronic conditions. Like the ACO model, health homes are also similar to the PCMH model in that they have the same overall goals and objectives for improving the quality of care while reducing the costs of care. This option reflects the popularity and interest of the PCMH model and chronic care management. In order to have a health home program recognized, states must submit a State Plan Amendment (SPA) to CMS and have said SPA approved. As part of the SPA, each state is required to describe the goals and performance metrics of their health home model, categorized by clinical outcomes, experience of care, and quality of care.

² PQRS: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

³ HEDIS: <http://www.ncqa.org/HEDISQualityMeasurement/WhatIsHEDIS.aspx>

Performance Metrics for Alaska

DHSS will want to identify performance metrics that determine the success of the stated goals and standards. The state must also align staffing to develop baseline data and regular reporting for the PCMH program. That being said, a source for Alaska to consider in selecting metrics is the Commonwealth Fund's Data Brief entitled, "Recommended Core Measures for Evaluating the Patient-Centered Medical Home: Cost, Utilization, and Clinical Quality."⁴ This report provides a listing of recommended measures for PCMH programs keeping in mind the goals and objectives. There is some overlap with these measures and the existing metrics referenced in the previous section as many sources use HEDIS and PQRS metrics. The matrix in *Appendix A* provides a side by side comparison of the Commonwealth Fund's recommended core measures, EHR Meaningful Use, PQRS, HEDIS, and Health Home SPA metrics. This comparison matrix provides DHSS with an overview of metrics that are most common among the different organizations, programs, and states, metrics that Alaska can easily incorporate into their PCMH program, and metrics that comprise the Commonwealth Fund's recommended PCMH measures.

All sources include a variety of quality, cost and utilization, measures. It cannot be emphasized enough that the selected measures must reflect the vision and goals for the program.

Each health home program identified in the measure list is customized dependent on the state's goals for their programs. Therefore, each State Plan amendment (SPA) consists of many different measures. The comparison matrix focuses on and captures any measures from an approved health home SPA that clearly are included in either the Commonwealth Fund's recommended PCMH measures or the HEDIS ACO measures. The SPAs provide both quality and utilization measures in this comparison. Refer to *Appendix B* for a complete summary of goals and measures from eight approved health homes SPAs. *Appendix B* demonstrates what other states are using to gauge their health home models and gives Alaska a more detailed set of and additional options to consider when selecting performance metrics.

Technically, all the quality of care metrics listed in *Appendix A* have some degree of overlap with the EHR Meaningful Use Measures because the EHR system would be used to record and report on all of these measures, if selected, as part of the PCMH model. However, for purposes of this comparison, the focus is on EHR Meaningful Use metrics that clearly reference the

⁴Rosenthal, Meredith B., Abrams, Melinda K., Bitton, Asaf, and the Patient-Centered Medical Home Evaluators' Collaborative. "Recommended Core Measures for Evaluating the Patient-Centered Medical Home: Cost, Utilization, and Clinical Quality". The Commonwealth Fund. May 2012.

http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2012/1601_Rosenthal_recommended_core_measures_PCMH_v2.pdf



specifics of a measure from another entity already listed in the matrix. Primarily, the checked-marked EHR metrics relate to medication management, review, and reconciliation; recording specific patient information; and providing patient-specific resources. A full listing of all Meaningful Use Objectives and Measures can be found in *Appendix C*. The Core Objectives/Measures must all be met and at least 5 of the 10 Menu Objectives/Measures must be met in order for a provider to receive an EHR incentive payment.

As mentioned earlier, there are over 200 PQRS measures⁵ that providers can report to CMS. Similar to the health home SPA and the EHR metrics, the PQRS comparison includes only those that match to either the Commonwealth Fund and/or HEDIS metrics. There is a great deal of overlap with PQRS because NCQA's HEDIS measures are the primary source for the PQRS metrics.

The following appendices provide a comparison matrix and the additional listings of measures from other organizations, programs, and states which provide Alaska with options to identify and select performance metrics for their PCMH model.

Recommendations:

What are the right set of metrics for Alaska?

PCG has included a suggested set of measures that we believe reflect the goals and objectives as we understand them from the DHSS using following sources:

- conversations with DHSS staff,
- the Health Care Commission's report providing direction for a PCMH program,
- data captured from Alaska's initial set of utilization and cost data for ED use and hospital data,
- the Health Care Commission's report on chronic conditions, and;
- stated goals and objectives for the pilot.

The suggested set of measures takes into consideration the limited capabilities of providers and the State to report true outcomes data by focusing primarily, with some exceptions, on metrics that can be retrieved from claims data for the short term until the State's Health Information Exchange (HIE) is in a position to provide outcomes data.

⁵ The full list of 2012 PQRS Measures List can be found under **Downloads** on the following website:
[http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How To Get Started.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html)

Stated Goals and Objectives:

- Reduce disparities in health care access, service delivery, and health status;
- Develop a patient provider partnership supporting a holistic approach, and ensuring patients and their families have the information, skills and tools necessary to maintain and manage their health, and that they are treated in a way that is respectful, engaging and empowering;
- Create an active partnership between the primary care provider, community health and social service providers, and governmental public health agencies to effectively coordinate and manage the care of patients with complex health conditions and to support primary prevention for healthy patients.
- Integrate behavioral and physical health
- Improve the quality of health care and lower health care costs, thereby creating savings to allow more Alaskans to obtain health care coverage within a sustainable health care system; and
- Provide a pragmatic method to document that each eligible Alaskan has access to health care.

PCG suggests a set of metrics supporting these goals and objectives to include:

- Prevention and Screening
- Behavioral Integration
- Cost and Efficiency
- Chronic Condition Management
- Patient Satisfaction

Next Steps:

Alaska DHSS will want to review claims data to determine if the chronic conditions cited in the Health Care Commission Report hold true for the Medicaid population. This data was not run for purposes of PCG analysis. In addition, Alaska DHSS will require resources to:

- Run Baseline Data,
- Re- measure at agreed upon time frames, and;
- Conduct data analysis.

As well as determine how to collect and conduct analysis on metrics not available thru claims data.

Below is a beginning set of suggested metrics based on the information available to PCG. Alaska can use these metrics or modify the list as desired.



Prevention and Screening Metrics	Source	Additional Comments
<ul style="list-style-type: none"> • Children’s EPSDT: Percentage of members 0-20 years of age who had one or more EPSDT procedure(s) during the reporting period 	Claims	Determine if we Alaska wants to split this out in more finite bands
<ul style="list-style-type: none"> • Adult Preventive: Percentage of members 21 years or older who had one or more preventive procedure(s) during the reporting period 	Claims	
<ul style="list-style-type: none"> • Cervical Cancer Screening: Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer 	Claims	
<ul style="list-style-type: none"> • Chlamydia Screening in Women: Percentage of women 16-24 years of age who were identified as sexually active (via pharmacy and/or claims data) and had at least one test for Chlamydia during the measurement year 	Claims	
<ul style="list-style-type: none"> • Colorectal Cancer Screening: Percentage of male adults 50-64 years of age who had appropriate screening for colorectal cancer 	Claims	
<ul style="list-style-type: none"> • Breast Cancer Screening: Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer 	Claims	
<ul style="list-style-type: none"> • Adult weight screening and follow-up; BMI Assessment - Percentage of patients age 18 years and older with a calculated body mass index (BMI) in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented. Normal parameters: Age 65 and older BMI ≥ 23 and < 30 Ages 18–64 BMI ≥ 18.5 and < 25 	Medical Record or HIE	
<ul style="list-style-type: none"> • Weight Assessment and Counseling for Children and Adolescents - The percentage of patients 2-17 years of age who had an 	Medical Record or HIE	



<p>outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period.</p>		
<ul style="list-style-type: none"> Tobacco Use Assessment 	Medical Record or HIE	
<ul style="list-style-type: none"> Tobacco Cessation Intervention 	Claims	
Cost and Efficiency Metrics:		
<p>In Patient Hospitalization –</p> <ul style="list-style-type: none"> Number of admissions by practice for the patient panel 	Claims	
<p>Inpatient Hospital Readmissions –</p> <ul style="list-style-type: none"> Number of readmissions by practice within 7 days and 30 days 	Claims	
<p>ER Utilization (Utilization):</p> <ul style="list-style-type: none"> Average number of emergency room (ER) visits per member per reporting period 	Claims	
Chronic Condition Metrics:		
<p>Diabetic Care HbA1c:</p> <ul style="list-style-type: none"> Percentage of members 21-64 years of age with diabetes (type 1 and/or type 2) who had a Hemoglobin A1c test in the measurement year 	Claims	
<p>Diabetic Eye Care Exam:</p> <ul style="list-style-type: none"> Percentage of members 21-64 years of age with diabetes (type 1 and/or type 2) who had a retinal eye exam performed 	Claims	
<p>Diabetic LDL Screening:</p> <ul style="list-style-type: none"> Percentage of members any age with diabetes (type 1 and/or type 2) who had an LDL-C screening performed 	Claims	



<p>Behavioral Health:</p> <ul style="list-style-type: none"> Percentage of patients 18 years of age and older receiving depression screening through the use of a standardized screening instrument within the measurement period 	Medical Record or HIE	
<p>Behavioral Health:</p> <ul style="list-style-type: none"> Percentage of children screened through EPSDT for mental health issues 	Medical Record or HIE	
<p>Behavioral Health:</p> <ul style="list-style-type: none"> Percentage of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary 	Medical Record or HIE	
<p>Behavioral Health:</p> <ul style="list-style-type: none"> Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment 	Medical Record or HIE	
<ul style="list-style-type: none"> Behavioral Health Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification 	Claims	
<ul style="list-style-type: none"> Cardiovascular Disease: Cholesterol Management for Patients With Cardiovascular Conditions 	Claims	
<ul style="list-style-type: none"> Medication management for controlling High Blood Pressure 	Claims	
<ul style="list-style-type: none"> Care Coordination - Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP. 	Medical Record	
<ul style="list-style-type: none"> Patient Satisfaction CAHPS 4.0 survey administered by the State or providers participating in the pilot. 	Survey Data	



Appendix A – Metrics Comparison

Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Quality					
Adult weight screening and follow-up; BMI Assessment	✓	✓	✓	✓	✓
Weight Assessment for Children/ Adolescents	✓	✓	✓	✓	✓
Childhood Immunization Status	✓	✓		✓	✓
Immunizations for Adolescents	✓	✓		✓	
Breast Cancer Screening	✓	✓	✓		✓
Cervical Cancer Screening	✓	✓	✓		✓
Colorectal Cancer Screening	✓	✓	✓	✓	✓
Chlamydia Screening in Women	✓	✓	✓		✓
Care for Older Adults: Medication Review	✓	✓		✓	
Appropriate Testing for Children With Pharyngitis	✓	✓			✓
Appropriate Treatment for Children With Upper Respiratory Infection		✓			✓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓	✓			✓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		✓			✓
Use of Appropriate Medications for People With Asthma		✓	✓	✓	✓
Medication Management for People with Asthma	✓	✓	✓	✓	✓



Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Cholesterol Management for Patients With Cardiovascular Conditions	✓	✓	✓	✓	✓
Controlling High Blood Pressure	✓	✓	✓	✓	✓
Comprehensive Diabetes Care <i>Note: This measure includes 7 core measures as indicators.</i>	✓	✓	✓		
Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	✓	✓	✓		✓
Comprehensive diabetes care: HbA1c poor control (>9.0%)	✓	✓	✓		✓
Comprehensive diabetes care: HbA1c control (<8.0%)	✓	✓	✓		✓
Comprehensive diabetes care: blood pressure control (<140/80 mm Hg)	✓	✓	✓		
Comprehensive diabetes care: blood pressure control (<140/90 mm Hg)	✓	✓	✓		✓
Comprehensive diabetes care: Eye exam (retinal) performed	✓	✓	✓		✓
Comprehensive diabetes care: LDL-C screening	✓	✓	✓		✓
Comprehensive diabetes care: LDL-C <100 mg/dL	✓	✓	✓		✓
Comprehensive diabetes care: Medical attention for nephropathy	✓	✓			✓
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		✓			✓
Osteoporosis Management in Women Who Had a Fracture		✓			✓



Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Osteoporosis testing in older women	✓*				✓
Use of Imaging Studies for Low Back Pain	✓	✓			
Antidepressant Medication Management	✓	✓	✓	✓	✓
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓		
Annual Monitoring for Patients on Persistent Medications	✓	✓		✓	
Medication Reconciliation Post-Discharge	✓*	✓	✓	✓	✓
Potentially Harmful Drug-Disease Interactions in the Elderly		✓		✓	
Use of High-Risk Medications in the Elderly	✓*	✓		✓	
Fall risk management	✓*				✓
Flu shots for adults ages 50–64 and flu shots for older adults	✓*				✓
Management of urinary incontinence in older adults	✓*				✓
Pneumonia vaccination status for older adults	✓	✓			✓
Preventive Care and Screening Measure Pair a) Tobacco Use Assessment b) Tobacco Cessation Intervention	✓	✓		✓	✓
Medical assistance with smoking and tobacco use cessation	✓*			✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		✓	✓		✓
Adolescent well-care visits	✓		✓		
Well-child visit in the first 15 months of life	✓		✓		



Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Well-child visit in the third, fourth, fifth, and sixth years of life	✓		✓		
Utilization					
All-Cause Readmissions		✓	✓		
Emergency department visits, ambulatory care-sensitive and all	✓		✓		
Acute inpatient admissions, ambulatory care-sensitive and all	✓		✓		
Readmissions within 30 days	✓		✓		
Relative Resource Use for People With Diabetes		✓		✓	
Relative Resource Use for People With Asthma		✓		✓	
Relative Resource Use for People With Cardiovascular Conditions		✓		✓	
Relative Resource Use for People With Hypertension		✓		✓	
Relative Resource Use for People With COPD		✓		✓	
Cost					
Total per member per month costs	✓				
Total per member per month costs for high-risk patients	✓				

* = supplemental recommended measure



Appendix B – Health Home State Plan Amendments (SPA)

New York - Health Home SPA for Individuals with Chronic Behavioral and Mental Health Conditions	
Goal	Measure
Reduce utilization associated with avoidable (preventable) inpatient stays	Inpatient Utilization – General hospital/Acute Care
Reduce utilization associated with avoidable (preventable) emergency room visits	Ambulatory Care (ED Visits)
Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders	Mental Health Utilization
	Follow Up After Hospitalization for Mental Illness
	Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification
	Antidepressant Medication Management
	Follow Up Care for Children Prescribed ADHD Medication
	Adherence to Antipsychotics for Individuals with Schizophrenia
	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Improve Disease-Related Care for Chronic Conditions	Use of Appropriate Medications for People with Asthma
	Medication Management for People With Asthma
	Comprehensive Diabetes Care (HbA1c test and LDL-c test)
	Persistence of Beta-Blocker Treatment after Heart Attack
	Cholesterol Testing for Patients with Cardiovascular Conditions
	Comprehensive Care for People Living with HIV/AIDS
Improve Preventive Care	Chlamydia Screening in Women
	Colorectal Cancer Screening



Iowa - SPA	
Goal	Measure
Change patient behavior to increase the use of preventative services, and increase awareness of appropriate chronic condition management.	(NQF 038) Increase use of preventive services
	(NQF 055) Improve diabetes management: Dilated eye exam (annual by optometrist or ophthalmologist)
N/A	(NQF 062) Improve diabetes management: Micro albumin (annual)
	(NQF 056) Improve diabetes management: Foot exam (annual)
N/A	(NQF 0064) Improve diabetes management: Proportion with HgA1c less than 7
	(NQF 013) Improve diabetes management: Proportion with LDL less than 100
Transform provider practices by the adoption of the patient centered medical home model to improve the population health of members.	(CHIPRA 10) Well Child visits in the first 15 months of life The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. No well-child visits One well-child visit Two well-child visits Three well-child visits Four well-child visits Five well-child visits
	(CHIPRA 21) Follow-up care for children prescribed ADD medication The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.
N/A	(CHIPRA 13) Annual Dental Visit



Iowa - SPA	
Goal	Measure
N/A	(NQF 031) Breast cancer screening
	(NQF 032) The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer
	NQF 041 Percentage of patients aged 6 months and older who received an influenza immunization

Oregon - Health Home SPA	
Goal	Measure
Reduce the rate of potentially avoidable hospital readmissions.	Pneumonia (PN): hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.
Decrease potentially avoidable hospitalizations and increase the ratio of ambulatory care to emergency room visits.	Providers discuss illness prevention.
	Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits, emergency department visits. Ambulatory surgery/procedures and observation room stays.
Improve transitions of care between primary care providers and inpatient facilities.	Provider's aware of care that patients received from other health providers.
	Care transitions: Emergency department (ED) to ambulatory care.
Improve care transitions for people with mental health conditions.	Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.



Oregon - Health Home SPA	
Goal	Measure
Improve documentations, tracking, and reporting of health risks and use of preventive services.	Body mass index (BMI) assessment: percentage of members 18 to 74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.
Service	Measure
Comprehensive Care Management	Mental health care.
	Body mass index (BMI) assessment

North Carolina - Health Home SPA	
Goal	Measure
Reduce Avoidable ED Utilization	Any Diagnosis Emergency Department (ED) visit rate, non-dual ABD, non-ABD
	Access Getting Needed Care Getting Care Quickly
Reduce Avoidable Hospitalizations	1) Inpatient Admissions per 1000 Member Months, Enrolled Non-Dual ABD 2) Asthma: Asthma Hospitalization 3) Heart Failure: Heart Failure Admissions
Increase Integration of Primary Care and Behavioral Healthcare	CAHPS 4.0 Chronic Conditions supplemental questions
	Practices with co-located behavioral health providers



North Carolina - Health Home SPA	
Service	Measure
Comprehensive Care Management	Care Management Patients meeting CCNC priority criteria who received a Comprehensive Health Assessment or an Intervention.
Care Coordination	CAHPS Quality of Care Coordination of Care supplemental questions CAHPS Behavioral Health supplemental questions
Health Promotion	1) Mammography among women 40-69 2) Pap smear among women 21-64 3) Colorectal cancer screening among men and women 50-75 4) Well-child visits in the first 15 months of life 5) Well-child visits in the Third, Fourth, Fifth, and Sixth Years of Life 6) Adolescent well-care visits
	CAHPS HEDIS measure set supplemental questions
	1) Blood pressure control (good) - hypertension 2) Blood pressure control (good) - diabetes
Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	1) Any Diagnosis Potentially Preventable Readmissions as a Percent of Total Admissions, Enrolled Non-Dual ABD population 2) Heart Failure Heart Failure 30-day readmissions
	CAHPS 4.0 Survey CAHPS Quality of Care Coordination of Care supplemental questions
	Medication Reconciliation after non-mental health hospital discharge of targeted patients



Missouri - Community Mental Health Center Health Homes SPA	
Goal	Measure
Improve Health Outcomes for persons with Mental Illness	1. Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive conditions: age standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. 2. Emergency Department Visits: Preventable/ambulatory care-sensitive emergency room visits [algorithm, not formally a measure] 3. Hospital Readmission: Hospital readmissions within 30 days
	1. All Members: Medication Adherence to Antipsychotics, Antidepressants, and Mood Stabilizers 2. Care Coordination: Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.
Reduce Substance Abuse	1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months. 2. Reduce the proportion of adults (18 and older) who drank excessively in the previous 12 months.
Increase patient empowerment and self-management	Patient use of personal EHR (Direct Inform, or its successor)
	Satisfaction with services
Improve coordination of care	Care Coordination - Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.



Missouri - Community Mental Health Center Health Homes SPA	
Goal	Measure
	Use of CyberAccess per member per month (or its successor) for non-MCO enrollees
Improve preventive care	Body Mass Index (BMI) Control - Percentage of patients with documented BMI between 18.5–24.9
	Metabolic Screening - % of members screened in previous 12 months. Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG).
Improve Diabetes Care	Adult Diabetes - % of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.
	Preventive - % of members screened in previous 12 months. - Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)
Improve asthma care	1. Pediatric Asthma - % of patients 5-17 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. 2. Adult Asthma - % of patients 18-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.
	Members with Asthma: Adherence to prescription medications for asthma and/or COPD.
Improve Cardiovascular (CV) Care	1. Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement period 2. CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).



Missouri - Community Mental Health Center Health Homes SPA	
Goal	Measure
Improve Cardiovascular (CV) Care - continued	<ol style="list-style-type: none"> 1. Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds 2. Members with CVD: Use of statin medications by persons with a history of CAD (coronary artery disease).

Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	Measure
Improve Health Outcomes for Persons with Chronic Conditions	<ol style="list-style-type: none"> 1. Ambulatory Care - Sensitive Condition Admission: Ambulatory care-sensitive condition - age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs 2. Emergency Department Visits: preventive/ambulatory care-sensitive ER visits (algorithm, not formally a measure) 3. Hospital Readmission: Hospital readmissions within 30 days
	Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.
Improve Behavioral Healthcare	<ol style="list-style-type: none"> 1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days. 2. Reduce the proportion of adults (18 and older) who drank excessively



Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	Measure
Improve Behavioral Healthcare – continued	<ol style="list-style-type: none"> 1. % of patients 18 years of age and older receiving depression screening through the use of a standardized screening instrument within the measurement period 2. Percentage of children screened through EPSDT for mental health issues 3. % of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary
Increase patient empowerment and self-management	Patient Use of personal EHR (Direct Inform, or its successor) or practice EMR patient portal
	Satisfaction with services
Improve coordination of care	Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.
	Use of CyberAccess per member per month (or its successor) enrollees
Improve preventive care	<ol style="list-style-type: none"> 1. Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5-24.9 Adult Weight Screening and Follow-Up Percentage of patients aged 18 years or older with a calculated BMI in the past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. 2. Weight Assessment and Counseling for Children and Adolescents - The percentage of patients 2-17 years of age who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period.



Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	Measure
	% of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday.
Improve Diabetes Care	<ol style="list-style-type: none"> 1. Adult Diabetes - % of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0% 2. % of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP < 140/90 mmHg. 3. % of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100mg/dL. 4. Child Diabetes - % of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%
	Members with Diabetes: Adherence to prescription medications for Diabetes.
Improve asthma care	<ol style="list-style-type: none"> 1. Pediatric Asthma - % of patients 5-17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. 2. Adult Asthma - % of patients 18-50 years old who were identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.
	Members with Asthma: Adherence to prescription medications for asthma and/or COPD



Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	Measure
Improve Cardiovascular (CV) Care	1. Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least 2 office visits, w/blood pressure adequately controlled (BP<140/90) during the measurement period. 2. CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).
	Members with CVD: Adherence to Meds - CVD and Anti-Hypertensive Meds



Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	Measure
Improve care coordination	<p>1. Concept: Communication and collaboration between the Health Home Team and the Primary Care Physician during the development and review of the plan of care leads to a comprehensive plan of care Measure: Percentage of Physician Consultation claims to the number of Care plans developed and renewed.</p> <p>2. Concept: Use of an electronic medical record ensures that recommended screenings, immunizations and assessments are performed. Measure: Number of hits on the RI KIDSNET Child Health Information system per 1,000 enrollees (KIDSNET stores child specific information on blood lead levels, immunization, newborn developmental assessment, newborn blood spot screening, hearing assessment, home visiting, WIC and Early Intervention).</p> <p>3. Concept: Communication and collaboration between the Health Home Team and the Managed Care Plan ensures that services are not being duplicated. Measure: Percentage of CEDARR MCO enrollees with outreach to MCO documented in the CEDARR record.</p>



Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	Measure
Improve care coordination – continued	<p>1. Concept: Clients perceive that they are receiving appropriate and effective services Measure: Satisfaction with services, accessibility of services, availability of services \</p> <p>2. Concept: Timely delivery of Health Home services Measure: Percentage of Initial Assessment (IFIND) appointment dates offered within 30 days of request.</p> <p>3. Concept: Timely delivery of Health Home services Measure: Percentage of Care Plans completed within 30 days of completion of the Initial Assessment (IFIND)</p> <p>4. Concept: Timely delivery of Health Home services Measure: Percentage of Care Plans reviews completed prior to expiration of current care plan.</p>
	<p>1. Concept: Knowledge of condition by client and family leads to improved management of condition and access to care. Measure: % of clients who indicate having adequate or higher level of knowledge of condition</p> <p>2. Concept: Well coordinated care reduces caregiver stress. Measure: % of clients who indicate having a high level of stress caused by condition(s)</p>



Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	Measure
Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN)	<p>1. Concept: Increased knowledge of conditions and skills and strategies acquired to address consequences of condition will result in better health outcomes. Measure: % of clients who indicate having adequate or higher level of knowledge of condition.</p> <p>2. Concept: Provision of clinical information and community based treatment options Measure: Number of referrals to Community Based Resources per member per year</p>
	<p>1. Concept: Clients perceive that they are receiving appropriate and effective services Measure: Satisfaction with services, accessibility of services, availability of services</p> <p>2. Concept: Timely delivery of Health Home Care Coordination services Measure: Percentage of Community Based service treatment plans reviewed within 30 days of submission to the Health Home.</p>
	<p>1. Concept: Improved Medical Outcomes will result in lower stress levels related to the diagnosed condition Measure: % of clients who indicate having a high level of stress caused by condition(s)</p> <p>2. Concept: Increased participation in age appropriate activities Measure: Parent/Guardian self rating of child's ability to take part in age appropriate community and social activities</p>



Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	Measure
Decrease the occurrence of secondary conditions	<p>1. Concept: Regular screenings for Obesity will result in a decrease of related conditions Measure: Yearly BMI Index is calculated for all clients 6 years of age and older with documented intervention if <85th percentile</p> <p>2. Concept: Participants will be screened regularly for depression Measure: Yearly Screening for Depression for all clients 12 years of age or above</p>
	<p>1. Concept: Clients perceive that they are receiving appropriate and effective services Measure: Satisfaction with services, accessibility of services, availability of services</p>
	<p>1. Concept: Rates of Obesity as measured by BMI < 85th percentile will decrease over time Measure: Reduction of Clients with a BMI >85th percentile. 2. Concept: Treatment for Depression Measures: Clients who screened positive for depression who received further treatment or evaluation.</p>



Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	Measure
Decrease the use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions	<p>1. Concept: Clients do not use the emergency department for care or treatment of an illness that could have been treated in a different setting Measure: Percentage of patients with one or more ED visits for any conditions appearing in a state defined list of diagnoses that can be appropriately treated in a non-ED setting</p> <p>2. Concept: Acute admissions for Ambulatory Sensitive Conditions that could be avoided with proper preventive care. Measures: Percentage of patients with one or more acute care admissions for any conditions appearing in a state defined list of diagnoses that can be avoided through proper preventive care</p>
	<p>1. Concept: Clients perceive that they are receiving appropriate and effective services Measures: Satisfaction with Care, accessibility of care</p>
	<p>1. Concept: Prevention of further Acute Care utilization Measures: Medical Follow up within 7 days of ACS admission</p> <p>2. Concept: Prevention of additional ED utilization Measures: Medical Follow up within 7 days of ACS ED visit</p>



Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	Measure
Improve the quality of Transitions from Inpatient/Residential Care to Community	<p>1. Concept: Health Home staff is actively involved in discharge planning Measure: Percentage of discharges for admissions >7 days in length with active participation of Health Home staff.</p> <p>2. Concept: Health Home staff contacts client after discharge Measure: Percentage of discharges for admissions >7 days in length who are contacted by Health Home staff within 7 days of discharge.</p> <p>3. Concept: Re-Admissions for same diagnosis reduced Measure: Percentage of clients re-admitted or utilizing ED within 30 days of discharge with same diagnosis as admission</p>
	<p>1. Concept: Clients perceive that they are receiving appropriate and effective services Measures: Satisfaction with Care, accessibility of care</p>
	<p>1. Concept: Clients are able to avoid re-admissions for physical health conditions Measure: Percentage of clients with non-psychiatric admissions within 30 days of hospital discharge</p> <p>2. Concept: Clients are able to avoid re-admissions for psychiatric conditions Measure: Percentage of clients with a psychiatric admission within 30 days of psychiatric hospital discharge</p>



Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	Measure
Improve Care Coordination	<ol style="list-style-type: none"> 1. Percentage of patients whose chart includes documentation of physical and behavioral health needs 2. Percentage of hospital-discharged patients with a follow-up visit within 14 days of hospital discharge
	<ol style="list-style-type: none"> 1. Percentage of patients with a regular source of health care 2. Percentage of patients who had a physical exam in the past 12 months
	Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the health home team by phone or in person within 2 days of discharge
Reduce preventable hospital emergency department (ED) visits	<ol style="list-style-type: none"> 1. Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, available at: http://wagner.nyu.edu/ld.lpsr/Index.html?p=61 2. Percent of patients with one or more ED visits for a mental health condition
	Satisfaction with care, accessibility of care
	Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the Health Home team by phone or in person within 2 days of discharge
Increase use of preventive services	<ol style="list-style-type: none"> 1. Percentage of patients who report that they smoke 2. Percentage of patients who report using illicit substances or abusing alcohol 3. Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year 4. Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications.



Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	Measure
	<p>Percentage of patients who are satisfied with their access to outpatient services and with the quality of those services</p>
	<ol style="list-style-type: none"> 1. Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented 2. Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: (a) Initiation of AOD treatment (b) Engagement of AOD treatment 3. Percentage of patients having one or more well-visits/physical examination visits in 12 month period 4. Percentage of smokers counseled and referred for smoking cessation 5. Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment
Improve management of chronic conditions	<ol style="list-style-type: none"> 1. % of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0% 2. % of patients identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period. 3. % of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period 4. % of patients diagnosed with CAD with lipid level adequately controlled (LDL<100).



Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	Measure
	<ol style="list-style-type: none"> 1. % of patients who are adherent to prescription medications for asthma and/or COPD. 2. % of patients who are adherent to Meds – CVD and Anti-Hypertensive Meds 3. % of patients using statin medications who have a history of CAD (coronary artery disease).
Improve Transitions to CMHO Services	<p>Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965</p>
	<p>Percentage of patients satisfied with their access to outpatient services and with the quality of those services</p>
	<ol style="list-style-type: none"> 1. Percentage of hospital-discharged patients contacted by the CMHO hospital liaison/or a member of the Health Home team) by phone or in person within 2 days of discharge 2. Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178



Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	Measure
Reduce Hospital Readmissions	<p>1. Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067</p> <p>2. For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.</p>
	Satisfaction with care, accessibility of care
	<p>1. Percentage of hospital-discharged patients with a follow-up visit to a CMHO or medical provider within 14 days of hospital discharge.</p> <p>2. Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the Health Home team by phone or in person within 2 days of discharge</p>

Appendix C – EHR Meaningful Use

Meaningful Use Metrics			
<i>Eligible Professional (EP) Core Objectives and Measures</i>			
	Objective	Measure	Exclusion
1	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	
3	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	
4	Generate and transmit permissible prescriptions electronically (eRx).	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
5	Maintain active medication list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	
6	Maintain active medication allergy list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	



Meaningful Use Metrics			
<i>Eligible Professional (EP) Core Objectives and Measures</i>			
	Objective	Measure	Exclusion
7	Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth.	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.	
8	Record and chart changes in the following vital signs: (A) Height. (B) Weight. (C) Blood pressure. (D) Calculate and display body mass index (BMI). (E) Plot and display growth charts for children 2–20 years, including BMI.	For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.
9	Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Any EP who sees no patients 13 years or older.
10	Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.	
11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	



Meaningful Use Metrics			
<i>Eligible Professional (EP) Core Objectives and Measures</i>			
	Objective	Measure	Exclusion
12	Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.	Any EP who has no office visits during the EHR reporting period.
14	Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	
15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	



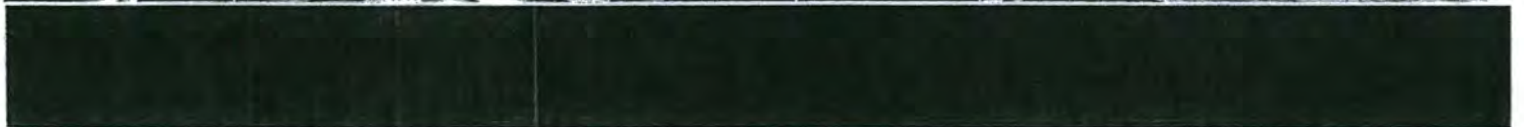
Meaningful Use Metrics			
<i>Eligible Professional (EP) Menu Objectives and Measures</i>			
Objective	Measure	Exclusion	
1	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2	Incorporate clinical lab-test results into EHR as structured data.	More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.	
4	Send patient reminders per patient preference for preventive/follow-up care.	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
5	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.	At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.



Meaningful Use Metrics			
<i>Eligible Professional (EP) Menu Objectives and Measures</i>			
	Objective	Measure	Exclusion
6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.	
7	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	An EP who was not the recipient of any transitions of care during the EHR reporting period.
8	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
9	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.



Meaningful Use Metrics		
<i>Eligible Professional (EP) Menu Objectives and Measures</i>		
Objective	Measure	Exclusion
10 Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.



4/9/15

PeaceHealth *Innovation* Team



Envisioning Better Care, Better Health, a Better You!

A Team of Care Coordinator Nurses,
Social Worker & Educator

CMS.gov
Centers for Medicare & Medicaid Services

 PeaceHealth
Ketchikan Medical Center
The *spirit* of healing®

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PeaceHealth Ketchikan Medical Center



Ketchikan Population: 12,000



**Prince of Wales Population:
4,000**

CMS Demonstration Project

- 2010 Affordable Care Act: Healthcare Innovation Awards
 - 3 Year, \$3.1 million award
 - Functionally started in January 2013
 - Over 3300 Unique/Individual Encounters



POPULATION HEALTH CONFIDENCE

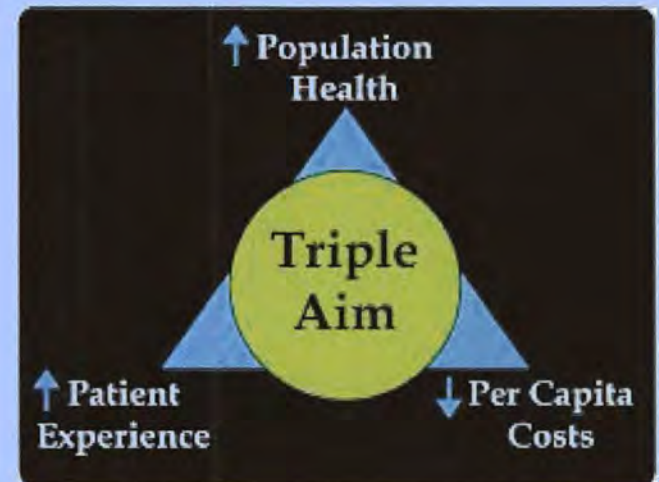
A photograph of a young boy in blue patterned shorts, wearing a rainbow cape and goggles, striking a superhero pose with his arms raised. The text 'POPULATION HEALTH CONFIDENCE' is written in large, red, slanted letters across the image.

Demonstration Project

Goal: Explore primary care redesign model of Patient Centered Medical Home, particularly care coordination to work toward the Triple Aim.

Reduce cost of care per beneficiary per encounter:

1. Reduce Readmission Rates
2. Reduce Unnecessary Utilization
3. Increase Chronic Disease Care
4. Increase Community Literacy
5. Increase Access



Outcomes

(Some examples)

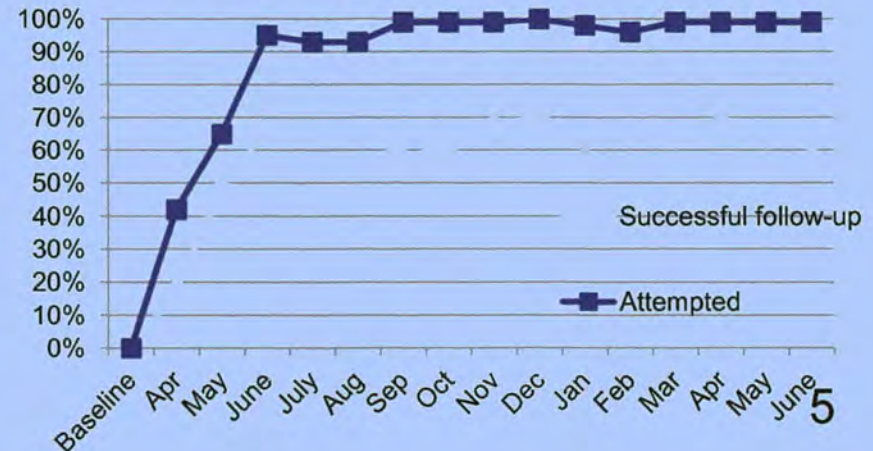
Diabetes A1c Poor Control



Emergency Room Clinic Referrals



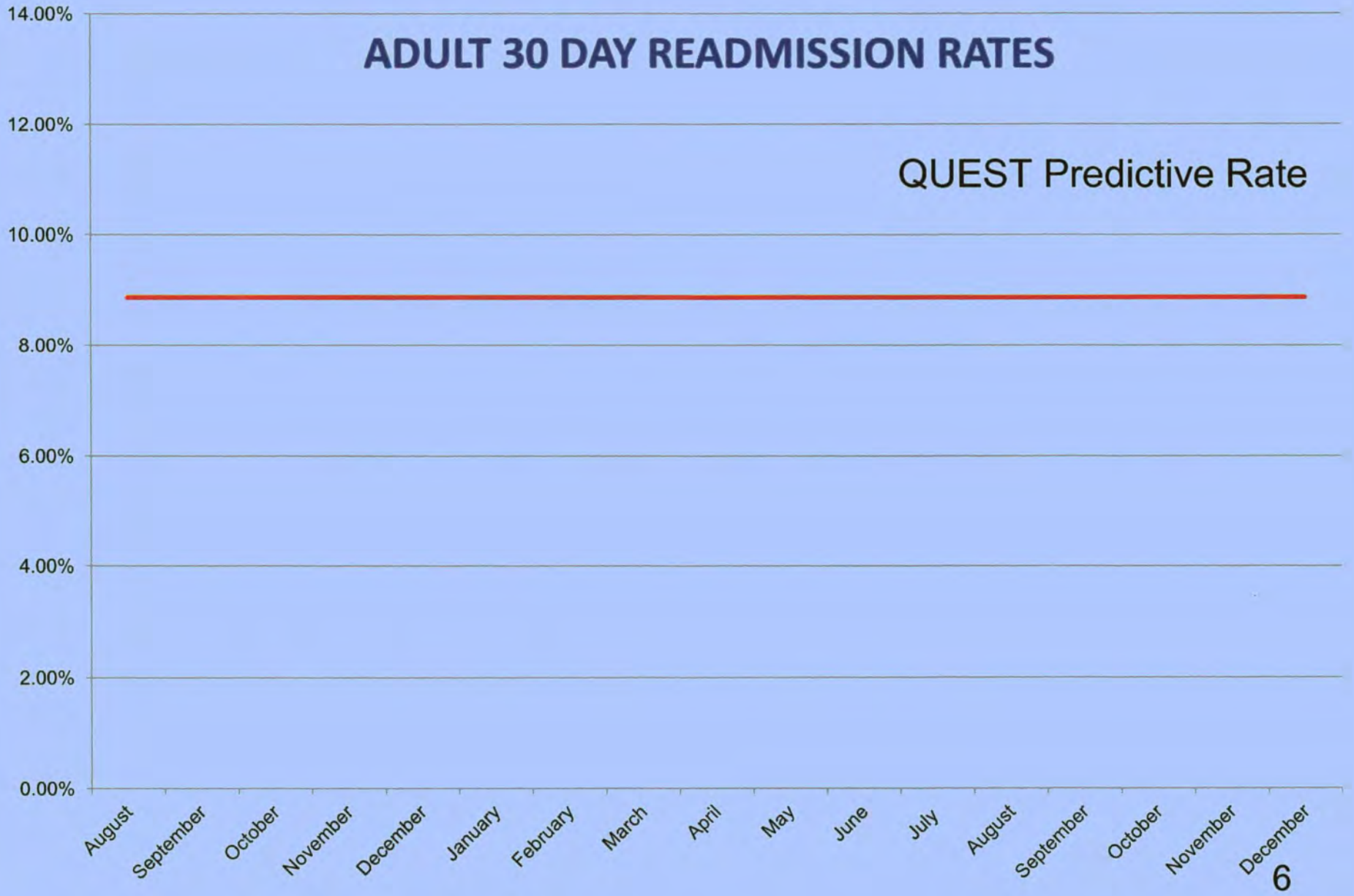
Discharged Patient Follow-Up



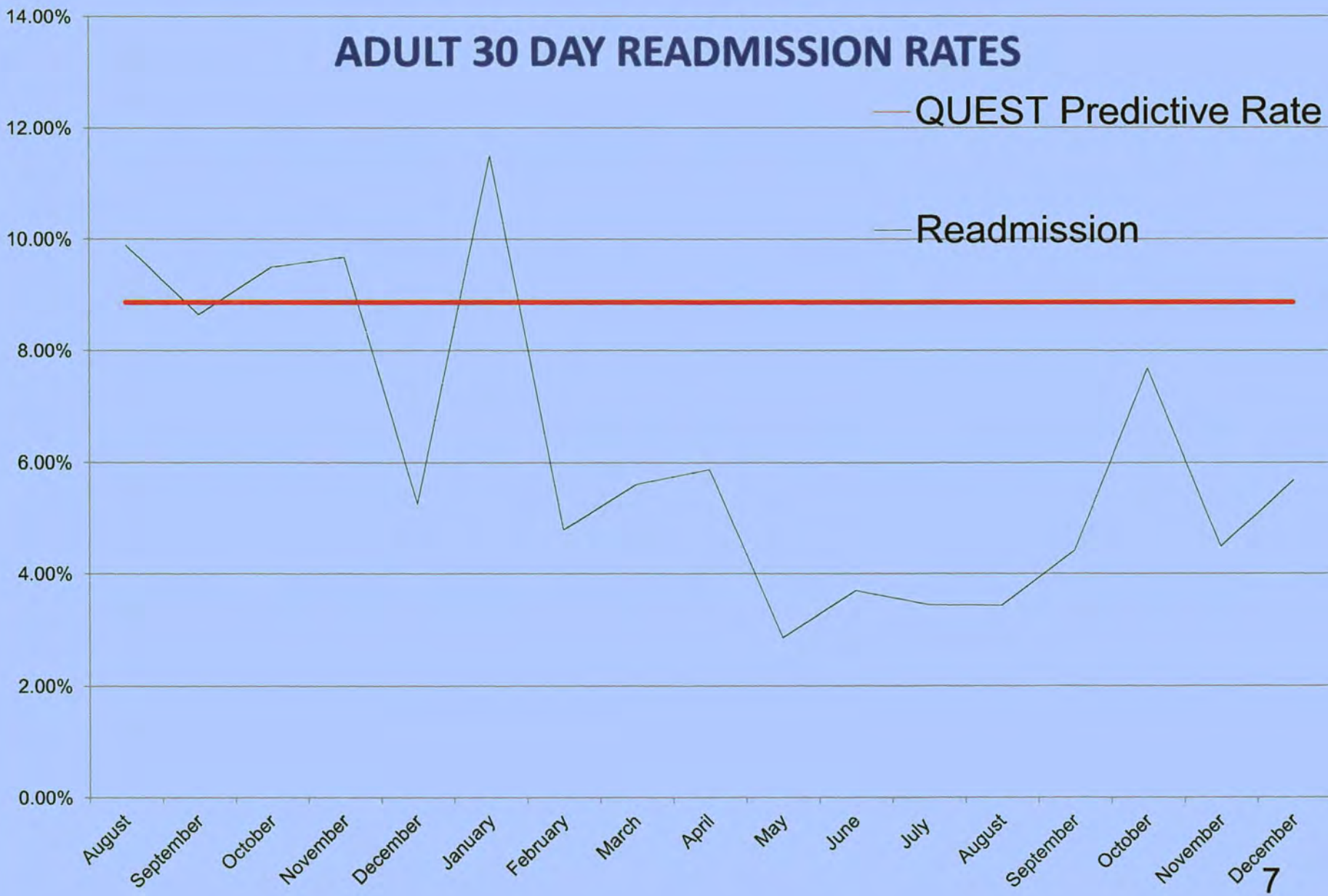
Hypertension patients on active management plan has risen from 84% to 89%

ADULT 30 DAY READMISSION RATES

QUEST Predictive Rate



ADULT 30 DAY READMISSION RATES

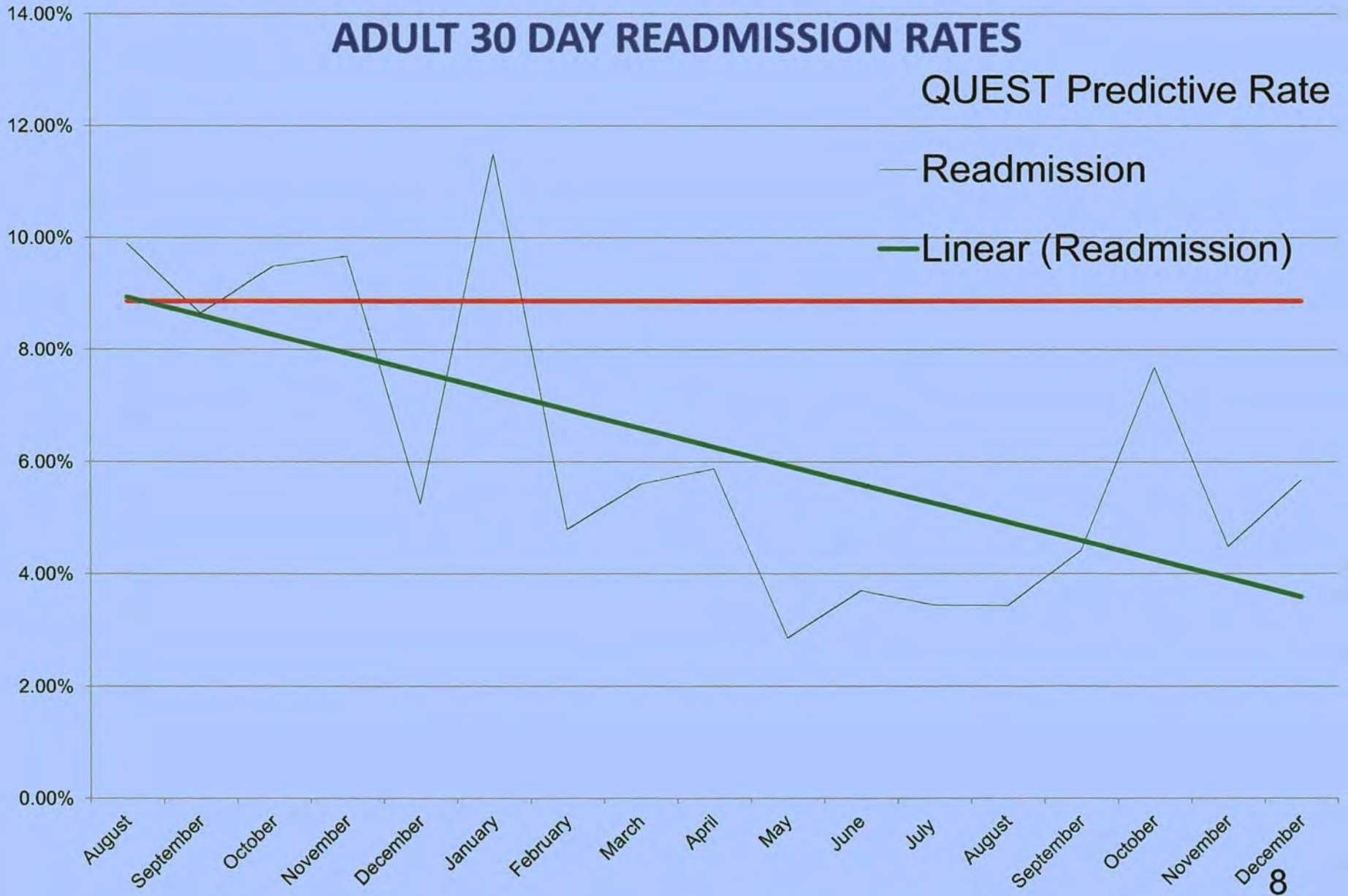


ADULT 30 DAY READMISSION RATES

QUEST Predictive Rate

— Readmission

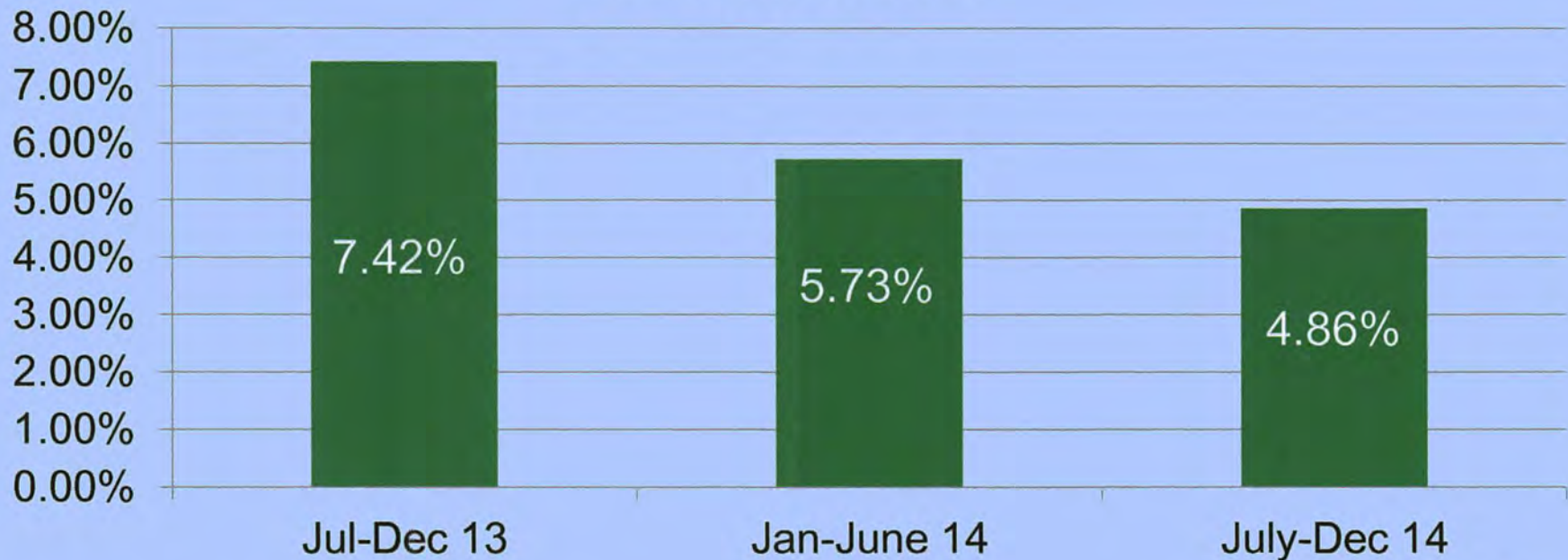
— Linear (Readmission)



Adult Readmission Rate: 5.93% (n=1821)

- 33% reduction compared to expected 8.87%
- Historically we were a bit higher

Six Month Periods

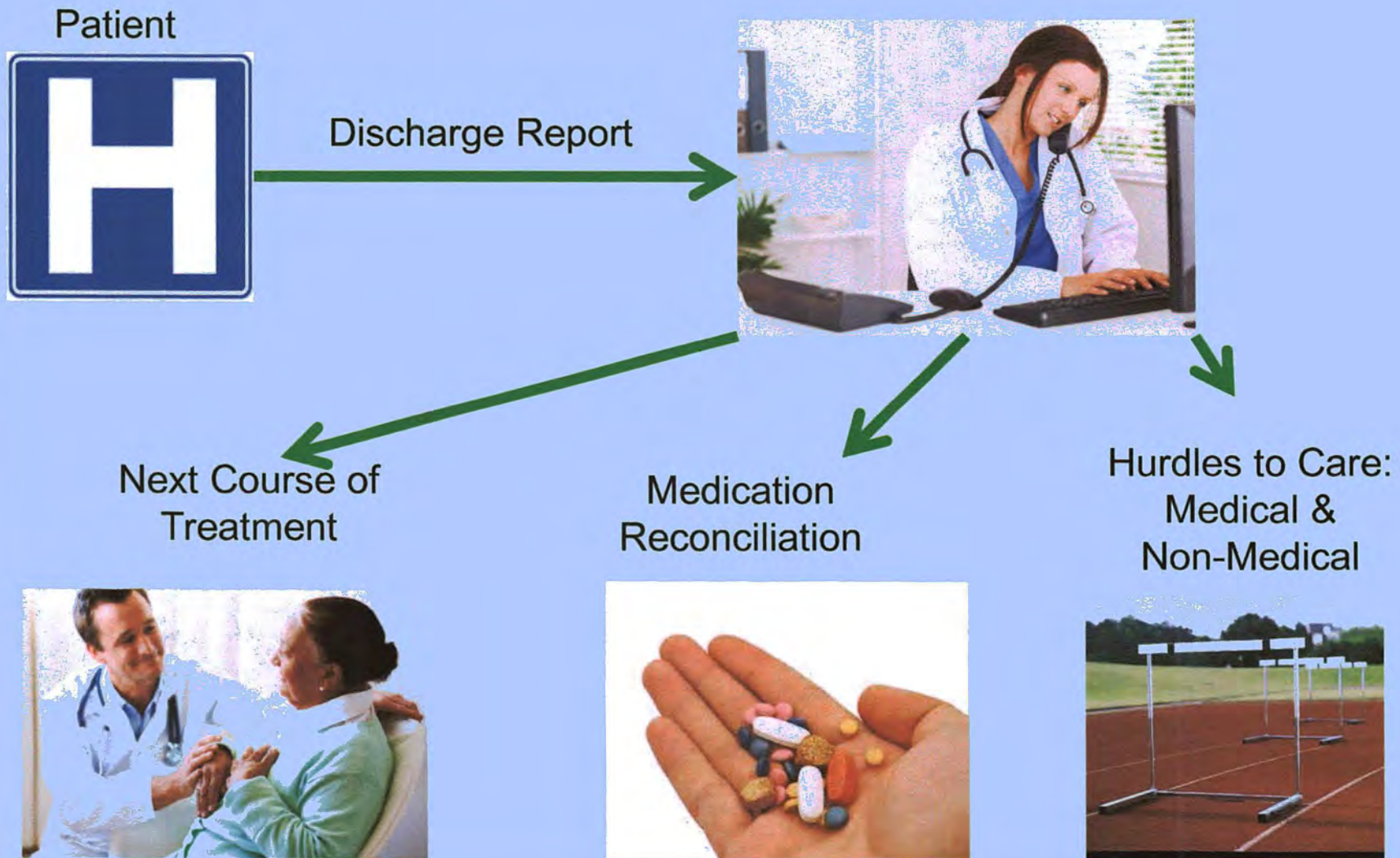


Per Beneficiary Per Encounter Cost Reduction

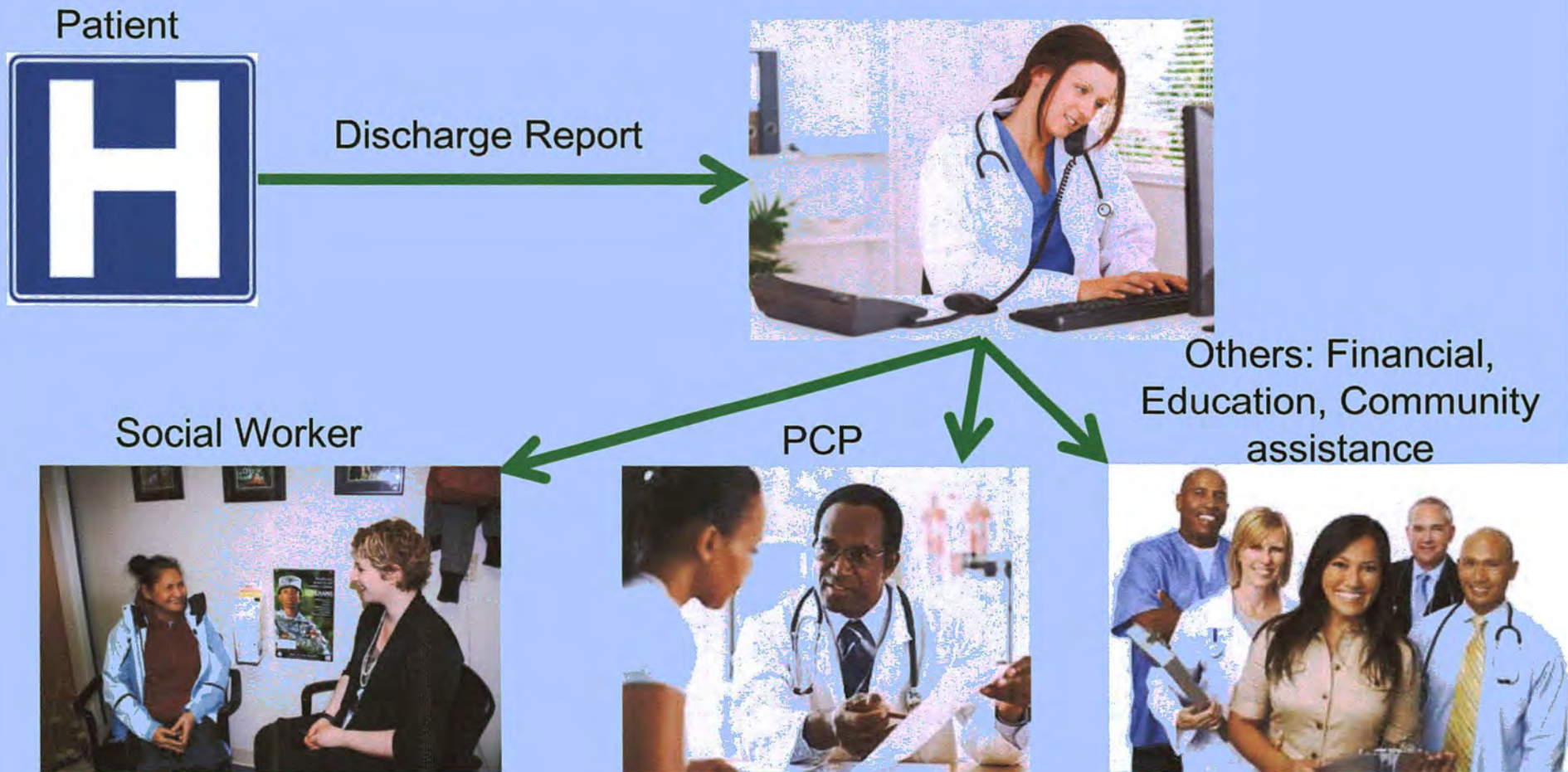
Payer	FY12	FY13	Net Change
Medicare/ Medicaid	\$536/encounter	\$457/encounter	-15%
All Payers	\$630/encounter	\$545/encounter	-14%

Payer	Clinic PBPE		Hospital PBPE	
	2012	2013	2012	2013
Medicare/ Medicaid	\$134	\$130	\$1,187	\$921
All Payers	\$203	\$207	\$1,373	\$1,028

Example: Transitional Care



Example: Transitional Care



TRANSITION OF CARE CALL TEMPLATE

(Daily Discharge Report is Mailed to CC)

ADMITTED on: [Date]

DISCHARGED from: [ER, In-Patient, Observation, etc.]

First call attempted within: [Within 2 business days]

Face to face within: [Protocol for visit in clinic]

DISCHARGE DIAGNOSIS:

PRE CALL PREPERATION/BACKGROUND (gathered from chart review):

Education Resources/Red Flag Conditions:

Specific symptoms to watch for include:

Medication review:

Medications discontinued:

Medications changed:

Medications added:

Follow Up Appointment(S) Scheduled:

Home Health:

Other Community Support:

Supplies and Equipment:

PHONE CALL/ASSESSMENT:

Next Steps for Care

Confirm Follow-up Appointments

Confirm further follow-up tests, etc.

Education of red flag symptoms: is able to verbalize instructions for care and concerning symptoms to report, with cues.

Medication Reconciliation

Psychosocial assessment/support needs

Motivation Interviewing/active listening

Barriers/Other: List services/referrals

RECOMMENDATION:

Psychological and Social (Non-Medical) Hurdles to Follow-Up Care:

- Financial
 - No insurance/Under insured
 - Fear of non-coverage (ignorance of plan benefits)
 - Lack of pricing transparency for follow-up care
- Housing (homeless, marginal housing, boats)
- Family/social support
- Transportation challenges (cost, knowledge of bus routes, etc.)
- Access to food and basic needs
- Disabilities
- General medical literacy challenges

QUESTIONS AND DISCUSSION

- Tough Math: \$700,000 in operational costs results in about a \$1.5 million in lost revenue. Where is the incentive to change?
- Key ingredient currently missing in most facilities is **capital** and **confidence**.
- Care Coordination requires local knowledge by care-givers.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-BHTRG-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Behavioral Health Treatment and Recovery
Grants
OMB Component Number: 3099

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits	(1,558.7)		(5,000.0)	(12,501.0)	(16,528.7)	(19,556.6)	(19,584.7)	
Miscellaneous								
Total Operating	(1,558.7)	0.0	(5,000.0)	(12,501.0)	(16,528.7)	(19,556.6)	(19,584.7)	

Fund Source (Operating Only)

1037 GF/MH	(1,558.7)		(5,000.0)	(12,501.0)	(16,528.7)	(19,556.6)	(19,584.7)
Total	(1,558.7)	0.0	(5,000.0)	(12,501.0)	(16,528.7)	(19,556.6)	(19,584.7)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? **yes**
If yes, by what date are the regulations to be adopted, amended or repealed? **07/01/17**

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148.

Prepared By: <u>Albert Wall, Director</u>	Phone: <u>(907)465-4841</u>
Division: <u>Behavioral Health</u>	Date: <u>04/04/2015 12:40 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance & Management Services</u>	Date: <u>04/04/15</u>
Agency: <u>Health & Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 7 of this bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska.

As Medicaid financing becomes available for behavioral health services, reductions in general fund grant funding will become feasible. Behavioral health grant reductions will be accomplished through a phased, strategic process in order to stabilize services and avoid service reductions in communities. While this is a reduction in State expenditures, DBH expects no loss of services available to Alaskans in need. Primarily federal Medicaid funds, rather than GF/MH grant funds, will cover the cost of services provided to the expansion population. The Department anticipates that behavioral health grants will be reduced through Medicaid expansion by the following amounts: \$1,558.7 in FY2016, \$5,000.0 in FY2017, \$9,000.0 in FY2018, \$13,000.0 in FY2019, \$16,000.0 in FY2020, and \$16,000.0 in FY2021.

Section 13 directs the Department to apply for the section 1915(i) option. This option will serve Medicaid-eligible adults with behavioral health needs that result in multiple admissions to inpatient or residential care. The population includes homeless, those re-entering from incarceration, and others who intermittently use services. These services are currently provided through behavioral health grants with 100% general funds. The Department anticipates that behavioral health grants will be reduced through the 1915(i) option beginning in FY2018 by the following amounts: \$3,501.0 in FY2018, \$3,528.7 in FY2019, \$3,556.6 in FY2020, and \$3,584.7 in FY2021.

Specific services that are currently offered through grant (GF) dollars that will be transitioned to Medicaid reimbursement include services for those adults with Serious Mental Illness (SMI grants) and those adults with Substance Use Disorders (SUD grants). Grants will not be completely eliminated as some services provided through grants are not reimbursable through Medicaid.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-BHA-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Behavioral Health Administration
OMB Component Number: 2665

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services	100.9		100.9	100.9	100.9	100.9	100.9	100.9
Travel	2.0		2.0	2.0	2.0	2.0	2.0	2.0
Services	9.4		9.4	9.4	9.4	9.4	9.4	9.4
Commodities	8.1		0.5	0.5	0.5	0.5	0.5	0.5
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	120.4	0.0	112.8	112.8	112.8	112.8	112.8	112.8

Fund Source (Operating Only)

1002 Fed Rcpts	60.2		56.4	56.4	56.4	56.4	56.4	56.4
1003 G/F Match	60.2		56.4	56.4	56.4	56.4	56.4	56.4
Total	120.4	0.0	112.8	112.8	112.8	112.8	112.8	112.8

Positions

Full-time	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Part-time								
Temporary								

Change in Revenues								
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148.

Prepared By: <u>Albert Wall, Director</u>	Phone: <u>(907)465-4841</u>
Division: <u>Behavioral Health</u>	Date: <u>04/04/2015 12:30 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance & Management Services</u>	Date: <u>04/04/15</u>
Agency: <u>Health & Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 13 of this bill directs the department to apply for the 1915(i) option under Medicaid. The 1915(i) option provides a federal match of 50%, reducing general fund needed by 50%.

Staffing:

One position, Health Program Manager II (GP, Range 19, in Anchorage at \$100.9 annually) will be required for program development, coordination and oversight beginning in FY2016. Funding for this position will be 50% federal and 50% GF match. Though the effective date of the bill is August 1, 2015, the Division of Behavioral Health requests funding for all 12 months of FY2016. The incumbent will be expected to come up to speed and work quickly to complete the intensive application and program development process in a short period of time. The Division of Behavioral Health anticipates having this position filled by July 1, 2015.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-CCIA-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Catastrophic and Chronic Illness Assistance (AS 47.08)
OMB Component Number: 2330

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits	(916.7)		(1,300.0)	(1,400.0)	(1,471.0)	(1,471.0)	(1,471.0)	(1,471.0)
Miscellaneous								
Total Operating	(916.7)	0.0	(1,300.0)	(1,400.0)	(1,471.0)	(1,471.0)	(1,471.0)	(1,471.0)

Fund Source (Operating Only)

1004 Gen Fund	(916.7)		(1,300.0)	(1,400.0)	(1,471.0)	(1,471.0)	(1,471.0)
Total	(916.7)	0.0	(1,300.0)	(1,400.0)	(1,471.0)	(1,471.0)	(1,471.0)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/15

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015 for Medicaid expansion in FY2016. Savings have been adjusted to reflect the change of start date.

Prepared By: <u>Margaret Brodie, Director</u>	Phone: <u>(907)334-2520</u>
Division: <u>Health Care Services</u>	Date: <u>04/04/2015 01:00 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance & Management Services</u>	Date: <u>04/04/15</u>
Agency: <u>Health & Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 7 of this bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. We estimate 20,066 enrollees in FY2016; 23,273 enrollees in FY2017; 26,492 in FY2018; 26,535 in FY2019; 26,580 in FY2020; and 26,623 in FY2021.

Chronic and Acute Medical Assistance (CAMA) is a state-funded program serving just under 500 low-income Alaskans each month who have inadequate or no health insurance, but who do not qualify for Medicaid. CAMA provides limited services to eligible individuals only if diagnosed with one of the following conditions:

- Terminal illness
- Cancer requiring chemotherapy
- Chronic diabetes or diabetes insipidus
- Chronic seizure disorder
- Chronic mental illness
- Chronic hypertension

Covered services for those who qualify for CAMA are limited and specific to the medical condition.

The services provided under this program will begin being absorbed by Medicaid expansion on July 1, 2015.

FY2016 will see a cost savings to the general fund by shifting expenses to federal funds for the newly eligible adult group, at 100% federal participation.

The Department will continue to see an escalating cost savings in the Catastrophic and Chronic Illness Assistance component of \$1,300.0 in FY2017 and a savings of \$1,400.0 in FY2018. The Department anticipates a savings of \$1,471.0 from FY2019 and beyond.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-MAA-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Medical Assistance Administration
OMB Component Number: 242

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services	425.0		463.6	576.2	576.2	688.8	688.8	
Travel	1.8		2.0	2.0	2.0	2.0	2.0	
Services	34.5		37.6	47.0	47.0	56.4	56.4	
Commodities	37.8		8.0	17.6	10.0	19.6	12.0	
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	499.1	0.0	511.2	642.8	635.2	766.8	759.2	

Fund Source (Operating Only)

1002 Fed Rcpts	249.6		255.6	321.4	317.6	383.4	379.6
1003 G/F Match	61.6		255.6	321.4	317.6	383.4	379.6
1092 MHTAAR	187.9						
Total	499.1	0.0	511.2	642.8	635.2	766.8	759.2

Positions

Full-time	4.0		4.0	5.0	5.0	6.0	6.0
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015 for Medicaid expansion in FY2016. Costs have been adjusted to reflect the change of start date.

Prepared By: <u>Margaret C. Brodie, Director</u>	Phone: (907)334-2520
Division: <u>Health Care Services</u>	Date: 04/04/2015 01:30 PM
Approved By: <u>Sarah Woods, Deputy Director Finance & Management Services</u>	Date: 04/04/15
Agency: <u>Health & Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 7 of this bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. We estimate 20,066 enrollees in FY2016; 23,273 enrollees in FY2017; 26,492 in FY2018; 26,535 in FY2019; 26,580 in FY2020; and 26,623 in FY2021.

Health Care Services projects that it will need a total of five positions to fully implement Medicaid expansion. Beginning with FY2016, the division projects that it will need one full-time, range 20, Anchorage, Medical Assistance Administrator III (06-#103); and two full-time, range 21, Anchorage, Medical Assistance Administrator IV positions (06-#104 and 06-#105). These costs have been projected out to include the hiring of a second Medical Assistant Administrator III position in FY2018, and a third Medical Assistant Administrator III in FY2020.

Under Section 13(d)(1) and 13(e), the Department anticipates that the Division of Health Care Services will need to add one Medicaid Assistance Administrator III to develop, design and begin implementation of the 1115 waiver program and perform extensive data analytics to measure outcomes. The Department anticipates hiring the Medical Assistance Administrator III in FY2016.

Administrative costs assume \$9.4 per full time equivalent (FTE) annually for office space, phones, and other contractual costs; \$2.6 *one-time* costs per FTE for computers and software; \$5.0 *one-time* costs per FTE for office equipment; \$2.0 per full time equivalent FTE annually for supplies; \$2.0 per year for total travel costs for all positions.

FY2016 costs assume an August 1, 2015 start date.

2 Medical Asst Administrator III - range 20, $\$112.6 \times 2 = \$225.2/12 = \$18.8 \times 11 = \206.4

2 Medical Asst Administrator IV - range 21, $\$119.2 \times 2 = \$238.4/12 = \$19.9 \times 11 = \218.6

FY2016 Personal services total \$425.0

Travel total $\$2.0/12 = \$.166 \times 11 = \$1.8$

Lease costs, phone, etc - $\$9.4 \times 4 = \$37.6/12 = \$3.1 \times 11 = \34.5

FY2016 Services total \$34.5

Office supplies - $\$2.0 \times 4 = \$8.0/12 = \$0.7 \times 11 = \7.4

FY2016 Commodities, ongoing total \$7.4

Computer, software - $\$2.6 \times 4 = \10.4

One-time office set-up - $\$5.0 \times 4 = \20.0

FY2016 Commodities, one-time total \$30.4

Section 11 requires the Department to prepare an annual report describing costs for both mandatory and optional services. The Division of Health Care Services already produces reports that include this information, so there will be no additional cost to the Department.

Section 18(a) requires the Department to prepare for the Legislature a report on results from the contracted FY2015 - 2016 Medicaid Redesign and Expansion Technical Assistance study and a program for reforming Medicaid. The report represents no additional cost to the Department, as it is included in the contract deliverables.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis Continued

Section 18(b) requires the Department to prepare a report on cost sharing implementation before October 1, 2015. The report should result in a nominal expense to the Department. However, with anticipated future impacts from federal cost sharing regulations, reporting requirements may require MMIS and ARIES system changes in order to capture the income contingent cost sharing rules set in new federal regulations.

#11

HB 148
Back-up

From: Jane and Bill Wiebe <homerwiebe@yahoo.com>
Sent: Friday, April 10, 2015 11:26 AM
To: House Finance Legislation
Subject: HB 148

Dear Members of the House,

A few of you are opposed to the Medicaid expansion that was proposed by the feds. Some of you think it will cost the State a bundle ten years from now, and others are opposed because of political reasons because it happened to be part of the Affordable Care Act

As Republican Representatives of Alaska, I urge you to get over the national politics. As a small population state your resistance will have almost no impact on the national stage, it wastes your time, and it is just not a high priority Alaska issue.

The impact on the State budget is a definite concern, but there are \$148 million federal dollars hanging out there for you to take this year, more if you play your cards right. Take the money now and deal with the undetermined costs later. They may be smaller that you fear.

I'll just list a few Alaskans who benefit:

- * Alaska doctors, nurses, and medical staff.
- * Every hospital in Alaska.
- * Social service people who have to deal with poor, sick, or unemployed Alaskans

Prominently missing from this list are the medicare patients themselves. If Medicaid is expanded, 40,000 Alaskans will get federal health coverage. They may get healthy enough to get a job, but they don't pocket the payments and they will still be broke.

Oh yea, I forgot the big dog on the benefit list. That would be the State of Alaska. Currently, it is the State that pays for poor folks to visit the ER, the State that subsidizes never to be paid medical bills incurred by broke people, and the State that covers what the feds do not.

Regards,
Bill Wiebe



Council of Athabascan Tribal Governments
Health Department
P.O Box 309
Fort Yukon, AK 99740
907-662-2460

April 16, 2015

House Finance Committee
c/o Capitol Building
Juneau, Alaska 99801

Dear Honorable House Finance Committee

The Council of Athabascan Tribal Governments strongly urges the Alaska Legislature to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid

program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Council of Athabascan Tribal Governments endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "Melinda L. Peter". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

Melinda L Peter
CATG Health Director

From: Ann Bayes <bayes@xyz.net>
Sent: Friday, April 10, 2015 10:21 PM
To: House Finance Legislation
Subject: HB 148

It is time for this legislation to be passed so Alaskans can take advantage of the financial benefits provided through its enactment, and we can see more Alaskans able to get medical care when they need it.

As it stands now, the local taxpayers and insured individuals are covering the cost of emergency care for the uninsured through our local hospitals. This means there is no preventative care being provided, only the more expensive acute care when a person's condition requires emergency care.

Please bring the benefits of this legislation to Alaska through the enactment of HB 148.

Thank you,
Ann Bayes

To House Finance Committee
RE: HB 148

Dear Legislators,

We urge you to pass Governor Walker's Medicaid Expansion Bill. Please do not play politics with the health of the 40,000 uninsured Alaskans. It could be a matter of life or death. It's the right thing to do, morally and ethically. It also makes fiscal sense as accepting the federal government's \$146 million will save \$6 million from the general fund.

Thank you,
Karen Murdock
Bill Marshall
Box 1622
55200 East Road
Homer, AK 99603

Mary A Minor, ND

Dear Representatives Neuman, Thompson and members of the House Finance Committee,

Re: Medicaid expansion

I would like to share my perspective with you on HB 148. In December, 2008, I was working at a clinic in Fairbanks. I was paying \$400 a month for health insurance with a \$3000 deductible. I was in my early 50's. I had never been in the hospital, no injuries, never been sick, didn't smoke but, knowing that no one is invincible, I paid it out of my own pocket. Then I had a skiing accident. My injuries sent me to the hospital in Fairbanks in an ambulance. After paying my deductible, my health insurance kicked in at less than \$10. Ambulance, ER visit, MRI—it is not cheap.

In January, 2009, I was shocked to find out my premiums were going up. Way up. Now I would be paying \$800 per month with a \$5000 deductible. I had no choice. I was going to need major reconstructive surgery to my knee which ended up costing \$60,000, so I just had to pay it.

By 2010 I could no longer afford health insurance at all. I have been able to get my current health insurance through the Affordable Care Act and it has been a real blessing. My premiums are now \$22 for health insurance and \$38 for dental. I am also now unemployed and I don't know how long I can keep paying these premiums but for the moment, I don't fear bankruptcy due to illness or injury and I am grateful.

I realize some conservative legislators worry about waste, fraud and abuse in the healthcare system and I couldn't agree more. But that has to be dealt with separately. Hospitals, whether profit or nonprofit use a "chargemaster" to determine what they will charge for every bandage, every aspirin. It is completely unrelated to what these items cost. These are the costs for the uninsured; the people least likely to be able to pay these exorbitant costs. According to Steven Brill in his book "The Bitter Pill", 60% of the nearly 1 million personal bankruptcies in 2013 were due to medical bills. Insurance companies routinely pay less than these charges because of their agreements with the providers.

The situation is unsustainable. Our country spends more on health care than the next 10 big spenders combined. We spend more on health care than the GDP of France. The health industry stands alone as the only industry where high tech advances have increased costs rather than lowering them.

PO Box 2844
Homer, AK 99603

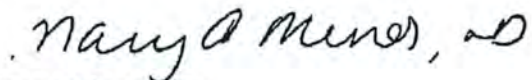
(907)699-7346 phone or text
mminor6@gmail.com

Mary A Minor, ND

I know that fight will be a difficult one but in the meantime, if we can get more people covered by Medicaid, we can address the truly thorny question, why does health care cost so much.

Thanks again for your support of this vital expansion. Regardless of what some may think, none of us is invincible. We should not have to face bankruptcy because of that fact.

Sincerely,



Mary Minor, ND
Mminor6@gmail.com

PO Box 2844
Homer, AK 99603

(907)699-7346 phone or text
mminor6@gmail.com

From: Rob Lund <summersong@alaska.net>
Sent: Thursday, April 09, 2015 5:23 PM
To: House Finance Legislation
Subject: HB 148

Please expand medicaid. You are making a life or death decision for many Alaskans—the wrong choice could haunt you for the rest of your lives.

Thank you.

Rob Lund
Homer

From: Griswold Mary <mgrt@xyz.net>
Sent: Thursday, April 09, 2015 6:41 PM
To: House Finance Legislation
Subject: HB 148

I enthusiastically support Medicaid expansion. It will provide health insurance for a critical segment of our residents. It will lower bad debt and charity charges at our hospitals. It will help our economy with an infusion of federal funds. If Alaska does not accept Medicaid expansion, these federal dollars will go to the enlightened states who do.

Mary Griswold
Homer

From: Lund Judy <jclhomer@xyz.net>
Sent: Thursday, April 09, 2015 8:17 PM
To: House Finance Legislation
Subject: HB 148 - In support

The South Peninsula Hospital Service Area Board has moved to support the South Peninsula Hospital Operating Board's resolution 2015-07 urging the Alaska Legislature to expand Medicaid coverage to improve the Health of Alaskans and to Improve the Alaskan Economy. We, as a group, strongly urge the Legislature to approve HB 148 and to expand Medicaid.

On behalf of the entire board
Sincerely
Judith Lund, Chairperson
South Peninsula Service Area Board

From: Lund Judy <jclhomer@xyz.net>
Sent: Thursday, April 09, 2015 8:24 PM
To: House Finance Legislation
Subject: HB 148

I would like to personally urge passage of HB 148 expanding Medicaid Coverage in the State of Alaska. As an Enrolled Agent preparing taxes for individuals in Homer, Alaska I have personally encountered many individuals who need this coverage. Further as a volunteer for the South Peninsula Service Area Board and for the South Peninsula Hospital Foundation, Inc. I know the problems of the uninsured and the bad debt burdens. These would all be greatly eased with Medicaid expansion. With the influx of substantial Federal Funds at a time of financial stress it seems to be a win-win situation. Please vote to support HB 148.

Sincerely
Judith Lund, E.A.
Sundog Consultants, Inc.

From: Stan Anderson <stan@stananderson.us>
Sent: Thursday, April 09, 2015 11:12 PM
To: House Finance Legislation
Subject: HB 148

HB 148, Medicaid expansion makes dollars and sense for Alaska by providing health and hope which are fundamental to making a go of things in life. Alaskans want Medicaid expansion, now.

Stan Anderson
59835 Tern Ct
Homer, AK 99603

From: Jeff Pearce <jp7seas@hotmail.com>
Sent: Friday, April 10, 2015 3:16 AM
To: House Finance Legislation
Subject: What you propose is horrible

Honorable Representative Paul Seaton.

I appreciate your work in Juneau thus far. However, that being said, please do not consider a state income tax. I know that state revenues are down. Please do not use this as an excuse to tax Alaskan's income. There are other ways to derive an income than this. American founding fathers based the financing of their government on excise taxes, NOT income taxes. Do not go there. The price of crude oil will go back up again. Whether it does or does not is irrelevant. DO NOT tax Alaskans income. There are other ways to procure needed finances. Thank you and may God bless. -Jeff Pearce, Anchor Point

From: Mike and Cathy McCarthy <cathmac@gci.net>
Sent: Friday, April 10, 2015 9:06 AM
To: House Finance Legislation
Subject: Medicaid Expansion

Dear House of Representative Legislators,

We are strongly supporting HB 148. It's the right of every Alaskan to have a medical insurance safety net. No one should lose their home or life savings because of illness or injury. The 40,000 Alaskans who would be covered by this bill are mostly people who are working low paying jobs and have difficulty just paying their rent and food! It is imperative that their needs be met! What's more, it is far more expensive to provide medical care through emergency room services than to take care of medical needs early in less expensive clinics.

We do not buy the argument that the federal government can't be trusted to pay. It is apparent that we trust the federal government to pay for many services in the State of Alaska. Those who oppose this bill on those grounds are the same representatives who want the federal government to pay for Kabata and also a variety of state roads and services that THEY would like to see! Citizens of Alaska are far more important than these items. Give up that argument! It is totally invalid!

There are many organizations in the State that favor this bill including the Alaska Chamber of Commerce! Listen to your citizens!

Thank you for your attention to this matter.

Sincerely,

Mike and Cathy McCarthy

Homer, Alaska 99603

Alaska State Legislature
120 4th Street
Juneau, AK 99801

Dear Representative Steve Thompson,

Thank you for your service to our great state. As your constituent, I respectfully ask that you read this letter and honor my request. As you and your colleagues consider whether to expand Medicaid under Obamacare, I ask that you vote against any legislation that includes expansion. I know special interests have been lobbying you and your colleagues in an attempt to influence your vote. I may not have the ability to travel to Juneau to deliver this message in person but I still hope that you give my request equal consideration. I will remember how you vote on this issue.

The Obamacare Medicaid expansion may provide additional federal taxpayer money for special interests in the health care industry but it comes at a cost to Alaskans in the long run. Expanding Obamacare in Alaska supplants the private sector with more government. We don't need more government here, we need less of it. Most of the time it feels like we are powerless in pushing back on the endless encroachment of government in our lives. But on this issue, you have the opportunity to say no to more government.

Say no to the Obamacare Medicaid expansion. Don't give in to the special interests short-term desire for more taxpayer money. I'll be watching to see who you represent.

From: Nancy Osborne <petero1951@gmail.com>
Sent: Friday, April 10, 2015 3:53 PM
To: House Finance Legislation
Subject: HB 148

Our wish is to address the incredible government waste that comes with Medicare Expansion. That is critical! Just adding more poor folks onto a broken government handout is NOT something we want to see our State do! It only makes them more dependent and that does not bode well for anyone despite what they think! There has to be a better way to get health care to needy folks!

Nancy and Tom Osborne
102 Madison St Box 2375
Seward, AK 99664

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-RR-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Rate Review
OMB Component Number: 2696

#2

HB148
BACK-UP

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel							
Services	200.0		100.0	100.0	100.0	100.0	100.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	200.0	0.0	100.0	100.0	100.0	100.0	100.0

Fund Source (Operating Only)

1002 Fed Rcpts	100.0		50.0	50.0	50.0	50.0	50.0
1003 G/F Match	100.0		50.0	50.0	50.0	50.0	50.0
Total	200.0	0.0	100.0	100.0	100.0	100.0	100.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. The CS calls for a contractor, rather than Department staff, to develop a provider tax proposal. This note also addresses new Section 13, requiring a demonstration project for innovative payment models.

Prepared By: <u>Margaret Brodie, Director</u>	Phone: (907)334-2520
Division: <u>Health Care Services</u>	Date: 04/04/2015 01:50 PM
Approved By: <u>Sarah Woods, Deputy Director Finance & Management Services</u>	Date: 04/04/15
Agency: <u>Health & Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 1(3) requires the Department to contract with an independent third party for advice on developing a provider tax proposal that must be submitted to the legislature by January 25, 2016. The Department intends to issue an RFP and award a contract prior to July 1, 2015. The estimated cost of the contract is \$175.0. Since the contract will be covered entirely with FY2015 funds, there is no fiscal impact for future fiscal years.

Section 13(e)-(f) require the Department to apply for a §1115 demonstration waiver to establish one or more demonstration projects focused on innovative payment models. The projects may include managed care organizations, community care organizations, patient-centered medical homes, or innovative payment models.

One demonstration project must focus on coordinated care that includes a global payment fee structure (i.e. a "managed care system"). One goal of the managed care system is to reduce the per capita growth rate for medical assistance expenditures by at least two percentage points. The managed care system will be measured based on quality and performance outcomes.

Redesigning payment processes and/or service delivery models would require changes in regulation, and possibly State Plan Amendments (in addition to the demonstration waiver). Changes in regulation would vary for each provider type and would require stakeholder input before implementation.

Demonstration projects that focus on innovative payment models, including a managed care system with care coordination and global payments, will involve complex data analysis and calculations that require actuarial expertise. Once an innovative payment model is established, administration of the system would still require actuarial expertise that is available by contract.

The initial and ongoing costs associated with hiring a contractor to perform this work are unknown at this time. It is estimated that the State currently spends approximately \$100,000 annually on actuarial services for two of its health plans. The Department will continue to consult with other states and experts concerning the cost of actuarial services for Medicaid managed care systems. At this time the department estimates: a one-time \$200.0 contract for a firm to analyze and implement one or more innovative payment models, and an annual \$100.0 contract for actuarial work and assistance with administration.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-PAFS-04-07-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Public Assistance
Allocation: Public Assistance Field Services
OMB Component Number: 236

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services	1,715.0		1,715.0	543.7	543.7	543.7	543.7	543.7
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	1,715.0	0.0	1,715.0	543.7	543.7	543.7	543.7	543.7

Fund Source (Operating Only)

1002 Fed Rcpts	857.5		857.5	271.9	271.9	271.9	271.9
1003 G/F Match			857.5	271.8	271.8	271.8	271.8
1092 MHTAAR	857.5						
Total	1,715.0	0.0	1,715.0	543.7	543.7	543.7	543.7

Positions

Full-time	6.0		6.0	6.0	6.0	6.0	6.0
Part-time							
Temporary	17.0		17.0				

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/15

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the Department modified its assumptions and now plans to retain and utilize existing long-term non-permanent staff. No funds for one-time startup or ongoing position support are requested.

Prepared By:	Ron Kreher, Interim Director	Phone:	(907)465-5847
Division:	Public Assistance	Date:	04/07/2015 03:20 PM
Approved By:	Sarah Woods, Deputy Director Finance & Management Services	Date:	04/07/15
Agency:	Health & Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSHB148(HSS)

Analysis

Section 7 of the bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska.

In order for the division to absorb additional applications submitted for eligibility determinations and to maintain the additional caseload of renewal and report of change information submitted by the new clients on an ongoing basis, additional permanent positions will be necessary. While the additional caseload resulting from this bill is projected to increase each year, the division will be able to find administrative efficiencies as the new staff become proficient at eligibility determinations.

Costs identified with this request are for 17 long-term nonpermanent positions and 6 full-time permanent positions. The benefit to the state in utilizing long-term nonpermanent positions will be realized by attrition. As efficiencies are identified and demonstrated, the division will eliminate the nonpermanent positions. The division anticipates utilizing existing long-term nonpermanent staff to the extent possible to reduce the amount of time spent recruiting, hiring and training staff for the implementation timeframes. The following list outlines the staffing levels being requested with this fiscal note:

Full time permanent positions

- 2 Eligibility Technician III - $\$85.3 \times 2 = \170.6
- 2 Eligibility Technician IV - $\$92.3 \times 2 = \184.6
- 1 Research Analyst II - $\$88.8$
- 1 Public Assistance Analyst II - $\$99.7$

17 Long-term Nonpermanent Eligibility Technician II - $\$68.9 \times 17 = \$1,171.3$

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-SDSA-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior and Disabilities Services Administration
OMB Component Number: 2663

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services	99.0		324.0	324.0	324.0	324.0	324.0	324.0
Travel	2.1		6.8	6.8	6.8	6.8	6.8	6.8
Services	186.5		193.9	540.8	10.6	10.6	10.6	10.6
Commodities	2.3		7.6	7.6	7.6	7.6	7.6	7.6
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	289.9	0.0	532.3	879.2	349.0	349.0	349.0	349.0

Fund Source (Operating Only)

1002 Fed Rcpts	185.1		306.2	479.7	174.5	174.5	174.5
1003 G/F Match	104.8		226.1	399.5	174.5	174.5	174.5
Total	289.9	0.0	532.3	879.2	349.0	349.0	349.0

Positions

Full-time	1.0		3.0	3.0	3.0	3.0	3.0
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015 for Medicaid expansion in FY2016. Costs have been adjusted to reflect the change of start date. The note also provides a technical correction; the position count for FY2017 has been corrected from the original version.

Prepared By:	Duane Mayes, Director	Phone:	(907)269-2083
Division:	Senior and Disabilities Services	Date:	04/01/2015 12:00 PM
Approved By:	Sarah Woods, Deputy Director Finance & Management Services	Date:	04/04/15
Agency:	Health & Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 13 of the bill requires the State to apply to the Centers for Medicare and Medicaid Services (CMS) to develop two new Medicaid funding authorities, the 1915(i) and 1915(k) State Plan options. Under these new authorities the state will realize savings in the provision of home and community-based services (HCBS).

Services under these new funding authorities will reduce general fund expenditures by replacing 100% general fund services (1915(i) option) or capturing a higher federal match rate (1915(k)).

In FY2018 the Department anticipates new costs associated with initial eligibility assessments of individuals previously served through the general fund grant programs or services. The estimated number of new assessments = 1,539. Cost per assessment = \$225.41 (not including travel). Estimated cost to manage the 1,539 initial eligibility assessments = \$346.9 in FY2018.

In FY2016, FY2017, and FY2018 the Department anticipates additional expenditures related to the "Automated Services Plan" management information system. State staff, providers, and consumers will have access to the system and a public web resource center. The Department will plan and configure substantial, necessary software changes to this system for new assessments, additional programmatic elements, and interfaces with other department data management systems. Additional user accounts and licenses, and training and support for all users, will need to be developed and supported.

Estimated costs for system changes and development = \$550.0, of which \$300.0 is eligible for enhanced federal funding at a 90% federal match, and the remaining \$250.0 is eligible for the standard 50% federal match. Much of these costs will be realized in the development years (one-third each in FY2016-FY2018), while the savings will continue and grow as overall expenditures grow.

To plan, develop, and manage the new program, beginning in FY2016 Senior and Disabilities Services will require 3 additional full-time staff: one staff person beginning in August of FY2016 and two more staff beginning in FY2017. These will be Health Program Manager II positions, each = \$108.0; Travel = \$2.3; Services = \$3.5; Commodities = \$2.5. FY2016 costs are prorated to reflect the August 1, 2015 start date.

Regulation changes are required to implement the new options and would involve extensive public comment. The estimated effective date of regulation changes is July 2017.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-GRTAL-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: General Relief/Temporary Assisted Living
OMB Component Number: 2875

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Miscellaneous							
Total Operating	0.0	0.0	0.0	(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)

Fund Source (Operating Only)

1004 Gen Fund				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Total	0.0	0.0	0.0	(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148.

Prepared By: Duane Mayes, Director	Phone: (907)269-2083
Division: Senior and Disabilities Services	Date: 04/02/2015 12:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services	Date: 04/04/15
Agency: Health & Social Services	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 13 of the bill directs the Department to apply for the 1915(i) option under Medicaid.

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs. The Department will use the 1915(i) funding option to refinance this 100% general fund program for Medicaid-eligible individuals.

Current funding for GR program: \$8,113.0

Total number served: 630

Average cost per individual: \$12,878.00

Estimated eligible for 1915(i): 349

General fund to be refinanced w/Medicaid: \$ 4,494.3

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-SCBG-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior Community Based Grants
OMB Component Number: 2787

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					(716.3)	(716.3)	(716.3)	(716.3)
Miscellaneous								
Total Operating	0.0	0.0	0.0	(716.3)	(716.3)	(716.3)	(716.3)	(716.3)

Fund Source (Operating Only)

1004 Gen Fund				(716.3)	(716.3)	(716.3)	(716.3)
Total	0.0	0.0	0.0	(716.3)	(716.3)	(716.3)	(716.3)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148.

Prepared By: Duane Mayes, Director	Phone: (907)269-2083
Division: Senior and Disabilities Services	Date: 04/04/2015 02:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services	Date: 04/04/15
Agency: Health & Social Services	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 13 of the bill directs the department to apply for the 1915(i) option under Medicaid.

The department will use this option to refinance the Senior Community Based Grant component's Adult Day and Senior In-Home Services for those who are receiving the service and are also Medicaid eligible.

Adult Day Grant: Total general fund expenditures = \$1,757.0 serving 416 recipients. SDS anticipates serving 114 under the 1915(i) option with an average cost per individual of \$4,223.58. Estimated general fund to be reduced for the Adult Day Grant = \$481.5.

Senior In-Home Grant: Total general fund expenditures = \$2,917.3, serving 1,528 individuals. SDS anticipates serving 123 under the 1915(i) option with an average cost per individual of \$1,909.20. Estimated general fund to be reduced for the Senior In-Home Grant = \$234.8.

The combined estimated general fund to be reduced through the use of the 1915(i) option = \$716.3

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-CDDG-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Community Developmental Disabilities Grants
OMB Component Number: 309

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous								
Total Operating	0.0	0.0	0.0	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)

Fund Source (Operating Only)

1004 Gen Fund				(5,000.0)	(5,000.0)	(5,000.0)	(5,000.0)
1037 GF/MH				(6,635.8)	(6,635.8)	(6,635.8)	(6,635.8)
Total	0.0	0.0	0.0	(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, this note provides a technical correction; the fund sources above have been corrected from the original version.

Prepared By: <u>Duane Mayes, Director</u>	Phone: (907)269-2083
Division: <u>Senior and Disabilities Services</u>	Date: 04/01/2015 12:00 PM
Approved By: <u>Sarah Woods, Deputy Director Finance & Management Services</u>	Date: 04/04/15
Agency: <u>Health & Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 13 of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Individuals receiving home and community-based services through the Community Developmental Disabilities Grant (CDDG) program must meet the eligibility requirements in AS 47.80.900. The CDDG program provides home and community-based services to support individuals' desire to live as independently as they are able.

The Department will use the 1915(i) funding option to refinance the Community Developmental Disabilities Grant program using the following assumptions:

953 individuals accessed CDDG services in FY2014 with an average cost per recipient of \$12.2 per individual per year.
Current program and funding (general fund) = \$11,635.8; Average cost per individual = \$12.2
Estimated general fund to be refinanced with Federal Funds = \$11,635.8

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148 CS(HSS)-DHSS-BHMS-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits	4,399.5		5,323.5	16,728.5	21,227.5	26,534.9	26,605.2
Miscellaneous							
Total Operating	4,399.5	0.0	5,323.5	16,728.5	21,227.5	26,534.9	26,605.2

Fund Source (Operating Only)

1002 Fed Rcpts	4,399.5		5,206.4	12,846.0	16,984.6	21,354.2	21,162.9
1003 G/F Match			117.1	3,882.5	4,242.9	5,180.7	5,442.3
Total	4,399.5	0.0	5,323.5	16,728.5	21,227.5	26,534.9	26,605.2

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015 for Medicaid expansion in FY2016. Costs have been adjusted to reflect the change of start date.

Prepared By:	Albert Wall, Director	Phone:	(907)465-4841
Division:	Behavioral Health	Date:	04/04/2015 12:48 PM
Approved By:	Sarah Woods, Deputy Director Finance & Management Services	Date:	04/04/15
Agency:	Health & Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 7 of this bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. We estimate 20,066 enrollees in FY2016; 23,273 enrollees in FY2017; 26,492 in FY2018; 26,535 in FY2019; 26,580 in FY2020; and 26,623 in FY2021.

As Medicaid financing for the expansion group becomes available for behavioral health services, the Department will be able to reduce general fund grants. This will be accomplished through a phased process in order to stabilize services and avoid service reductions in communities.

Section 13 directs the Department to apply for the section 1915(i) option. This option will serve Medicaid-eligible adults with behavioral health needs that result in multiple admissions to inpatient or residential care. The population includes homeless, those re-entering from incarceration, and others who intermittently use services.

Note: The effective federal match rate for the expansion population is based on calendar year. To estimate savings based on state fiscal year we averaged the calendar rates to approximate the fiscal year federal medical assistance percentage (FMAP) rates; we also adjusted the rates to reflect enhanced federal match for tribal services provided to Indian Health Service beneficiaries. These rates are: 100% in FY2016, 97.8% in FY2017, 95.2% in FY2018, 94.3% in FY2019, 92.6% in FY2020, and 91.3% in FY2021.

Plan and regulation changes are required to implement these changes. The estimated effective date of regulation changes is July 2017.

The federal match rate for the 1915(i) option is the regular match rate, usually 50% but 65% for the Children's Health Insurance Program (CHIP) and 100% for tribal services provided to Indian Health Service beneficiaries. Behavioral Health Medicaid Services average 56% federal match.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-APDMS-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Adult Preventative Dental Medicaid Services
OMB Component Number: 2839

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits	4,932.8		6,454.2	7,598.6	7,871.6	8,156.0	8,307.0	
Miscellaneous								
Total Operating	4,932.8	0.0	6,454.2	7,598.6	7,871.6	8,156.0	8,307.0	

Fund Source (Operating Only)

1002 Fed Rcpts	4,932.8		6,312.2	7,233.9	7,422.9	7,552.5	7,584.3
1003 G/F Match			142.0	364.7	448.7	603.5	722.7
Total	4,932.8	0.0	6,454.2	7,598.6	7,871.6	8,156.0	8,307.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/15

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015 for Medicaid expansion in FY2016. Costs have been adjusted to reflect the change of start date.

Prepared By: Margaret Brodie, Director Phone: (907)334-2520
Division: Health Care Services Date: 04/04/2015 01:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services Date: 04/04/15
Agency: Health & Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 7 of the bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. We estimate 20,066 enrollees in FY2016; 23,273 enrollees in FY2017; 26,492 in FY2018; 26,535 in FY2019; 26,580 in FY2020; and 26,623 in FY2021.

Alaska Medicaid will cover the newly eligible population for non-emergent adult dental services up to a limit of \$1,150 annually. These services include preventive and restorative care such as cleanings, exams, crowns, root canals, and dentures.

Note: The effective federal match rate for the expansion population is based on calendar year. To estimate savings based on state fiscal year we averaged the calendar rates to approximate the fiscal year federal medical assistance percentage (FMAP) rates; we also adjusted the rates to reflect enhanced federal match for tribal services provided to Indian Health Service beneficiaries. These rates are: 100% in FY2016, 97.8% in FY2017, 95.2% in FY2018, 94.3% in FY2019, 92.6% in FY2020, and 91.3% in FY2021.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148CS(HSS)-DHSS-HCMS-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services	330.4		360.4	360.4	360.4	360.4	360.4	360.4
Commodities								
Capital Outlay								
Grants & Benefits	114,679.4		151,859.9	177,435.4	179,915.2	182,726.8	186,575.2	
Miscellaneous								
Total Operating	115,009.8	0.0	152,220.3	177,795.8	180,275.6	183,087.2	186,935.6	

Fund Source (Operating Only)

1002 Fed Rcpts	118,195.8		158,761.5	198,511.4	229,726.7	229,146.0	260,688.0
1003 G/F Match	(3,124.1)		(6,406.3)	(20,538.2)	(49,231.3)	(45,839.0)	(73,532.6)
1108 Stat Desig	(61.9)		(134.9)	(177.4)	(219.8)	(219.8)	(219.8)
Total	115,009.8	0.0	152,220.3	177,795.8	180,275.6	183,087.2	186,935.6

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015. It also contains projected cost savings from case management for Medicaid super utilizers. Sections 10 and 17 require the Department to establish a primary care case management system for super utilizers, and to produce a report to the legislature on the program.

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2520
Division:	Health Care Services	Date:	04/04/2015 01:00 PM
Approved By:	Sarah Woods, Deputy Director Finance & Management Services	Date:	04/04/15
Agency:	Health & Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 1 (4) amends the intent language to establish prevention of disease as a primary model of health care.

Section 3 (18) adds a new paragraph to the duties of the department to "establish guidelines for medical assistance providers to develop health care delivery models that encourage adequate nutrition and disease prevention." Guidelines for preventive services covered under the Affordable Care Act are based on recommendations from the U.S. Preventive Services Task Force (<http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>). The Department currently provides guidelines aligned with the U.S. Preventive Services Task Force to health care providers regarding disease prevention, such as guidelines around preventive screenings for a number of cancers (including colorectal, cervical, and breast), hypertension, high cholesterol, diabetes, and tobacco use. Although these resources are not currently being provided in a targeted manner to medical assistance providers per se, they are being disseminated to health care providers in Alaska.

Section 4 of the bill decreases the number of required audits of Medicaid providers, conducted by an independent contractor, from at least 75 annually to at least 50 annually. Audits are conducted on a representative sample of all Medicaid providers in order to identify both overpayments and violations of criminal statutes. The department is directed to attempt to minimize concurrent state or federal audits of specific providers.

This section of the bill will have no fiscal impact on the department. Any change in the cost of audits is estimated to be offset by a change in recoveries.

Section 5 of the bill allows the Department to assess interest on recoveries for audits performed under AS 47.05.200 as well as other audits and reviews conducted by the state and federal government. There is no additional cost to the department to implement interest penalties on identified overpayments, but recoveries will increase.

The Department estimates it will take four years to reach the current volume of outstanding appeals subject to interest penalties. Interest penalty recoveries are calculated by taking the current amount of outstanding appeals and applying an estimated recovery percentage. The result is multiplied by the statutory rate for post judgment interest of 3.75% and phased in over a period of four years, as shown below.

Amount of Interest Penalty Recoveries FY2016	\$ 42,455
Amount of Interest Penalty Recoveries FY2017	\$ 84,910
Amount of Interest Penalty Recoveries FY2018	\$127,365
FY2019 and beyond	\$169,821

Section 6 of this legislation grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers, in the event they are found to have violated AS 47.05, AS 47.07, or regulations adopted under these chapters. Fines are to be assessed within a range of from \$100 to \$25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section.

Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. In addition there would be a phase-in for the first year. The estimated amount of the recoveries would be \$25.0 in FY2016 and \$50.0 in subsequent years.

Section 7 of the bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. We

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis Continued

and 26,623 in FY2021. The effective federal match rate for the expansion population is based on calendar year. To estimate savings based on state fiscal year we averaged the calendar rates to approximate the fiscal year federal medical assistance percentage (FMAP) rates; we also adjusted the rates to reflect enhanced federal match for tribal services provided to Indian Health Service beneficiaries. These rates are: 100% in FY2016, 97.8% in FY2017, 95.2% in FY2018, 94.3% in FY2019, 92.6% in FY2020, and 91.3% in FY2021.

The Health Care Medicaid Services component covers a range of both direct and indirect health care services for eligible Alaskans.

Regulations will be required to implement several provisions of the bill, both for expansion and for reform, beginning with regulations effective July 1, 2015.

Sections 10 and 17 require the Department to establish a primary care case management system for super-utilizers, and produce a report to the legislature on the program. This will require an assigned case manager to who will enroll and approve certain services for super-utilizers.

Costs to implement include:

- Increase Alaska Medicaid Coordinated Care Initiative contract (current contract cost is \$3.85 per client per month) to manage this population: $\$3.85 \times 7,800 \times 12 = \360.4 .

For FY2016, assumes a start date of August 1, 2015: $\$360.4/12 = \$30.03 \times 11 = \$330.4$

Savings from implementation include:

The estimated cost savings is based upon a Medicaid emergency room overutilizer population of 7,800. The Department believes that it can reduce the number of emergency room visits by this overutilizer group by 30% with case management.

Number of paid ER visits in FY2014 - 114,570

Average price per ER visit FY2014 (only for physician services) - \$613.39

Assumes overutilizer made at least five trips to ER in FY2014 - $7,800 \times \$613.39 \times 5 = \$23,922.2 \times 30\% = \$7,176.7$

For FY2016, assumes a start date of August 1, 2015: $\$7,176.7/12 = \$598.1 \times 11 = \$6,578.6$

Under Section 13 of the bill, the Department is directed to apply for an 1115 Demonstration Waiver to use innovative service delivery models to improve Medicaid use of tribal health providers. The Department anticipates that it will apply and be approved for a waiver, beginning in FY2017. Initially, the waiver would consolidate medical transportation management of travel of Medicaid eligible, Indian Health Service (IHS) beneficiaries through tribal facilities. A second phase of the waiver, estimated to begin in FY2019, would seek to transition the provision of most, if not all, tribal services to Medicaid eligible, IHS beneficiaries through the demonstration waiver, consolidating the management and delivery of medically necessary services provided directly through tribal facilities and those contracted or referred to non-tribal facilities.

Under federal rules, Medicaid services provided at or through tribal health facilities to Medicaid eligible, IHS beneficiaries are funded at a 100% federal match rate. The Department anticipates that this waiver will substantially increase the percentage of Medicaid services provided to Medicaid eligible, IHS beneficiaries at the 100% federal match rate. The Department recognizes that the degree of savings is directly contingent on the provisions of the waiver that CMS approves.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis Continued

We assume that in FY2017, 25% of all travel for Medicaid eligible, IHS beneficiaries will be covered under the waiver, with a general fund savings of \$6,500.0. In FY2018, we assume 100% of all travel will be covered, with a general fund savings of \$26,000.0. In FY2019 and 2020, we anticipate an additional \$30,500.0 annually in general fund savings for increased coverage of other services through tribal facilities, for a combined general fund savings of \$56,500.0. For FY2021, we assume savings of \$26,000.0 in travel and \$61,000.0 for other services through tribal facilities, for a combined general fund savings of \$87,000.0.

Section 16 amends the uncodified law by adding a new section requiring the department to investigate before Jan. 1, 2018 the design of a demonstration project to reduce pre-term births. The project would voluntarily enroll 500 Medicaid recipients and offer pregnancy and nutritional counseling, and Vitamin D supplementation as necessary to maintain 40 mg/ml levels. The department will work with the Department of Health and Human Services' Centers for Disease Control and Prevention, Health Services Resource Administration/Maternal Child Health Bureau, the National Institute of Health, and the Centers for Medicaid and Medicare to investigate the feasibility and design of a demonstration project to analyze the administration of Vitamin D supplementation above the current recommended levels to pregnant women and its effects on the preterm birth rate in Alaska.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB148 CS(HSS)-DHSS-SDMS-04-04-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: House Finance Committee

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Senior and Disabilities Medicaid Services
OMB Component Number: 2662

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits	2,666.4		3,488.8	20,953.8	21,101.4	21,255.1	21,336.7	
Miscellaneous								
Total Operating	2,666.4	0.0	3,488.8	20,953.8	21,101.4	21,255.1	21,336.7	

Fund Source (Operating Only)

1002 Fed Rcpts	2,666.4		3,412.0	18,983.2	19,085.5	19,155.5	19,172.6
1003 G/F Match			76.8	1,970.6	2,015.9	2,099.6	2,164.1
Total	2,666.4	0.0	3,488.8	20,953.8	21,101.4	21,255.1	21,336.7

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for HB 148. Additionally, the note assumes a start date of August 1, 2015 instead of July 1, 2015 for Medicaid expansion in FY2016. Costs have been adjusted to reflect the change of start date.

Prepared By: Duane Mayes, Director Phone: (907)269-2083
Division: Senior and Disabilities Services Date: 04/02/2015 12:00 AM
Approved By: Sarah Woods, Deputy Director Finance & Management Services Date: 04/04/15
Agency: Health & Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis

Section 7 of the bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (PPL) for Alaska. We estimate 20,066 enrollees in FY2016; 23,273 enrollees in FY2017; 26,492 in FY 2018; 26,535 in FY2019; 26,580 in FY2020; and 26,623 in FY2021.

Note: The effective federal match rate for the expansion population is based on calendar year. To estimate savings based on state fiscal year we averaged the calendar rates to approximate the fiscal year federal medical assistance percentage (FMAP) rates; we also adjusted the rates to reflect enhanced federal match for tribal services provided to Indian Health Service beneficiaries. These rates are: 100% in FY2016, 97.8% in FY2017, 95.2% in FY2018, 94.3% in FY2019, 92.6% in FY2020, and 91.3% in FY2021.

Senior and Disabilities Medicaid Services covers Personal Care Assistance (PCA) services, which provide support related to an individual's activities of daily living (i.e. bathing, dressing, eating) as well as instrumental activities of daily living (i.e. shopping, laundry, light housework). This new group of eligible individuals could potentially access PCA services. Three percent of the currently eligible Medicaid enrollees receive Personal Care Assistance (PCA) services. The expansion group is thought to be healthier than current Medicaid population groups. The Department assumes that less than 1% would require and be found eligible for PCA services with an estimated annual cost increase as enrollment among the newly expanded eligible group increases.

FY2016 new enrollees: 20,066
0.7% of new enrollees: 139 recipients
PCA expenditures: per person: \$21.0

Section 13 of the bill directs the department to apply for the 1915(k) option under Medicaid. The "Community First Choice Option" (CFC), also known as 1915(k), will be used for people who meet an institutional level of care (LOC). The 1915(k) option authorities will replace all current 1915(c) waivers, as all 1915(c) recipients do meet the LOC. The 1915(k) option offers a 56% federal match, an increase of 6%, thus lowering the general fund match to 44%.

The 1915(c) waivers are:

- Children with Complex Medical Conditions (CCMC)
- Adults with Physical and Developmental Disabilities (APDD)
- Alaskans Living Independently (ALI)
- Intellectual and Developmental Disabilities (IDD)

All four of the waivers would transition to the 1915(k) option authority.

Estimated 1915(c) recipients transitioning to the 1915(k) option = 5,200
Federal funding under current 1915(c) waiver at FMAP (50%) = \$ 110,827.7
Federal funding under proposed 1915(k) option at FMAP (56%) = \$ 117,477.4
The program transition results in an increase of \$6,649.7 in federal receipts, and a corresponding GF decrease.

Implementation of the new funding option will require substantial changes to the current Home and Community Based Services (HCBS) operational infrastructure. The estimated effective date for this refinancing proposal from (c) to (k) is FY2018.

This section also directs the Department to apply for the 1915(i) option under Medicaid. The 1915(i) option includes a federal match of 50%, reducing to 50% what is currently a 100% general fund contribution for certain services.

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB 148

Analysis Continued

The Department will use this option to refinance the following 100% GF-funded grant programs: General Relief/Temporary Assistance (GR), certain Senior Community Based Grant components, and Community Developmental Disabilities Grant (CDDG).

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs.

Current funding for GR program: \$8,113.0
Total number served: 630
Average cost per individual: \$12,878.00
Estimated eligible for 1915(i): 349
General fund to be reduced: \$ 4,494.3

Senior Community Based Grant component's Adult Day and Senior In-Home Services serve some individuals who are Medicaid eligible.

Adult Day Grant:
Total general fund expenditures: \$1,757.0
Total number served: 416
Average cost per individual: \$4,223.58.
Estimated eligible for 1915(i): 114
General fund to be reduced for the Adult Day Grant: \$481.5.

Senior In-Home Grant:
Total general fund expenditures: \$2,917.3
Total number served: 1,528
Average cost per individual: \$1,909.20.
Estimated eligible for 1915(i): 123
Estimated general fund to be reduced for the Senior In-Home Grant: \$234.8.

The combined estimated general fund to be reduced through the use of the 1915(i) option = \$716.3

Community Developmental Disabilities Grant (CDDG) program provides home and community-based services to support individuals to live as independently as they are able.

Total general fund expenditures: \$11,635.8
Total number served: 953
Average cost per recipient: \$12.2
Estimated eligible for 1915(i): 953
Estimated general fund to be reduced: \$11,635.8

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 148
Fiscal Note Number: _____
() Publish Date: _____

Identifier: CSHB148-DOC-PHC-03-16-15
Title: MEDICAL ASSISTANCE COVERAGE; REFORM
Sponsor: RLS BY REQUEST OF THE GOVERNOR
Requester: GOVERNOR

Department: Department of Corrections
Appropriation: Health and Rehabilitation Services
Allocation: Physical Health Care
OMB Component Number: 2952

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services	(4,108.2)		(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	(4,108.2)	0.0	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)

Fund Source (Operating Only)

1004 Gen Fund	(4,108.2)		(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)
Total	(4,108.2)	0.0	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)

Positions

Full-time								
Part-time								
Temporary								

Change in Revenues								
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

This version of the HB 148 fiscal note reflects the FY16 reduction has been moved from Governor's FY16 Request column to the FY16 Appropriation Requested column. This reduction submitted in the Governor's Budget Request was denied by both the House and Senate and remains reflected in the FY2016 Operating Budget for the department.

Prepared By: April Wilkerson, Director
Division: Administrative Services - Department of Corrections
Approved By: Remond Henderson, Deputy Commissioner
Agency: Department of Corrections

Phone: (907)465-3460
Date: 04/16/2015 12:00 PM
Date: 04/16/15

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSHB 148

Analysis

Section 7 of the bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. This revision will allow vendors who provide inpatient inmate medical care to bill Medicaid directly for payment rather than the Department of Corrections for those offenders that meet the eligibility criteria of the expanded Medicaid program.

Federal law prohibits state from obtaining federal Medicaid matching funds for health care services provided to inmates with the exception of when they are patients in medical facilities for at least 24 hours.

In September 2014 the US Governmental Accountability Office reported that New York and Colorado, where Medicaid has expanded, estimated that 80-90% of the inmate population hospitalized outside of a correctional facility for more than 24 hours would meet the income eligibility criteria for Medicaid.

In FY2014 Department of Corrections processed approximately \$8.5 million in expenditures for 170 inmates that incurred in-patient stays that lasted more than 24 hours. Under Medicaid expansion, it is estimated that \$6.8-\$7.65 million could have been paid for by Medicaid rather than State fund if 80%-90% of the inmate population in a medical care facility more than 24 hours had been eligible.

Based on this, the department is projecting a conservative reduction in general funds of \$7 million with a reduction of \$4.1 in the first year and **an additional** \$2.9 in the second year based on the estimated amounts from FY2014.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version:	HB 148
Fiscal Note Number:	2
(H) Publish Date:	3/18/2015

Identifier: 0055-DOC-PHC-03-14-15
 Title: MEDICAL ASSISTANCE COVERAGE; REFORM
 Sponsor: RLS BY REQUEST OF THE GOVERNOR
 Requester: GOVERNOR

Department: Department of Corrections
 Appropriation: Health and Rehabilitation Services
 Allocation: Physical Health Care
 OMB Component Number: 2952

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel							
Services		(4,108.2)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	(4,108.2)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)

Fund Source (Operating Only)

1004 Gen Fund		(4,108.2)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)
Total	0.0	(4,108.2)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)	(7,000.0)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?
 If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

vs

Prepared By: April Wilkerson, Director	Phone: (907)465-3460
Division: Administrative Services - Department of Corrections	Date: 03/14/2015 02:00 PM
Approved By: Remond Henderson, Deputy Commissioner	Date: 03/15/2015
Agency: Department of Corrections	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

Analysis

Section 6 of the bill expands Medicaid coverage to a new group: adults 19 through 64 years of age who are currently not eligible for Medicaid or Medicare who have income at or below 138% of the Federal Poverty Level (FPL) for Alaska. This revision will allow vendors who provide inpatient inmate medical care to bill Medicaid directly for payment rather than the Department of Corrections for those offenders that meet the eligibility criteria of the expanded Medicaid program.

Federal law prohibits states from obtaining federal Medicaid matching funds for health care services provided to inmates with the exception of when they are patients in medical facilities for at least 24 hours.

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Based on this, the department is projecting a conservative reduction in general funds of \$7 million with a reduction of \$4.1 in the first year and **an additional** \$2.9 in the second year based on the estimated amounts from FY2014.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version:	HB 148
Fiscal Note Number:	1
(H) Publish Date:	3/18/2015

Identifier: LL055-DOA-OAH-03-15-15
 Title: MEDICAL ASSISTANCE COVERAGE; REFORM
 Sponsor: RLS BY REQUEST OF THE GOVERNOR
 Requester: Rules by Request of the Governor

Department: Department of Administration
 Appropriation: Centralized Administrative Services
 Allocation: Office of Administrative Hearings
 OMB Component Number: 2771

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel							
Services	16.8		19.5	22.2	22.2	22.3	22.3
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	16.8	0.0	19.5	22.2	22.2	22.3	22.3

Fund Source (Operating Only)

1007 I/A Rcpts	16.8		19.5	22.2	22.2	22.3	22.3
Total	16.8	0.0	19.5	22.2	22.2	22.3	22.3

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
---------------------------	--	--	--	--	--	--	--

Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
 If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Chris Kennedy, Deputy Chief Administrative Law Judge
 Division: Office of Administrative Hearings
 Approved By: Sheldon Fisher, Commissioner
 Agency: Department of Administration

Phone: (907)269-8170
 Date: 03/14/2015 01:00 PM
 Date: 03/15/15

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

Analysis

This bill would alter the income eligibility criteria for certain categories of Medicaid eligibility and would add an eligibility category for persons under 65 who are not pregnant and whose income does not exceed 138 percent of the federal poverty line. The bill also makes changes to the provider audit process and addresses certain cost control measures.

Section 3 of the bill alters the minimum number of provider audits that the Department of Health and Social Services is required to perform. The Office of Administrative Hearings (OAH) hears appeals from provider audits. The current cost of handling these appeals is approximately \$60.0 per year (thousand). A significant change in the number of audits performed could affect the number of appeals and the cost of hearing them. Based on information from the Department of Health and Social Services, OAH has determined that the number of audits that generate appeals is expected to remain approximately the same if this provision is enacted, and therefore no fiscal impact has been projected.

Section 6 of the bill expands the number of Alaskans eligible for Medicaid, and would result in a larger overall enrollment in the program. OAH hears appeals from decisions to deny or limit Medicaid coverage. Based on data supplied by the Department of Health and Social Services, OAH anticipates that the number of administrative law judge hours required to hear Medicaid appeals from the Division of Public Assistance and the Division of Health Care Services would increase by approximately 16.1% in the first year of expanded eligibility and by slightly higher percentages in succeeding years. OAH has determined that appeals from the Division of Senior and Disabilities Services would not increase appreciably. Costs have been projected above using OAH's approved cost allocation rate of \$165 per hour.

OAH is presently operating at or beyond capacity. The additional hearing load of this work alone would not support the creation of a new full-time administrative law judge position. In the absence of a new PCN, OAH will instead contract out hearing responsibilities to contractors as appropriate.

A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends, neighbors and working poor have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs; \$1.2 billion more in wages and salaries paid to Alaskans; and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, **Valdez Health Advisory Council** endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

NOW THEREFORE BE IT RESOLVED, **Valdez Health Advisory Council** endorses meaningful Medicaid reform; and

BE IT FURTHER RESOLVED, that **Valdez Health Advisory Council** strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.



IMPACT OF MEDICAID EXPANSION ON HOSPITAL UNCOMPENSATED CARE

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.¹

ASHNHA has data representing 17 acute care hospitals for cost reporting period Oct 1, 2012 – Sept 30, 2013. **For 2013, 17 Alaska hospitals provided over \$100 million in uncompensated care.**

To ensure accuracy, uncompensated care numbers are taken from hospital's cost reports that are required to be submitted annually to Medicare and Medicaid.² Many tribal hospitals are not included in this data because of differences in cost reporting requirements.³ Tribal hospitals do have uncompensated care, but because of the difference in reporting requirements it is difficult to compare their data to the non-tribal facilities. Tribal facilities report data from patient accounting and general ledger systems and the uncompensated care represents the total amount of gross charges written off for care provided to patients who have no payer source.

This summary seeks to quantify the potential impact of Medicaid expansion on hospital uncompensated care.

- Early evidence shows a dramatic drop in uncompensated care for hospitals in states that have expanded Medicaid, due to an increase in Medicaid patient volume. At the same time, the proportion of self-pay and overall charity care has declined in expansion-state hospitals.⁴
- A Colorado study analyzed data from 465 hospitals in 30 states in the first four months of Medicaid expansion. It found that unpaid care decreased by 30 percent in expansion states and remained essentially unchanged in non-expansion states. The report links an enrollment surge in expansion states to not only the reduction in uncompensated care but also the 25-percent decrease in people paying out of pocket.⁵
- In Alaska, if Medicaid is expanded a decrease in uncompensated care is anticipated. Based on the experience in other states a 20%-30% reduction of uncompensated care could be achieved. This could amount to decrease of between \$20 and \$30 million in uncompensated care at Alaska hospitals.
- A decrease in uncompensated care could result in improved financial sustainability for Alaska's small/rural hospitals that are currently operating at a deficit. Additional resources will allow Alaska hospitals to better respond to community health needs and provide community benefits.
- Hospitals face looming uncertainty as federal cuts authorized by the ACA increase. These cuts amount to more than \$591 million over fifteen years for Alaska hospitals.⁶ Hospitals agreed to payment reductions based on the assumption that expanding Medicaid would be mandatory for all states and would make up for losses.

What would a reduction in uncompensated care mean for Alaska's health care system?

Small and large hospitals are under increasing regulatory and financial pressure to adapt to a rapidly changing business model and declining reimbursement. For small, rural hospitals, a reduction in uncompensated care could have a huge impact on future sustainability. Across the country, Critical Access Hospitals (CAH) with under 25 beds are shutting their doors. Across the country, 43 CAHs have closed since 2010.⁷ In Iowa, if a CAH closes it means you might have to drive 20 miles more down the road. In Alaska, if a CAH closes it means an expensive Medevac and delayed treatment.

The health care industry is faced with significant financial pressure and at the same time being asked to transform health care, from a system that rewards volume to one that rewards value. Incentives within the current system are not aligned. Hospitals get paid when people are sick – not for keeping them well or for delivering high-quality, cost-effective care. Health care is undergoing radical transformation, away from a system that pays for volume to a system that pays for value. The reduction in uncompensated care can give hospitals the capital needed to support transformation.

¹ American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet

² Hospital cost report data, schedule S-10 includes the uncompensated care cost numbers - non-Medicare bad debt on line 23 and charity care to uninsured patients line 29.

³ Hospitals operated by Native health organizations are required to file a Schedule E cost report. The Schedule E cost report is an abbreviated form of cost reporting. As a result they are not obligated by CMS to report charity care or bad debt, simply because this is not a component of Schedule E cost report. Schedule S-10 is not a part of their cost report.

⁴ Colorado Hospital Association, Center for Health Information and Data Analytics, June 2014

⁵ Ibid.

⁶ Medicare Payments Cuts in Alaska, February 2015, DataGen Medicare Cut Analysis report

⁷ USA Today, Nov. 11, 2014 <http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicare-aca/18532471/>

Oregon Medicaid reforms meet savings goals as more enroll

By Andis Robeznieks | January 14, 2015

Oregon's 380,000 new Medicaid enrollees are younger and healthier than anticipated, so the influx into the state's coordinated-care system did not negatively affect its ability to meet targeted savings of \$11 billion over 10 years, the state reported Wednesday.

A 21% decline occurred in emergency department visits for patients served by Oregon's coordinated-care organizations since the 2011 baseline, the state reported. Also reported—a 9.3% decline in hospital admissions related to short-term diabetes complications, and a 48% decrease in hospital admissions for chronic obstructive pulmonary disease.

Oregon's Medicaid reform initiative was launched in 2012 after receiving a \$1.9 billion grant from the CMS. There are now 16 CCOs managing the care of the 990,000 Oregon Health Plan enrollees.

The effort to get enrollees connected to a patient-centered medical home could be partially responsible for the care improvements. CCOs also have been motivated to improve care by receiving incentive payments if they meet or exceed 17 performance-measure targets, such as controlling diabetes and hypertension. Some argue that the CCOs have been given the freedom to be innovative and they've risen to the challenge.

"We are succeeding with coordinated care if you use emergency-department utilization as an indicator," said Lori Coyner, Oregon Health Authority director of health analytics. About 90% of the state's Medicaid population receives care through a CCO, with another 5% opting for care either through Medicare or the Indian Health Service, she said.

Originally, the state was issuing quarterly reports. The latest edition covers six months, from July 2013 through June 2014. It also includes the 380,000 new patients who enrolled in Medicaid after Oregon chose to expand coverage to include residents up to 138% of the federal poverty level.

"There was a lot of trepidation around the new influx of enrollees, especially since there

were only 560,000 when we started, but it's looking quite encouraging" Coyner said. "The new covered population is largely younger adults and with a higher percentage of males than we've had before."

The new Oregon Health Plan members had lower utilization rates than existing members, but Coyner said the state is watching to ensure the lower utilization rates have not been caused by access issues.

Inpatient costs have fallen 5.7% to \$82.31 per member per month from the 2011 baseline of \$87.45. The largest drops have been for mental health and maternity services, at 12.7% and 11.1%, respectively.

Coyner said they are still studying the data to find an explanation, though she noted how most Oregon hospitals in 2011 voluntarily chose to not perform early elective deliveries before 39 weeks of pregnancy.

"We're not really certain why mental health inpatient costs have decreased," she added. "We're hoping it's because of the integration of physical and behavioral health in primary care."

The state withholds 3% of its payments to CCOs and puts the money into a bonus pool which gets distributed in June, according to how well each did on the individual incentive measures.

"We believe that fundamental piece is leading to the positive results we're seeing," Coyner said. "That's definitely a learning from this process."

Other drivers in the improvement have stemmed from the flexibility CCOs were given and the innovation this spurred, said Cynthia Ackerman, a nurse and the vice president of community engagement and government programs for the AllCare CCO which covers southwest Oregon.

When the reform was being launched, Gov. John Kitzhaber, a former emergency medicine physician, described how he envisioned the program purchasing inexpensive air conditioners for seniors to avoid the expense of heat-related hospitalizations. Ackerman said her CCO has used these "flexible service" funds for services for which healthcare has no billing code.

Ackerman said her CCO care coordinators, mostly nurses and social workers, are empowered to go after the "social determinants" of health that impact health but their cures are not medical in nature.

"You really have to drink the Kool-Aid and not be so rigid and think that a doctor's office or an ER has all the answers to a person's health problems," Ackerman said.

She told of a man with mental illness who wouldn't bathe. This made the staff at his

doctor's office uncomfortable when treating him and led to him being barred from the local grocery store and other locations. A care coordinator discovered the man did not have hot water in his apartment and paid a plumber to fix it, which helped end his social isolation.

"For \$60, that piece of his situation was solved," Ackerman said.

Another man was severely depressed, morbidly obese and was developing stasis ulcers from his lack of movement.

"We provided him with every professional service available—and it wasn't touching him at all," Ackerman said.

The care coordinator came up with solution: Get the man a dog.

"He was thrilled," Ackerman said. "He completely opened up, and dogs need to be walked, need to be fed and offer unconditional love. It was a win-win."

In another case, the CCO was trying to help an obese woman in her late 30s or early 40s who had diabetes, hypertension and mental health issues. She was enrolled in a health and wellness program at the local YMCA, but she only went once. The care coordinator discovered it was because the bulky clog shoes she worked out in gave her blisters. The care coordinator then had her fitted for \$30 athletic shoes and she now regularly works out at the Y, where the CCO paid for her membership.

"A doctor can talk and talk and counsel," Ackerman said. "But it took someone going into her house and asking why she didn't participate in the YMCA program."

Both Ackerman and Coyner discounted the findings of a study published last January in the journal *Science*, which reported that new enrollees in Oregon's Medicaid program faced barriers to care and increased their visits to the emergency department by 40%

Though published last year, the study used data from 2008.

"It's a different world," Coyner said. "There have been a lot of changes since that study happened and the data was from prior to our health system reform efforts."

Follow Andis Robeznieks on Twitter: @MHARobeznieks

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Source: American College of Emergency Physicians

<http://www.acep.org/News-Media-top-banner/EMTALA/>

What is EMTALA?

EMTALA is a federal law that requires anyone coming to a hospital emergency department to be assessed, stabilized and treated, whether or not they can pay for that care. EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Any hospital that takes Medicare is required to comply with EMTALA.

What does EMTALA require?

Hospitals have three main requirements under EMTALA:

1. Any individual presenting at the emergency department and requesting care must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment.
2. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.
3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Scope of EMTALA:

EMTALA applies to hospital emergency departments. It does not apply to other outpatient settings, like primary care or specialty clinics. It also does not apply to inpatient care. The hospital's EMTALA obligation ends when the patient is stabilized or admitted as an inpatient.

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EXECUTIVE SUMMARY

Incentives for better services

This report lays out the progress of Oregon's coordinated care organizations (CCOs) on quality measures from July 1, 2013 through June 30, 2014. This is the fifth such report since coordinated care organizations were launched in 2012. It is also the first report to include data on some key measures for the more than 380,000 additional Oregonians who have enrolled in the Oregon Health Plan since the Affordable Care Act (ACA) took effect January 1, 2014. The Oregon Health Plan (OHP) is now open to more adults as allowed under the Affordable Care Act. Today, approximately 990,000 Oregonians are enrolled in the Oregon Health Plan.

The coordinated care model is progressing beyond the first year and continues to show improvements in a number of areas of care such as reductions in emergency department visits; and increases in developmental screening, follow-up after hospitalization for mental illness, and hospital readmissions -- even with the significant addition of new Oregon Health Plan members. These areas of care represent positive changes toward better care coordination and integration of services. Additionally, new and existing members continue to be connected with health care teams that are part of patient centered primary care homes (PCPCHs).

The coordinated care model continues to show large improvements in the following areas for the state's Oregon Health Plan members:

Decreased emergency department visits. Emergency department visits by people served by CCOs have decreased 21 percent since 2011 baseline data.

Decreased hospital admissions for short-term complications from diabetes. The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 9.3 percent since 2011 baseline data.

Decreased rate of hospital admissions for chronic obstructive pulmonary disease. The rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 48 percent since 2011 baseline data.

Patient-centered Primary Care Home (PCPCH) enrollment continues to increase. Coordinated care organizations continue to increase the proportion of members enrolled in a patient-centered primary care homes -- indicating continued momentum even with the new members added since January 1. PCPCH enrollment has increased 55 percent since 2011. Additionally, primary care costs continue to increase, which means more health care services are happening within primary care rather than other settings such as emergency departments.

EXECUTIVE SUMMARY

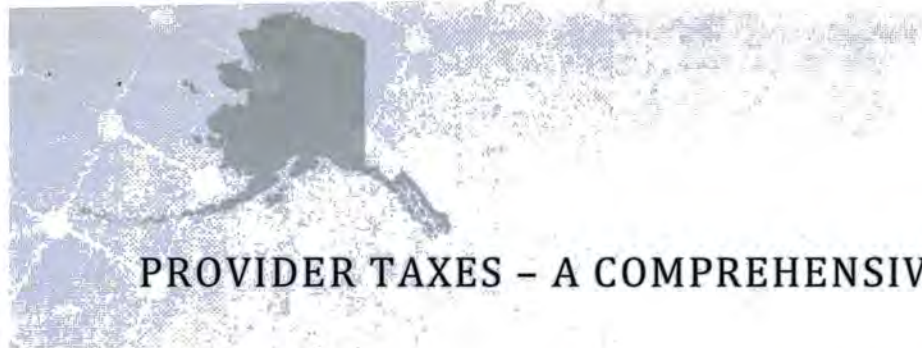
We're also continuing to see improvement in the Screening, Brief Intervention, and Referral to Treatment measure, also referred to as "SBIRT." This measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse. One coordinated care organization has -- for the first time -- exceeded the benchmark, and another is close to achieving it. While there is still much progress to be made, the data point to progress across all CCOs. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has room to improve.

For the first time, core metrics are reported. The core performance metrics are a third set of metrics included in Oregon's 1115 demonstration waiver. OHA reports these measures to CMS (Center for Medicare and Medicaid Services) each year. There are no financial incentives or penalties associated with them. The core performance measures have more focus on population health, including the prevalence of obesity and tobacco use among Oregon Health Plan members. Both of these metrics show areas where improvements can be made.

With the significant increase in new Oregon Health Plan members through the Affordable Care Act, this report also includes a special section on these new enrollees. This section highlights emergency department usage of those newly enrolled through the Affordable Care Act compared to those who were enrolled in the Oregon Health Plan prior to January 1, 2014, and compared to those who had been enrolled in the Oregon Health Plan in recent years. Statewide, newly enrolled ACA members use emergency rooms less frequently than other members. Newly enrolled Affordable Care Act members also have fewer avoidable emergency room visits than other members.

Additionally, financial data indicates coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by two percentage points per member, per year.

Oregon is continuing its efforts to transform the health delivery system. By measuring our progress, sharing it publicly and learning from our successes and challenges, we can see clearly where we started, where we are, and where we need to go next.



PROVIDER TAXES – A COMPREHENSIVE OVERVIEW

Provider taxes are a strategy that almost every state employs to help fund Medicaid programs while leveraging additional federal dollars. To control federal costs of the Medicaid program, there are certain limitations, restrictions, and other requirements that policy makers and health care providers must be aware of and take into consideration when contemplating the use of provider taxes to support Medicaid programs. Additionally, the type, amount, and use of provider taxes vary dramatically among states. This briefing will provide case studies of tax models used in different states as well as an overview of how provider taxes are being used to leverage Medicaid expansion in various states.

Key Points

General

- Provider taxes are defined as any fee, assessment, or mandatory payment where 85% of the burden falls upon health care providers.¹
- There are 19 classes of providers that may be taxed as identified by CMS.²

Requirements

- Provider taxes must meet three general requirements in order for the funds to be eligible to count as part of the state's Medicaid match. These three requirements are:³
 - 1) The tax must be broad based, meaning it must apply to all non-federal, non-public providers or services within that class;
 - 2) The tax must be uniform, meaning the same fee (amount, rate, percentage, etc.) must be applied to all providers or services within that class; and
 - 3) The tax cannot hold providers harmless, meaning it cannot guarantee that providers will be made financially whole through direct or indirectly means. However states can provide an indirect guarantee if the tax is 6% or less of net patient revenues within the class of providers or services being taxed.
- Eligible provider taxes may not make up more than 25% of the state's share of Medicaid expenditures within a state fiscal year.⁴

Waivers

- States may apply to the Secretary of the Department of Health and Human Services (DHHS) for a waiver from the broad based and uniform requirements, but not the hold harmless requirement.
- In general, waivers must show that the proposed tax is generally distributive, that the tax is not directly correlated to Medicaid payments, and that it does not hold providers harmless. This is tested with specific formulas outlined in regulations.
- Establishing different thresholds or excluding rural access hospitals and sole community hospitals are specifically identified in statute as examples for which a waiver would be viewed favorably.⁵

Provider taxes are complex and require in depth analysis and modeling to avoid unintended negative consequences on the health care infrastructure.

Federal and State Funding for Medicaid

The Medicaid program is jointly financed by the federal government and state government. The amount the federal government pays is based on each state's Federal Medical Assistance Percentage (FMAP). The FMAP is calculated using a variety of different factors, but is largely based on a state's per capita income. The actual amount of federal assistance received by states is based on the FMAP and on reported Medicaid expenditures for both medical costs and administrative costs.

In order to receive federal funding for Medicaid, each state must provide matching funds to help pay for their portion of the program cost. In the late 1980s, states realized that they could leverage provider taxes to increase the federal funding they received for the program and to decrease state general funds as a portion of the state required match. They did this by taxing health care providers, collecting the taxes and putting them towards the state required match. The increased income from provider taxes resulted in an increase in state funding for the program, which in turn drew down additional federal funds. These funds were then passed back to providers through increased rates and supplemental payments above and beyond what providers had paid in taxes.

States were so successful in using provider taxes to leverage federal funds that, in an effort to contain Medicaid costs in the early 1990s, the federal government began regulating provider taxes in effect limiting a state's ability to use these funds in a way that qualifies for federal matching dollars. In order for funds generated by provider taxes to count as part of the state's match, the provider taxes must meet several requirements outlined and determined by the Center for Medicaid and Medicare Services (CMS). If CMS determines that a provider tax does not meet the requirements outlined in statute and regulation, then CMS will subtract the amount of ineligible provider tax dollars from the total state Medical assistance expenditures before calculating the federal match.⁶

In general, requirements for state matching funds include:

- At least 40% of matching funds must be state funds.⁷
- No more than 25% of a state's match can come from provider tax funds.⁸
- Up to 60% of a state's match can come from local government funds or Certified Public Expenditures (CPE).⁹ CPEs are the reported expenditures for Medicaid services performed by a hospital or provider that is owned by a local government entity. CPEs are reported to the state Medicaid program and added to the Medicaid expenditure total when calculating federal assistance. States can choose to pass all or a portion of the federal funds received for CPEs back to the local government entity.¹⁰

Provider Tax Definition & Requirements-

Provider taxes are defined as any "fee, assessment, or mandatory payment" for which 85% or more of the burden of the payment is shouldered by health care providers.¹¹ Although often thought of as primarily a "hospital tax," there are 19 classes of health care providers that fall under this definition as outlined in federal regulations:¹²

- 1) Inpatient hospital services;
- 2) Outpatient hospital services;
- 3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);
- 4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities;
- 5) Physician services;
- 6) Home health care services;

- 7) Outpatient prescription drugs;
- 8) Services of managed care organizations (including HMO & PPO);¹³
- 9) Ambulatory surgical center services (facility only, not procedures);
- 10) Dental services;
- 11) Podiatric services;
- 12) Chiropractic services;
- 13) Optometric/optician services;
- 14) Psychological services;
- 15) Therapist services (including PT, SLP, OT, respiratory therapy, audiological services, and rehabilitative specialist services);
- 16) Nursing services (including nurse midwives, nurse practitioners, and private duty nurses);
- 17) Laboratory and x-ray services in a licensed, free-standing laboratory or x-ray facility (excludes those provided in a physician's office, hospital inpatient outpatient department);
- 18) Emergency ambulance services; and
- 19) Other health care items or services not listed above on when the state has enacted a licensing or certification fee, subject to the broad based, uniformity, and hold harmless requirements.

CMS has established three thresholds that a provider tax must pass in order to be eligible for federal matching funds. These include: 1) the tax must be broad based; 2) the tax must be uniform; and 3) the tax must not hold providers harmless. In general, these three requirements are evaluated based on how a tax is applied to a class of providers or services and are calculated in aggregate. States may apply to the DHHS Secretary for waiver of the broad based and uniform requirements, however there is no allowable waiver for the hold harmless provision. The details and process associated with each requirement (where applicable) are described below. From 2008 through 2012, CMS approved broad based and/or uniform waivers in 29 states.¹⁴

1. Broad based requirement

This requirement states that a tax must be applied to "all services or items within a class including all non-federal or non-public providers within the class."¹⁵ States can apply for a waiver from this requirement if they are seeking to impose a tax that excludes certain providers within a class as long as they can show that the tax is "generally redistributive in nature."¹⁶

States are automatically granted a broad based waiver if the proposed tax is no more than \$1,000 annually per provider, or if the total amount of the tax is used to cover the cost of a licensing and certification program.¹⁷ To evaluate other proposed taxes for a broad based waiver, CMS applies a formula that divides the estimated amount of the tax if it were applied to all providers within that class by the estimated amount of the tax as applied to providers under the proposed waiver. If the result is 1 or higher, the waiver is automatically approved. If the result is between 0.90 and 1, CMS will review the waiver and will approve if the proposed tax only excludes or treats differently providers in the classes listed below:¹⁸

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act
- Financially distressed hospitals only if:
 - 1) Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
 - 2) No more than 10% of hospitals are excluded from the tax

- Psychiatric hospitals
- Hospitals owned and operated by HMOs

2. Uniform requirement

An additional requirement for any provider tax is that it be uniformly imposed, meaning it is applied to all providers or services within that class and that it is applied to the same degree.¹⁹ Examples identified in regulation are listed below:

Example 1: If the tax is a bed tax, the same amount per bed must be applied to all providers within that class.

Example 2: If the tax is a certification fee, the fee must be the same for all providers within that class.

Example 3: If the tax is based on gross revenue receipts or net operating revenue, the tax rate must be the same for all providers within that class.

Specifically, in order to be uniform the tax must be “generally redistributive in nature,” just as with the broad based requirement, but the tax must also prove that provider revenues are not correlated with Medicaid payments at any point in time. Also, there is repeated and significant emphasis that any taxes providing credits, exclusions, or direct or indirect payment to providers would violate the uniformity clause and the hold harmless clause. Some states have developed methods to work around this clause that are discussed further in this paper.

States applying for a waiver to the uniform requirement must also pass a test used to evaluate if there is any correlation between the receipt of Medicaid payments and the amount of provider taxes paid.²⁰ To determine if this relationship exists, and to what extent it does exist if at all, CMS divides the slope of the linear regression if the state’s tax were broad based and uniform to the slope of the linear regression of the tax as proposed in the waiver. If the result is 1 or more, the waiver is automatically approved. If the result is between 0.90 and 1, the waiver may be approved only if it applies the tax in a non-uniform manner to the following providers (note this list is slightly different than the list of providers allowed under the broad based exclusion):²¹

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act.
- Financially distressed hospitals only if:
 - Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
 - No more than 10% of hospitals are excluded from the tax
- Psychiatric hospitals
- Providers or payers with varying tax rates based exclusively on region subject to certain requirements

2. Hold harmless requirement

This requirement essentially acts as a way to prohibit states from taxing providers, using those funds to pull down enhanced federal funding, and passing those dollars back to providers through direct or indirect means. There are no waivers to this requirement which CMS evaluates two ways:²²

- 1) Does the tax use direct or indirect means to ensure the providers paying the tax are made financially whole through non-Medicaid payments; and

- 2) Does the amount providers receive from those payments positively correlate at any point in time to the amount the providers pay in taxes or the difference between their Medicaid revenues and the amount they pay in taxes. The positive correlation still counts even if it is not constant over time.

Despite the lack of waiver for this requirement, there is an established “safe harbor” threshold that allows for a certain amount of flexibility. States can provide an indirect guarantee if the tax produces revenues less than 6% or more of the net patient revenue attributed to the class of health care providers or services being taxed.²³ This safe harbor provision is currently set at 6%, but it is important to note that this has changed within the past decade falling to 5.5% from 2008 to 2011 before returning to 6%. There are ongoing discussions in Congress debating the impact and financial benefit to the federal government of lowering this threshold and at one point in the past few years President Obama’s budget proposed lowering the threshold to 3.5% as part of his administration’s effort to reduce the federal deficit.²⁴

To determine if there is a positive correlation or if the tax holds providers harmless, CMS applies a “two prong test:”

- Prong 1: Does the tax create more revenue than 6% of the net patient revenue attributed to the class of health care providers or services being taxed?²⁵
- Prong 2: If so, do 75% of the providers taxed recover 75% or more of their total costs back through enhanced Medicaid or other state payments?

According to a 2014 report by the GAO, all of the 63 taxes implemented between 2008 and 2012 as a percentage of net patient revenues were below the safe harbor threshold and would have passed the hold harmless test.²⁶ This is significant in understanding how some states are able to leverage provider taxes to fund expanded Medicaid programs, and in effect be “held harmless” despite the regulatory and statute provisions.

Provider Donations

Similar to provider taxes, provider donations have also come under scrutiny and both statute and regulations outline requirements that provider donations must meet in order for states to avoid reductions in federal matching funds. These requirements are:

- Provider donations can be cash, in-kind, direct or indirect services or payments to the state from a health care provider offering services under the state plan.²⁷
- Donations from individuals of \$5,000 or less annually are allowed.²⁸
- Donations from a health care provider/entity of \$50,000 annually or less are allowed.²⁹

Bona fide donations are donations for which providers are not held harmless. Specifically this means that there is no positive correlation at any time between provider donations and the amount of Medicaid payments the provider receives.

Bona fide donations from hospitals, FQHC, clinics, or similar provider classes are specifically allowed if they cover the costs of staff providing Medicaid eligibility determinations or redeterminations for the state at that facility.³⁰ These types of donations are limited to no more than 10% annually of the state’s Medicaid assistance administrative cost.³¹ The donation must be a direct donation defined as costs for salaries, training, or fringe benefits for on-site or local agency support staff. Eligibility outreach costs may also be considered an allowable donation if those costs are prorated and calculated as a percentage of the state’s aggregate outreach cost. The cost of agency overhead and the space are specifically excluded as allowable bona fide donations.³²

Reporting Requirements

Reporting requirements for both provider taxes and donations are outlined in regulations, however the requirements are rather vague. States are required to report provider taxes and donations on a quarterly basis in summary form.³³ This information should include the source of tax or donation revenue and how the state is using these funds. Additionally the state is required to provide a legal basis for the donation or tax program.

The United States Government Accountability Office (GAO) has raised concerns that the current reporting system is not adequate and that CMS is not enforcing the existing reporting requirements.³⁴ CMS has indicated that they do not agree with the GAO assessment but will consider improving the reporting system at some point in the near future.

Process for Implementing Provider Taxes

Generally provider taxes are enacted by a state legislature through statute. The state then adds the proposed tax to their Medicaid state plan through a State Plan Amendment (SPA). During the SPA process CMS evaluates the taxes based on the requirements outlined above. Typically the fees are collected by provider association groups and are then passed along to the Medicaid program through an intergovernmental transfer.³⁵ In some states however, a state agency is responsible for collecting the taxes from each provider.

Provider Taxes that are not Regulated by CMS

Several states have implemented provider taxes that do not meet the definition in federal statute or regulation for provider taxes and thus are not subject to the requirements laid out by CMS. They have achieved this by making the taxable entities a mix of health care and non-health care providers so the total tax burden for health care providers is under the 85% threshold identified in statute. Specific examples are listed below:³⁶

- Washington enacted a business and occupation gross receipts tax. Health care providers, specifically hospitals are taxed based on their profit or non-profit status at 1.8% of gross revenue from health care activities.³⁷ Preferential tax rates are applied to other types of health care services such as room and domiciliary care to patients in an assisted living facility which is taxed at 0.27%.³⁸
- Maine taxed 5% of the value of mental health, intellectually disabled, and autistic home-support and institutional services along with cable and satellite television, fabrication services, video equipment and media rental, and telecommunication services.
- West Virginia enacted a 5% severance and business privilege tax on behavioral health services (inpatient, outpatient, residential) and the severing, extraction, and sale of commercial coal, limestone, or sandstone.

State Trends

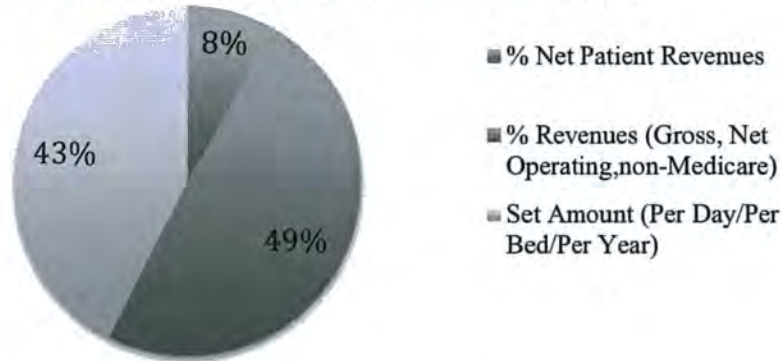
According to the Kaiser Family Foundation in their annual state survey, 49 states reported assessing at least one provider tax with most states reporting multiple taxes. Alaska was the only state that had not implemented a provider tax, but Delaware, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Virginia, and Wyoming all reported assessing only one type of provider tax in 2015.³⁹ The other 41 states reported assessing two or more taxes on health care providers in 2015.

The most popular type of tax was a tax on nursing facilities (44 states), followed by hospital services (38 states), and intermediate care facilities (37 states). Among states that tax additional services

beyond hospital, intermediate, and nursing facilities, the most common taxes were on ambulatory surgical center services, laboratory and x-ray services and emergency ambulance services.⁴⁰

States have been creative with the way that they implement taxes. Some examples of provider taxes include licensing fees, bed taxes, a tax per hospital admission, a tax per hospital discharge, a tax on gross revenue, a tax on net revenue, prescription taxes, etc.⁴¹

Type of Provider Taxes Among All States (2008 - 2012)



A recent report from the GAO highlights the increasing reliance of state Medicaid funding through provider taxes. According to their report, the amount of provider taxes funding Medicaid programs across the US increased from \$10 billion in 2008 to around \$19 billion by 2012 and increases were largely seen in provider taxes on inpatient hospitals and nursing homes.⁴² Specifically, in 2008 there were 117 provider taxes implemented in 42 states, and by 2012 that increased to 159 provider taxes implemented across 47 states. This represents a 36% increase over the 5-year period and a net increase of 42 taxes.⁴³

Increasingly, states have turned to provider and local government funds in order to finance the non-federal portion of supplemental payments. In 2012, seven states reported relying exclusively on provider taxes and local government funds for the non-federal portion of their Disproportionate Share Hospital (DSH) match.⁴⁴ Seven other states used a mix of provider taxes and local funding to provide their portion of matching funds for supplemental non-DSH payments.⁴⁵ Notably, Idaho and Nevada made both lists and reported funding all of their supplemental payments, DSH and non-DSH, with 100% provider taxes and local government funds. From 2009 through 2010, Idaho eliminated the use of state general funds for supplemental payments by increasing or establishing new taxes for inpatient and outpatient hospital services and nursing homes.⁴⁶ This increase in provider taxes and local government funding made Idaho the state with the largest increase in provider taxes in the U.S. during that time period. While Idaho is at one end of the spectrum of choices states have made in funding their Medicaid programs, the overall 5-year trend has been an increase in taxes on provider and services.

Just as every Medicaid program is unique to each state, so is their provider tax structure. Summarized below are some notable models/elements of provider taxes in a variety of states.

Kansas

Assesses a 1.83% tax on hospital net inpatient operating revenue and a flat rate of \$1,950 per nursing home bed. State statute dictates that at least 80% of the revenues from the hospital tax must be redistributed to hospital providers, and 20% is redistributed to physicians. Additionally all of the revenue from the nursing home tax must be used to improve quality of health care in those facilities

including offsetting nursing home rate reductions and covering the cost of the assessment.⁴⁷ Critical access hospitals, teaching hospitals and public hospitals are exempted and state legislation specifies that the cost of the tax may not be passed onto consumers.

Minnesota

This state has enacted some of the widest variety of provider taxes among all of the states with a focus on using provider taxes to fund public health programs for those who were uninsured and previously ineligible for Medicaid under a health plan called MinnesotaCare. MinnesotaCare was funded through the creation of the Health Care Access fund. This fund was made up of state taxes totaling 2% of hospital, surgical centers, health care providers, and wholesale drug distributor's gross revenues.⁴⁸ While the fund was created with the intention of funding MinnesotaCare, during challenging budget times provider tax funds were actually used to balance the state budget and were not fully put towards supporting health care programs. As a result of a combination of advocacy by provider associations and the expansion of Medicaid to uninsured, childless adults, the state decided to slowly phase out the provider taxes with the intention of eliminating them by 2019.⁴⁹

Washington

Aside from the Business and Occupation Tax described on page 8, the State of Washington implemented a hospital assessment to support safety net services in 2010 when the state was facing a budget shortfall.⁵⁰ The assessment was intended to pull down matching federal funds which would then be passed onto hospitals through increased rates with a small portion (\$50 million) being put towards the general fund. A year later, the legislature reversed course reducing Medicaid rates and directing \$110 million in Safety Net Assessment funds to the general fund. This in turn reduced the state's federal match for Medicaid and resulted in an estimated \$260 million impact. This disproportionately impacted Prospective Payment System (PPS) hospitals in the state as they ended up paying more in taxes than they were receiving. Critical access hospitals, public hospitals, and psychiatric hospitals were not impacted as deeply by the changes.

The Washington State Hospital Association filed a lawsuit in 2011 and, in an effort to avoid a contentious legal battle, the hospital association and the legislature crafted a provider tax structure that is currently in place.⁵¹ Under this structure the state established a dedicated fund within the treasury called the Safety Net Assessment Fund.⁵² The stated legislative intent is that as Medicaid expansion brings additional federal dollars to the state health care system to cover individuals in the safety net, the need for this assessment will decrease. Beginning in state fiscal year 2016, the assessment program will be phased out ending entirely in 2019.⁵³ Additionally, the legislation contains stipulations that protect hospitals from having the fund be misused or diverted as they were in the past.⁵⁴

- The state cannot pull more than \$100 million per year from the assessment fund to put towards general fund spending in the Medicaid program.
- The bulk of the funds must be used to help hospitals support vulnerable patients.
- Any dollars remaining in the fund in 2019 must be distributed back to the hospitals.
- Hospitals engage in a contract with the state Health Care Authority each biennium to ensure there are no additional legislative changes to the supplemental payments, rates, assessments, DSH payments, capitation payments, or other financial arrangements outline in statute.⁵⁵

Hospitals agreed to accept 2009 Medicaid rate levels for inpatient and outpatient services for both Fee for Service (FFS) and Managed Care (MC).⁵⁶ For PPS hospitals, the assessment is based on a flat rate per non-Medicare inpatient bed day up to a set limit of 54,000 bed days per year.⁵⁷ Once that threshold is reached, any additional bed patient days are assessed at a lower rate. Overall, the assessment rate is

higher for PPS hospitals than for critical access hospitals, psychiatric hospitals, and rehabilitation hospitals.

In turn, hospitals receive direct quarterly supplemental payments from the state for inpatient and outpatient FFS Medicaid services. The quarterly payments are based on a set amount fixed in statute for fiscal years 2014 and 2015 per hospital class. Should the combination of Medicaid revenues and additional supplemental payments exceed the Upper Limit (UL), the supplemental payments must be reduced until they are within the UL threshold. The remaining funds will be paid to Medicaid Managed Care organizations.⁵⁸

Notably, the statute also includes a provision requiring hospitals to treat the assessment as part of their operating overhead and restricts them from passing on these costs to consumers and third-party payers through increased charges.⁵⁹

Arizona

In 2013 Arizona established a hospital assessment intended to cover the state's portion of the cost to expand Medicaid coverage to non-disabled, childless adults with incomes between 100% and 133% of the Federal Poverty Level (FPL) along with restoring funding for a program called Prop 204 which provided coverage for childless adults with incomes 100% FPL or less.⁶⁰ Rather than the Legislature developing the assessment, Governor Brewer directed the Director of the Arizona Health Care Cost Containment System (AHCCS) to develop an assessment model not codified in statute in order to retain flexibility.⁶¹

Ultimately the assessment model was supported by the Arizona Hospital and Healthcare Association (AHHA) because of a shared understanding that the assessment would be designed in such a way that no hospital would experience financial harm.⁶² In order to achieve this, the assessment model uses a variety of exemptions and variable rates to ensure the assessment does not harm different hospital models. In a move similar to that of Washington state, legislation was crafted that specifically prohibits hospitals from passing on the cost of the assessment to consumers.

The assessment itself is at the heart of a legal challenge to Arizona's decision to expand Medicaid. Arizona requires that state taxes be approved by a two-thirds majority rather than a simple majority. Governor Brewer's administration determined the assessment was not a tax, and the enabling legislation for the hospital assessment was passed with a simple majority, however that is now being challenged in the court system.⁶³

Indiana

In order to maintain his commitment to not use taxpayer funds to support Medicaid expansion, Governor Pence worked with the hospital association to develop a funding mechanism that uses tobacco tax revenues and increases an existing provider tax to cover the state's portion of the cost to expand Medicaid.⁶⁴ Specifically, Indiana's expansion model uses a tax on acute and private psychiatric hospitals that was established in 2011 with proposed increases taking effect as the federal funding match for the expansion population begins to drop in 2017. The hospital tax will provide \$959 million of the estimated \$1.6 billion state required match while revenue from a tobacco tax increase will cover the additional \$640 million.

In return for the assessment, the hospitals will benefit by avoiding rate reductions and increased reimbursement for physician services from around 55% of Medicare rates to 75%.⁶⁵ Additionally, some of the assessment funds will be used to establish a trust fund to cover administrative costs for

the program. Indiana also established a Hospital Assessment Fund board that oversees the formula used to determine the assessment. The board is made up of two members from the hospital association and two appointees from the state.⁶⁶

Considerations for Provider Taxes in Alaska

Should Alaska providers and policy makers engage in the discussion of enacting a provider tax or assessment, some considerations are listed below:

- 1) Ensure that the tax is not misappropriated by future legislatures as much as possible. With Alaska's constitutional prohibition against dedicated funds, it may be appropriate to consider taking Washington's approach and having a state agency contract with hospitals and using the contract terms to protect against misappropriation.
- 2) Can tribal health providers be included in a provider tax structure? This is an important issue that would need to be resolved early in the process. A discussion on what providers are included in a tax structure is a critical question.
- 3) Ensure that supplemental payments to hospitals or other provider classes are not in excess of the upper payment limit and develop a plan to manage any excess payments in advance.
- 4) Consider establishing a board made up of state agency representatives and hospital association or provider representatives to manage the assessment process on an annual or biennial basis.
- 5) Consider the staff time necessary to manage the tasks associated with an assessment. Specifically staff would be needed to manage the quarterly reporting requirements, the collection of the assessment, and the development of any waivers.
- 6) Ensure providers are not financially harmed by an assessment. This would require a balance of the following:
 - Staying under the 6% safe harbor threshold;
 - Ensuring that supplemental payments to make hospitals whole do not exceed Medicaid upper payment limit; and
 - Providing variable tax rates or exemptions for critical access hospitals and/or sole community hospitals.
- 7) States typically require outside expertise to assist in the development of a provider tax through modeling the impact of rates and types of taxes (e.g. bed, revenue, discharge, etc.) on different providers. Arriving at a methodology that will meet the needs of diverse providers and fulfill complex CMS requirements makes consultant support critical.

¹ 42 C.F.R. § 433.55

² 42 C.F.R. § 433.56

³ 42 C.F.R. § 433.68

⁴ Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b

⁵ Social Security Act § 1903 (w)(3), 42 U.S.C. § 1396b

⁶ 42 C.F.R. § 433.57

⁷ 42 C.F.R. § 433.53

⁸ Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b

⁹ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*.

<http://www.gao.gov/assets/670/665077.pdf>

¹⁰ Ibid.

¹¹ 42 C.F.R. § 433.55

¹² 42 C.F.R. § 433.56

¹³ Health insurance and HMO premiums are not considered a provider tax and are specifically excluded per 42 CFR § 433.55.

¹⁴ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from

<http://www.gao.gov/assets/670/665077.pdf>

¹⁵ 42 C.F.R. § 433.68

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ 42 CFR § 433.68

²¹ Ibid.

²² Ibid.

²³ 42 CFR § 433.68

²⁴ Kaiser Commission on Medicaid and the Uninsured. (2013). *Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts*. Retrieved from <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>

²⁵ 42 CFR § 433.68

²⁶ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from

<http://www.gao.gov/assets/670/665077.pdf>

²⁷ Social Security Act § 1903 (w)(2), 42 U.S.C. § 1396b

²⁸ 42 CFR § 433.55

²⁹ 42 CFR § 433.55

³⁰ 42 CFR § 433.66

³¹ 42 CFR § 433.67

³² 42 CFR § 433.66

³³ 42 CFR § 433.74

³⁴ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from

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³⁵ Boothe, A. & Kim, S. (2014). *Medicaid Provider Fees Explained*. American Action Forum. Retrieved from

<http://americanactionforum.org/insights/medicaid-provider-fees-explained>

³⁶ Pacific Health Policy Group. (2012). *Health Care-Related Tax Study Report [Prepared for the Department of Vermont Health Access]*. Retrieved from <http://dvha.vermont.gov/budget-legislative/2health-care-related-tax-study-report-01-12-12.pdf>

³⁷ State of Washington Department of Revenue. (n.d.). *Business and Occupation (B&O) Tax Classification Definitions*. Retrieved from http://dor.wa.gov/Content/FileAndPayTaxes/BeforeIFile/Def_TxClassBandO.aspx#0135

³⁸ WAC § 458-20-168

³⁹ Kaiser Family Foundation. (2014). *State Health Facts: Medicaid Provider Taxes*. Retrieved from <http://kff.org/medicaid/state-indicator/medicaid-provider-taxes-in-place/>

- ⁴⁰ Pacific Health Policy Group. (2012)
- ⁴¹ Kaiser Family Foundation. (2014).
- ⁴² United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>
- ⁴³ Ibid.
- ⁴⁴ Ibid. The seven states are Colorado, Florida, Idaho, Mississippi, Nevada, South Carolina, and Tennessee.
- ⁴⁵ Ibid. The seven states are Alabama, Idaho, Illinois, Nebraska, Nevada, North Carolina, and Wyoming.
- ⁴⁶ Ibid.
- ⁴⁷ Kansas Health Institute. (2014). *Kansas Medicaid: Beyond the Basics*. Retrieved from <http://media.khi.org/news/documents/2014/06/04/MedicaidSupplementREVISED.pdf>
- ⁴⁸ Minn. Stat. § 295.52
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- ⁵⁰ Washington State Hospital Association. (2014). Questions and Answers About the Safety Net Assessment Lawsuit. Retrieved from <http://www.wsha.org/LawsuitFAQ.cfm>
- ⁵¹ Ibid.
- ⁵² Wash. Rev. Code § 74.60
- ⁵³ Wash. Rev. Code § 74.60
- ⁵⁴ Wash. Rev. Code § 74.60
- ⁵⁵ Wash. Rev. Code § 74.60.160
- ⁵⁶ Wash. Rev. Code § 74.60.020
- ⁵⁷ Wash. Rev. Code § 74.60.030
- ⁵⁸ Wash. Rev. Code § 74.60.120
- ⁵⁹ Wash. Rev. Code § 74.60.070
- ⁶⁰ Hospital Assessment. (n.d.)
- ⁶¹ Arizona Hospital and Healthcare Association. (2014). *Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm [Issue Paper]*.
- ⁶² Arizona Hospital and Healthcare Association. (2014). *Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm [Issue Paper]*.
- ⁶³ Williams, T. & Rojas, R. (31 Dec. 2014). Arizona Supreme Court Allows Challenges to State's Medicaid Expansion. *New York Times*. Retrieved from http://www.nytimes.com/2015/01/01/us/politics/arizona-supreme-court-allows-challenge-to-states-medicaid-expansion.html?_r=0
- ⁶⁴ Daly, R. (2015). *Indiana Hospitals Help Fund Medicaid Expansion*. Healthcare Financial Management Association. Retrieved from <https://www.hfma.org/Content.aspx?id=27903>
- ⁶⁵ Ibid.
- ⁶⁶ Indiana Family and Social Services Administration. (n.d.). *Healthy Indiana Plan 2.0*. Retrieved from http://www.in.gov/fssa/hip/files/HIP_2_0_Roadshow_DM_FINAL.pdf



MEDICARE PAYMENT CUTS IN ALASKA

Since 2010, Congress and the Centers for Medicare and Medicaid Services (CMS) have enacted a series of Medicare payment cuts for hospital services in their effort to address the federal deficit and offset other program costs, including the cost of expanding insurance coverage under the ACA.

This summary is intended to support an understanding of existing Medicare provider cuts that Alaska hospitals are facing now and in the future. This analysis includes estimated Medicare fee-for-service payments and payment changes from 2010-2024 based on legislative payment changes adopted by Congress and regulatory payment changes adopted CMS and additional cuts under consideration.

These cuts will cost Alaska hospitals \$591 million over 15 years.¹
Cuts under consideration could reduce revenue by an additional \$320 million if enacted.

Enacted Cuts as a Percent of Total FFS Medicare Revenue ² 15 year summary value	-10.0%
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Cuts Enacted (2010-2024): Legislative

ACA Marketbasket Cuts	(\$266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
Total Legislative Cuts	(\$458,675,800)

Cuts Enacted (2010-2024): Regulatory

Coding Cuts	(\$127,744,400)
2-Midnight Offset	(4,769,600)
Total Regulatory Cuts	(\$132,514,000)
Total Cuts Enacted	(\$591,189,800)

Cuts Under Consideration (2015-2024)

Rural Cuts	(\$228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
Total Cuts Under Consideration	(\$319,764,800)

Over the past few years, law makers have repeatedly turned to cutting Medicare payments to providers to address federal budget shortfalls and/or offset the costs associated with implementing new programs including the expansion of insurance coverage provided by the Affordable Care Act (ACA). As Congress looks for ways to further reduce federal spending, address the debt ceiling, and offset costs associated with fixing the sustainable growth rate, Medicare payments to hospitals remain vulnerable. This prospect is particularly troubling in light of uncertainty surrounding implementation of the ACA, including the lack of Medicaid expansion in Alaska and the uncertainty of the subsidies received through the federal marketplace.

ASHNHA opposes additional Medicare payment cuts without full implementation of the expanded coverage promised through the ACA. ASHNHA also opposes poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead we support the development of more rational long-term payment methodologies that reward quality and promote better health outcomes, such as value-based purchasing and accountable care models.

Cuts enacted – Summary of 15 year impact

- **ACA Marketbasket Cuts: \$266,013,300**
The impact shown reflects the Affordable Care Act (ACA) of 2010 authorized hospital/health system payment cuts,
- **Sequestration Cuts: \$93,961,800**
The impact reflects the 2% sequester reduction on total Medicare payments currently in effect for years 2013-2024.
- **Medicare DSH Cuts: \$79,884,200**
Impacts reflect the estimated reductions to the national uncompensated care payment pool amount based on projected changes to the national uninsured rate provided by the CBO.
- **Quality Cuts: \$6,743,300**
Reflect payment adjustments related to ACA-mandated Quality Based Payment Reform including value based purchasing, readmissions, and hospital acquired conditions.
- **Bad Debt Payment Cuts: \$2,180,700**
The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65%.
- **ATRA Coding: \$9,932,500**
The impact reflects the American Taxpayer Relief (ATRA) of 2012-authorized retrospective (one-time) coding adjustment cuts totaling at least -9.3% that CMS must implement over a 4 year period.

Total Legislative Cuts = \$458,675,800

- **Regulatory Coding Adjustments \$ 127,744,400**
The impact shown reflect annual adjustments made to the standard amount/federal rate in order to recoup for increases in gross payments due solely to the transition to new DRGs and/or DRG weights.
- **2-Midnight Rule Offset: \$4,769,600**
The impact reflects the -0.2% adjustment to the IPPS federal rate established by CMS in order to offset grown in IPPS expenditures as a result of increased inpatient admissions associated with the "2-Midnight Rule".

Total Regulatory Cuts =\$132,514,000

¹ 15-Year Medicare Cut Analysis, DataGen, February 2015.

² This value is calculated by first estimating and aggregating Medicare Fee-for-Service (FFS) revenue overall a 15 year period (2010-2024) without the effect of existing legislative or regulatory payment cuts. Then the estimated impact of the existing cuts over the same 15 year period are aggregated and divided by the aggregated revenue calculated in the first step. The result is a 15 year summary value of cuts as a percent of total Medicare FFS revenue. This does not include any of the cuts under consideration.

CSHB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

Sponsor: Governor

House Finance Committee - April 8, 2015

	OMB Component	FY16 Appropriation Requested	FY17 Base	FY17 New	FY17 Total	FY18 Base	FY18 New	FY18 Total	FY19 Base	FY19 New	FY19 Total	FY20 Base	FY20 New	FY20 Total	FY21 Base	FY21 New	FY21 Total	
Department of Health and Social Services																		
	Adult Prevent Dental Medicaid Svcs	2839	\$ 4,932.8	\$ 4,932.8	\$ 1,521.4	\$ 6,454.2	\$ 6,454.2	\$ 1,144.4	\$ 7,598.6	\$ 7,598.6	\$ 273.0	\$ 7,871.6	\$ 7,871.6	\$ 284.4	\$ 8,156.0	\$ 8,156.0	\$ 151.0	\$ 8,307.0
	Behavioral Health Admin	2665	\$ 120.4	\$ 120.4	\$ (7.6)	\$ 112.8	\$ 112.8	\$ -	\$ 112.8	\$ 112.8	\$ -	\$ 112.8	\$ 112.8	\$ -	\$ 112.8	\$ 112.8	\$ -	\$ 112.8
	Behavioral Health Medicaid Svcs	2660	\$ 4,399.5	\$ 4,399.5	\$ 924.0	\$ 5,323.5	\$ 5,323.5	\$ 11,405.0	\$ 16,728.5	\$ 16,728.5	\$ 4,499.0	\$ 21,227.5	\$ 21,227.5	\$ 5,307.4	\$ 26,534.9	\$ 26,534.9	\$ 70.3	\$ 26,605.2
	Catastrophic & Chronic Ill Assist.	2330	\$ (916.7)	\$ (916.7)	\$ (383.3)	\$ (1,300.0)	\$ (1,300.0)	\$ (100.0)	\$ (1,400.0)	\$ (1,400.0)	\$ (71.0)	\$ (1,471.0)	\$ (1,471.0)	\$ -	\$ (1,471.0)	\$ (1,471.0)	\$ -	\$ (1,471.0)
	Comm Dvlpmt Disabilities Grants	309	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (11,635.8)	\$ (11,635.8)	\$ (11,635.8)	\$ -	\$ (11,635.8)	\$ (11,635.8)	\$ -	\$ (11,635.8)	\$ (11,635.8)	\$ -	\$ (11,635.8)
	Gen Relief/Temp Assisted Living	2875	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (4,494.3)	\$ (4,494.3)	\$ (4,494.3)	\$ -	\$ (4,494.3)	\$ (4,494.3)	\$ -	\$ (4,494.3)	\$ (4,494.3)	\$ -	\$ (4,494.3)
	Health Care Medicaid Services	2077	\$ 115,009.8	\$ 115,009.8	\$ 37,210.5	\$ 152,220.3	\$ 152,220.3	\$ 25,575.5	\$ 177,795.8	\$ 177,795.8	\$ 2,479.8	\$ 180,275.6	\$ 180,275.6	\$ 2,811.6	\$ 183,087.2	\$ 183,087.2	\$ 3,848.4	\$ 186,935.6
	Medical Assistance Administration	242	\$ 499.1	\$ 499.1	\$ 12.1	\$ 511.2	\$ 511.2	\$ 131.6	\$ 642.8	\$ 642.8	\$ (7.6)	\$ 635.2	\$ 635.2	\$ 131.6	\$ 766.8	\$ 766.8	\$ (7.6)	\$ 759.2
	Public Assistance Field Services	236	\$ 1,715.0	\$ 1,715.0	\$ -	\$ 1,715.0	\$ 1,715.0	\$ (1,171.3)	\$ 543.7	\$ 543.7	\$ -	\$ 543.7	\$ 543.7	\$ -	\$ 543.7	\$ 543.7	\$ -	\$ 543.7
	Rate Review	2696	\$ 200.0	\$ 200.0	\$ (100.0)	\$ 100.0	\$ 100.0	\$ -	\$ 100.0	\$ 100.0	\$ -	\$ 100.0	\$ 100.0	\$ -	\$ 100.0	\$ 100.0	\$ -	\$ 100.0
	Senior Community Based Grants	2787	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (716.3)	\$ (716.3)	\$ (716.3)	\$ -	\$ (716.3)	\$ (716.3)	\$ -	\$ (716.3)	\$ (716.3)	\$ -	\$ (716.3)
	Sen. Dis Medicaid Services	2662	\$ 2,666.4	\$ 2,666.4	\$ 822.4	\$ 3,488.8	\$ 3,488.8	\$ 17,465.0	\$ 20,953.8	\$ 20,953.8	\$ 147.6	\$ 21,101.4	\$ 21,101.4	\$ 153.7	\$ 21,255.1	\$ 21,255.1	\$ 81.6	\$ 21,336.7
	SDS Administration	2663	\$ 289.9	\$ 289.9	\$ 242.4	\$ 532.3	\$ 532.3	\$ 346.9	\$ 879.2	\$ 879.2	\$ (530.2)	\$ 349.0	\$ 349.0	\$ -	\$ 349.0	\$ 349.0	\$ -	\$ 349.0
	Treatment & Recovery Grants	3099	\$ (1,558.7)	\$ (1,558.7)	\$ (3,441.3)	\$ (5,000.0)	\$ (5,000.0)	\$ (7,501.0)	\$ (12,501.0)	\$ (12,501.0)	\$ (4,027.7)	\$ (16,528.7)	\$ (16,528.7)	\$ (3,027.9)	\$ (19,556.6)	\$ (19,556.6)	\$ (28.1)	\$ (19,584.7)
	Health & Social Services Total:		\$ 127,357.5	\$ 127,357.5	\$ 36,800.6	\$ 164,158.1	\$ 164,158.1	\$ 30,449.7	\$ 194,607.8	\$ 194,607.8	\$ 2,762.9	\$ 197,370.7	\$ 197,370.7	\$ 5,660.8	\$ 203,031.5	\$ 203,031.5	\$ 4,115.6	\$ 207,147.1
	Positions: (17 Temp in FY16 FY17)		29	29	2	31	31	-16	15	15	0	15	15	1	16	16	0	16

Department of Corrections																		
	Physical Health Care	2952	\$ (4,108.2)	\$ (4,108.2)	\$ (2,891.8)	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)
	Corrections Total:		\$ (4,108.2)	\$ (4,108.2)	\$ (2,891.8)	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)	\$ (7,000.0)	\$ -	\$ (7,000.0)

Department of Administration																		
	Office of Admin Hearings (IA)	2771	\$ 16.8	\$ 16.8	\$ 2.7	\$ 19.5	\$ 19.5	\$ 2.7	\$ 22.2	\$ 22.2	\$ -	\$ 22.2	\$ 22.2	\$ 0.1	\$ 22.3	\$ 22.3	\$ -	\$ 22.3
	Administration Total:		\$ 16.8	\$ 16.8	\$ 2.7	\$ 19.5	\$ 19.5	\$ 2.7	\$ 22.2	\$ 22.2	\$ -	\$ 22.2	\$ 22.2	\$ 0.1	\$ 22.3	\$ 22.3	\$ -	\$ 22.3

Grand Total:		\$ 123,266.1	\$ 123,266.1	\$ 33,911.5	\$ 157,177.6	\$ 157,177.6	\$ 30,452.4	\$ 187,630.0	\$ 187,630.0	\$ 2,762.9	\$ 190,392.9	\$ 190,392.9	\$ 5,660.9	\$ 196,053.8	\$ 196,053.8	\$ 4,115.6	\$ 200,169.4
Position Totals:		29	29	2	31	31	-16	15	15	0	15	15	1	16	16	0	16

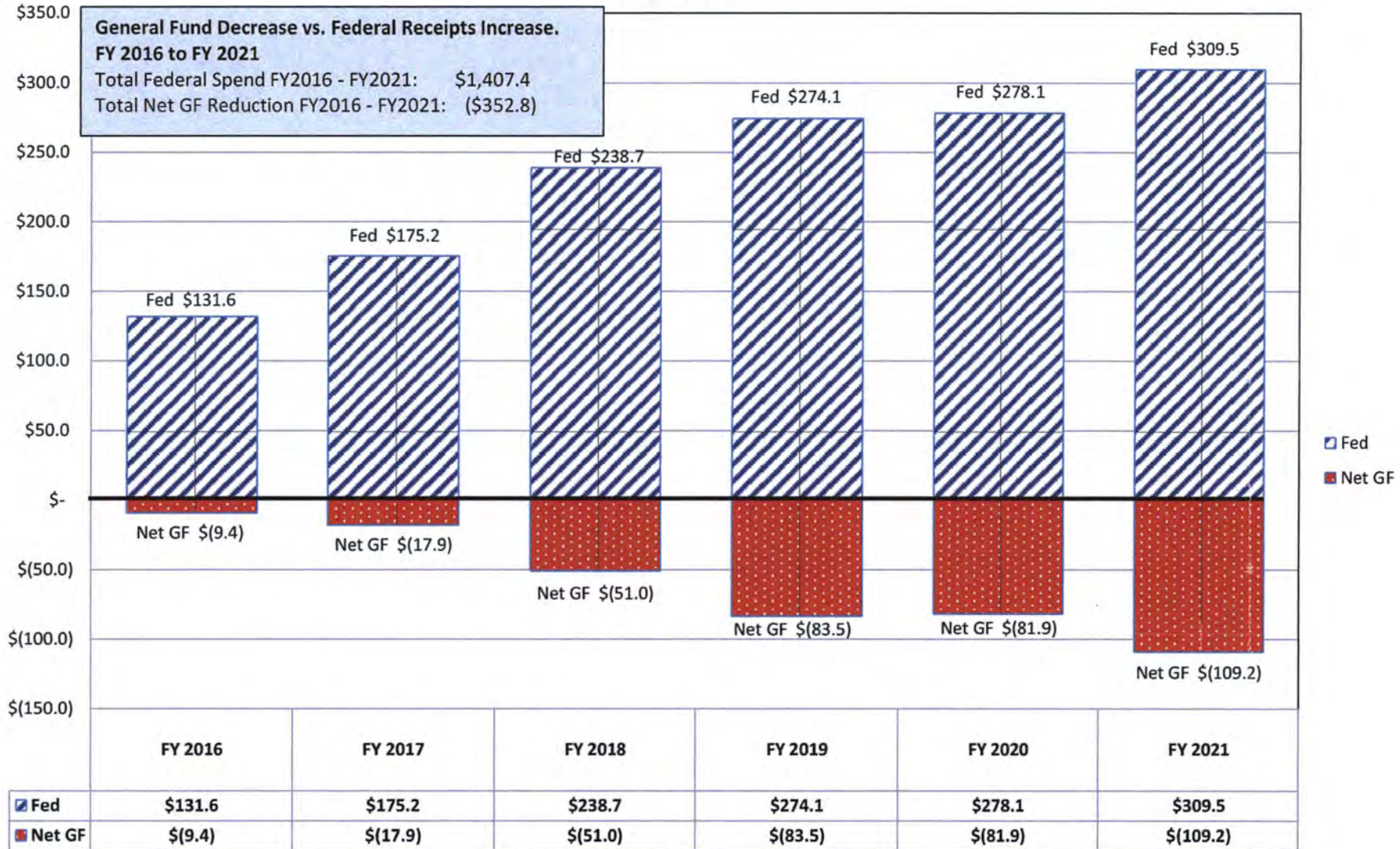
Cumulative by Fund Source (FY16-FY21)		FY16 Appropriation Requested	FY17 Base	FY17 New	FY17 Total	FY18 Base	FY18 New	FY18 Total	FY19 Base	FY19 New	FY19 Total	FY20 Base	FY20 New	FY20 Total	FY21 Base	FY21 New	FY21 Total
\$1,407,393.3	Fed	\$ 131,646.9	\$ 131,646.9	\$ 43,570.9	\$ 175,217.8	\$ 175,217.8	\$ 63,536.1	\$ 238,753.9	\$ 238,753.9	\$ 35,336.2	\$ 274,090.1	\$ 274,090.1	\$ 4,054.3	\$ 278,144.4	\$ 278,144.4	\$ 31,395.8	\$ 309,540.2
(\$163,587.4)	GF Match	\$ (2,797.5)	\$ (2,797.5)	\$ (1,827.3)	\$ (4,624.8)	\$ (4,624.8)	\$ (8,596.5)	\$ (13,221.3)	\$ (13,221.3)	\$ (28,432.2)	\$ (41,653.5)	\$ (41,653.5)	\$ 4,634.4	\$ (37,019.1)	\$ (37,019.1)	\$ (27,252.1)	\$ (64,271.2)
(\$87,980.3)	UGF	\$ (5,024.9)	\$ (5,024.9)	\$ (3,275.1)	\$ (8,300.0)	\$ (8,300.0)	\$ (10,310.6)	\$ (18,610.6)	\$ (18,610.6)	\$ (71.0)	\$ (18,681.6)	\$ (18,681.6)	\$ -	\$ (18,681.6)	\$ (18,681.6)	\$ -	\$ (18,681.6)
(\$101,272.9)	GF/MH	\$ (1,558.7)	\$ (1,558.7)	\$ (3,441.3)	\$ (5,000.0)	\$ (5,000.0)	\$ (14,136.8)	\$ (19,136.8)	\$ (19,136.8)	\$ (4,027.7)	\$ (23,164.5)	\$ (23,164.5)	\$ (3,027.9)	\$ (26,192.4)	\$ (26,192.4)	\$ (28.1)	\$ (26,220.5)
\$1,045.4	AMHTAAR	\$ 1,045.4	\$ 1,045.4	\$ (1,045.4)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$125.3	IA	\$ 16.8	\$ 16.8	\$ 2.7	\$ 19.5	\$ 19.5	\$ 2.7	\$ 22.2	\$ 22.2	\$ -	\$ 22.2	\$ 22.2	\$ 0.1	\$ 22.3	\$ 22.3	\$ -	\$ 22.3
(\$1,033.6)	SDPR	\$ (61.9)	\$ (61.9)	\$ (73.0)	\$ (134.9)	\$ (134.9)	\$ (42.5)	\$ (177.4)	\$ (177.4)	\$ (42.4)	\$ (219.8)	\$ (219.8)	\$ -	\$ (219.8)	\$ (219.8)	\$ -	\$ (219.8)
\$1,054,564.5		\$ 123,266.1	\$ 123,266.1	\$ 33,911.5	\$ 157,177.6	\$ 157,177.6	\$ 30,452.4	\$ 187,630.0	\$ 187,630.0	\$ 2,762.9	\$ 190,392.9	\$ 190,392.9	\$ 5,660.9	\$ 196,053.8	\$ 196,053.8	\$ 4,115.6	\$ 200,169.4

* Total Does Not Include IA

\$ (352,840.6)	GF Reduction	\$ (9,381.1)	\$ (8,543.7)	\$ (17,924.8)	\$ (33,043.9)	\$ (50,968.7)	\$ (32,530.9)	\$ (83,499.6)	\$ 1,606.5	\$ (81,893.1)	\$ (27,280.2)	\$ (109,173.3)
\$ 1,407,393.3	Federal Increase	\$ 131,646.9	\$ 43,570.9	\$ 175,217.8	\$ 63,536.1	\$ 238,753.9	\$ 35,336.2	\$ 274,090.1	\$ 4,054.3	\$ 278,144.4	\$ 31,395.8	\$ 309,540.2
\$ 1,054,552.7		\$ 122,265.8	\$ 35,027.2	\$ 157,293.0	\$ 30,492.2	\$ 187,785.2	\$ 2,805.3	\$ 190,590.5	\$ 5,660.8	\$ 196,251.3	\$ 4,115.6	\$ 200,366.9

CSHB 148 - Medical Assistance Coverage; Reform
House Finance Committee
April 8, 2015

Millions





ALASKA STATE LEGISLATURE
HOUSE FINANCE COMMITTEE

State Capitol, Room 519

Rep. Mark Neuman, Co-Chair

Rep. Steve Thompson, Co-Chair

Wednesday, April 8, 2015

8:30AM

Agenda:

HB 148 - MEDICAL ASSISTANCE COVERAGE; REFORM

Gov - Department of Health and Social Services

Discussion of Fiscal Notes

Presenting in Person:

Valerie Davidson, Commissioner, Dept. of Health and Social Services

Jon Sherwood, Deputy Commissioner, Dept. of Health and Social Services

Available for Questions in person from DHSS:

Monique Martin, Health Care Policy Advisor

Ron Kreher, Director Public Assistance,

Albert Wall, Director Division of Behavioral Health

Chris Ashenbrenner, Medicaid Expansion Program Director

David Teal, Director, Legislative Finance Division

Arnold Liebelt, Policy Analyst, Office of Management & Budget

Available for Questions via teleconference DHSS:

Margaret Brodie, Health Care Services Division Director

Jared Kosin, Executive Director, Office of Rate Review

Prepared by the Departments of Law and Health & Social Services, April 4, 2105

CS HB 148 (HSS), "An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

Sectional Analysis:

Section 1

Adopts intent language and legislative findings related to Medicaid expansion and the need to reform the existing Medicaid program, including instructing the Department of Health and Social Services (DHSS) to propose legislation to implement a provider tax in January 2016, to help offset the cost of the Medicaid program.

Section 2

Amends AS 44.23.075 to exclude the expansion population from the current Permanent Fund Hold Harmless program.

Section 3

Amends the duties of the department under AS 47.05.010 to include a requirement that DHSS develop a health care delivery model that encourages good nutrition and disease prevention.

Section 4

Amends AS 47.05.200(a) to clarify the minimum number of audits that DHSS should conduct each year, along with instructions that DHSS should to the extent possible, minimize duplicative state and federal audits for Medicaid providers.

Section 5

Amends AS 47.05.200(b) to allow DHSS to impose interest penalties on identified overpayments using the post-judgment statutory rate.

Section 6

Adopts AS 47.05.250 that authorizes DHSS to develop provider fines through regulation for violations of AS 47.05, AS 47.07 or regulations adopted under those chapters.

Section 7

Amends AS 47.07.020(b) including technical corrections related to eligibility for Medicaid authorized under the Affordable Care Act. This section also provides the authority for DHSS to expand Medicaid to adults aged 19-64 who are not caring for dependent children, are not disabled or pregnant, and who earn at or below 138 percent of the federal poverty guidelines for Alaska including the five percent income disregard.

Section 8

This section amends AS 47.07.020(g) to clarify that, for a person whose Medicaid eligibility is not calculated using the modified adjusted gross income standard established in federal regulations, DHSS may not deny or delay the person's eligibility for medical assistance on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship. It further requires that DHSS may only consider information provided by a person claiming undue hardship that the department has verified through a source other than the person's own statement.

Section 9

Amends AS 47.07.020 (m) to clarify that, for persons whose Medicaid eligibility is not calculated using the modified adjusted gross income standard established in federal standards and as provided in Section 8 (above), the department shall

impose a penalty period of ineligibility for the transfer of an asset for less than fair market value by an applicant or applicant's spouse consistent with federal rules

- Section 10 Amends AS 47.07.030(d) to require the department to develop a primary care case management system or managed care organization contract including super-utilizers, who must enroll in the program and seek approval from a case manager before receiving certain services.
- Section 11 Amends AS 47.07.030 to require a report to the legislature describing the costs for mandatory and optional Medicaid services.
- Section 12 Amends AS 47.07.036(b) to make conforming edits so this section of the statute is consistent with Section 13 of the bill.
- Section 13 Amends AS 47.07.036(d) to outline cost containment and reform measures that DHSS must undertake, including seeking demonstration waivers related to innovative service delivery models, and to include applying for other options under the Medicaid Act and improving telemedicine for Medicaid recipients. This section also requires DHSS to apply for a 1115 waiver for a demonstration project for one or more groups of Medicaid recipients in one or more geographic area. The demonstration project may include managed care organizations, community care organizations, or patient-centered medical homes, but at least one project will be a coordinated care project that operates within a fixed budget to reduce medical cost inflation, improve the quality of health care for recipients, and result in a healthier population. DHSS shall design the managed care system to reduce the growth in medical assistance expenditures by at least two percentage points, and the system must implement alternative payment methodologies and create a network of patient-centered primary care homes. The department shall prepare a report regarding the progress of this demonstration project and shall deliver it to the legislature by February 1, 2019.
- Section 14 and 15 Amends AS 47.07.900(4) and (17) to remove the requirement that behavioral health providers be a grantee of the State of Alaska in order to bill Medicaid.
- Section 16 Authorizes DHSS to investigate the design of a demonstration project to help reduce pre-term births to include voluntary enrollment of approximately 500 recipients eligible for medical assistance. DHSS shall offer pregnancy counseling, nutritional counseling, and, as necessary, vitamin D supplementation. The project can be modeled after a project implemented in South Carolina.
- Section 17 Authorizes DHSS to engage in a demonstration project for super-utilizers as outlined in section 13, and report to the legislature on the project.
- Section 18 Outlines a series of records that DHSS must provide to the legislature relating efficacy of the reform measures taken by the Department, including any cost savings.
- Section 19 Authorizes DHSS to immediately amend its state plan and seek all necessary approvals consistent with this Act.

- Section 20 Authorizes DHSS to engage in emergency rule making under the Alaska Administrative Code to implement Medicaid reform measures and the provisions of this Act.
- Section 21 Provides that Section 20 of the Act is repealed on June 30, 2017.
- Section 22 Provides instructions to the revisors of the statutes to amend the title of AS 47.07.036 to include Medicaid Reform.
- Section 23 Provides that Section 19 and 20 are effective immediately.
- Section 24 Provides that all other sections of the Act are effective on August 1, 2015.

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Governor Bill Walker
STATE OF ALASKA

March 17, 2015

The Honorable Mike Chenault
Speaker of the House
Alaska State Legislature
State Capitol, Room 208
Juneau, AK 99801-1182

Dear Speaker Chenault:

Under the authority of Article III, Section 18, of the Alaska Constitution, I am transmitting a bill relating to eligibility for medical assistance.

The bill would make technical amendments to AS 47.07.020 related to Medicaid eligibility and would authorize Medicaid expansion as permitted under the Patient Protection and Affordable Care Act.

The bill also would provide express authority for the Department of Health and Social Services to engage in various Medicaid cost containment and reform measures, including expanding the use of waivers, using demonstration projects to engage in innovative practices, and expanding telemedicine capability and reimbursement to incentivize innovative service delivery models.

Finally, the bill would amend a number of existing statutes that are designed to assist the Department of Health and Social Services in its oversight of Medicaid providers.

Medicaid expansion and Medicaid reform are in the best interest of the state, and I urge your prompt and favorable action on this measure.

Sincerely,

A handwritten signature in cursive script that reads "Bill Walker".

Bill Walker
Governor

Enclosure

HOUSE BILL NO. 148

HB148 Summary of Changes Version A to Version H
Prepared by the Department of Health & Social Services
April 1, 2015

Section 1. The CS states DHSS shall contract with an independent third party to advise the department during the development of the provider tax proposal, and shall establish prevention of disease as a primary model of health care in the state.

Section 2. No changes to this section, which amends the existing AS 44.23.075 to exclude the expansion population from the current Permanent Fund Dividend “hold harmless” program.

Section 3. Adds new subsection (18) to AS 47.05.010 Duties of Department to state that DHSS shall establish guidelines for medical assistance providers to “develop health care delivery models that encourage adequate nutrition and disease prevention.”

Section 4. No changes to this section, which clarifies minimum number of audits DHSS shall perform. (Section 3 in original HB 148.)

Section 5. No changes to this section, which allows DHSS to impose interest penalties on identified overpayments using the post-judgment statutory rate. (Section 4 in original HB 148.)

Section 6. No changes to this section, which authorizes DHSS to develop provider fines through regulation for violations. (Section 5 in original HB 148.)

Section 7. No changes to this section, which amends AS 47.07.020(b) to include technical corrections related to eligibility for Medicaid authorized under the Affordable Care Act and provides the authority for DHSS to expand Medicaid to adults aged 19-64 who are not caring for dependent children, are not disabled or pregnant, and who earn at or below 138 percent of the federal poverty guidelines for Alaska including the 5% income disregard. (Section 6 in original HB 148.)

Section 8. This section originally clarified that, for a person whose Medicaid eligibility is not calculated using the modified adjusted gross income standard established in federal regulations, DHSS may not deny or delay the person’s eligibility for medical assistance on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship. The CS states that DHSS may only consider information provided by a person claiming undue hardship that the department has verified through a source other than the person’s own statement. (Section 7 in original HB 148.)

Section 9. No changes to his section, which clarified that, for persons whose Medicaid eligibility is not calculated using the modified adjusted gross income standard established in federal

standards and as provided in Section 8 (above), the department shall impose a penalty period of ineligibility for the transfer of an asset for less than fair market value by an applicant or applicant's spouse consistent with federal rules (Section 8 in original HB 148.)

Section 10. New section that amends existing AS 47.07.030(d) to state the department shall (not may) establish a primary care case management system or a managed care organization contract in which certain eligible individuals, including super-utilizers as identified by the department, are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services.

Section 11. New section that amends existing AS 47.07.030 by adding a new subsection (g) to require DHSS to submit an annual report to the legislature describing state costs for optional and mandatory services.

Section 12. No changes to this section, which removes language from AS 47.07.036(b) to allow cost containment measures in later sections. (Section 9 in original HB 148.)

Section 13. Amended to add demonstration projects to the list of reforms under this section. The demonstration projects would focus on innovative payment models for one or more groups of medical assistance recipients in one or more specific geographic areas. These demonstration projects may include managed care organizations, community care organizations, or patient-centered medical homes, but at least one project will be a coordinated care project that operates within a fixed budget to reduce medical cost inflation, improve the quality of health care for recipients, and results in a healthier population. DHSS shall design the managed care system to reduce the growth in medical assistance expenditures by at least two percentage points, and the system must implement alternative payment methodologies and create a network of patient-centered primary care homes. The department shall prepare a report regarding the progress of this demonstration project and shall deliver it to the legislature by February 1, 2019. (Section 10 in original HB 148.)

Sections 14 and 15. No changes to these sections, which remove the requirements that behavioral health providers be a grantee of the state in order to bill Medicaid. (Sections 11 and 12 in original HB 148.)

Section 16. New section for the CS establishing a demonstration project to reduce pre-term births. The project includes voluntary enrollment of approximately 500 recipients eligible for medical assistance. DHSS shall offer pregnancy counseling, nutritional counseling, and, as necessary, vitamin D supplementation. The project can be modeled after a project implemented in South Carolina.

Section 17. New section for the CS establishing, by January 1, 2017, a primary care case management system or a managed care organization contract for super-utilizers. Requires a report to the legislature.

Section 18. New section for the CS requiring DHSS to: present to the legislature by the tenth day of the second session of the 29th Legislature the results of the Medicaid Redesign and Expansion technical assistance study; prepare a report summarizing cost-sharing measures implemented before Oct. 1, 2015 and the effect of those measures on the state budget, with the report due by March 1, 2016; complete by Feb. 1, 2019 a report to the legislature on the results of the applications for waivers and options required in the bill, and the extent of the waivers and options in achieving the savings estimated by DHSS.

Section 19. No changes to this section, which instructs DHSS to amend any state plan it has with the federal government to be consistent with the Act. (Section 13 in original HB 148.)

Section 20. No changes, except for section numbering changes to conform with the CS. This section authorizes DHSS to engage in emergency rule-making under the AK Admin Code to implement Medicaid reform measures and the provisions of this Act. (Section 14 in original HB 148.)

Section 21. New section repealing Section 21, so that emergency rule-making authority for Sections 1 and 13 is repealed on June 30, 2017.

Section 22. No changes to this section, which instructs the Revisor of Statutes to make technical amendments to the title of AS 47.07.036 to conform to amendments in the Act. (Section 15 in original HB 148.)

Section 23. No changes except for section numbering changes to conform with the CS. (Section 16 in original HB 148.)

Section 24. The CS will delay implementation of the Medicaid expansion section of the bill to August 1, 2016, not July 1, 2016 as in the original HB 148.



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MEMORANDUM

March 31, 2015

To: Valerie Davidson, Commissioner, Alaska Department of Health and Social Services

Re: Response to Representative Vazquez Memorandum *Medicaid expansion cost and savings estimates vary dramatically*, March 30, 2015

The purpose of this memorandum is to explain the differences between the Lewin Group report "An Analysis of the Impact of Medicaid Expansion in Alaska" and the Evergreen Economics memorandum "Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016." In order to more easily explain the differences, it is first necessary to compare findings from the two reports on an "apples-to-apples" basis.

Making an Apples-to-Apples Comparison

- 1. Comparison of costs from the two studies must be based on the same start date.** The Lewin study presents the results based on Medicaid expansion beginning in either January 2014, January 2015, or January 2016. The most logical start date to consider is January 2016. For the Lewin study, the estimates of costs based on a January 2016 start date are found in Figure B-6. For the Evergreen study, which was presented with a July 2015 start date (beginning of FY2016), it is a simple matter to move to a January 2016 start date.
- 2. Comparison of costs from the two studies must be based on the same year.** The Evergreen study was presented on a fiscal year basis; however, because the Lewin study presents results based on calendar year, I will compare the two studies on the same basis.
- 3. Comparison of costs from the two studies must be based only on the cost of Medicaid expansion.** As I explained in the Legislative Lunch and Learn on March 19, 2015, the "woodwork" or "welcome mat" effect associated with the Affordable Care Act (ACA) occurs regardless of whether Alaska expands Medicaid or does not expand Medicaid. In fact, Alaska has already experienced a substantial welcome mat effect. The welcome mat effect is based on (1) the insurance mandate, (2) the "no-wrong-door" interface associated with the federal exchange, and (3) the modified adjusted gross income (MAGI) standard. Alaska, just like every other state, has been subject to these three issues since January 2014. Alaska has been experiencing increased Medicaid enrollment due to the three issues since January 2014; most or all of their collective effect has already been realized.

Comparing the Lewin and Evergreen Results for CY2016–CY2020

Table 1 summarizes the key results from the Lewin and Evergreen studies with respect to the size of the newly eligible population, enrollment by those who are newly eligible, spending per newly eligible enrollee, and total and state costs of providing Medicaid Services to newly eligible enrollees. The results shown in Table 1 are directly comparable because both the Lewin and Evergreen projections are on a calendar year basis, both begin in January 2016, and only costs associated with expansion are included.

Table 1: Enrollment in and Spending on Medicaid Expansion Services by Calendar Year

Study	Component	2016	2017	2018	2019	2020
Lewin Group	Newly Eligible Adults	65,619	66,571	67,496	68,560	69,684
	Newly Eligible Enrollees	31,572	36,929	42,401	43,029	43,687
	Cost Per Enrollee	\$9,708	\$10,208	\$10,730	\$11,272	\$11,839
	Total Cost	\$306,500,976	\$376,971,232	\$454,962,730	\$485,022,888	\$517,210,393
	State Cost	\$0	\$18,848,562	\$27,297,764	\$33,951,602	\$51,721,039
Evergreen Economics	Newly Eligible Adults	41,945	42,015	42,085	42,155	42,225
	Newly Eligible Enrollees	20,083	23,293	26,514	26,558	26,602
	Cost Per Enrollee	\$7,372	\$7,624	\$7,885	\$8,155	\$8,363
	Total Cost	\$148,051,876	\$177,585,832	\$209,062,890	\$216,580,490	\$222,472,526
	State Cost	\$0	\$8,879,292	\$12,543,773	\$15,160,634	\$22,247,253

Source: Analysis by Evergreen Economics of data from various sources

To compare the results from the two studies, one needs to consider three issues:

1. The size of the newly eligible population and growth in this population over time;
2. How many of those newly eligible for Medicaid actually enroll (i.e., the take-up rate); and
3. Average annual spending on Medicaid services for the newly eligible enrollees.

The Expansion Population

Lewin Group

In the Lewin study, the authors utilized the Health Benefits Simulation Model (HBSM), a proprietary model of the Lewin Group, and data from the Current Population Survey (CPS) for the years 2008-2010 to simulate the number of people who would become newly eligible for Medicaid through Medicaid expansion in Alaska.

Between 2014 and 2020, the Lewin Group projects that the average annual growth rate of the newly eligible population will be about 1.4 percent, far greater than the growth rate of .04

percent projected by the Alaska Department of Labor for the 19-64 year old population over that same period.

Evergreen Economics

The Evergreen estimates of the expansion population are based on recent data and did not require any simulation or modeling. Instead, we directly estimated the number of persons newly eligible for Medicaid expansion, using data collected by the State of Alaska through the Behavioral Risk Factor Surveillance System (BRFSS) survey for 2012 and 2013 and population estimates and projections reported by the Alaska Department of Labor. The BRFSS survey is a statewide household survey that collects detailed demographic, household, and health-related information on Alaskans. In this survey, adult respondents are asked their age, the number of other adults living in the home, the presence and ages of any dependent children living in the home, and household income.

In the Evergreen study, growth in the expansion population is slightly faster than that projected by the Alaska Department of Labor (0.17 percent versus 0.04 percent). We used this slightly faster growth rate to ensure that our projection did not under-predict population growth.

Take-up Rate of Medicaid

Lewin Group

The Lewin Group assumes a 63 percent Medicaid take-up rate by the newly eligible population, which requires a two-year “ramp-up” period.

Evergreen Economics

We believe the take-up rate and the ramp-up rates are reasonable and we adopted them in the Evergreen study.

Average Annual Spending per Newly Eligible Medicaid Enrollee

Lewin Group

The Lewin Group does not state how or where it developed estimates of spending per newly eligible enrollee. The estimates used in the Lewin Group are less than, but fairly close to, the average annual cost of providing Medicaid services for all working-age adults—including those that are disabled or pregnant.

Evergreen Economics

In the Evergreen study, we used working-age adults enrolled through the Family Medicaid eligibility category, which is comprised of non-disabled adults who are eligible for Medicaid

services due to being low income with dependent children.¹ With the exception of having dependent children, we believe these enrollees are a good proxy for the expansion population.²

Based on our analysis of data from the Department's Medicaid Budget Group, between FY2009 and FY2013, average spending per enrollee for adults in Family Medicaid grew on an average annual basis by just 1.0 percent to \$6,560 in FY2013 (see Table 2). Over this same period, average spending per enrollee was little changed for all working-age adults (growing from \$12,282 to \$12,374). The substantial difference in average spending per enrollee is due to the fact that the overall working-age population includes individuals who are disabled or pregnant.

Table 2: Historical Average Per-Enroll Cost of Services

Fiscal Year	Adults in Family Medicaid *	All Working-Age Adults
2009	\$6,359	\$12,282
2010	\$6,708	\$13,079
2011	\$6,934	\$13,301
2012	\$6,593	\$12,684
2013	\$6,560	\$12,374
Annual % Growth	1.0%	0.2%

Source: Analysis by Evergreen Economics of data from Alaska DHSS, Medicaid Budget Group

* Based on Family Medicaid eligibility, ages 19-64

Our estimated annual cost of Medicaid services for the expansion population is weighted by gender and age to account for expected demographic characteristics of the expansion population.

Concluding Remarks

In the end, cost estimates from the Lewin and Evergreen studies are a function of the assumptions made by the researchers. I believe that the most reasonable assumptions are those based on the most recent data from Alaskan sources. For the Evergreen analysis, we developed estimates of the newly eligible population based on information Alaskan households reported to Alaskan researchers. And for the estimates of annual Medicaid cost per newly eligible enrollee, we relied on the most currently available data for Medicaid enrollees most like the newly eligible population.

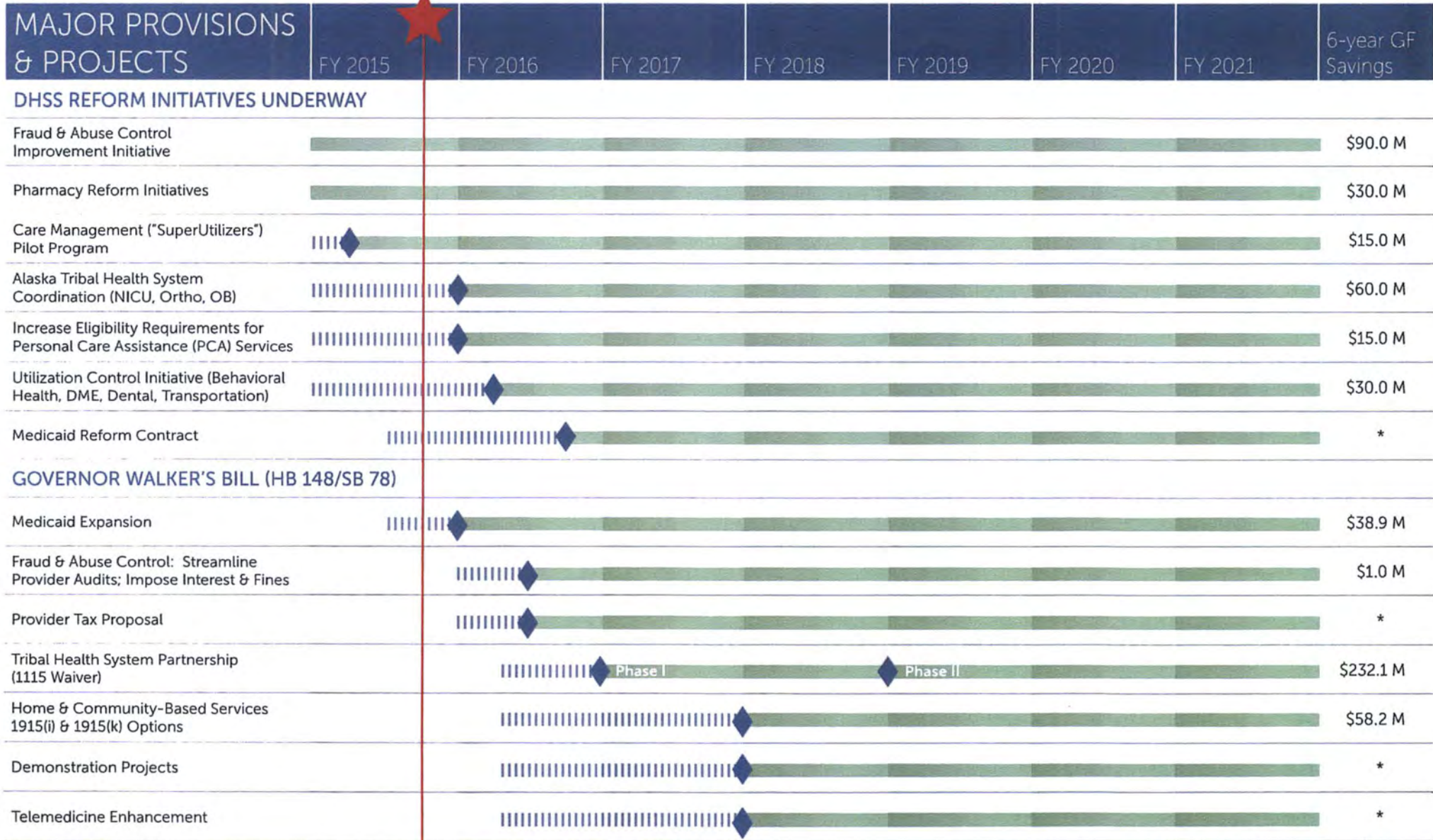
¹ There are also a small number of disabled adults in the expansion population. We relied on data for Medicaid enrollees 19-64 years of age, enrolled through the SSI/APA, Medicare, and Other Disabled eligibility categories in developing estimates of Medicaid costs for the expansion population.

² We base this conclusion on our comparative analysis of data from the 2012 and 2013 BRFSS surveys on the health status of the expansion population and the current Medicaid-eligible population. Please see the tables in the appendix of this memo to see the comparison in health status between the expansion population, current Medicaid enrollees, and Alaskan adults not in Medicaid and not in the expansion population.

MEDICAID EXPANSION & REFORM TIMELINE

- ||||| Planning Timeframe
- ◆ Implementation "Go-Live" Date
- Post-Implementation Monitoring Period

YOU ARE HERE



*Savings indeterminate at this time.

White Paper

**Medicaid Expansion and the Alaska
Department of Corrections**

April 3, 2015



In the United States inmates have a constitutionally protected right to evidence-based care that meets community standards. Prior to the Patient Protection and Affordable Care Act (PPACA), financial responsibility for securing these rights fell almost exclusively to the states. In Alaska, inmate health care comprises approximately 13% of the Alaska Department of Corrections (ADOC) budget and is largely funded through General Fund expenditures. The costs associated with providing health care to inmates are expected to rise due to an aging inmate population and increasing health care costs. Medicaid expansion in Alaska has the potential to bend this cost curve and shift a portion of inmate health care costs to federal sources of funding.

Prior to incarceration many prisoners do not receive regular medical, mental health or dental care. The ADOC is the largest provider of mental health services in the state and medical staff are responsible for more than 6,000 inmate-patients on any given day. The inmate population presents with significantly greater health care needs than the general population:

- Approximately 30% of the inmate population has Hepatitis C, compared to 1% of Alaska's general population (Department of Health & Social Services, Division of Epidemiology).
- 65% of ADOC inmates have a diagnosable mental health disorder (Trust Beneficiaries in Alaska's Department of Corrections, May 2014).
- As much as 80% of the Alaskan inmate population has struggled with substance abuse disorders (*Ibid*, 2014).
- 65% of the women at Hiland Mountain Correctional Center report having been sexually victimized (Alaska Department of Corrections survey, 2012).
- For every 100,000 Alaskans, there were 11.1 deaths due to liver disease (Alaska Bureau of Vital statistics, 2013). For every 100,000 individuals booked into ADOC, 15.3 die of liver disease while incarcerated.
- Compared to other Americans of the same age, prisoners are:
 - 31% more likely to have asthma;
 - 55% more likely to have diabetes;
 - 90% more likely to have a heart attack; and
 - 100%-300% more likely to have a serious mental illness (Harvard University, 2009).

Every individual who is arrested in Alaska receives a health care screening at remand; during this evaluation issues such as suicide risk, injuries, medications, illness, and mental status are assessed. Nearly 50% of inmates report having ongoing medical problems other than colds or viruses.

Intake nurses refer inmates to in-house clinics, medical and dental providers, mental health clinicians and psychiatrists. The Department maintains an 11-bed medical infirmary where staff provide care for pre-op, post-op and other medically complex cases; a 28-bed acute care psychiatric unit for men, an 18-bed acute care psychiatric unit for women, 40 beds for women with subacute psychiatric needs and 126 beds for men's subacute needs. When an inmate's medical needs exceed what can be provided in ADOC facilities, a referral is made to specialists in the community or the inmate is taken to a hospital.

The ADOC pays for all of these medical costs, including costs associated with transport and security for outside medical appointments and hospitalizations.

Because Alaska's jails and prisons contain the highest concentration of individuals in the state with mental health and substance use disorders, infectious diseases and chronic health conditions, there needs to be continued collaboration between the ADOC, the Department of Health and Social Services (DHSS), the Department of Law (DOL) and the Alaska Court System to ensure these individuals have appropriate access to health care services when they return to Alaskan communities.

Inmate Hospitalizations

There has been mounting interest in how Medicaid coverage will be handled for incarcerated individuals. The federal Centers for Medicare & Medicaid Services' (CMS) policy regarding coverage of inmates was clarified in a 1997 memorandum sent to states. The memorandum states that federal funding is not available for inmates of a public institution.

However, CMS provided additional guidance to states in 2007 clarifying that inmates who leave a correctional facility for more than 24 hours for in-patient treatment in a hospital or long-term care facility are no longer considered "inmates," and Medicaid can be billed for qualifying services. As such, the cost of eligible in-patient services provided to Medicaid-eligible inmates of prisons or jails can be supported by federal dollars.

States did not widely use this opportunity until after passage of the Affordable Care Act. Medicaid expansion extends Medicaid eligibility to a majority of inmates, greatly expanding states' potential for cost savings.

In order to receive federal funding for Medicaid-covered services to inmates receiving in-patient care at a hospital, the inmate must be determined eligible by the state. Currently, to be eligible for Medicaid an adult has to qualify as low-income, and must meet one of the following criteria: be a parent or caretaker of a dependent child; be age 19-20 or 65 or older; or be pregnant or disabled. Medicaid expansion will add a new category of adults who are not otherwise eligible for Medicare or Medicaid and whose income does not exceed 138% of the Federal Poverty Level (FPL).

The Government Accountability Office in September 2014 reported that a majority of inmates in the 27 states that had expanded Medicaid eligibility under PPACA were likely to be Medicaid-eligible under expansion. A March 2015 poll by ADOC of the departments of corrections in Expansion states puts that number consistently around 90%.

The only significant inmate group other states report finding ineligible is non-citizens. Medicaid eligibility requires that an individual have a Social Security number or have applied for one. In Alaska, 98.2% of offenders currently in correctional facilities have a Social Security number documented in the offender management system.

Following is a list of states that responded to inquiries regarding the percent of hospitalized offenders who qualified for Medicaid in Expansion states.

- Arizona "all except non-citizens"
- Arkansas 98%
- California 72%*
- Colorado 90%
- Connecticut 90-95%
- Delaware "virtually all"
- Hawaii 97%
- Michigan 97%
- Nevada "all except non-citizens"
- New York 80%*
- Ohio 95%
- Pennsylvania "virtually all"
- Rhode Island 95%
- Washington 90%

*California and New York reported lower inmate eligibility due to their states' high number of non-citizens and those who lack a Social Security number.

Medicaid will not cover health care services provided within ADOC facilities or outpatient medical appointments such as x-rays, orthopedic exams, specialty consults or emergency room visits. However, the cost of the qualifying hospitalizations is significant.

In FY14, 163 Alaskan inmates were hospitalized for more than 24 hours at a total cost of \$8.5 million. Although less than 3% of the inmate population was hospitalized for more than 24 hours, the cost of these hospitalizations accounted for more than 25% of ADOC's inmate health care budget. Based on a conservative 80% of the population being eligible for Medicaid under expansion, this represents potential savings of approximately \$6.8 million. Estimated savings rise to \$7.6 million if 90% are eligible**. The following table lists prior-year data along with estimates of potential savings.

	# hospitalized for 24+ hours	Total cost of hospitalizations	State savings if 80% eligible	State savings if 90% eligible
FY12	128	\$6,310,490	\$5,048,392	\$5,679,441
FY13	145	\$6,221,409	\$4,977,127	\$5,599,268
FY14	163	\$8,511,300	\$6,809,040	\$7,660,170
FY15*	113	\$6,483,522	\$5,186,817	\$5,835,169

*FY15 billings through March 25, 2015

**It is important to note that cost reductions expected from the use of Medicaid can be estimated but not ensured, as inmate health care costs and number of hospitalizations can fluctuate significantly from year to year.

Experience in Expansion States

In states that have expanded Medicaid, departments of corrections have realized significant savings.

- Ohio saved \$10 million in FY14 and expects to save \$18 million a year from Medicaid-paid hospitalizations (Ohio Department of Medicaid, September 2014).
- Michigan expects to save \$16.8 million in FY15 (The Council of State Governments, *Billing Medicaid for Inmate Care Saves California, Other States Millions*, September 2014).
- California reported \$31 million savings the first year (FY13) and \$52 million in FY14, and projects \$69 million in FY15 (*Ibid*, September 2014).
- Kentucky reported \$5.4 million in savings in FY14 (first year) and anticipates \$11 million in 2015 (The Henry J. Kaiser Family Foundation, *The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States*, March 2015).

Regulation Changes

Several existing regulations must be addressed to ensure a simplified process for determining eligibility for the inmate population. This includes wording changes to 7 AAC 100.068 and 7 AAC 105.110(6) that will clarify language allowing Medicaid coverage for hospitalized offenders. DHSS and the ADOC have drafted these changes and they are currently out for public comment.

Once the ADOC is able to start using Medicaid for approved services, there is, at times, the challenge of securing inmate-patient cooperation. Other states that have gone through Expansion cite inmate resistance as a barrier to successful use of Medicaid funds for hospitalization and, as such, have implemented statutes and regulations to ensure such barriers are removed (Oregon HB2087, 2013; Arkansas HB1351, 2013; ADOC Listserve Inquiry, March 2015; https://www.ncdps.gov/div/Prisons/HealthServices/CC_ContinuityPatientCare/cc14.pdf; http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0351-0400/ab_396_cfa_20110621_174445_sen_comm.html).

The ADOC is working with the Alaska Department of Law (DOL) to write a regulation that will allow a representative from the ADOC to apply for Medicaid benefits on behalf of an inmate who is either unwilling or unable to give consent. AS 33.30.028 provides the ADOC statutory authority to seek third-party payors for health care, and AS 33.30.021 provides authority to adopt regulations to implement the chapter. Until such regulations are in place in Alaska, the DOL will seek court orders allowing the ADOC to sign for hospitalized offenders who refuse to sign or who are incapacitated.

Suspension vs. Termination of Medicaid benefits

Currently, when an individual who is enrolled in Medicaid is detained, his or her Medicaid benefits are terminated at the end of the first full calendar month of incarceration. DHSS is working on changing internal policies so Medicaid-approved individuals who are incarcerated will have their benefits suspended rather than terminated. Benefits can be suspended for up to 12 months following incarceration. Suspended benefits can be reinstated more easily than terminated benefits in the event

an inmate is hospitalized. Suspending rather than terminating benefits will also make it easier to reinstate benefits for inmates who are released within 12 months of entering the corrections system.

Offender Reentry and Recidivism

A majority of those released from prison or jail each year are uninsured (Council of State Governments Justice Center, *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System*, December 2013). As such, another important benefit of expansion is that inmates who enroll in Medicaid as part of their reentry plan will have coverage when they are released to the community.

There is growing evidence to suggest that offenders who are able to access medical and behavioral health services in the community have lower rates of recidivism compared to those who do not (Center for Health and Justice, *Leveraging National Health Reform to Reduce Recidivism and Build Recovery*, May 2013).

For example, a peer-reviewed study of ex-prisoners in a King County, Washington and Pinellas County, Florida, found: "Persons with severe mental illness who were enrolled in Medicaid at jail release had 16% fewer detentions and stayed out of jail longer, on average, than those who either did not have benefits or had them for a shorter time. Thus, in combination with our earlier work, the findings reported here suggest that Medicaid is associated with positive gains for the mental health system in keeping people engaged in services and for the criminal justice system in reducing recidivism." ("The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness," *Psychiatric Services*, June 2007, pp. 794-801, v. 58 n. 6. Accessed online at <http://ps.psychiatryonline.org/doi/abs/10.1176/ps.2007.58.6.794>)

A Michigan project linking ex-prisoners to medical services found, "The overall recidivism rate for parolees has fallen since the program began, from 46 percent when the program began in 2007 to 21.8 percent in 2012 for 2-year parolees." (<https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline>)

Access to health care upon release is particularly important for inmates with serious chronic mental illness. Without continuity of care for the mentally ill population, they often quickly decompensate, become psychotic and commit another crime that brings them back into ADOC custody. Having Medicaid available immediately upon release improves their chances of remaining stable in the community because they can access critical resources without delay.

Conclusion

While the intent of Medicaid expansion is directed toward the expansion of health coverage, containment of rising health care costs, and improvement of health care delivery, the potential achievements of health care reform are not limited to the health and social services arena. Successful Medicaid expansion in Alaska has the potential for significant cost savings in inmate health care; improve the quality of health care delivery to inmates leaving correctional facilities; and improve the health and safety of communities by making critical treatment programs available to the offender population – ultimately reducing recidivism and helping to stem the growth of Alaska's crime and imprisonment rates.



Supporters of Medicaid Reform & Expansion

AARP Alaska

Abused Women's Aid in Crisis, Inc. (AWAIC)

Ahtna, Incorporated

AK Child & Family

Alaska AIDS Assistance Association

Alaska Association on Developmental Disabilities

Alaska Brain Injury Network

Alaska Chamber of Commerce

Alaska Federation of Natives

Alaska Geriatric Exchange Network

Alaska Injury Prevention Center

Alaska Legal Services Corp.

Alaska Literacy Program

Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse

Alaska Mental Health Trust Authority

Alaska Municipal League

Alaska Native Brotherhood and Alaska Native Sisterhood Camp 70

Alaska Native Health Board

Alaska Native Tribal Health Consortium

Alaska Physicians & Surgeons

Alaska Primary Care Association

Alaska State Hospital & Nursing Home Association

Alaska Women's Lobby



Aleutian Housing Authority
Aleutian Probilof Island Association
American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association in Alaska
Anchorage Coalition to End Homelessness
Anchorage Community Mental Health Services
Anchorage Human and Social Services Executive Directors
Anchorage Municipal Assembly
Anchorage Neighborhood Health Center
Anchorage Youth Development Coalition (AYDC)
ANCSA Regional Association
Bartlett Regional Hospital
Bering Straits Native Corporation
Bristol Bay Area Health Corporation
Bristol Bay Native Association
Bristol Bay Native Corporation
Camp Fire USA Alaska Council
Cancer Action Network
Catholic Social Services
CCS Early Learning
City of Barrow



Congregation Sukkat Shalom

Cook Inlet Region Inc.

Covenant House Alaska

Curyung Tribal Council

Doyon Limited

Effective Health Design

Enroll Alaska

Fairbanks Community Mental Health Services

Fairbanks Economic Development Corporation

Food Bank of Alaska

Foraker Group

Governor's Council on Disabilities & Special Education

Greater Fairbanks Community Hospital Foundation

Identity Inc.

Iliuliuk Family and Health Services

Juneau City & Borough Assembly

Juneau Economic Development Council

Juneau Tlingit & Haida Community Council

Kenai Peninsula Borough Assembly

Kenaitze Indian Tribe

Kodiak Area Native Association

League of Women Voters of Alaska

March of Dimes Foundation Alaska Chapter



Mat-Su Health Foundation

Mountain-Pacific Quality Health Foundation

Municipality of Skagway

NAMI

NANA Regional Corporation

NEA Alaska

New Koliganek Village Council

Nine Star Education and Employment Services

Nondalton Tribal Council

Planned Parenthood of the Great Northwest

Professional Nursing Consultants

RurAL CAP

Sitka Borough Assembly

Southeast Alaska Independent Living, Inc.

Statewide Independent Living Council of Alaska

Tanana Chiefs Conference

Tangirnaq Native Village/ Woody Island Tribal Council

thread

United Way of Anchorage

Valley Medical Care

Volunteers of America Alaska

YWCA Alaska

A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, AARP ALASKA endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that AARP ALASKA strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.



March 6, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Ahtna, Incorporated supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor

Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Ahtna, Incorporated endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in cursive script that reads "Michelle Anderson". The signature is written in black ink and is positioned above the printed name and title.

Michelle Anderson
President



AADD
ALASKA ASSOCIATION ON
DEVELOPMENTAL DISABILITIES
P.O. Box 241742
Anchorage, Alaska 99524

A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

NOW THEREFORE BE IT RESOLVED, AADD (Alaska Association on Developmental Disabilities) endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that AADD (Alaska Association on Developmental Disabilities) strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.



March 25, 2015

Office of the Governor
Alaska State Legislature
State Capitol Building
Juneau, AK 99811-0001

Dear Governor Walker and the Alaska State Legislature,

The Alaska Brain Injury Network supports Medicaid expansion and reform. These efforts will allow more low-income Alaskans, seniors, and people with disabilities to receive basic health insurance, while improving the efficiency and effectiveness of Alaska's Medicaid health care service system.

The State of Alaska will benefit from Medicaid expansion and reform in many ways. \$1.1 billion in federal dollars will become available to support expansion; 4,000 new jobs are predicted; \$1.2 billion more in wages and salaries to Alaskans; 40,000 uninsured Alaskans will be eligible for basic health care coverage.

Medicaid expansion is the catalyst for Medicaid reform. Both efforts will improve the efficiency and effectiveness of Alaska's current Medicaid health care service system and make it sustainable. Innovative models of care and other reforms can create efficiencies that can save money, reduce fraud and waste, remove ineffective services, and reduce unnecessary spending.

We support reforms that would include payment reform, patient centered medical/health homes, care management, expanded telemedicine to improve access to care and reduce travel costs, reduced overutilization of emergency room services, increased fraud prevention and waste reduction efforts, coordination with the Alaska tribal health system, interagency and interdepartmental collaborations to leverage human and financial resources, improved use of patient health information to achieve positive health outcomes, increased access to preventative services and incentives for healthy behaviors, cost-sharing requirements for certain enrollees and certain services, increased access to supportive services to reduce emergency, institutional, and acute care costs

The Alaska Brain Injury Networks supports the 1915(i) Home and Community-Based Services State Plan Option. A person qualifying for 1915(i) state plan option will have access to home and community based services that help him or her maintain a healthy, stable life through supported housing, employment/training, and appropriate health care services. The 1915(i) state plan option opens eligibility for home and community-based services, that were previously not open — including



services for people with behavioral health and other brain-based disorders. The 1915(i) state plan option has been used by other states to reduce recidivism by providing appropriate services to people cycling through the correctional system, and by increasing access to trauma-informed care, peer support, supported housing, supported employment, and recovery services. Eligibility requirements for the 1915(i) state plan option will incorporate needs-based criteria that look at medical risk factors and cognitive and adaptive function. Adopting the 1915(i) state plan option, will allow for the state to receive a federal Medicaid match for lower-cost community services and supports which can reduce the utilization of higher-cost emergency and institutional services.

The Alaska Brain Injury Network supports community-based services that include case management, in-home assistance with activities of daily living, psycho-social rehabilitation services, pre-vocational supports, education and training, supported employment, assistance with getting and maintaining housing, peer support, mobile crisis intervention, intensive crisis respite and short term crisis respite support, family and caregiver training and supports, transitional services for individuals returning from foster care, juvenile justice, residential treatment, or incarceration

Thank you for your consideration of this issue, which is very critical to all Alaskans.

Sincerely,

Tawny Buck
Executive Director

Dr. Adam Grove
Board Chair

Medicaid Expansion – It's *Your* Business

The issue of Medicaid expansion in Alaska is finally garnering the attention of Alaska businesses. After all, the new federal health care law makes health care everyone's business. This issue is not alone in affecting the business environment in Alaska.

Alaska Chamber members recently met and adopted 40 policy positions. When asked to prioritize these policies, members selected opposition to the referendum to repeal oil tax reform, support for comprehensive workers' compensation reform, and support for Medicaid expansion as priorities.

The Alaska Chamber Board ratified these priorities and decided to also keep the high cost of energy, permitting efficiencies and access to resources as priorities. While each of these top priorities is distinct, the fundamental underlying issue is the same – the cost of doing business in Alaska.

The Alaska Chamber's core mission is to make Alaska the best place to do business. It's about making Alaska competitive and there are many factors businesses consider when deciding how much and where to invest.

The decision of the Alaska Chamber to support Medicaid expansion is a pragmatic one. Like it, love it, or hate it, the Affordable Care Act is the law of the land and businesses have no choice but to deal with it. Most importantly, Alaska businesses are looking for ways to stay in Alaska and grow our economy. To stay in the competitive game, Alaska businesses are looking to reduce and contain costs.

Given the federal fiscal situation, and the track record the feds have with keeping commitments, Alaska Chamber members support Medicaid expansion with caveats. Those caveats include support for a fail-safe provision and/or supporting an alternative to Medicaid expansion. A fail-safe provision means that if the feds renege on their funding commitment, Alaska will opt out of the expansion. Alaska Chamber members are also open to finding a private sector alternative to address Alaska's uninsured under the new federal law.

As taxpayers, all Alaskans are subject to the increased federal taxes established to fund the Affordable Care Act. If Alaska does not expand Medicaid, Alaskan's taxes will pay for the uninsured in other states. Alaska businesses and all insured Alaskans will bear even higher insurance premiums and health care costs to cover those uninsured.



Currently, the cost of care for uninsured Alaskans who are unable to pay for their care are covered by those who are insured. In the health care industry it is called uncompensated care. Employers providing insurance to their employees and individuals buying health insurance pay for this uncompensated care in the form of increased premiums costs.

If Alaska does not expand Medicaid, we will continue to pay these increased premiums as well as pay the new federal taxes. If Alaska expands Medicaid, a portion of the federal taxes Alaskans pay will return to the state and uncompensated care losses will decrease. Alaska Chamber members believe this will result in lower or slower growth of health care premiums.

It's worth noting that the Alaska Chamber also supports a reduction in the State of Alaska's spending levels to a more sustainable level of \$5.5 billion in total general fund spending. Current state spending levels are unsustainably high and are damaging to Alaska's competitiveness and our economic future.

Make no mistake, even with expected cost offsets, expanding Medicaid increases costs for the State of Alaska. How then can the Alaska Chamber support Medicaid expansion? It's simple. Alaska businesses, which fund the state's coffers, simply can not afford to pay once, much less twice, to provide health care for Alaska's uninsured.

To compete, to grow, and to secure a future for our state, Alaska businesses know that costs must be controlled. This means the Alaska Chamber promotes policies that create a good business environment. We support reasonable tax structures, sustainable state budgets, efficient permitting systems, increased access to resources, meaningful changes to workers' comp and taking a pragmatic approach in response to the Affordable Care Act. That's our business, and it's your business too.

Rachael Petro
President & CEO
Alaska Chamber of Commerce



ALASKA FEDERATION OF NATIVES, INC.
2013 ANNUAL CONVENTION
RESOLUTION 13-18

- TITLE:** A RESOLUTION URGING THE GOVERNOR AND THE ALASKA STATE LEGISLATURE TO ENSURE THAT THE FULL IMPACT OF POTENTIAL MEDICAID EXPANSION IS CONSIDERED AND TO TAKE COMPLETE ADVANTAGE OF FEDERAL RESOURCES TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY
- WHEREAS:** The Alaska Federation of Natives (AFN) is the largest statewide Native organization in Alaska and its membership includes 118 federally-recognized tribes, 133 village corporations, 13 regional corporations, and 11 regional nonprofit and tribal consortiums that contract and run federal and state programs; and
- WHEREAS:** The mission of AFN is to enhance and promote the cultural, economic, and political voice of the entire Alaska Native community; and
- WHEREAS:** Alaska has the option to expand Medicaid benefits by increasing the income eligibility level to 138% of the federal poverty level; and
- WHEREAS:** Independent analyses indicate significant benefits to individual Alaskans and to the Alaskan economy; and
- WHEREAS:** Approximately 40,000 more Alaskans (including 16,000 Alaska Natives and American Indians) would be covered by Medicaid; and
- WHEREAS:** The increase in eligible beneficiaries would provide increased access to care, patient travel and services that individuals are not able to afford, such as glasses, certain dental and other procedures; and
- WHEREAS:** Increasing access to care leads to healthier Alaskans; and
- WHEREAS:** The State would receive \$1.1 billion in federal revenues for the first seven years of implementation (2014-2020) for a net state contribution of \$23.4 million (\$90.7 million minus \$67.3 in offsets); and
- WHEREAS:** 4,000 new jobs would be created with \$1.2 billion in Alaskan wages and salaries throughout Alaska (2014-2020); and

WHEREAS: The multiplier effect of additional resources will benefit the State economy and all Alaskans by an estimated \$2.49 billion in increased economic activity throughout Alaska (2014-2020); and

WHEREAS: Medicaid expansion would benefit health care providers and payers, who are effectively required to subsidize care for uninsured and underinsured patients as well as businesses and other patients who support those subsidies through higher premiums, deductibles and copays. The uninsured and underinsured patients now seek care in the most expensive settings, often after their condition has become more serious and complicated than it would have been if they had access to primary care; and

WHEREAS: The federal match to the State of Alaska would be 100% for 2014-2016, then gradually transition to 90% by 2020 and beyond; and

WHEREAS: This federal match is consistent with the federal match for other programs (roads at 9%; runways at 5%); and

WHEREAS: The State has the option of Medicaid Expansion authorization contingent upon receiving a federal match rate of at least 90%; and

WHEREAS: The State has the option of various Medicaid Expansion demonstration projects it may also consider

NOW THEREFORE BE IT RESOLVED by the delegates to the 2013 Annual Convention of the Alaska Federation of Natives Inc., that that the Alaska Federation of Natives urges the Governor and the Alaska Legislature to continue their efforts to conduct responsible, thorough analyses of potential models for implementing Medicaid expansion to determine their full potential impact on Alaska, including potential improvement to the health status of Alaskans who currently lack sufficient health coverage, enhanced support to businesses involved in the health care industry, the multiplier effect on Alaska's economy, the potential ability to reduce or eliminate cross-subsidies for health care now provided to the uninsured and underinsured and financing models for Alaska

BE IT FURTHER RESOLVED that the Alaska Federation of Natives urges the Governor and the Alaska State Legislature to adopt Medicaid expansion effective January 1, 2014 so that so that Alaska residents can benefit from the services at the earliest opportunity.

BE IT FURTHER RESOLVED that this resolution shall be the policy of AFN until it is withdrawn or modified by subsequent resolution.

SUBMITTED BY: COUNCIL FOR THE ADVANCEMENT OF ALASKA NATIVES

COMMITTEE RECOMMENDATION: DO PASS

CONVENTION ACTION:



AGENET

Alaska Geriatric Exchange Network

An Association of Advocates and Service Providers for Older Alaskans

Resolution

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

Mailing Address: c/o Marianne Mills, 419 6th Street, Juneau, Alaska 99801

Phone: 907-463-6194

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

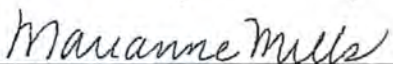
WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

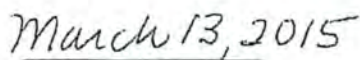
NOW THEREFORE BE IT RESOLVED, AgeNet endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that AgeNet strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The undersigned President of AgeNet hereby certifies that the Members of Agenet duly adopted this resolution on March 12, 2015.



Marianne Mills
President
AgeNet



Date

**Advisory Board on Alcoholism
and Drug Abuse**



Alaska Mental Health Board

**ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE**

431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 19, 2015

Governor Bill Walker
State Capitol, 3rd Floor
Juneau, Alaska 99801

Dear Governor Walker,

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse support Medicaid Expansion and Reform so that more low-income Alaskans (earning less than \$9.76/hour) who experience a behavioral health disorder (mental illness and/or substance use disorders) can receive basic health insurance.

The State of Alaska currently spends millions of dollars for uninsured, low-income and disabled citizens using emergency levels of care. Alaskans living without adequate health care are more likely to use these expensive acute care services, like hospital emergency rooms, psychiatric hospitals, and nursing homes. They are also more likely to end up in prison or jail as a result of un-treated behavioral health conditions. State and local governments will always pay — either in the end for more costly acute care, or up front for less costly preventative services.

Alaskans with behavioral health disorders are at higher risk for being uninsured. The services available under Medicaid Expansion will offer more effective and less expensive solutions. A person with a disability is more likely to hold down a job, maintain a stable household, and contribute positively to his or her community when basic health care needs are met.

The Boards also support Reform efforts that will improve the efficiency and effectiveness of Alaska's current Medicaid health care service system and make it sustainable. We support measures designed to create efficiencies in the Medicaid health care delivery system that will save the state money, reduce fraud and waste, remove ineffective services, and reduce unnecessary spending.

Thank you for your leadership and efforts to support the health of all Alaskans.

Sincerely

J. Kate Burkhart
Executive Director

Medicaid expansion may serve as a catalyst for meaningful Medicaid reform and we support these discussions. We are pleased to hear that the Department of Health and Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Aleutian Housing Authority endorses Medicaid expansion, recognizing that we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Duame", with a long, sweeping horizontal line extending to the right.

Dan Duame
Executive Director



217 Second Street, Suite 200 • Juneau, Alaska 99801
Tel (907) 586-1325 • Fax (907) 463-5480 • www.aiuml.org

**ALASKA MUNICIPAL LEAGUE
BOARD OF DIRECTORS**

BOARD OF DIRECTORS RESOLUTION #2015-01

**A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID
COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE
ALASKAN ECONOMY**

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.48 billion in new federal economic activity throughout the state; and

WHEREAS, with expansion, the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, Medicaid expansion must absolutely only move forward side-by-side with Medicaid reform, as the current system is known to have many substantial problems; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform.

NOW, THEREFORE BE IT RESOLVED that the Alaska Municipal League Board of Directors ~~endorses Medicaid expansion, recognizing we all have an interest in ensuring~~ that Alaskans are as productive as possible, so they can contribute to our communities and economy; and

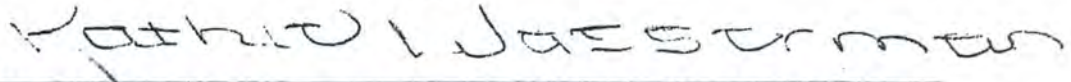
BE IT FURTHER RESOLVED that the Alaska Municipal League strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Signed:



Linda Murphy, President, Alaska Municipal League

Attest:



Kathie Wasserman, Executive Director, Alaska Municipal League



FYE HV
LO
OAS

Please date
Stamp
3/12

RESOLUTION NO. #2015-1

Sponsored by: Alaska Native Brotherhood and Alaska Native Sisterhood
Glacier Valley

TITLE: A RESOLUTION URGING THE GOVERNOR OF THE STATE OF ALASKA AND THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years which will substantially improve the State's fiscal position; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion would benefit health care providers and payers, who are effectively required to subsidize care for uninsured and underinsured patients as well as businesses and other patients who support those subsidies through higher premiums, deductibles and copays; and

WHEREAS, The uninsured and underinsured patients now seek care in the most expensive settings, often after their condition has become more serious and complicated than it would have been if they had access to primary care

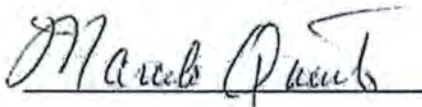
WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

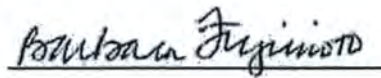
WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, that the Alaska Native Brotherhood Glacier Valley Camp 70 and the Alaska Native Sisterhood Glacier Valley Camp 70 endorse Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that the Alaska Native Brotherhood Glacier Valley Camp 70 and the Alaska Native Sisterhood Glacier Valley Camp 70 strongly urge the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.



Marcelo Quinto, President
ANB Glacier Valley Camp 70



Barbara Fujimoto, President
ANS Glacier Valley Camp 70



Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

☎ 907.562.6006 ☎ 907.583.2001 · 4000 Ambassador Dr, Suite 101 · Anchorage, Alaska 99508 · www.anhb.org

March 12, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

On behalf of the Alaska Native Health Board (ANHB), I write to support your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Established in 1968, ANHB serves as the statewide voice on Alaska Native health issues. ANHB represents 25 tribal health providers operating compact/contracts under public law 93-638. Representing 229 federally-recognized tribes and working on behalf of over 145,000 Alaska Native people, ANHB's purpose is to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

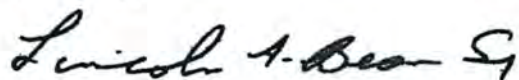
Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

ALASKA NATIVE TRIBAL
HEALTH CONSORTIUM
ALEUTIAN PIRIBILOF
ISLANDS ASSOCIATION
ARCTIC SLOPE
NATIVE ASSOCIATION
BRISTOL BAY AREA
HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER
NATIVE ASSOCIATION
COUNCIL OF
ATHABASCAN
TRIBAL GOVERNMENTS
EASTERN ALEUTIAN
TRIBES
KARLUK IRA
TRIBAL COUNCIL
KENAITZE INDIAN TRIBE
KETCHIKAN
INDIAN COMMUNITY
KODIAK AREA
NATIVE ASSOCIATION
MANILAQ ASSOCIATION
METLAKATLA INDIAN
COMMUNITY
MT. SANFORD
TRIBAL CONSORTIUM
NATIVE VILLAGE
OF EKLUTNA
NATIVE VILLAGE
OF TYONEK
NINILCHIK
TRADITIONAL COUNCIL
NORTON SOUND
HEALTH CORPORATION
SELDOVIA
VILLAGE TRIBE
SOUTHCENTRAL
FOUNDATION
SOUTHEAST ALASKA
REGIONAL HEALTH
CONSORTIUM
TANANA CHIEFS
CONFERENCE
YUKON-KUSKOKWIM
HEALTH CORPORATION
VALDEZ NATIVE TRIBE

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Alaska Native Health Board endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink that reads "Lincoln A. Bean Sr." The signature is written in a cursive style with a large, stylized initial 'L'.

Lincoln Bean, Sr., Chairman
Alaska Native Health Board



Andy Teuber
ANTHC Chairman and President

Alaska Native Tribal Health Consortium
4000 9th Avenue, Suite 100
Juneau, Alaska 99801
(907) 586-1000
info@anthc.org

March 12, 2015

The Honorable Bill Walker
Governor of Alaska
Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

The Alaska Native Tribal Health Consortium (ANTHC) fully supports your efforts to expand Medicaid by July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support the administration's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

ANTHC's endorsement of Medicaid expansion recognizes we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "Andy Teuber". The signature is fluid and cursive, with a prominent initial "A" and a long, sweeping underline.

Andy Teuber
Chairman and President



Resolution 2012 #2

A resolution of support by the Executive Committee of the Alaska State Hospital and Nursing Home Association on behalf of its membership concerning the expansion of the Medicaid Program in Alaska.

WHEREAS: Affordability and accessibility of health care is an important issue for all Alaskans;

WHEREAS: On June 28, 2012 the Supreme Court of the United States ruled on certain aspects of the Affordable Care Act and its constitutionality;

WHEREAS: As part of this ruling the Supreme Court allows, without penalty, states to either expand their Medicaid program to serve certain recipients up to 138% of FPL or decline to expand their Medicaid program to serve these recipients;

WHEREAS: Governor Parnell must now determine if Alaska will expand their Medicaid coverage in accordance with these provisions;

WHEREAS: Approximately 35,000-55,000 uninsured or underinsured Alaskans will be eligible for Medicaid under this expansion;

WHEREAS: Expanding this coverage will lessen the financial impact to the state's employers, increase access for needy and uninsured Alaskans and alleviate the uncompensated care burden with Alaska hospitals and providers;

WHEREAS: The federal government will fund the first three years of the expansion at 100% federal funding for programmatic services and then stepping down funding to 90% in 2019 and beyond resulting in approximately \$2 billion in new health care funding over the next five years;

WHEREAS: The ACA and other Congressional actions will reduce or *likely* will reduce Medicare payments to hospitals over a similar period;

THEREFORE BE IT RESOLVED, THAT:

The Executive Committee of the Association, on behalf of its members, formally supports the expansion of Medicaid recipients to 138% FPL,

FURTHER BE IT RESOLVED, THAT:

The Association pledges to support Governor Parnell and his Administration in any way feasible to provide information, resources and support to gain the information necessary to fully evaluate the benefits and the costs of such an expansion.

Passed by the majority of the Executive Committee this 16th day of August, 2012

ATTEST:

Signature to follow
Bruce Lamoureux
Chair

Alaska Women's Lobby

P.O. Box 20891, Juneau, AK 99802-0891
AWL@akwomenslobby.org ~ www.akwomenslobby.org
Like us on Facebook at AK Women's Lobby

ALASKA WOMEN'S LOBBY Resolution Adopted March 13, 2015

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, the current threshold for Medicaid eligibility in Alaska is 81 percent of the Federal Poverty Level (FPL) for working parents and 77 percent of the FPL for jobless parents, while there is currently no income eligibility threshold for adults who are not parentsⁱ; and

WHEREAS, the current expansion to Medicaid will increase eligibility of both parents and non-parent adults up to 138 percent of the FPLⁱⁱ; and

WHEREAS, women represented 47.9% of the Alaska workforce, but only earned 38.2% of the total earnings for 2010, averaging \$.67 for every \$1 earned by their male counterpartsⁱⁱⁱ; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate, thereby supporting healthier families; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state^{iv}; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

NOW THEREFORE BE IT RESOLVED, the Alaska Women's Lobby endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that the Alaska Women's Lobby strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Defending and advancing the rights and needs of women, children, and families in Alaska.

Committee Members: Jayne Andreen, Elizabeth Belknap, Nancy Courtney, Heather Davis, LaRae Jones, Rebecca Madison, Nicole Nelson, Jorden Nigro, Taber Rehbaum, Kari Robinson, Shannon Vargas
Lobbyist: Caren Robinson

ⁱ The Urban Institute, Health Policy Center. Medicaid in Alaska under the Affordable Care Act. 2013.

ⁱⁱ The Urban Institute, Health Policy Center. Medicaid in Alaska under the Affordable Care Act. 2013.

ⁱⁱⁱ Alaska Legislative Research Services. Women in Alaska, LRS Report 13.072. December 2012.

^{iv} The Lewin Group. An Analysis of the Impact of Medicaid Expansion in Alaska. 2013.



March 11, 2015

The Honorable Paul Seaton
House of Representatives
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Representative Seaton:

The Aleutian Housing Authority (AHA) is the Tribally Designated Housing Entity for the Aleutian Pribilof Islands Region of Alaska. Our mission is, in part, to contribute to the building of healthy, stable and sustainable communities throughout our region. AHA strongly urges the Alaska Legislature to expand Medicaid in July 2015, or as soon as possible for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

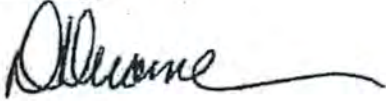
In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic and Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion may serve as a catalyst for meaningful Medicaid reform and we support these discussions. We are pleased to hear that the Department of Health and Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Aleutian Housing Authority endorses Medicaid expansion, recognizing that we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

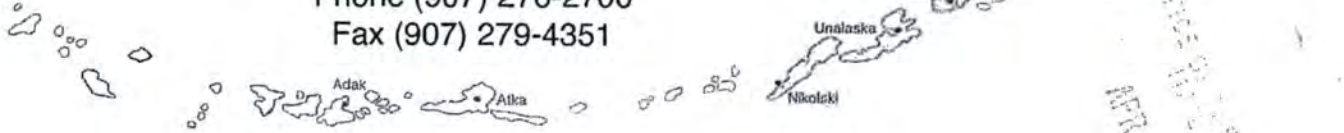
Sincerely,

A handwritten signature in black ink, appearing to read "Dan Duame", with a long horizontal flourish extending to the right.

Dan Duame
Executive Director

Aleutian Pribilof Islands Association, Inc.

1131 E. International Airport Rd.
Anchorage, Alaska 99518-1408
Phone (907) 276-2700
Fax (907) 279-4351



March 23, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

The Aleutian Pribilof Islands Association supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

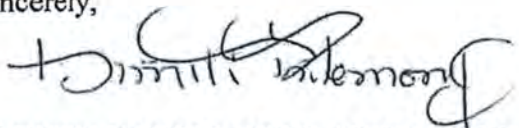
In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Aleutian Pribilof Islands Association endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "Dimitri Philemonof". The signature is written in a cursive style with a large initial "D".

ALEUTIAN PRIBILOF ISLANDS ASSOCIATION

Dimitri Philemonof
President & CEO

Cc: Charles Fagerstrom, APIA Health Director
Mark Hamm, APIA Chief Financial Officer



American Heart Association | American Stroke Association

Learn and Live.

Western States Affiliate
3700 Woodland Drive, Suite 700
Anchorage, AK 99517
(907) 865-5300
www.heart.org

March 30, 2015

Governor Walker
Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

RE: HB 148 – Support

Dear Governor Walker,

The American Heart Association/American Stroke Association (AHA/ASA) supports your HB 148. This bill expands Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half and improving preventative and primary care access. Patients with heart disease and stroke with Medicaid coverage are more likely to take their medication appropriately, have their blood pressure controlled, and more likely to have been checked for high cholesterol, compared to the uninsured.

Heart Disease and Stroke combined, are responsible for more deaths in Alaska than any other cause. Medicaid is already an important source of health insurance coverage for patients with heart disease, stroke, and other cardiovascular diseases (CVD), and through Medicaid expansion, it will become an even more important source of coverage for currently uninsured adults with or at-risk for CVD.

There are significant economic benefits associated with Medicaid expansion. Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. More than \$1 billion in new federal revenues to the state will be realized, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years.

Chairman of the Board
Janice Murphy, CFA
Oakland

President
Robert C. Robbins, M.D.
Houston

Chairman-Elect
Mike Bolen
Newport Beach

President-Elect
Kirk Knowlton, M.D.
La Jolla

Secretary
Deepak Srivastava, M.D.
San Francisco

Treasurer
Pierre P. Habis
Los Angeles

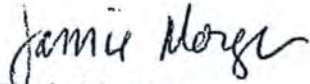
Executive Vice President
Kathy Rogers

Chief Development Officer
Ginnie Gallin

In addition to new federal revenue, savings to the state budget have also been identified. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget.

The AHA/ASA supports HB 148 and the positive impact it will have on the health of Alaskans and the economy.

Sincerely,

A handwritten signature in cursive script that reads "Jamie Morgan".

Jamie Morgan
Senior Director of Advocacy and Policy Campaigns



A Resolution in Support of Medicaid Expansion

March 2015

ACEH Resolution #1501

Whereas, nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion; and

Whereas, the second highest reason for a crisis leading to homelessness in Alaska last year was an injury, illness or maternity (Homeless and At-Risk Data Report, Alaska Housing Finance Corporation); and

Whereas, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

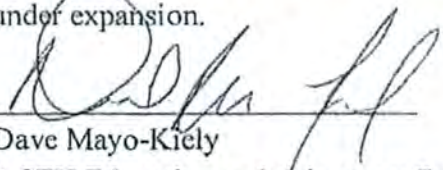
Whereas, expanding Medicaid will improve the access to substance abuse treatment and mental health counseling. Client eligibility for and enrollment in Medicaid will allow community organizations the ability to bill for services they currently provide their clients ensuring sustainability for the safety net services in our communities; and

Whereas, access to Medicaid coverage is already showing a positive difference for people who experience homelessness in other states. A Kaiser Family Foundation report recently showed that Medicaid expansion is contributing to improved access to care as well as broader benefits for homeless individuals, such as the improved capability to gain employment; and


Whereas, the health and wellness of Alaskans is a Constitutional priority and is vital to each individual, family, community and our entire State; and

Therefore be it resolved, the Anchorage Coalition to End Homelessness endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

Be it further resolved, that the Anchorage Coalition to End Homelessness strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.


Dave Mayo-Kieley

ACEH Education and Advocacy Committee


Carmen Springer

ACEH Coalition Director

Whereas, good health and wellness are supporting factors in children staying and succeeding in school; adults getting and keeping a job; and, in healthy, competitive communities;

Whereas, the State of Alaska has an opportunity now to develop an Alaska Medicaid Expansion Program which meets the needs of vulnerable Alaskans, communities and Alaska as well as being an effective component of the Alaska health care system and is funded by the Federal government at least at 90% and has the potential to provide additional offsets to program expansion administration;

Whereas, Medicaid Expansion would provide a revenue stream covering a portion of the health care costs of vulnerable Alaskans and in doing so support financial stability and organization sustainability of the Alaska health safety net: community health centers, community mental health centers, tribal clinics, rural hospitals, urban hospitals;

Whereas, in FY2014, as partners in caring for vulnerable Alaskans, coalition members contributed directly to customer health or provided supports to increase the likelihood of short term and lifelong health and wellness. We

- provided 18,805 customers health care services 26,529 customers health screenings; 68,841 customers health education; \$17,690,505 donated logistical or financial assistance; 14,848 with a patient centered medical home; and, 31,793 or 84% of customers surveyed demonstrated/reported healthy behaviors and 8,073 or 84% met the terms of their health treatment plan; and,
- Served 994,312 meals/snacks/ box lunches; sheltered 17,103 homeless individuals/families; provided 24,695 households prevention services and/or income boosts; distributed 540,037 pounds of food; and 1,484 or 64% of participating customers demonstrating improved coping skills, better ability to return to daily life, *ability to return to work and/or home after completing crime or violence prevention and/or stabilization programs* and 1,532 or 70% of participating customers had *increased self-sufficiency levels after exiting a program operating in the community*; and,
- 1,037 children 0-5 screenings; 1,684 children provided with quality care and education services; 109,165 free books distributed to children 0-5; and, 2,167 or 89% of participating parents/families had increased knowledge of parenting and child development
- 20,948 of youth participating in activities that promote youth development; 196 or 67% participating youth decreasing substance use; 6,000 or 69% youth more engaged with education, learning and school; and, 10,860 or 74% youth with conflict resolution skills (*Note: the information above is a sample based on data provided is based on annual reporting by partner agencies to United Way of Anchorage.*); and,
- We, our partners, business people, teachers, students and parents have been working together to increase the Anchorage School District graduation to 90% by the year 2020, and have together increased graduation rates from 59% in 2005 to 74% in 2014 which contributes as a positive determinant in lifelong health.

Therefore, we the undersigned non-profits support the following Medicaid Expansion strategies:

- Approve Medicaid Expansion
- Fix and clear backlogs for
 - the State of Alaska Medicaid eligibility determination system, Alaska's Resource for Integrated Eligibility Services (ARIES), and;
 - the payment system, Medicaid Management Information System (MMIS) prior to Medicaid Expansion
- Accept federal money for Medicaid Expansion
- Approve supplemental funding for Medicaid Expansion administration

And;

Commit to being partners in this effort by continuing to care for vulnerable Alaskans and by working with the Governor, State of Alaska Legislature, the State of Alaska Department of Health and Social Services, the business community and other stakeholders to develop a sustainable Alaska Medicaid Expansion Program.

Hilary A. Morgan, Co-Chair

CEO, YWCA Alaska

Signatories

Abused Women's Aid in Crisis, Inc. (AWAIC)

AK Child & Family

Alaska Injury Prevention Center

Alison Kear, Chief Executive Officer, Covenant House Alaska

American Diabetes Association

Anchorage Neighborhood Health Center

Anchorage Youth Development Coalition (AYDC)

Barbara Dubovich, Chief Executive Officer, Camp Fire USA Alaska Council

CCS Early Learning

Food Bank of Alaska

Jerry A. Jenkins, Chief Executive Officer, Anchorage Community Mental Health Services (and Fairbanks Community Mental Health Services)

Lisa Aquino, Executive Director, Catholic Social Services

Francine Harbor, NAMI

Nine Star Education and Employment Services

Pauline P. Smith, Executive Director, Alaska Literacy Program

RurAL CAP

Stephanie Berglund, CEO, thread

Volunteers of America Alaska

YWCA Alaska

CLERK'S OFFICE

APPROVED

3-3-2015

Date:

Submitted by: ASSEMBLY CHAIR TRAINI,
VICE-CHAIR GRAY-JACKSON, ASSEMBLY
MEMBERS FLYNN, HALL, HONEMAN, PETERSEN,
STARR, STEELE

Prepared by: Office of the Municipal Clerk

For reading: March 3, 2015

ANCHORAGE, ALASKA

AR NO. 2015-71

1 A RESOLUTION OF THE ANCHORAGE MUNICIPAL ASSEMBLY URGING THE
2 ALASKA STATE LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE
3 THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

4
5 WHEREAS, nearly 42,000 of our family members, friends and neighbors have the
6 opportunity to gain health care coverage under expansion; and

7
8 WHEREAS, Medicaid expansion will improve health outcomes by reducing the
9 number of uninsured Alaskans by half, improving preventive and primary care access,
10 providing substance abuse treatment and mental health counseling, and reducing the
11 mortality rate; and

12
13 WHEREAS, Medicaid expansion brings over \$1 billion in new Federal revenue into
14 Alaska over the first five years; and

15
16 WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion
17 more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic
18 activity throughout the State; and

19
20 WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using
21 Federal funds to pay for health services currently paid for with State general funds; and,

22
23 WHEREAS, Federal funds will pay for 100% of services provided to the expansion
24 population through 2016 and will transition to 90% in 2020 and beyond; and

25
26 WHEREAS, the State's continued participation is contingent upon maintaining the
27 90% match; and

28
29 WHEREAS, Medicaid expansion will significantly reduce the burden of
30 uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013;
31 and

32
33 WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid
34 reform; and

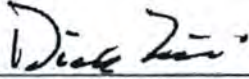
35
36 WHEREAS, leveraging the Federal resources that come with expansion is the
37 State's biggest opportunity to finance reform efforts; and
38

1 WHEREAS, the State has the option of various Medicaid expansion demonstration
2 projects it may also consider as part of reform.
3

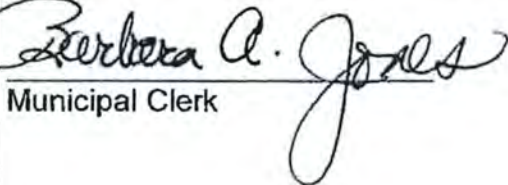
4 NOW, THEREFORE, the Anchorage Municipal Assembly resolves:
5

6 That the Alaska State Legislature is urged to expand Medicaid for the benefit of
7 Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts
8 should be of utmost importance, this work should not delay health care coverage for those
9 Alaskans who would be eligible for Medicaid under expansion, recognizing that we all have
10 an interest in ensuring that Alaskans are as productive as possible so they can contribute
11 to our communities and economy.
12

13 PASSED AND APPROVED by the Anchorage Assembly this 3rd day of
14 March, 2015.
15

16 
17 _____
18 Chair of the Assembly
19

20 ATTEST:

21 
22 _____
23 Municipal Clerk
24

Resolution 15-01

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100 percent of services provided to the expansion population through 2016 and will transition to 90 percent in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90 percent match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

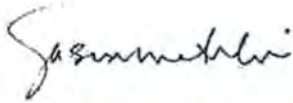
WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, The ANCSA Regional Association endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that the ANCSA Regional Association strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

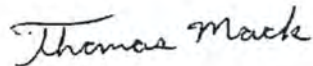
ADOPTED AND DATED THIS 10th DAY OF MARCH, 2015 BY THE ANCSA REGIONAL ASSOCIATION BOARD OF DIRECTORS.



Jason Metrokin, Chairman of the Board

3.10.15
Date

ATTEST:



Thomas Mack, Secretary

3.10.15
Date

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801

907.796.8900

www.bartletthospital.org

RESOLUTION OF THE BOARD OF DIRECTORS OF BARTLETT REGIONAL HOSPITAL

Serial No. 15-01

A Resolution Urging the Alaska Legislature to Expand Medicaid Coverage to Improve the Health of Alaskans and Alaska's Economy.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, approximately 2400 Juneau residents are eligible for coverage under expansion, and 1140 of those are expected to enroll; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, Juneau enrollees alone bring in \$8.3 million in just the first year; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, Medicaid currently accounts for 23% of Bartlett Regional Hospital's patient mix; and

WHEREAS, with expansion of Medicaid, the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds, reducing the need to cut public services; and

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Bartlett Regional Hospital suffers charity care and bad debt expenses of \$10-\$13 million per year; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and


NOW THEREFORE BE IT RESOLVED, BY THE BOARD OF DIRECTORS OF BARTLETT REGIONAL HOSPITAL, JUNEAU, ALASKA;

Section 1. Bartlett Regional Hospital endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

Section 2. Bartlett Regional Hospital strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Section 3. Effective Date. This resolution shall be effective immediately after its adoption.

Adopted this 24th day of November 2015.



Robert Storcr, Board Chair

HV



12-3-3 2015

March 6, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Bering Straits Native Corporation supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

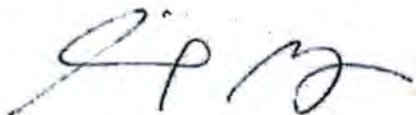
Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be

of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Bering Straits Native Corporation endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read 'G. Schubert', written in a cursive style.

Gail R. Schubert,
President & CEO



**Bristol Bay Area
Health Corporation**
8000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5201
FAX (907) 842-8354

*Bristol Bay Area Health
Corporation is a tribal
organization representing
34 villages in Southwest
Alaska:*

Aleknagik
Chignik Bay
Chignik Lagoon
Chignik Lake
Clark's Point
Dillingham
Egagik
Ekuk
Ekwook
Goodnews Bay
Igluqig
Ilamna
Ivanof Bay
Kanatak
King Salmon
Knugank
Kokhanok
Kolliganek
Lavelock
Manokotak
Naknek
New Stuyahok
Newhalen
Nondalton
Pedro Bay
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togalak
Twin Hills
Ugashik

*Our mission is to
provide health care
with competence
and sensitivity*

Via email and fax

March 13, 2015

The Honorable Governor Bill Walker
Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

The Bristol Bay Area Health Corporation a consortium of 34 tribes in southwest Alaska supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should

not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Bristol Bay Area Health Corporation endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

BRISTOL BAY AREA HEALTH CORPORATION



Robert J. Clark
President/Chief Executive Officer

cc: Commissioner Valerie Davidson
Alaska Native Health Board
BBAHC Executive Committee
BBAHC Division Managers
Representative Bryce Edgmon
Representative Lyman Hoffman
Senator Gary Stevens



BRISTOL BAY NATIVE ASSOCIATION

PO BOX 310 DILLINGHAM ALASKA 99576

PHONE: (907) 842-5257

TOLL FREE 1-800-478-5257

FAX: (907) 842-5932

FAX TRANSMISSION COVER SHEET

DATE: March 25, 2015

TO: Governor Bill Walker

FAX: (907) 465-3532

SENDER: Ralph Andersen

RE: Resolutions

Fax Received
MAR 25 2015
Office of the Governor

*Please receive
- 615
- Corshin
- Plowman
- Mar 25 2015*



12 PAGE (S), INCLUDING THIS COVER SHEET
If you do not receive all the pages please call

 HARD COPY WILL FOLLOW IN THE MAIL ON THIS DATE
 HARD COPY WILL NOT FOLLOW.

FOOD BANK
(907) 842-3663
1-888-918-3663
FAX: 842-1092

REALTY
(907) 842-5257
1-800-478-5257
FAX: 842-5939

SOCIAL SERVICES
(907) 842-4139
1-800-478-4139
FAX: 842-4106

HEAD START
(907) 842-4059
1-800-478-4059
FAX: 842-2338

BRISTOL BAY NATIVE ASSOCIATION

P.O. BOX 310
DILLINGHAM, ALASKA 99576
PHONE (907) 842-5257



Tribal Councils
Served by BBNA:

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clarks Point
- Curyung
- Egegik
- Elak
- Elceok
- Igloopig
- Iliamna
- Ivanof Bay
- Kawatac
- King Salmon
- Kotchanok
- Koliganak
- Laviook
- Manokotak
- Nainok
- New Smyrna
- Nuvahon
- Noodahon
- Pedro Bay
- Panville
- Pilot Point
- Port Heiden
- Portage Creek
- South Naknek
- Togiak
- Twin Hills
- Ugashik

March 25, 2015

State of Alaska
Governor Bill Walker
Third Floor, State Capitol
P.O. Box 110001
Juneau, Alaska 99811-0001

Dear Governor Walker:

Via Fax - 465-3532

Enclosed please find resolutions:

- 2015-02 • 2015-03 • 2015-07 • 2015-08 • 2015-11

These resolutions were passed during the Full Board of Directors meeting of the Bristol Bay Native Association, March 18-20, 2015. BBNA, the regional non-profit for the Bristol Bay region, represents 31 tribes.

These resolutions represent a formal statement of considered opinion, intent, and resolve of the Association and its tribes. We have taken this action out of concern for our social, economic, and cultural well-being. We communicate these resolutions to inform you of our position and to earnestly solicit your assistance in our efforts.

Sincerely,

BRISTOL BAY NATIVE ASSOCIATION

Ralph Andersen
Ralph Andersen
President & CEO

Enclosure(s)

BRISTOL BAY NATIVE ASSOCIATION
P.O. BOX 310
DILLINGHAM, ALASKA 99576
(907) 842-5257
By the Full Board of Directors

Resolution 2015 - 02

A RESOLUTION URGING THE ALASKA STATE LEGISLATURE TO ENACT HOUSE BILL 148, GOVERNOR WALKER'S MEDICAID EXPANSION BILL

WHEREAS: The Bristol Bay Native Association (BBNA) is a regional Alaska Native non-profit corporation and tribal consortium serving 31 tribal communities in the Bristol Bay Region of Alaska; and

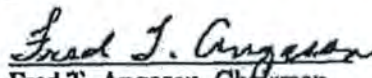
WHEREAS: On March 17, 2015 Governor Bill Walker transmitted to the Alaska State Legislature HB 148, a bill that would expand Medicaid to Alaskans who earn \$20,314 per year or less or married couples who earn \$27,490 or less, and makes various reforms to the Medicaid program in Alaska;

WHEREAS: The expansion of Medicaid would benefit an estimated 42,000 people, while bringing in \$146 million in new federal money in 2016 and subsequent years and generating an estimated 4,000 jobs and \$1.2 billion in wages and salaries, while actually reducing the state's general fund budget by \$6.5 million; and

WHEREAS: Many of the beneficiaries of the Medicaid expansion are Alaska Natives who are otherwise completely dependent on the under-funded Indian Health Service system for health care, and the Medicaid expansion will be a significant source of new third-party revenues for tribal health providers operating IHS programs;

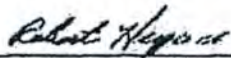
WHEREAS: Although the State of Alaska will have to assume 10% of the cost of the Medicaid expansion beginning in 2020, the additional cost will be more than offset by savings to the state and increased economic activity generated by the expansion;

NOW THEREFORE BE IT RESOLVED by the Bristol Bay Native Association Board of Directors that it urges the Alaska State Legislature to promptly enact House Bill 148, Governor Bill Walker's Medicaid expansion legislation.


Fred T. Angasan, Chairman

CERTIFICATION:

I, the undersigned Secretary of the Bristol Bay Native Association, Inc. do hereby certify that the foregoing resolution was passed by the Full Board of Directors of the Bristol Bay Native Association at a duly called and noticed meeting on the 20th day of March, 2015, and that a quorum was present.


Robert Heyano, Secretary



Enriching Our Native Way of Life

February 24, 2015

Governor Bill Walker
Alaska State Capitol Building
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker:

Bristol Bay Native Corporation (BBNC) supports Medicaid expansion. Medicaid expansion is critical to improving access to health care for thousands of Alaskans. Expansion will also bring the state close to a billion dollars in new federal spending over the short-term and will support programmatic reforms that will save the state additional Medicaid dollars over the long-term. Accordingly, BBNC encourages you to expand the Medicaid program.

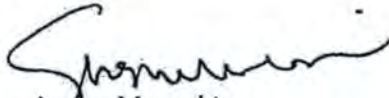
Studies suggest that expanding Medicaid will greatly reduce the number of uninsured Alaskans and will save lives - by some estimates 30 lives a year. Without insurance many individuals are forced to ignore health issues until they become unbearable and they are forced to seek care in an emergency room. Medicaid expansion will allow these individuals to seek medical attention much earlier and in a primary care setting.

Expansion will also increase the level of substance abuse treatment and care available to many Alaskans. A disproportionate number of Alaska Natives are incarcerated for offenses that are more often than not either directly or indirectly related to alcohol and substance abuse. While incarcerated individuals can often receive substance abuse treatment while they are in state custody, there is no continuing treatment available once these individuals are released. Medicaid expansion will increase the amount of drug and alcohol counseling available outside of incarceration and should reduce recidivism rates. This is of critical importance to rural Alaska.

Medicaid expansion also makes sense from a finance perspective. In 2011, Alaska hospitals provided 90 million dollars in uncompensated emergency room care. These are costs that the state's health care system had to absorb and spread to other patients (and their insurers) through higher health care rates. Other states that have expanded Medicaid have seen their uncompensated hospital costs fall by as much as 30%. Should Alaska hospitals see a similar reduction in uninsured costs, more than 10 million dollars per year in uninsured costs could be avoided.

Alaska currently faces numerous social and fiscal challenges. Medicaid expansion offers a rare opportunity to address one of the social challenges while also bringing new federal funding to the state. From this perspective, the decision to expand the state's Medicaid program should be any easy one. We encourage your administration to work with the legislature to get this important task completed. Alaska and Alaskans stand to benefit greatly.

Regards,

A handwritten signature in black ink, appearing to read "Jason Metrokin". The signature is fluid and cursive, with a prominent initial "J" and a long, sweeping underline.

Jason Metrokin
President & CEO



February 17, 2015

Governor Walker:

Cancer is the leading cause of death in Alaska, but there is good news: knowing what we know today, we could prevent half of all cancer deaths, saving over 300,000 lives annually in the US. Success on this scale will require the commitment of all levels of government and strong community and private sector support.

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. ACS CAN supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. We need your help.

We would like to draw your attention to two priority areas on the ACS CAN agenda this session:

- **100% Smoke-free Indoor Workplaces** ACS CAN strongly supports SB 1, protecting Alaskans from secondhand smoke in the workplace. Only half the state's population is currently protected by a smoke-free workplace ordinance. It is time for the legislature to act protect workers and patrons across the state from secondhand smoke and electronic cigarette aerosol.
- **Expanding Medicaid in Alaska** - ACS CAN supports the expansion of Medicaid eligibility in order to provide access to care that otherwise might not be accessible or affordable. Options like this increase the likelihood that cancers and other chronic diseases will be found at their earliest stages where treatment can be less costly and health outcomes greatly improved.

As these measures come before you in the Alaska Legislature, please consider our positions. We are always available as a resource to you and your constituents. Your vote can reduce the burden of cancer across our state. Together, we can and will save lives.

Sincerely,

A handwritten signature in cursive script that reads "Johna Beech".

Johna Beech
Volunteer State Lead Ambassador

American Cancer Society Cancer Action Network
3851 Piper Street, Suite U240, Anchorage, AK 99508

www.acscan.org/alaska



Catholic Social Services

OFFICE OF THE GOVERNOR
11.31

3710 East 20th Avenue, Anchorage, AK 99508 • (907) 222-7300 • Fax (907) 258-1091 • www.cssalaska.org

3-9-15

Brother Francis Shelter

Charlie Elder House

Clare House

Family Disability Services

Homeless Family Services

Pregnancy Support &
Adoption Services

Refugee Assistance &
Immigration Services

St. Francis House

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Catholic Social Services supports efforts to expand Medicaid in July 2015 for the benefit of Alaskans, in particular for the vulnerable Alaskans who we serve.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which is expected to bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. Medicaid expansion will serve as a catalyst for meaningful Medicaid reform.

Thank you for your thoughtful consideration on this issue. The mission of Catholic Social Services is to compassionately serve the poor and those in need; strengthen individuals and families; and advocate for social justice. We believe our support of Medicaid expansion speaks to every element of our mission.

Sincerely,

Lisa D.H. Aquino, MHS
Executive Director

*Providing Help
Creating Hope*





CITY OF BARROW

"Farthest North Incorporated City"

Fax Received
MAR 28 2015
Office of the Governor

PRIORITY IMPORTANCE

28 March 2015

Governor Bill Walker
State Capitol
PO Box 10000
Juneau, AK 99801-0001

Via FAX 907-485-2882

SUBJECT: City of Barrow Resolution in Support of Medicaid Expansion

Good afternoon, Governor Walker

Attached is a copy of City of Barrow Resolution 15-2015, "*A Resolution of the Barrow City Council Encouraging and Supporting the State Legislature to Expand Medicaid Coverage to Improve the Health of Alaskans and to Improve the Alaskan Economy*". The resolution was thoroughly discussed and vetted with community members prior to its adoption. All were completely in support of the resolution with not one dissenting voice being heard.

It was unanimously adopted by the City Council this past Thursday evening. I apologize for sending this to you just prior to the House Health and Social Services Committee hearing on HB 149 this afternoon. Even though the resolution was passed this past Thursday evening, I was unable to have the resolution formally attested to and stamped until about ten minutes ago. I have been unexpectedly and ridiculously short staffed for the past few weeks for a variety of reason.

I hope that it arrives in sufficient time for your staff to distribute it prior to the meeting of the House Health and Social Services Committee. I may and may not be able to personally call in for the meeting depending on the resolution of some tenuous issues.

Sincerely,

Bob Harcharik
Mayor

Cc: Barrow City Council
files



CITY OF BARROW

"Farthest North Incorporated City"

RESOLUTION 15-2015

A RESOLUTION OF THE BARROW CITY COUNCIL ENCOURAGING AND SUPPORTING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY

WHEREAS, nearly forty one thousand Alaskans - our family members, friends and neighbors currently without health insurance have the opportunity to obtain health care coverage through the expansion of Medicaid; and

WHEREAS, Medicaid expansion will improve the overall health of the residents of our State by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment, mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion will bring more than One Billion Dollars in new federal revenue into Alaska over the first five years of its implementation; and

WHEREAS, economic analyses suggest that expansion will yield approximately 4,000 new jobs in Alaska, an increase of more than One Million Dollars in wages and salaries paid to Alaskans, and Two and One-Half Billion Dollars in increased economic activity throughout the State; and

WHEREAS, in this period of reduced and declining oil generated revenues, expansion of Medicaid would save the State approximately Six Million Dollars in FY2016 by using federal funds to pay for health services currently being paid with state general funds; and

WHEREAS, federal funds will pay for 100% of the services provided in the expansion of Medicaid through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, Medicaid expansion will significantly reduce the burden to the State of paying for the uncompensated care rendered at non-native Alaska hospitals, which in 2013 exceeded \$90 million; and

WHEREAS, implementing Medicaid expansion throughout Alaska in the next fiscal year will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is one of the State's greatest opportunity to facilitate its finance reformation efforts; and

WHEREAS, the State has the option of implementing segments of numerous Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, that the Barrow City Council endorses Medicaid expansion, recognizing that we all have a vested interest in ensuring that Alaskans are as healthy and as productive as possible so they can all contribute to our communities and to the economy of the State of Alaska; and

BE IT FURTHER RESOLVED, that the Barrow City Council, through a unanimous vote, hereby formally requests the Alaska State Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

PASSED AND APPROVED UNANIMOUSLY BY THE BARROW CITY COUNCIL THIS 26th DAY OF MARCH 2015.

Attest:



Bob Harcharek

Bob Harcharek, Mayor

Aolele Poe

Aolele Poe, City Clerk



Congregation Sukkat Shalom "Shelter of Peace"

A RESOLUTION URGING THE ALASKA LEGISLATURE TO IMPROVE THE HEALTH AND WELL BEING OF ALASKANS, ALLOWING THEM BENEFITS SHARED BY OUR MEMBERSHIP AND THE MEMBERSHIP OF THE ALASKA LEGISLATURE BY EXPANDING MEDICAID

WHEREAS the Jewish virtue of "tikkun olam", repairing our world, calls upon us to fix the injustice of inequality and suffering; and

WHEREAS, the Jewish tradition of "tzedakah", giving to others less fortunate, is not considered charity but "the right thing to do"; and

WHEREAS, the majority of the membership of our congregation and the entire membership of our State Legislature are blessed with the benefit of insurance coverage so that we have access to preventive and healing health care for our families and our children; and

WHEREAS, we have knowledge that tens of thousands of Alaskans do not share our same access to health care; and

WHEREAS, nearly 42,000 other Alaskans would have the opportunity to gain health care coverage under Medicaid expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the numbers of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion would help Alaska economically by bringing in over \$1 billion in new federal revenue over the first five years; and

WHEREAS, the State would save \$6.1 million in 2016 by using federal funds to pay for health services currently paid for with state general funds; and

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond;

THEREFORE BE IT RESOLVED, as an act of "tikkun olam", healing the world, Congregation Sukkat Shalom urges Medicaid expansion in Alaska and deems it imperative that the Alaska Legislature expands Medicaid to take effect in July, 2015.

3/16/15

211 Cordova St. ✧ PO Box 22071 ✧ Juneau, AK 99802



March 9, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

RE: CIRI Support for Medicaid Expansion

Dear Governor Walker,

I am writing on behalf of Cook Inlet Region, Inc. (CIRI) to express support for your efforts to expand Medicaid in July 2015. CIRI believes Medicaid expansion provides an important opportunity to invest in the health of Alaskans and the health of our state's economy.

Medicaid expansion will give nearly 42,000 of our fellow Alaskans access to health care coverage that is otherwise unavailable to them. Expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, increase preventative and primary care access and provide substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion that will positively impact our state's economy, at a time we are faced with declining oil prices and the resulting budget challenges. It is estimated that Medicaid expansion will bring in more than \$1 billion in new federal revenue to our state, driving some 4,000 new jobs, \$1.2 billion in wages and salaries and \$2.49 billion in increased economic activity over the first five years. In addition to new revenue, the state budget will realize significant savings as well.

Medicaid expansion also will serve as a catalyst for meaningful Medicaid reform. We recognize that the state must do things differently to make Medicaid sustainable and are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. However, reform of the current program should not delay access to health care coverage for those Alaskans who would be eligible under Medicaid expansion.

CIRI endorses Medicaid expansion and believes that healthy Alaskans are productive Alaskans who will, in turn, contribute to the health of our communities and economy as a whole.

Sincerely,

Cook Inlet Region, Inc.

Sophie Minich
President and Chief Executive Officer

FYI LO
HV
Becca
Grace
Kate M

P.O. Box 218
Dillingham, AK 99576
Phone: (907) 842-2384/4508/2544/3363/1751
Fax: (907) 842-4510

Curyung Tribal
Council

Fax

To: Office of the Governor From: CM

Fax: 907-269-7461 Pages: 3

Phone: _____ Date: 3/19/15

Re: Resolution of Support CC: _____

Urgent For Review Please Comment Please Reply Please Recycle

• Comments

APR 21 2015

____ The original of this fax will be mailed on ____/____/____.

____ The original of this fax will not be mailed (unless specifically requested).



Curyung Tribal Council
PO Box 216 • 531 D Street
Dillingham, Alaska 99576
Phone: (907) 842-2384
Fax: (907) 842-4510

Curyung Tribal Council
Resolution 2015-09

**TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO
 EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF
 ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY**

- WHEREAS:** the Curyung Tribal Council is the federally recognized Alaska Native tribe serving its tribal members and the community of Dillingham; and
- WHEREAS:** Curyung Tribal Council, acting as the duly recognized governing body pursuant to the Constitution of Curyung, has the authority of establishing relationships and entering into contracts for the benefit and well-being of the Tribe; and
- WHEREAS:** nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and
- WHEREAS:** Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and
- WHEREAS:** Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and
- WHEREAS:** studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and
- WHEREAS:** with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,
- WHEREAS:** federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and
- WHEREAS:** the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS: Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS: Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS: leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS: the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, Curyung Tribal Council endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that Curyung Tribal Council strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

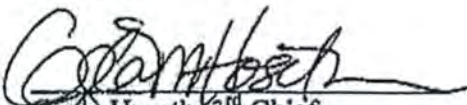
CERTIFICATION:

This resolution was duly considered and adopted by the Curyung Tribal Council in Dillingham, Alaska on March 18, 2015 at which a quorum of Council members were in attendance.

For <u>17</u>	Against <u>0</u>	Abstain <u>0</u>
Present <u>17</u>	Absent <u>0</u>	


Thomas Tilden, 1st Chief

ATTEST:


Gayla Hoseth, 3rd Chief



March 6, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

This letter is written on behalf of Doyon, Limited as a statement of support for your efforts to expand Medicaid for the benefit of Alaskans and the Alaska economy.

Doyon's mission is to continually enhance its position as a financially strong Native corporation in order to promote the economic and social well-being of its shareholders and future shareholders, to strengthen its Native way of life, and to protect and enhance its land and resources.

Through Medicaid Expansion, over 40,000 of our fellow Alaskans will be eligible for health coverage. This improves health outcomes by reducing the number of uninsured, improves preventative and primary care access, and provides substance abuse treatment and mental health counseling.

Medicaid expansion also provides significant associated economic benefits, including but not limited to more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years.

Doyon, Limited endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy. Again, thank you for the work you are doing on behalf of all Alaskans. If you have any questions regarding this letter, please do not hesitate to contact me at (907) 459-2000.

Sincerely,

Aaron M. Schutt
President and CEO



April 3, 2015

Alaska State Legislature
State Capitol Building
Juneau AK 99801

Dear Legislators,

As the President/CEO of Fairbanks Economic Development Corporation (FEDC) I am writing you in support of HB 148 and SB 78. Alaska, and particularly Alaskans, is in troubling economic times and all reasonable measures should and must be taken to assure our citizens' continued economic and personal well-being. Expansion of Medicaid can immediately extend access to health insurance for an estimated 42,000 low-income Alaskans. Support of Medicaid Expansion not only provides a safety net to our most economically vulnerable Alaskans, it also provides Alaska with an estimated additional \$1.1 billion in Federal Revenue.

That additional Federal Revenue will create approximately 4,000 jobs and help reduce the State budget by \$6 million. Support of this legislation is a win for Alaskans and a win for Alaska. On behalf of the FEDC staff and our Board of Directors, I am asking for your support for HB 148 and SB 78.

Thank you for your consideration,

Jim Dodson
President & CEO
Fairbanks Economic Development Corporation



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of
Health and Social Services**

GOVERNOR'S COUNCIL ON DISABILITIES
& SPECIAL EDUCATION
Patrick Reinhart, Executive Director

3601 C Street, Suite 740
Anchorage, Alaska 99503-5924
Main: 907.269.8990
Toll Free: 1.888.269.8990
Fax: 907.269.8995

Resolution 101

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, the Governor's Council on Disabilities and Special Education endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that the Governor's Council on Disabilities and Special Education strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

RESOLUTION OF THE EXECUTIVE COMMITTEE

OF THE

**THE GREATER FAIRBANKS COMMUNITY HOSPITAL FOUNDATION,
INCORPORATED**

RESOLUTION 2013-5

WHEREAS The Greater Fairbanks Community Hospital Foundation, Incorporated ("Fairbanks Hospital Foundation") is the owner of Fairbanks Memorial Hospital, which is operated by Banner Health.

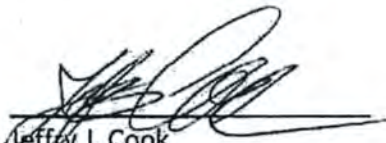
WHEREAS the Fairbanks Hospital Foundation was established to ensure that Fairbanks never again face the prospect of a community without health care by providing outstanding medical facilities and technology; overseeing an excellent operator; creating an environment that attracts quality, caring physicians who wish to be part of the community and; creating partnerships to deliver quality patient care.

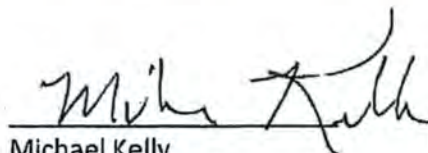
WHEREAS it is the belief of the Fairbanks Hospital Foundation that the Medicaid Expansion would provide underserved patients access to healthcare, thereby increasing the quality of care to the Fairbanks community and Interior Alaska.

WHEREAS the Fairbanks Hospital Foundation recognizes the complexities of the Affordable Care Act and the challenges the Governor and State of Alaska Legislature face in navigating what is best for Alaska, but they also believe that the Governor and the State of Alaska Legislature can and will accomplish a solution.

THEREFORE the Executive Committee of the Fairbanks Hospital Foundation requests that the Governor and State of Alaska Legislature consider adopting a Medicaid Expansion plan using tailored approaches that they feel best meet the needs of the Alaskan people, thereby providing underserved patients access to healthcare.

The foregoing resolution was adopted by the Executive Committee at a regularly scheduled meeting on October 10, 2013.


Jeffrey J. Cook
President


Michael Kelly
1st Vice-President

Presented by: The Manager
Introduced: 03/16/2015
Drafted by: A. G. Mead

RESOLUTION OF THE CITY AND BOROUGH OF JUNEAU, ALASKA

Serial No. 2724

A Resolution Urging the Alaska Legislature to Expand Medicaid Coverage to Improve the Health of Alaskans and Alaska's Economy.

WHEREAS, nearly 42,000 of our family members, friends and neighbors statewide have the opportunity to gain health care coverage under Medicaid expansion; and

WHEREAS, approximately 2,400 Juneau residents are eligible for coverage under Medicaid expansion, and 1,140 of those are expected to enroll; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, Juneau enrollees alone bring in \$8.3 million in just the first year; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the State; and

WHEREAS, Medicaid currently accounts for 23% of Bartlett Regional Hospital's patient mix; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds, reducing the need to cut public services; and

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Bartlett Regional Hospital suffers charity care and bad debt expenses of \$10 - \$13 million per year; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform.

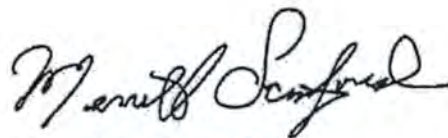
NOW, THEREFORE, BE IT RESOLVED BY THE ASSEMBLY OF THE CITY AND BOROUGH OF JUNEAU, ALASKA:

Section 1. The City and Borough of Juneau endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Section 2. The City and Borough of Juneau strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, while reform efforts are of tremendous importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

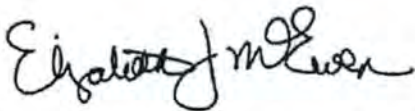
Section 3. Effective Date. This resolution shall be effective immediately after its adoption.

Adopted this 16th day of March, 2015.



Merrill Sanford, Mayor

Attest:



Elizabeth J. McEwen, Acting Clerk





JEDC.org

612 West Willoughby Ave. Suite A

Juneau, AK 99801

Phone 907-523-2300

Fax 907-463-3929

April 6, 2015

**The Honorable Governor Bill Walker
Alaska State Capitol
Juneau, Alaska 99801-1182**

Dear Governor Walker:

The Juneau Economic Development Council Board of Directors strongly urges support for legislation to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling. There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years.

We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges. According to data from the Bureau of Labor Statistics, healthcare and social assistance jobs grew over 30% faster between December 2013 and December 2014 for 24 states that implemented Affordable Care Act expansion on Jan. 1, 2014 than those that did not. Fitch Ratings says "...it could support a broader economic and tax base for state budgets and improve nonprofit hospital finances in those states."

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.



JEDC.org

612 West Willoughby Ave. Suite A

Juneau, AK 99801

Phone 907-523-2300

Fax 907-463-3929

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Juneau Economic Development Council Board of Directors recognizes the economic benefits associated with the Medicaid expansion in Alaska and thanks you for your efforts on behalf of Alaskans and our economy.

Sincerely,

Brian Holst
Executive Director
Juneau Economic Development Council

DRAFT



Juneau Tlingit & Haida Community Council
P.O. Box 020770, Juneau, Alaska 99802
Physically located at: 3235 Hospital Drive, Juneau, AK 99801



A T & H Community of the Central Council of Tlingit and Haida Indian Tribes of Alaska

Resolution 02-2015

**A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID
COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE
ALASKAN ECONOMY**

WHEREAS, Central Council Tlingit & Haida Indian Tribes of Alaska (Central Council) is a federally recognized tribe of more than 28,000 tribal citizens; and

WHEREAS, the Juneau Tlingit & Haida Community Council (JTHCC) is a federally recognized tribal political subdivision and subordinate entity of Central Council Tlingit & Haida Indian Tribes of Alaska. The JTHCC tribal member enrollment as of January 2015 is 6,746;

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

WHEREAS, Medicaid reform and expansion will provide for underserved tribal members: children in need of aid, pregnancies and birthing, people in prisons, mentally ill persons and veterans; and

NOW THEREFORE BE IT RESOLVED, that Juneau Tlingit & Haida Community Council endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED that Juneau Tlingit & Haida Community Council strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Passed and approved this 12th day of March 2015, at Juneau, Alaska.

X APPROVED _____ DISAPPROVED _____ TABLED

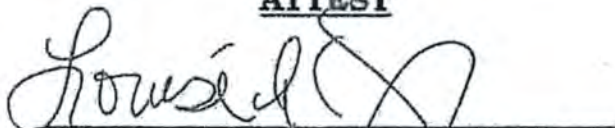
26 AYES _____ NAYS 19 ABSENT

CERTIFY



JTHCC President Janice L Hotch

ATTEST



JTHCC Secretary Louise Kadinger

Introduced by: Smith, Mayor
Date: 02/05/13
Action: Adopted
Vote: 8 Yes, 0 No, 1 Absent

**KENAI PENINSULA BOROUGH
RESOLUTION 2013-014**

**A RESOLUTION REQUESTING THE STATE OF ALASKA ADMINISTRATION AND
ALASKA STATE LEGISLATURE FULLY CONSIDER THE BENEFITS TO THE
RESIDENTS AND BUSINESSES OF THE KENAI PENINSULA BOROUGH WHEN
CONSIDERING THE EXPANSION OF MEDICAID UNDER THE AFFORDABLE
CARE ACT**

WHEREAS, the Affordable Care Act provides for expansion of Medicaid benefits by increasing the eligibility income level; and

WHEREAS, significant numbers of Kenai Peninsula Borough residents would become newly eligible for benefits if the State opted to agree to the Medicaid expansion; and

WHEREAS, the increase in eligible beneficiaries would provide increased care and improved health for many borough residents; and

WHEREAS, borough hospitals would see an increase in reimbursed care and a decrease in charity care; and

WHEREAS, other health care providers would see a similar benefit; and

WHEREAS, the increase in Medicaid funding would provide better health for our residents and an economic boost to the borough; and

WHEREAS, a preliminary evaluation by Northern Economics predicts for each \$1 in State funding related to Medicaid expansion, \$15.5 in new federal funds will be generated; and

WHEREAS, the evaluation also finds a net reduction of State costs because increased Medicaid eligibility will displace other costs borne by the State;

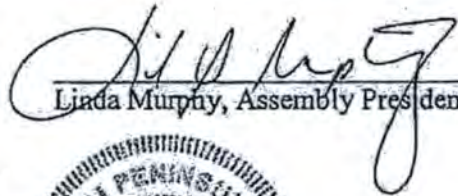
NOW, THEREFORE, BE IT RESOLVED BY THE ASSEMBLY OF THE KENAI PENINSULA BOROUGH:

SECTION 1. That the Kenai Peninsula Borough Assembly requests the State of Alaska Administration and the State Legislature to weigh heavily the great benefits that would accrue to the residents of the borough and to the borough economy while deciding whether to expand our Medicaid program.

SECTION 2. That copies of this Resolution be provided to Governor Sean Parnell and all members of the Legislature representing the Kenai Peninsula Borough.

SECTION 3. That this resolution takes effect immediately upon its adoption.

ADOPTED BY THE ASSEMBLY OF THE KENAI PENINSULA BOROUGH THIS 5TH DAY OF FEBRUARY, 2013.



Liada Murphy, Assembly President

ATTEST:



John Blankenship, MMC, Borough Clerk



Yes: Haggerty, Johnson, McClure, Pierce, Smith, Tauriainen, Wolf, Murphy
No: None
Absent: Smalley



KENAITZE
INDIAN
TRIBE

WWW.KENAITZE.ORG

PHONE: (907) 335-7200 • FAX: (907) 335-7239

P.O. Box 988 • KENAI, AK 99611

March 13, 2015

The Honorable Bill Walker
Governor of Alaska
P.O. Box 110001
Juneau, AK 99811-001

Dear Governor Walker;

The Kenaitze Indian Tribe supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Kenaitze Indian Tribe endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

Rosalie Tepp
Chairperson

AV
OMIB

KODIAK
AREA
NATIVE
ASSOCIATION

HU
OMB

3449 Rezanof Drive East
Kodiak, Alaska 99615
Phone 907.486.9800
www.kanaweb.org

1 100 001
1 100 001

MR 15 20

March 11, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Kodiak Area Native Association (KANA) supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support your position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Kodiak Area Native Association endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "Andy Teuber". The signature is fluid and cursive, with a prominent flourish at the end.

Andy Teuber
President and CEO

Cc: Commissioner Valerie Davidson, Alaska DHSS
Monique Martin, Alaska DHSS



The League of Women Voters

A Voice For Citizens, A Force For Change

P.O. Box 90079, Anchorage, AK 99509-0079

March 9, 2015

OFFICERS

Dear State of Alaska Legislators:

President

Pat Redmond

Vice-President

Carol Dickason

Past President

Linda Witt

Treasurer

Shari George

Secretary

Hetty Barthel

DIRECTORS

Judy Andree

Gail Knopf

Diane Mathisen

Marianne Mills

Lois Pillifant


The League of Women Voters of Alaska fully supports the expansion of Medicaid. The League of Women Voters of the United States (LWVUS) has long fought for basic health care for all citizens, stating the following in their Position Statement on Health Care: "Every U. S. resident should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care." The League also supports cost control efforts for health care that would go hand-in-hand with universal coverage as well as equity in the allocation of health care resources.


The State of Alaska has an opportunity to expand Medicaid at no immediate cost to the State through the federal Affordable Care Act. Reports from Alaska's own Department of Health and Social Services state that an expanded Medicaid program would save the State millions of dollars in Medicaid payments, reduce the number of missed work days, and bring 4000 new jobs to the State. These new jobs would come with \$1.2 billion in wages. All of these projections bring positive results to the citizens of Alaska. Expanding Medicaid seems like a wise choice for the entire State.

In addition, expansion of Medicaid would help up to 42,000 of the State's most vulnerable citizens. There is no more honorable cause for a free and democratic government than to assist the most vulnerable of its citizens. We urge all Senators and Representatives to expand access to quality health care for all Alaskans through Medicaid expansion. We are attaching the full LWVUS Position Statement for your reference.

Thank you for your service to Alaska.

Sincerely,


Pat Redmond, President
League of Women Voters of Alaska


Judy Andree, Chair
LWVAK Legislative Action

cc: Governor Bill Walker, Lt. Governor Byron Mallott, DHSS Commissioner Valerie Davidson

The League of Women Voters of the United States: Position on Health Care

GOALS: The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

BASIC LEVEL OF QUALITY CARE: Every U.S. resident should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care. Dental, vision and hearing care also are important but lower in priority. The League believes that under any system of health care reform, consumers/patients should be permitted to purchase services or insurance coverage beyond the basic level.

FINANCING AND ADMINISTRATION: The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums. As the United States moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable to the League. The League supports administration of the U.S. health care system either by a combination of the private and public sectors or by a combination of federal, state and/or regional government agencies. The League is opposed to a strictly private market-based model of financing the health care system. The League also is opposed to the administration of the health care system solely by the private sector or the states.

TAXES: The League supports increased taxes to finance a basic level of health care for all U.S. residents, provided health care reforms contain effective cost control strategies.

COST CONTROL: The League believes that efficient and economical delivery of care can be enhanced by such cost control methods as:

- △ the reduction of administrative costs,
- △ regional planning for the allocation of personnel, facilities and equipment,
- △ the establishment of maximum levels of public reimbursement to providers,
- △ malpractice reform,
- △ the use of managed care,
- △ utilization review of treatment,
- △ mandatory second opinions before surgery or extensive treatment,
- △ consumer accountability through deductibles and copayments.

EQUITY ISSUES: The League believes that health care services could be more equitably distributed by:

- △ allocating medical resources to underserved areas,
- △ providing for training health care professionals in needed fields of care,
- △ standardizing basic levels of service for publicly funded health care programs,
- △ requiring insurance plans to use community rating instead of experience rating,
- △ establishing insurance pools for small businesses and organizations.

ALLOCATION OF RESOURCES TO INDIVIDUALS: The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of health care resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

(Source: League of Women Voters of the United States. Impact on Issues: 2012-2014. Online.
<http://lwv.org/content/health-care>)

HV

GOVERNOR
2001

1-9 2015

March of Dimes Foundation

Alaska Chapter
3209 Denali Street, Suite 200
Anchorage, AK 99503
Telephone (907) 276-4111
Fax (907) 276-3375
dgolden@marchofdimes.com

marchofdimes.com/alaska

Debbie Golden
Director of Program Services

December 29th, 2014

The Honorable Bill Walker
Office of the Governor
PO Box 110001
Juneau, Alaska 99811-0001

Dear Governor Walker:

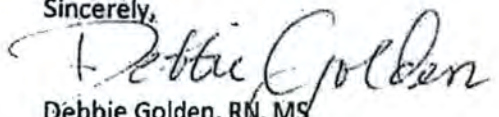
On behalf of the Alaska Chapter March of Dimes, I would like to thank you for making Medicaid expansion a priority for your administration. The mission of the March of Dimes is to improve the health of all children by preventing birth defects, preterm birth and infant mortality. We are thankful for this and other opportunities to improve the health of pregnant women and babies.

Another important aspect of our work is newborn screening. During the 2003 and 2004 legislative session, Alaska March of Dimes led the effort – with technical assistance from the Alaska Division of Public Health (ADPH) – that resulted in mandatory newborn hearing screening for all Alaska babies. In the spring of 2015, I have been told the ADPH will add screening for an important condition called Severe Combined Immunodeficiency (SCID) to the newborn metabolic screening panel. SCID is a term used to describe a group of rare inherited disorders which makes affected infants more susceptible to infection. With newborn screening, SCID can be identified early, and infants can be treated and survive. We commend ADPH for taking steps to implement this important addition to newborn screening.

In November, March of Dimes released the annual Premature Birth Report Card. The early birth of a baby has huge human and financial costs. We are disheartened to see that Alaska's grade went from an A in 2012 to a B in 2013. March of Dimes and ADPH staff are in regular communication and will continue to partner to address the problem of premature birth.

Again, thank you for already setting things in motion to improve the health of Alaska's babies and families! I look forward to continuing the strong partnership between State of Alaska and March of Dimes. Please do not hesitate to contact me if you have any questions.

Sincerely,



Debbie Golden, RN, MS
Director of Program Services





Medicaid Expansion and Reform: Impact on the Mat-Su

The Mat-Su Health Foundation Board supports:

- Using Medicaid expansion dollars as a catalyst to reform Medicaid to control costs and make the program more sustainable.
- Designing Alaska's Medicaid expansion as a path to self-sufficiency for individuals to ensure they enter or remain in the workforce.
- Building an "opt out" provision into State statute if the federal government reneges on its obligations.
- Expanding Medicaid to cover more Mat-Su residents so they can access care in more cost-effective ways to lead more productive lives.

The Mat-Su economy will benefit greatly from Medicaid expansion:

- Medicaid expansion will bring \$20 million in new federal revenue annually to Mat-Su.
- Medicaid expansion will lead to 72 new jobs and \$1.3 million more in wages and salaries.

The health insurance coverage gap affects Mat-Su disproportionately:

- 20% Mat-Su residents do not have health insurance, as compared to 15% of Anchorage residents and 17% of people statewide.

Mat-Su residents are more likely to be uninsured if they:

- Are white;
- Under the age of 45;
- Have a low income;
- Have not gone to college; and,
- Live in a rural part of the Borough.

Of Mat-Su residents eligible under expanded Medicaid:

- About 2000 Mat-Su residents are employed
- About 1000 Mat-Su residents are "not in the workforce," meaning they may be in school, raising a family, or retired
- Approximately 250 Mat-Su residents are unable to work
- Around 1,400 Mat-Su residents are in the labor force looking for work or seasonally employed

As many as 4,800 Mat-Su residents will be eligible for basic health care coverage if Medicaid is expanded:

- About 1,400 are between the ages of 55 and 64.
- About 1,100 age 45-54.
- About 500 age 35-44.
- About 1,500 age 19-34.

Both men and women fall in the coverage gap:

- 54% are men.

- 46% are women.

Faces of the Uninsured in Mat-Su:

John Doe: He is one of our neighbors who works several part-time jobs, none of which offer health insurance. His wages are less than 138% of the Federal Poverty Level, so he does not qualify for a subsidy to purchase insurance at healthcare.gov but is still legally required to have it or pay the penalty.

Jane Smith: She is a senior citizen who is not yet old enough to qualify for Medicare and Social Security benefits. She works at Mat-Su Senior Services, which does not provide health insurance. Like John, her wages are too low to get help buying an affordable plan in the insurance marketplace.

Jill Jones: She is a Mat-Su College student who has a part time job who is eligible to be on her parents' health insurance until age 26 – except that her parents have a small family construction business and they don't have insurance either.

Dave Green: He has worked in construction for 20 years, mostly for small firms. Last year, he fell off a roof and became critically injured. He didn't qualify for charity care at Mat-Su Regional because his income was too high the previous year. Now, he's try to get strong again so that he can work to pay back his hospital bill. With no current income, he does not qualify for a subsidy and cannot purchase insurance on the exchange.

All of these individuals will face a penalty for not having health insurance, yet none can afford to buy it. When they have a health crisis, they will either leave it untreated, or, when it gets bad enough, visit an emergency room. There, the cost of treatment will be much higher than it would have been if problems could have been addressed before they reached the crisis stage.

These stories can change with Medicaid expansion and reform.

- 4,800 Mat-Su residents will be eligible for basic health care coverage if Medicaid is expanded (40,000 statewide).

Sources: Mat-Su estimates for employment, age, and gender of potential new Medicaid enrollees were created using statewide data from the Evergreen Economic and the Department of Health and Social Services Healthy Alaska Plan and House Finance Budget Subcommittee FY2016 Division Overview report applied to the Mat-Su population. Data about how many Mat-Su residents have insurance and the characteristics of the uninsured if from the Behavioral Health Surveillance System State of Alaska, Division of Public Health.



Municipality of Skagway

GATEWAY TO THE KLONDIKE

P.O. BOX 415 SKAGWAY, ALASKA 99840

(PHONE) 907-983-2297 – Fax 907-983-2151

WWW.SKAGWAY.ORG

SENT VIA EMAIL

March 10, 2015

The Honorable Dennis Egan
Alaska State Senate
State Capitol Room 417
Juneau, AK 99801-1182
Senator.Dennis.Egan@akleg.gov

Dear Senator Egan:

The Municipality of Skagway strongly urges the Alaska Legislature to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic and Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health and Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

The Municipality of Skagway endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Schaefer". The signature is fluid and cursive, with the first name "Mark" being the most prominent.

Mark Schaefer
Borough Mayor

**A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE
THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY**

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, NAMI JUNEAU, the local affiliate of the National Alliance on Mental Illness, endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that NAMI JUNEAU strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Crystal Bourland, Executive Director

Telephone: (907) 463-4251 Fax: (907) 500-9914 Email: namijuneau@gmail.com

Address: 9000 Glacier Highway, Suite 201, Juneau, AK 99801-8032

March 6, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

NANA Regional Corporation supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

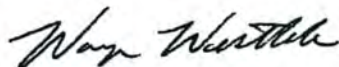
In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

NANA Regional Corporation endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,



Wayne Westlake
President/CEO



NEA-ALASKA

Affiliated with the National Education Association

March 16, 2015

Honorable Bill Walker
Governor, State of Alaska
PO Box 110001
Juneau, AK 99511-0001

Dear Governor Walker,

On behalf of Alaska's 13,000 education support professionals and teachers, in order to improve the health, safety, and well-being of our 130,000 public school students, I am writing to affirm NEA-Alaska's support of Medicaid expansion in Alaska.

Some may not see Medicaid expansion as an education issue. As someone who taught in our schools for over 30 years with some of Anchorage's most at-risk students, including at Clark Middle School and the McLaughlin Youth Center, I can tell you that the lack of access to quality, affordable healthcare in our communities directly impacts too many Alaskan children. When I taught at Clark and McLaughlin, I went to work every day to help as many of my students as possible to succeed and turn their lives around. I wish I could tell you that all of them did, but that is not the world we live in.

In 2014, NEA-Alaska partnered with the Anchorage Chamber of Commerce, Alaska PTA, United Way of Anchorage, Citizens for the Educational Advancement of Alaska's Children, and a number of other partners to commission a statewide study by Northern Economics on the social and environmental issues that are impacting student learning and achievement in Alaska. The results were clear: parents and teachers alike found that student learning was severely impacted by a number of issues outside the classroom, such as poverty, drug and alcohol abuse, and domestic violence. These issues leave children without safe and supportive home environments, which can lead to chronic absence, a lack of academic preparation, and low levels of student achievement.

Too many of my students had the deck stacked against them by these social and economic factors. Would Medicaid expansion solve all these issues? No, but it would surely help some of our most disadvantaged students. Medicaid expansion is no silver bullet, but it would reduce the number of uninsured Alaskans by half – extending health coverage to more than 40,000 low-income Alaskans. Many of these new enrollees will *not* have dependent children (some will, but many low-income children are already covered by Medicaid and Denali KidCare), but expanding health coverage in low-income communities and neighborhoods will improve the quality of life for all the children who live in them.

By most estimates, Medicaid expansion will bring \$1.1 billion in new federal revenue into Alaska. It will create 4,000 new jobs, \$1.2 billion more in wages and salaries, and \$2.49 billion in increased economic activity across Alaska. In addition, Medicaid expansion will create millions in cost savings for the state of Alaska at a time when we are searching for ways to close a projected \$3.5 billion budget deficit.

ANCHORAGE OFFICE • 4100 Spenard Road • Anchorage, Alaska 99517 • (907) 274-0536 • FAX: (907) 274-0551
JUNEAU OFFICE • 201 Main Street, Suite 300 • Juneau, Alaska 99801 • (907) 586-3090 • FAX: (907) 586-2744
FAIRBANKS OFFICE • 2118 S. Cushman Street • Fairbanks, Alaska 99701 • (907) 456-4435 • FAX: (907) 456-2159

Honorable Bill Walker
March 16, 2015
Page 2

As educators, we are deeply committed to the success of every one of our students. Medicaid expansion will be good for the state, it will be good for the economy, but for us this issue comes down to one simple statement: Medicaid expansion will be good for our students.

Thank you for taking action on one of the most important public policy issues that will affect Alaska's students this legislative session.

Sincerely,

A handwritten signature in black ink, appearing to read "Ron Fuhrer". The signature is written in a cursive style with a large initial "R".

Ron Fuhrer
President

cc: Alaska Legislature

fyi HU
LO
Berca
Grace
Natic
Paulette

Fax Cover Sheet

New Koliganek Village Council

P.O. Box 5057

Koliganek, AK 99576

Ph: 907-596-3434

Fax: 907-596-3462

e-mail: newkgkvc@hotmail.com

Send To: Paulette	From: NKUC
Attention:	Date: 3/20/15
Office Location:	Office Location:
Fax Number: 465-3532	Phone Number:

Total Pages, including cover:

3

Comments:

Resolution 2015- 02

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, New Koliganek Village Council endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that New Koliganek Village Council strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Passed and approved on the 19 day of March 2015.


Tribal Council President

Nondalton Tribal Council
P.O. Box 49
Nondalton, A.K. 99640
Ph. (907) 294-2257
Fax (907) 294-2271
nondaltontribe@yahoo.com

Resolution 03-05-15-1

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

- WHEREAS,** nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and
- WHEREAS,** Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and
- WHEREAS,** Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and
- WHEREAS,** studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and
- WHEREAS,** with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,
- WHEREAS,** federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and
- WHEREAS,** the State's continued participation is contingent upon maintaining the 90% match; and
- WHEREAS,** Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and
- WHEREAS,** Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, Nondalton Tribal Council endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that Nondalton Tribal Council strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

CERTIFICATION

This is to certify that the foregoing resolution was adopted by the Nondalton Tribal Council at a duly called regular meeting of the Nondalton Tribal Council and was adopted by a vote of 7 for, and 0 against with 0 abstention 0 absent, this 15th day of March, 2015.

William Evanoff
William Evanoff,
President

Kristy Jeffries
Kristy Jeffries,
Secretary

Nondalton Tribal Council
P.O. Box 49
Nondalton, A.K. 99640
Ph. (907) 294-2257
Fax (907) 294-2271
nondaltontribe@yahoo.com

March 3, 2015

The Honorable Lisa Murkowski
State Senate
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Murkowski,

Nondalton Tribal Council strongly urges the Alaska Legislature to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.


Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid

program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Nondalton Tribal Council endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,



William Evanoff,
President



Planned Parenthood Votes Northwest

Governor Bill Walker
Alaska State Capitol
Juneau, AK 99801

Re: Medicaid Expansion

March 18, 2015

Dear Governor Walker,

On behalf of Planned Parenthood Votes Northwest, I write today to thank you for your leadership and for introducing legislation to expand Medicaid in Alaska. As a healthcare provider that serves thousands of low-income women and men every year, we are keenly aware of the needs of vulnerable adults in Alaska.

Today, a childless adult without a disability making less than \$20,000 has no affordable health care coverage available. This has to change. We cannot continue to abandon our most vulnerable Alaskans. Expansion would bring nearly 42,000 people onto Medicaid, finally giving them access to preventive coverage like vaccinations, cancer screenings, and mental health services. What's more, the increase in healthcare usage will be an economic driver, creating thousands of jobs and generating billions in new wages and economic activity.

Medicaid expansion also gives Alaskans the opportunity to take entrepreneurial risks without the fear of losing insurance coverage. Expansion would ensure coverage for working adults while they look for work, start a business, or seek an education. Instead of worrying about how—or if—they can get health care, Alaskans can focus on building businesses, bettering themselves, and growing our economy.

With expansion, Alaskans who have been foregoing care to manage their high blood pressure so they can pay rent will no longer have to make that decision. Women who have put off their annual visits for years so they can afford bus fare can finally get cancer screenings. Our neighbors will no longer see the emergency room as their only health care option. Expansion gives us the opportunity to do what is right for all Alaskans.

We appreciate your leadership and hard work on bringing change to Alaska. We look forward to supporting your efforts to bring Medicaid to our most vulnerable Alaskans.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jessica Cler'.

Jessica Cler
Alaska Public Affairs Manager

Planned Parenthood Votes Northwest
4050 Lake Otis Parkway Suite 205 Anchorage, AK 99516
907.770.9705 | jessica.cler@ppvotessouthwest.org

RESOLUTION 2015-10

**A RESOLUTION OF THE ASSEMBLY OF THE CITY AND BOROUGH OF SITKA
URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO
IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE
THE ALASKAN ECONOMY.**

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, the Assembly of the City and Borough of Sitka endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

Resolution 2015-10

Page 2.

BE IT FURTHER RESOLVED, that the Assembly of the City and Borough of Sitka strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

PASSED, APPROVED AND ADOPTED by the assembly of the City and Borough of Sitka, Alaska on this 10th day of March 2015.


Matt Hunter, Deputy Mayor

ATTEST:


Colleen Ingman, MMC
Municipal Clerk



Resolution

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

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WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, Southeast Alaska Independent Living, Inc. (SAIL) endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that SAIL strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

A handwritten signature in black ink, appearing to read 'R. Purvis', is written over a horizontal line.

Robert J. Purvis, Board Chair
Southeast Alaska Independent Living, Inc. (SAIL)

03-13-15

Date

STATEWIDE INDEPENDENT LIVING
COUNCIL of ALASKA



Resolution

WHEREAS, with Medicaid expansion, over 40,000 Alaskans between the ages of 19 and 64 will have access to healthcare, and

WHEREAS, the Medicaid expansion would cut in half the number of uninsured Alaskan, and, at least 4,000 jobs will be generated, and more than a billion new federal dollars will be infused into the Alaska economy over the next five years, and

WHEREAS, the Medicaid expansion program will improve the numbers of Alaskans who have access to preventative and primary care; and

WHEREAS, the revamped system will ensure these individuals have access to appropriate levels of healthcare services in the most cost effective settings, to not only improve the quality of life for their families, but also reduce costs to the system, and

WHEREAS, studies show Medicaid expansion would result in a \$2.5 billion increase in economic activity throughout the state, and

WHEREAS, the same studies show there will be fewer lost work days and less employee turnover, and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, Statewide Independent Living Council of Alaska (SILC) endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that SILC strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Joan O'Keefe, Chair
Statewide Independent Living Council of Alaska

03-13-15
Date

SUPPORTING MEDICAID EXPANSION IN ALASKA
RESOLUTION NO. 2015-10

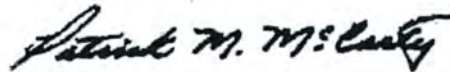
- WHEREAS,** the Affordable Care Act (ACA) provides states with additional funding to expand their Medicaid program to cover adults under the age of 65 and children under the age of 18 who live slightly above the federal poverty level; and
- WHEREAS,** the State of Alaska has chosen not to participate in Medicaid expansion; however, Governor Walker is seriously considering it; and
- WHEREAS,** Alaska's Medicaid program is unsustainable as currently designed and needs reform in order to best serve the health of Medicaid beneficiaries, operate more efficiently for providers, and improve value; and
- WHEREAS,** nearly 42,000 Alaskans, including almost 6,000 in the Interior, would be eligible for health coverage under Medicaid expansion in Alaska; and
- WHEREAS,** studies have shown that Medicaid expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling; and
- WHEREAS,** studies have also shown that there are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years; and
- WHEREAS,** Other benefits of Medicaid Expansion include bringing Alaska tax dollars back to Alaska and potentially stabilizing rising insurance premiums and medical prices by reducing uncompensated care that health providers currently provide to Alaskans with no insurance coverage.

NOW THEREFORE BE IT RESOLVED that the Tanana Chiefs Conference Full Board of Directors supports Medicaid expansion for Alaska.

CERTIFICATION

I hereby certify that this resolution was duly passed by the Tanana Chiefs Conference Full Board of Directors on March 18, 2015 at Fairbanks, Alaska and a quorum was duly established.

18



Pat McCarty
Secretary/Treasurer





RESOLUTION 2015-07

**TITLE: TANGIRNAQ NATIVE VILLAGE aka WOODY ISLAND TRIBAL COUNCIL
RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID
COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE
ALASKAN ECONOMY.**

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

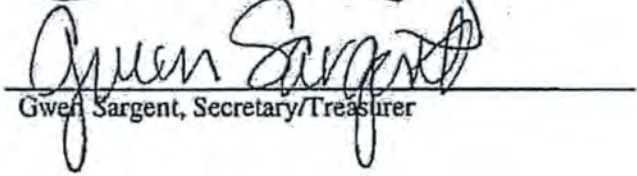
NOW THEREFORE BE IT RESOLVED, TANGIRNAQ NATIVE VILLAGE endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

CERTIFICATION

This resolution was duly adopted at a meeting of the Tangirnaq Native Village, aka Woody Island Tribal Council at which time a quorum of Council members were in attendance. This resolution was adopted by a vote of 6 for, 0 against, with 0 abstaining.

IN WITNESS THEREOF, and signed this 17 Day of March, 2015.


Chrislyn Hoen, Vice President


Gwen Sargent, Secretary/Treasurer



Woody Island Tribal Council

March 13, 2015

Office of Governor Bill Walker
Alaska State Capitol
PO box 110001
Juneau, Alaska 99811

Dear Governor Walker,

Tangirnaq Native Village, aka Woody Island Tribal Council, strongly urges the Alaska Legislature to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance

related to reform efforts. Though reform of the current Medicaid program should be of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Tangirnaq Native Village, aka Woody Island Tribal Council endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Stauffer", written over a horizontal line.

Robert Stauffer
Tribal Administrator
On behalf of Tribal Council
Resolution 2015-07

701 West 8th Avenue, Suite 230
Anchorage, Alaska 99501
tel 907.263.3800
fax 907.263.3801
www.unitedwayofanchorage.org

AV

FEB 17 2015



United Way of Anchorage

February 17, 2015

Governor Bill Walker
Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Thank you for your efforts to expand Medicaid in Alaska under the Affordable Care Act.

United Way of Anchorage has consistently supported Medicaid expansion. Access to health care is a core goal for us, and access to insurance coverage is a critical aspect of all Alaskans planning for and taking care of their health needs. To that end, UWA has served for two years as a navigator under the Affordable Care Act, and Alaska 2-1-1 has been a focal point for getting Alaskans connected with information and assistance for ACA and other enrollment opportunities.

Going forward, we appreciate that Medicaid expansion is not just a yes/no policy decision. It begins with that, certainly, but it will take a cross-sector, systematic approach to make it happen as smoothly as possible. We stand ready to assist you and the State.

Similarly, we offer you our partnership in helping improve other health and quality of life outcomes for Alaskans. In these tough financial times, we must break down the siloes among the sectors to join forces and resources around a shared vision for Alaskans to lead stable, healthy, and safe lives. Alaska 2-1-1 serves clients statewide, with over 3000 resources in the database, and robust provider partnerships throughout the state. That, coupled with United Way of Anchorage's focus on multi sector, data driven, results-focused collaboration, is a platform for the public private partnerships we all need to measurably improve the lives of Alaskans.

Best regards,

Michele Brown
President

cc Commissioner Valerie Davidson

LIVE UNITED™



1801 Salmon Creek Lane • Juneau, Alaska 99801
Phone: (907) 586-2434 • Fax: (907) 586-2416

Bob Urala, M.D.
Sharon Fisher, M.D.
Priscilla Valentine, M.D.
Lindy Jones, M.D.
Anyia Maier, M.D.
Richard Welling, M.D.
Joseph Roth, M.D.
Dorothy Hernandez, M.D.
Don Schneider, M.D.
Daniel Kim, M.D.
Taylor Dunn, M.D.
Justine Emerson, E.N.P.
Matthew Jones, E.N.P.
Rebecca Young, E.N.P.
Kim Gardner, E.N.P.
Tina Pleasants, E.N.P.
Rachel Gladhart, C.N.M.

Valley Medical Care Medicaid Expansion

TITLE: A RESOLUTION URGING THE ALASKA LEGISLATURE TO EXPAND MEDICAID COVERAGE TO IMPROVE THE HEALTH OF ALASKANS AND TO IMPROVE THE ALASKAN ECONOMY.

WHEREAS, Valley Medical Care is the largest primary care provider in Juneau, Alaska, comprised of 11 board certified Family Physicians and 6 advanced nurse practitioners; and

WHEREAS, On a daily basis we see the adverse health consequences Alaskans suffer from the lack of health care coverage; and

WHEREAS, nearly 42,000 of our family members, friends and neighbors have the opportunity to gain health care coverage under expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the state; and

WHEREAS, with expansion the state would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds; and,

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform; and

NOW THEREFORE BE IT RESOLVED, Valley Medical Care endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy; and

BE IT FURTHER RESOLVED, that Valley Medical Care strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, though reform efforts should be of utmost importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Don Schneider, MD
Valley Medical Care PC President



Declaration of Agreement

The undersigned, representing health and social service industries and key stakeholders in Alaska present this unified position regarding the goal of Coverage for All Alaskans. We agree to the purpose and principles declared herein, and will support each other as we work to achieve them through educational advocacy efforts.

We concur that the purpose of agreement is to advise and recommend to the Governor and Legislature of the State of Alaska to:

Fully leverage federal Medicaid Expansion dollar to cover uninsured Alaskans and to build a better Alaska health care delivery system.

The parties to this letter of agreement also concur to the following guiding principles on the operation and implementation of the development of the Alaska solution to achieve Coverage for All Alaskans:

1. All Alaskans will have access to basic health care coverage
 - Basic: defined as essential health benefits under the Affordable Care Act (ACA); including for Alaska: vision, dental and medically necessary travel.
2. Health care providers will receive reasonable and sustainable compensation for services provided
 - Providers include: health care professionals, licensed clinicians, health related entities and facilities.
3. Minimize uncompensated care that results in cost shifting
4. We support the Institute for Health Care Improvement's Triple Aim Framework: improve the health of the population served, enhance the patient care experience, affordability measured by the total cost.

The Coverage for All Alaskans Partnership is not a closed group and additional parties are encouraged to join by attesting to agree to the purpose and principles.

This letter of support was agreed by this group:

Alaska Primary Care Association, United Way of Anchorage, Effective Health Design, Catholic Social Services, Mountain-Pacific Quality Health Foundation, Professional Nursing Consultants, American Cancer Society, Alaska Native Health Board, Foraker Group, Alaska State Hospital and Nursing Home Association, Alaska AIDS Assistance Association, Alaska Mental Health Trust Authority, Anchorage Neighborhood Health Center, AARP, American Lung Association in Alaska, Mat-Su Health Foundation, Enroll Alaska, Alaska Physicians & Surgeons, Alaska Legal Services Corp. Identity. Inc., Iliuliuk Family and Health Services

Presented by: The Manager
Introduced: 03/16/2015
Drafted by: A. G. Mead

RESOLUTION OF THE CITY AND BOROUGH OF JUNEAU, ALASKA

Serial No. 2724

A Resolution Urging the Alaska Legislature to Expand Medicaid Coverage to Improve the Health of Alaskans and Alaska's Economy.

WHEREAS, nearly 42,000 of our family members, friends and neighbors statewide have the opportunity to gain health care coverage under Medicaid expansion; and

WHEREAS, approximately 2,400 Juneau residents are eligible for coverage under Medicaid expansion, and 1,140 of those are expected to enroll; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the number of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion brings over \$1 billion in new federal revenue into Alaska over the first five years; and

WHEREAS, Juneau enrollees alone bring in \$8.3 million in just the first year; and

WHEREAS, studies project expansion will likely yield 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity throughout the State; and

WHEREAS, Medicaid currently accounts for 23% of Bartlett Regional Hospital's patient mix; and

WHEREAS, with expansion the State would save \$6.1 million in FY2016 by using federal funds to pay for health services currently paid for with state general funds, reducing the need to cut public services; and

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond; and

WHEREAS, the State's continued participation is contingent upon maintaining the 90% match; and

WHEREAS, Medicaid expansion will significantly reduce the burden of uncompensated care, which was over \$90 million at non-tribal Alaska hospitals in 2013; and

WHEREAS, Bartlett Regional Hospital suffers charity care and bad debt expenses of \$10 - \$13 million per year; and

WHEREAS, Medicaid expansion will serve as a catalyst for meaningful Medicaid reform; and

WHEREAS, leveraging the federal resources that come with expansion is the State's biggest opportunity to finance reform efforts; and

WHEREAS, the State has the option of various Medicaid expansion demonstration projects it may also consider as part of reform.

NOW, THEREFORE, BE IT RESOLVED BY THE ASSEMBLY OF THE CITY AND BOROUGH OF JUNEAU, ALASKA:

Section 1. The City and Borough of Juneau endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Section 2. The City and Borough of Juneau strongly urges the Alaska Legislature to expand Medicaid for the benefit of Alaskans and the Alaska economy to take effect in July 2015 and, while reform efforts are of tremendous importance, this work should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

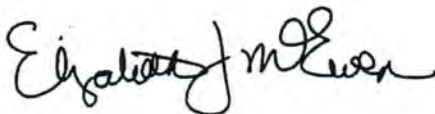
Section 3. Effective Date. This resolution shall be effective immediately after its adoption.

Adopted this 16th day of March, 2015.



Merrill Sanford, Mayor

Attest:



Elizabeth J. McEwen, Acting Clerk





Enriching Our Native Way of Life

February 24, 2015

Governor Bill Walker
Alaska State Capitol Building
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker:

Bristol Bay Native Corporation (BBNC) supports Medicaid expansion. Medicaid expansion is critical to improving access to health care for thousands of Alaskans. Expansion will also bring the state close to a billion dollars in new federal spending over the short-term and will support programmatic reforms that will save the state additional Medicaid dollars over the long-term. Accordingly, BBNC encourages you to expand the Medicaid program.

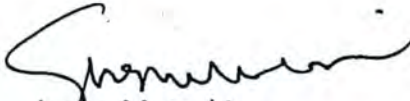
Studies suggest that expanding Medicaid will greatly reduce the number of uninsured Alaskans and will save lives - by some estimates 30 lives a year. Without insurance many individuals are forced to ignore health issues until they become unbearable and they are forced to seek care in an emergency room. Medicaid expansion will allow these individuals to seek medical attention much earlier and in a primary care setting.

Expansion will also increase the level of substance abuse treatment and care available to many Alaskans. A disproportionate number of Alaska Natives are incarcerated for offenses that are more often than not either directly or indirectly related to alcohol and substance abuse. While incarcerated individuals can often receive substance abuse treatment while they are in state custody, there is no continuing treatment available once these individuals are released. Medicaid expansion will increase the amount of drug and alcohol counseling available outside of incarceration and should reduce recidivism rates. This is of critical importance to rural Alaska.

Medicaid expansion also makes sense from a finance perspective. In 2011, Alaska hospitals provided 90 million dollars in uncompensated emergency room care. These are costs that the state's health care system had to absorb and spread to other patients (and their insurers) through higher health care rates. Other states that have expanded Medicaid have seen their uncompensated hospital costs fall by as much as 30%. Should Alaska hospitals see a similar reduction in uninsured costs, more than 10 million dollars per year in uninsured costs could be avoided.

Alaska currently faces numerous social and fiscal challenges. Medicaid expansion offers a rare opportunity to address one of the social challenges while also bringing new federal funding to the state. From this perspective, the decision to expand the state's Medicaid program should be any easy one. We encourage your administration to work with the legislature to get this important task completed. Alaska and Alaskans stand to benefit greatly.

Regards,

A handwritten signature in black ink, appearing to read "Jason Metrokin". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

Jason Metrokin
President & CEO



March 6, 2015

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Bering Straits Native Corporation supports your efforts to expand Medicaid in July 2015 for the benefit of Alaskans and the Alaska economy.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which will bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years. We should view Medicaid expansion as an economic driver that will positively impact our state's economy as we are faced with declining oil prices and the resulting budget challenges.

In addition to new federal revenue, savings to the state budget have also been identified in the Department of Corrections, the Chronic & Acute Medical Assistance (CAMA) Program and behavioral health grants. In FY2016, the state would realize \$6.1 million in savings. Medicaid expansion is healthy for Alaskans and healthy for the state's budget. We encourage the continued internal evaluation to identify other potential savings and offsets attributable to expansion and reform.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. We support Governor Walker's position that Alaska's participation is contingent on the federal match remaining at 90%.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. We are pleased to hear that the Department of Health & Human Services has issued an RFP for technical assistance related to reform efforts. Though reform of the current Medicaid program should be

of utmost importance, reform efforts should not delay health care coverage for those Alaskans who would be eligible for Medicaid under expansion.

Bering Straits Native Corporation endorses Medicaid expansion, recognizing we all have an interest in ensuring that Alaskans are as productive as possible so they can contribute to our communities and economy.

Sincerely,

A handwritten signature in black ink, appearing to read 'G. Schubert', written in a cursive style.

Gail R. Schubert,
President & CEO



Catholic Social Services

3710 East 20th Avenue, Anchorage, AK 99508 • (907) 222-7300 • Fax (907) 258-1091 • www.cssalaska.org

3-9-15

Brother Francis Shelter

Charlie Elder House

Clare House

Family Disability Services

Homeless Family Services

Pregnancy Support &
Adoption Services

Refugee Assistance &
Immigration Services

St. Francis House

Office of the Governor
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Walker,

Catholic Social Services supports efforts to expand Medicaid in July 2015 for the benefit of Alaskans, in particular for the vulnerable Alaskans who we serve.

Nearly 42,000 of our fellow Alaskans will be eligible for health coverage under Medicaid expansion. Expansion improves health outcomes by reducing the number of uninsured Alaskans by half, improving preventative and primary care access, and providing substance abuse treatment and mental health counseling.

There are significant economic benefits associated with Medicaid expansion, which is expected to bring more than \$1 billion in new federal revenue to our state, 4,000 new jobs, \$1.2 billion more in wages and salaries paid to Alaskans, and \$2.49 billion in increased economic activity over the first five years.

Federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond. Medicaid expansion will serve as a catalyst for meaningful Medicaid reform.

Thank you for your thoughtful consideration on this issue. The mission of Catholic Social Services is to compassionately serve the poor and those in need; strengthen individuals and families; and advocate for social justice. We believe our support of Medicaid expansion speaks to every element of our mission.

Sincerely,

Lisa D.H. Aquino, MHS
Executive Director



Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

April 2, 2015

The Honorable Steve Thompson
Alaska House of Representatives
State Capital Room 515
Juneau, AK 99801

RE: House Bill 178

Dear Representative Thompson:

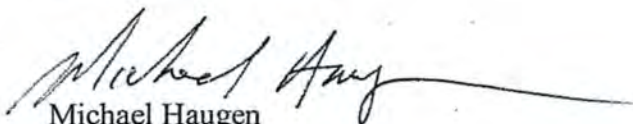
The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

As the Legislature debates Medicaid reform and expansion measures this Session we would like to make you aware of our current policy position on access to healthcare in Alaska. ASMA strongly supports access to healthcare for all Alaskans, and in that context supports robust and sustainable payment mechanisms for the Alaska healthcare industry. ASMA supports expansion of coverage of the approximately 30,000 currently uninsured Alaskans.

Improved access to healthcare in Alaska and improving the efficiency and effectiveness of Alaska's current Medicaid health care service system are important to improving the health outcomes of Alaskans.

Please let us know if there is anything we can do to further support passage of this legislation.

Sincerely,



Michael Haugen
Executive Director: The Alaska State Medical Association

April 06, 2015

The Honorable Paul Seaton, Chair
House Health & Social Services Committee
House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Support for HB148 - Medical Assistance Coverage; Reform

Dear Representative Seaton,

We, the Board of Directors at Tanana Valley Clinic, are writing in support of SB 78 and HB148, which declares a plan for Medicaid reform and expansion and is currently before the Alaska Legislature. Tanana Valley Clinic has a team of 54 physicians and mid-level providers, almost all of whom work with low-income, uninsured adult patients. In 2014, out of 118,000 clinical encounters, Tanana Valley Clinic saw 19,182 Medicaid visits, equating 16% of our total care for low-income, uninsured adults. As physicians and administrators at a community healthcare facility, we are impacted on a daily basis by the effects of healthcare costs on hard-working members of our community.

More health coverage means a healthier population, fewer life interruptions and burdens due to health crises, greater community-wide productivity at work, and less strain on our hospital and clinic budgets. With the expansion of Medicaid, our providers will be able to effectively administer care without the added consideration of a patient's economic limitations. Many exams, treatments and procedures that our physicians and mid-levels provide can leave patients with mountains of medical bills and heavy financial burdens; this can create an ethical dilemma for providers who attempt to find a balance between the necessity of treatment, and the patient's financial welfare. By providing more families with coverage through a Medicaid reform and expansion, the scope of this problem would decrease, and more of our community would receive better care without financially debilitating consequences.

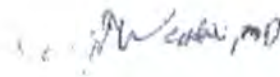
A plan for Medicaid reform and expansion may also prevent families from compromising their standard of care due to financial constraints. This compromise often means the difference between making ER visits only in dire situations and scheduling preventative visits that ultimately generates healthier members of society. A plan for Medicaid reform and expansion may further elevate our community's overall health in the future and reduce the long-term cost of healthcare to the state.

With the expansion of Medicaid, not only will members of our community receive the care they need but it will help reduce uncompensated care at our community-owned hospital and our local clinic. As a leading health care provider in the state, we strongly support this plan to allow us to provide the right care, at the right time, in the right place. A plan for Medicaid reform and expansion would enable us to fulfill our mission and serve more members of our Interior community.

Sincerely,



Clay Triplehorn, DO
Sleep Medicine
Board President



Grayson Westfall, MD
1st Care
Medical Director



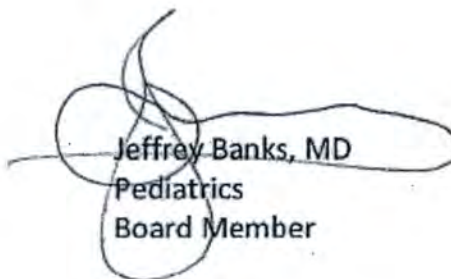
Corrine Leistikow, MD
Family Practice
Medical Director



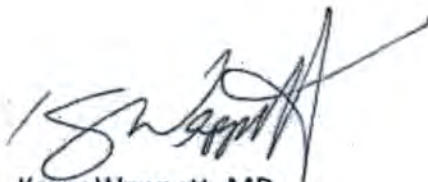
George Rice, MD
Family Medicine
Board Member



Zachary Werle, DO
1st Care
Board Member



Jeffrey Banks, MD
Pediatrics
Board Member



Kerry Wappett, MD
OB/GYN
Board Member

To House Finance Committee:

5/5/15

I oppose adding medicare funding.

These are appropriate considerations: April 13, 2015

I strongly oppose Resolution Serial No. 15-10: a resolution of The City of Wasilla to expand Medicaid Coverage.

Problems with this State expanding Medicaid coverage were presented this morning on Mr. Ridell's Radio talk show from a knowledgeable caller. Essentially, physicians receive more reimbursement for Medicaid patients than they do for Medicare service. If they choose to serve such programs it seems logical they will select ^{patients} ones whom will return a higher payment. To date, fewer and fewer physicians are treating either of these "federally subsidized" Medicare/Medicaid individuals.

Should the State of Alaska opt to add Medicaid to qualified folks to its healthcare rolls, it may bump other folks to the back of the line & ^{therefore} increase the costs of emergency room use.

Furthermore, with the many documented failures of "Obama Care" health programs at the federal level Alaska should be looking to

2 of 2

trust promises of the Fed's to sustain either the amount or the duration of any federal health care subsidy.

Don't be too eager to support this misguided resolution No 15-10 until you verify these points. Check with the Medical Community your city, State supported health care programs - your individual health care premiums will increase no doubt.

Sincerely,

Lawson Bucaria

P.O. Box 870799

Wassella, AK 99687

ANCHORAGE LEGISLATIVE INFORMATION OFFICE

Email: Anchorage.lio@akleg.gov 907-269-0111/ phone, 907-269-0229/fax

WRITTEN TESTIMONY

NAME: LORNA FARR MD

REPRESENTING: AFMC

BILL#/ SUBJECT: HB 148
COMMITTEE &

HEARING DATE: 4/11/15

- 1) American Surg Assoc
→ Medical power outcomes
- 2) Heartland - The True Cost
of Medical
- 3) Dr. Milton Wolf - letter
- 4) Cato Institute - Should
Vergara Expand Medicaid
- 5) ACA Impacts on Medical
Care in Alaska Exchanges
and Medicaid Expansion
Power Point Presentation
Lorna Farr
- 6) Parnell Strever - MESA
study 2013 - already
presented to House
Finance 2015



American Surgical Association

The oldest surgical association in the United States

Established in 1880

130th Annual Meeting Abstracts

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[Back to Program Outline](#)

Primary Payer Status Affects Mortality For Major Surgical Operations

*Damien J LaPar, *Castigliano M. Bhamidipati, *Carlos M Mery, *George J Stukenborg, David R Jones, Bruce D Schirmer, Irving L Kron, MD, *Gorav Ailawadi, MD
University of Virginia, Charlottesville, VA

Objectives: Medicaid and Uninsured populations are a significant focus of current healthcare reform. We hypothesized that outcomes following major surgical operations in the United States is dependent on primary payer status.

Methods: From 2003-2007, 893,658 major surgical operations were evaluated using the Nationwide Inpatient Sample (NIS) database: lung resection, esophagectomy, colectomy, pancreatectomy, gastrectomy, abdominal aortic aneurysm repair, hip replacement, and coronary artery bypass. Patients were stratified by primary payer status: Medicare (n=491,829), Medicaid (n=40,259), Private Insurance (n=337,535), and Uninsured (n=24,035). Multivariate regression models were applied to assess outcomes.

Results: Unadjusted mortality for Medicare (4.4%, OR= 3.51), Medicaid (3.7%, OR: 2.86) and Uninsured (3.2%, OR: 2.51) patient groups were higher compared to Private Insurance groups (1.3%, p<0.001). Moreover, mortality was lowest for Private Insurance patients independent of operation. Importantly, after controlling for age, gender, income, geographic region, operation, and 30 comorbid conditions, Medicaid payer status was associated with the longest length of stay and highest total costs (p<0.001). In addition, Medicaid (p<0.001) and Uninsured (p<0.001) payer status independently conferred the highest adjusted risks of mortality (Table 1).

Table 1: Multivariate regression analyses for adjusted outcomes.

Outcome	Medicaid	Uninsured	Medicare	Private Insurance
In-Hospital Mortality*	1.97 (1.84-2.10)	1.74 (1.60-1.90)	1.54 (1.48-1.61)	Ref
Length of Stay (days)*	10.49±0.04	7.01±0.03	8.77±0.01	7.38±0.01
Total Costs (\$)*	\$79,140±251.4	\$65,667±231.0	\$69,408±53.1	\$63,057±53.0

* p<0.001. Reference group: Private Insurance. In-hospital mortality reflected as Odds Ratios (95% Confidence Interval), Length of Stay and Total Costs reflected as adjusted means.

Conclusions: Medicaid and Uninsured payer status confers increased risk of adjusted mortality. Medicaid was further associated with the greatest adjusted length of stay and total costs despite risk factors or operation. Possible explanations include delays in access to care or disparate differences in health maintenance.

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American Surgical Association
500 Cummings Center, Suite 4550, Beverly, MA 01915
(978) 927-8330 | FAX (978) 524-8890
[Email ASA](#)

12:42:25 AM
Saturday, April 11, 2015

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The True Cost of Medicaid

Quick Facts

1. Medicaid's health care outcomes for the population it serves are terrible and unacceptable in any civilized society.
2. The costs of Medicaid for states are growing at an unsustainable rate, a problem accelerated as millions more Americans are added to the system under President Obama's health care law.
3. Medicaid's system is purposefully designed to be resistant to flexibility and positive, forward-thinking reform.

Studies and Reports

- Medicaid is already the largest budget expense for the states, accounting for nearly 22 percent of total spending in FY 2010.
- [The University of Virginia finds it is better to be uninsured than to be on Medicaid](#): A large survey by UVA which compensated for several major factors found startling data last year. [As Avik Roy writes](#): "surgical patients on Medicaid are 13% more likely to die than those with no insurance at all, and 97% more likely to die than those with private insurance. The Virginia group evaluated 893,658 major surgical operations from the Nationwide Inpatient Sample database from 2003 to 2007. They divided the patients up by the type of insurance—private insurance, Medicare, Medicaid, and uninsured—and adjusted the database in order to control for age, gender, income, geographic region, operation, and comorbid conditions (having 2 or more diseases simultaneously). That way, they could correct for the obvious differences in the patient populations (for example, older and poorer patients being more likely to have ill health)." The researchers found "Medicaid patients were almost twice as likely to die as those with private insurance; their hospital stays were 42% longer, and cost 26% more. Compared to those without health insurance, Medicaid patients were 13% more likely to die, stayed in the hospital for 50% longer, and cost 20% more. It is hard to see how this problem doesn't get significantly worse when Obamacare's expansion of Medicaid is fully phased in."
- [Final Notice: Medicaid Crisis, A Forecast of Texas' Medicaid Expenditures Growth](#), is a paper by Jagadeesh Gokhale, Senior Fellow at the Cato Institute, conducted for the Texas Public Policy Foundation and released December 2010. It produces a far more significant expectation in terms of cost increases for states of the expansion of the Medicaid system. [Cato Institute analyst Michael Cannon notes the cost increases Gokhale found](#) are much greater than would be expected without Obama's health care regime: "Compared to a world without ObamaCare, state Medicaid spending will rise by 4.5 percent in California, 24.2 percent in Florida, 32.1 percent in Illinois, 22.9 percent in New York, and 24.1 percent in Texas over the first 10 years of full implementation."

The need to reform the broken Medicaid system has never been greater. Medicaid fails to serve people who need care the most and burdens states with unsustainable costs as more people are added to the system. The only way Medicaid can be saved from collapse is through responsible national reform. This site is dedicated to that mission.

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- **Topics**

- An Easy Path to Billions—Medicare and Medicaid Fraud: This 60 Minutes report provides examples of the sizeable fraud and ludicrous criminal operations that are robbing the nation's taxpayers: "The tiny medical supply company billed Medicare almost \$2 million in July and a half-million dollars while 60 Minutes was there in August, but we never found anybody inside, and our phone calls were never returned."
- Jim Capretta and Tom Miller write: "Medicaid remains separate and not equal to the rest of the insurance system for working-age Americans. Its current structure provides no coordination or transition between Medicaid coverage and private health insurance. A move to replace both traditional Medicaid assistance and the tax preference for employer-paid health insurance with defined contribution payments would open up new possibilities for more beneficial coordination between both types of coverage. Integrating coverage options for the poorest Americans into the choices available to those with higher incomes will not be easy, in light of broader fiscal and political constraints, but it should proceed with all deliberate speed. Moving toward defined contributions across Medicare and Medicaid, as well as employer-based plans, involves a complex transition well beyond just hitting new budgetary targets. ... Nevertheless, it's clear that taking the defined contribution route to health reform would create tremendous competitive pressure on the entire health sector to deliver more for less. Any player that did not step up would risk losing market share. That's the way to slow rising costs while also improving, not compromising, quality."
- Pennsylvania Medicaid Waste Estimated at a Quarter of a Billion Per Year: States routinely underestimate the levels of fraud in their states, as Pennsylvania experienced earlier this year, this article from Health Care News notes: "A new state government report shows fraud in Pennsylvania's Medicaid program may have cost taxpayers more than \$1 billion over the past four years—more than three times what the state had previously reported. An audit by Pennsylvania Auditor General Jack Wagner found improper Medicaid eligibility determinations on nearly 2,000 randomly selected Medicaid applications between 2005 and 2009. The audit found a 14.7 percent fraud rate, three times the rate anticipated by the Pennsylvania Department of Welfare."
- The True Costs of Medical Fraud: Wide-Ranging Effects: Two leading University of Miami health academics, both of whom support national health care reform, say fraud cuts off resources to people who need them.
- A University of Pennsylvania study published in *Cancer* found that for patients undergoing surgery for colon cancer, the mortality rate was higher for Medicaid patients than for the uninsured or those with private insurance, and the rate of surgical complications was highest for Medicaid patients as well.
- A Columbia-Cornell study in the *Journal of Vascular Surgery* examined outcomes for vascular disease found that patients with clogged blood vessels in their legs or clogged carotid arteries fared worse on Medicaid than did the uninsured.
- A study of Florida patients published in the *Journal of the National Cancer Institute* found that Medicaid patients were 31% more likely to have late-stage breast cancer and 81% more likely to have late-stage melanoma than the uninsured.
- Aging America's Achilles' Heel: a 2005 report from Stephen A. Moses, president of the Center for Long-Term Care Reform, a Medicaid state representative for the Health Care Financing Administration and senior analyst for the inspector general of the U.S. Department of Health and Human Services: "While Social Security and Medicare have spurious "trust funds," Medicaid draws its financing from general tax revenue without even the pretense of a trust fund. Medicaid is the principal payor for long-term care (LTC), especially nursing home care. LTC is an 800-pound gorilla of social problems that lurks just around the bend. If we wait to deal with Medicaid and LTC until after we handle Social Security and Medicare, it will be too late."

• **Reform + Medicaid**

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- *“Long before Social Security goes bankrupt, Medicaid is going to bankrupt all the states.”*
-Sen. Mark Warner (D-VA)
- **📰 Medicaid News**
 - [Viewpoints: Kansas And Abortion: Stop Missouri’s Move To Medicaid Managed Care](#)
 - [After Procedural Play, Montana Medicaid Expansion Gets Initial House Approval](#)
 - [Medicaid Expansion One Step Closer To Reality In Montana](#)
 - [Research Roundup: Young Adult Coverage; Alternatives To Subsidies; Critical Care Hospitals](#)
 - [Montana Moderates Revive Medicaid Expansion](#)
 - [Viewpoints: ‘Medicaid Shenanigans’ In Florida: The Need For Better Food Safety](#)
 - [Gilead’s Pricey Hep C Drug Drives State Medicaid Spending](#)
 - [Balanced Budget, Abortion Dominate Paul Campaign’s First Day](#)
 - [Rep. Lois Capps To Retire After 10 Terms In House](#)
 - [In Montana, Bipartisan Effort Muscles Medicaid Expansion Bill To House Floor](#)
- **Blogroll**
 - [Avik Roy: The Apothecary](#)
 - [Cato Institute: Medicaid](#)
 - [Center for Long Term Care Reform](#)
 - [Don Berwick Online](#)
 - [e21: Medicaid](#)
 - [Greg Scandlen: Real Health Reform](#)
 - [Health Affairs: Medicaid](#)
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 - [John Graham: Free American Health Care](#)
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 - [Thomas Sullivan: Policy and Medicine](#)

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OLF: Obamacare wrecks Medicare by design, but why?

The clue lies in the president's own words

By Dr. Milton R. Wolf
The Washington Times
6:43 p.m., Wednesday, June 8, 2011

"We don't want to take away people's health insurance," Health and Human Services Secretary Kathleen Sebelius so graciously declared earlier this year. But then she quickly qualified that with these ominous words: "before they have some realistic other choices."

Americans have overwhelmingly, consistently and wisely been opposed to a European-style, single-payer, government-run, socialized health care system. So how might the big- government types who are hell-bent on forcing their will upon us attempt to implement this oppressive system in America? Simple. By creating medical refugees desperate for any port in a storm. That storm is coming and, unlike global warming, it's actually man-made.

America somehow managed to survive for 189 years without Medicare or Medicaid and, in fact, became the greatest nation in the history of humankind. Established in 1965 - a mere 46 years ago - too many politicians today lack the perspective to understand this health care altar at which they worship. Instead of reforming the system to align it with American values, they abuse it as an eternal source of giveaways to buy votes. As for the politicians of the 1960s, except for the mop tops and go-go boots, they were very much like the politicians of today: They made a lot of empty promises.

President Lyndon B. Johnson promised that Medicare would cost about \$500 million a year - yes, million. He even said that if costs went higher, then he was going to look like the "worst kind of damn fool." Just a year later, in 1966, the House Ways and Means Committee estimated that Medicare would cost about \$12 billion a year by 1990. The actual 1990 cost was \$107 billion - off by an order of magnitude but close enough for government work. And that's when costs really took off. By 2008, annual costs hit \$599 billion and the program for the first time went into deficit-spending mode.

For all the Democrats' dishonesty and reckless spending, Republicans weren't exactly blameless either. In 2003, President George W. Bush and a Republican Congress doubled down and ushered in the largest expansion in Medicare history with their senior citizen prescription drug entitlement program. They claimed the price tag would be \$400 billion for the first decade but quietly adjusted that estimate upward to \$534 billion just one month after passage.

Parenthetically, just three years later, in 2006, the free market roared as a private company in Bentonville, Ark. - without a single dime of taxpayer money or the compulsion from know-it-all government bureaucrats - lowered prices of the top 331 prescription medications to just \$4 per month (and later to \$10 per three months), not just for seniors but for all Americans. And equally importantly, Wal-Mart did not send the bill to our children.

Today we know that LBJ and a lot of other politicians indeed are the worst kind of damn fools. Medicare - like Social Security - is collapsing under its own weight and threatens to take America with it. The Medicare Trustees declared last month that Medicare Part A (Hospital Insurance Trust Fund) will be insolvent by 2024, a mere 13 years from now. Others estimate it will be only nine years. The entitlement program has racked up almost \$25 trillion in unfunded liabilities. Others say it's actually \$38 trillion. It turns out free health care is pretty expensive.

Despite Democrats' breathless claims that private insurance companies are the enemy, it is our federal government that is the largest denier of medical claims in the world. And that's before the president unleashes his rationing board, the Independent Payment Advisory Board (IPAB) or so-called "death panel." And if that wasn't enough, the Democrats have plundered \$1.9 trillion from Medicare over the next decade (\$8.2 trillion over 20 years) to fund Obamacare and have all but destroyed the popular Medicare Advantage program. Make no mistake: Obamacare is killing Medicare.

We have selfishly forced our children into lifelong indentured servitude to pay our debts, and for what, exactly? World-class, government-run health care? Not quite. The average U.S. life expectancy in 1965, the first year of Medicare, was 70.2 years. Forty years later, in 2005, it rose to 77.4 years, an improvement of 10 percent. Compare that to the 40 years before Medicare, from 1925 to 1965, when life expectancy improved by nearly twice that - 19 percent.

Medicaid is even worse. A recent University of Virginia study shows Medicaid surgical patients, for example, are 97 percent more likely to die than private insurance patients. And get this: They are 13 percent more likely to die than uninsured patients. This shouldn't surprise you. Health care decisions that are based on political considerations are meant to benefit politicians, not patients. President Obama's solution is to force even more people into government health care. Obamacare will increase the Medicaid rolls by 16 million poor souls.

In the few remaining years Medicare has left, dispirited doctors are already fleeing the program in droves - and medicine altogether - leaving behind helpless patients. Democrats' only plan is to maintain the crumbling status quo: Plunder Medicare, chase more doctors away with an additional 30 percent cut in reimbursement next year, and then watch from the bleachers as Americans are turned into medical refugees desperate for any salvation.

The president's intentions are chillingly clear: "I happen to be a proponent of a single payer universal health care program. ... That's what I'd like to see." Obamacare is a major step in that direction. "I don't think we're going to be able to eliminate employer coverage immediately," he says, but he can envision it "a decade out, or 15 years out, or 20 years out."

Rep. Paul Ryan, Wisconsin Republican, has put forward the only serious proposal to date that can save Medicare by reforming it into a system that is in line with America's values. It wrestles control away from

Should Virginia Expand Medicaid?

Testimony of Michael F. Cannon
Director of Health Policy Studies, Cato Institute¹

Before the Medicaid Innovation and Reform Commission
Senate Room B, General Assembly Building, Richmond, VA

April 7, 2014

Chairman Hanger, Vice Chairman Landes, and members of the Medicaid Innovation and Reform Commission, thank you for the opportunity to share my views on why Virginia should not participate in the Patient Protection and Affordable Care Act's Medicaid expansion in any way, shape, or form.

My name is Michael F. Cannon. I live in the City of Alexandria and have been a resident of the Commonwealth for more than three decades. I am a product of Virginia elementary and secondary education. I received a degree in American Government from the University of Virginia, and degrees in economics and law & economics at night from George Mason University. I am the director of health policy studies at the Cato Institute. Founded in 1977, the Cato Institute is a non-partisan, non-profit, 501(c)(3) educational foundation located in Washington, D.C., whose mission is to promote the principles of individual liberty, limited government, free markets, and peace. To maintain its independence, the Cato Institute accepts no government funding.

In June 2012, the Supreme Court made the Patient Protection and Affordable Care Act's expansion of Medicaid optional for states. It is not in the interest of Virginia taxpayers, present or future, to participate in that expansion. Key points from my testimony include:

- Expanding Medicaid will not "recapture Virginia dollars being sent across the Potomac." If Virginia expands its Medicaid program, every single penny it receives from the federal Treasury will be raised by issuing new federal debt. The Medicaid expansion will not recapture Virginia dollars. It would impose an unfair tax on future generations who are not represented here today.
- Expanding Medicaid would require Virginia to increase taxes and/or reduce spending on education and other services by far more than initial projections suggest.
- Refusing to expand Medicaid would reduce federal deficits and the federal debt, which are an implicit tax on future Virginia taxpayers. A recent study estimated the states that have most forcefully rejected the expansion will reduce federal deficits and debt by more than \$8 billion per year.
- According to one estimate, the vast majority (82 percent) of those who would receive Medicaid coverage under the expansion already have private insurance today. Expansion could reduce their access to care, with potential negative health

Washington and instead entrusts states and empowers American citizens.
And this is precisely why Barack Obama and the Democrats oppose it.

Dr. Milton R. Wolf, a Washington Times columnist, is a board-certified
diagnostic radiologist and President Obama's cousin. He blogs at
miltonwolf.com.

consequences.

- Expansion would increase, not reduce, emergency-room use by an estimated 40 percent, leading to greater overcrowding. A back-of-the-envelope calculation suggests emergency-room spending could increase by \$43 million per year.
- Expanding Medicaid may not improve enrollees' health at all. A study of the most vulnerable people targeted by the expansion found "Medicaid coverage generated no significant improvements in measured physical health outcomes."
- Expansion would reduce jobs, not increase them.
- Expanding Medicaid means forcing Virginia taxpayers to give even more of their income to Medicaid fraudsters.
- The federal government has announced a plan to rescind the Medicaid "DSH" cuts that were leading many hospitals to argue for the expansion.
- Expanding Medicaid would neither eliminate discrimination against U.S. citizens nor eliminate penalties against employers. Alternative strategies are available that would completely eliminate both.
- The Medicaid expansion is all but irrevocable. Any "sunset" provision would be easily overridden – particularly if, as some legal scholars warn, the federal government prevents Virginia from exiting the expansion.
- Covering the expansion populations through the state's health insurance "exchange," as Arkansas has proposed, would increase the expansion's cost to both to the state and the federal government by 50 percent, and is likely unlawful.
- Under *NFIB v. Sebelius*, Virginia can refuse to implement all mandatory Medicaid provisions in the PPACA—including eligibility for all children below 138 percent of poverty, "maintenance of effort," the "MAGI" income standard, and eligibility determinations for Exchanges—not just the newly eligible adult population.
- Virginia would have plenty of company if it chose not to participate. Twenty or more states are refusing to implement the Medicaid expansion.
- Expanding Medicaid exposes Virginia to the risk of becoming a "Medicaid magnet," where people move to the Commonwealth from non-expansion states such as North Carolina or Tennessee for the purpose of enrolling in Medicaid and taking advantage of other state services.

Finally, there are better alternatives. Rather than burden taxpayers with this new expense, Virginia should continue to refuse to implement the Medicaid expansion or a health insurance Exchange; join Maine in challenging HHS's attempt to force states to implement parts of the

expansion the Supreme Court rendered optional; join Oklahoma in challenging the IRS's attempt to issue subsidies and impose taxes that Congress did not authorize; launch an Oregon-like study to discern what impact if any Medicaid has on the health of existing populations; and enact a Tennessee-style "Good Samaritan" law and medical malpractice liability reforms that expand access to care for the poor without imposing new burdens on taxpayers.

Background

The "Patient Protection and Affordable Care Act" of 2010 carries costs that far outweigh its benefits. The PPACA makes access to care less secure for millions of Americans, depresses economic activity, eliminates jobs, increases health care costs, increases the burden of government, and traps people in poverty.² It imposes \$1.2 trillion in new taxes through 2022.³ According to one estimate, these taxes will reduce economic output by as much as \$750 billion in just the first six years.⁴

The PPACA commits taxpayers to pay for an estimated \$1.6 trillion in new federal spending through 2023.⁵ Roughly half of this new spending consists of subsidies to private health insurance companies that will flow through new government agencies called health insurance "exchanges." The balance comes from a 50 percent increase in the number of nonelderly Medicaid enrollees.⁶ This is money the federal government simply does not have.

The non-partisan Congressional Budget Office estimates the PPACA will eliminate roughly 2.5 million jobs by 2019.⁷ The Federal Reserve has reported, "Employers in several Districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff."⁸ The law has caused employers to cut hours for everything from waiters to college professors. Former Obama economic advisor Austan Goolsbee predicts that even if overall hiring in the economy increases, the PPACA could cause overall hours worked to fall,⁹ while former advisor Jared Bernstein admitted, "I'm a little nervous about that [Federal Reserve report]...I think there's something to it...I've got a news flash for you. The Affordable Care Act is not a jobs program."¹⁰

Congress and President Obama have already repealed one of the PPACA's three new entitlement programs—the Community Living Assistance Services and Supports Act, or CLASS Act¹¹—as well as other provisions of the law.¹² Repealing the remaining provisions of the PPACA is essential to making health care better, more affordable, and more secure, as well as making the federal government live within its means. A union that formerly supported the PPACA, the United Union of Roofers, Waterproofers and Allied Workers, has reversed its position and is now calling for the law's repeal.¹³

The Role of States in the PPACA

The PPACA relies on states to implement the Exchanges and Medicaid expansion.¹⁴ Each provision would impose significant costs on the state of Virginia. Virginia is under no obligation to implement either. Between the two, the Medicaid expansion would cost the state far more.¹⁵ Whether to implement the expansion may be the most important decision facing Virginia officials.

Somewhat ironically, the PPACA gives Virginia officials considerable power to shape how the Act operates, but only if state officials refuse to implement these provisions. Implementing either an Exchange or the Medicaid expansion cedes more control over the state's health care sector and destiny to the federal government. If Virginia officials wish to reassert control over their health care sector, they must refuse to implement these provisions.

The Unknowable Cost of Medicaid Expansion

Under the PPACA, Virginia has the option of expanding its Medicaid program to cover all citizens and legal immigrants below 138 percent of the federal poverty level. The federal government will cover 100 percent of one category of spending (i.e., claims) for one category of enrollees (newly eligible adults), for the first three years. Virginia would be responsible for funding the administrative costs, plus the cost of covering newly eligible children, plus the cost of any already-eligible new enrollees at the state's current matching rate (roughly 50 percent).¹⁶

Beginning in 2017, Virginia would also begin to pick up a larger share of the cost of claims for newly eligible adults. That share would rise to 10 percent by 2019. According to one news report, "States will receive more than \$9 in federal money for every \$1 they spend to cover low-income residents under" the expansion.¹⁷ This offer stands, as one observer puts it, in "theoretical perpetuity."¹⁸

The Kaiser Family Foundation and the Urban Institute project Virginia's share would total a considerable \$2.6 billion over 10 years.¹⁹ Economist Jagadeesh Gokhale is a leader in his field and a member of the Social Security Administration's advisory board; when the Social Security program wants to know how to make these sorts of projections, they come to him. Gokhale more realistically projects the expansion will cost up to 45 percent more than the Kaiser/Urban estimates,²⁰ which suggests the expansion, under current law, would cost the state of Virginia close to \$4 billion.

The actual cost is likely to be much higher, for two reasons.

First, actual enrollment and spending in government health programs typically far surpasses initial projections. Congress' Joint Economic Committee notes, "In 1967, the House Ways and Means Committee predicted that the new Medicare program, launched the previous year, would cost about \$12 billion in 1990." Instead, "Actual Medicare spending in 1990 was \$110 billion—off by nearly a factor of 10."²¹ Jonathan Ingram of the Foundation for Government Accountability reports that when Arizona expanded its Medicaid program in 2002, actual enrollment reached nearly three times the projected level, while spending quadrupled initial projections.²² In just one year, the actual cost to the federal government of establishing state-run Exchanges more than doubled the projected cost, from \$2 billion to \$4.4 billion.²³ Over the long term, such programs expand, and are almost never eliminated or pared back in any significant way.

Second, the federal government is likely to renege on the initial 9-to-1 match—because it must. The federal debt stands at \$12 trillion, or 74 percent of gross domestic product. In 2014,

the federal government will run a projected \$514 billion deficit. Under current law, annual deficits could cause the federal debt will grow to \$21 trillion by 2024.²⁴ According to the Congressional Budget Office (CBO):

Under current law, federal debt held by the public as a percentage of GDP in 2024 is projected to reach its highest level in more than 75 years and roughly double the average of about 40 percent experienced over the 1974–2013 period...

Continued rising debt would dampen economic growth and thus reduce people's income compared with what it would otherwise be. It would also increasingly restrict policymakers' ability to use tax and spending policies to respond to unexpected challenges and would boost the risk of a fiscal crisis, in which the government would lose its ability to borrow at affordable rates. To avoid those consequences, lawmakers will ultimately have to make significant changes to tax and spending policies—letting revenues rise more than they would under current law, reducing spending for large benefit programs below the projected amounts, cutting other federal spending to even lower levels by historical standards than currently projected, or adopting some combination of those approaches.²⁵

Since Congress tends to reverse spending cuts or tax increases before they take effect, the CBO also makes the more realistic projection that if current *policies* continue, federal debt will grow to \$28 trillion by 2023, or 83 percent of GDP,²⁶ and the adverse consequences “would be exacerbated if federal debt exceeded the amounts projected in CBO's baseline, as it would if certain deficit-reducing policies that are scheduled to take effect were instead reversed without being replaced by other policies with similar budgetary effects.”²⁷

It is unrealistic to assume the federal government will maintain the Medicaid expansion's 9-to-1 matching rate. House Budget Committee chairman Paul Ryan (R-WI) has told governors and state legislators, “The fastest thing that's going to go when we're cutting spending in Washington is a 100- or 90-percent match rate for Medicaid. There's no way. It doesn't matter if Republicans are running Congress or Democrats are running Congress. There's no way we're going to keep those match rates like that.”²⁸ Indeed, President Obama proposed renegeing on that commitment in two consecutive budget proposals.²⁹ Republicans in both the House and Senate have introduced legislation to eliminate the enhanced matching grant formula.³⁰ When Congress reneges on that commitment, the Medicaid expansion will cost Virginia even more than the direct projections.

Virginia currently spends about \$3.5 billion per year to cover 1 million residents through Medicaid.³¹ Under the Medicaid expansion, each of those numbers would rise dramatically and continue to climb.

South Carolina governor Nikki Haley summarized the situation: “The federal government likes to wave around a nine dollar match like it is some silver bullet, some extraordinary benefit that we cannot pass up. But what good do the nine dollars do us when we can't come up with the one? And what good are any dollars when they come through a program that doesn't allow us the flexibility to make the decisions that are in the best interest of the people?”³²

Medicaid Expansion Cannot and Will Not “Recapture Virginia Dollars”

Expanding Medicaid will not “recapture Virginia dollars being sent across the Potomac.”³³ That claim is innumerate, demonstrably false, and should have no part in this debate.

Every penny Virginia sends to the federal government has already been spent. If it hadn’t, the federal government would be running surpluses instead of deficits. If Virginia expands its Medicaid program, therefore, every single penny it receives from the federal Treasury will be raised by issuing new federal debt.

If you choose to expand Virginia’s Medicaid program, you will not be recapturing Virginia dollars from Washington.” You will be taking dollars from future generations who are not represented here today. It is unfair – it is immoral – to tax future generations to expand Medicaid for current generations. And it is the height of either ignorance or hypocrisy to say Virginia must expand Medicaid out of fairness to taxpayers.

Supporters of expanding Medicaid must to explain how it is unfair when Virginia must send tax dollars to Washington for the benefit of other states, but not unfair when they tax people who are not represented here today (future generations) for the benefit of those who are. If supporters of the Medicaid expansion want to live by their own standard of fairness, they would propose a new tax by which Virginia would cover the entire cost of the Medicaid expansion. The fact that they have not suggests their support for expanding Medicaid is less about fairness than the opportunity to hand out benefits to favored constituencies without having to be the ones to impose the taxes that pay for those benefits. If you ever wanted to know how important Virginia’s balanced-budget requirement is, look no further than how hungrily many Virginia elected officials eye an attempt to spend government funds that they themselves do not have to raise through taxation. Some are even willing to shut down the government to do it.

Virginia Officials Can Reduce Federal Deficits, Debt

Implementing the expansion would not only increase state spending. It would increase federal spending as well. But states can reduce federal spending, deficits, and debt by rejecting the expansion.

Shortly after the Supreme Court’s ruling, the CBO estimated that the handful of states that would refuse to expand Medicaid had reduced federal deficits by \$84 billion.³⁴ One study estimates that just 14 states will reduce federal deficit spending by \$8 billion per year by refusing the expansion.³⁵

More Medicaid, More Fraud

Expanding Medicaid means forcing Virginia taxpayers to give even more of their income to Medicaid fraudsters. The amount of fraud in Medicaid is stunning even by government standards.³⁶ In one example, a Brooklyn dentist billed taxpayers for nearly 1,000 procedures in a

single day.³⁷ Rampant fraud has led the Government Accountability Office to designate Medicaid as a “high-risk” program for the past decade.³⁸ Official estimates suggest Medicaid loses tens of billions of dollars to fraud annually—but experts deride those estimates as “comfortingly low and quite misleading.”³⁹

Crowding Out Private Coverage

Expansion is neither a wise or well-targeted use of Virginia taxpayers’ dollars, because it would spend scarce state resources on people who already have private insurance. A recent study by PPACA supporters projected “high rates of crowd-out for Medicaid expansions aimed at working adults (82%), suggesting that the Medicaid expansion provisions of PPACA will shift workers and their families from private to public insurance without reducing the number of uninsured very much.”⁴⁰ Medicaid expansions in Arizona, Delaware, Maine, and Oregon did not reduce those states’ uninsured rates at all, though they were accompanied by declines in private coverage.⁴¹

Worse Access to Care

When Medicaid crowds out private health insurance, it often leaves patients with less-secure access to care. Nationwide, roughly one third of physicians refuse to accept new Medicaid patients.⁴² According to the U.S. Department of Health and Human Services, “Only about 20 percent of the nation’s 179,000 practicing dentists accept Medicaid.”⁴³ In states like Maryland, the number is one in six.⁴⁴

According to the *Annals of Emergency Medicine*, Medicaid patients are twice as likely to experience barriers to primary care as privately insured patients. The authors conclude, “Expansion of Medicaid eligibility alone may not be sufficient to improve health care access.”⁴⁵

Medicaid Expansion Will Increase Emergency-Room Use

Supporters of have repeatedly promised that the Medicaid expansion will reduce emergency-room overcrowding. Yet the evidence shows that implementing the expansion will *increase* emergency-room use, not reduce it.

The Oregon Health Insurance Experiment – the largest and most reliable study ever conducted of Medicaid or any health-insurance expansion – found that when the State of Oregon opened its Medicaid program to the same target population, emergency-room use increased by 40 percent.⁴⁶ A back-of-the-envelope calculation suggests emergency-room spending in Virginia could increase by \$43 million per year.⁴⁷

Medicaid’s poor access to primary care leads enrollees often turn to emergency departments. As one emergency-room physician recently explained in *The Washington Post*:

In our hospital, about one in 10 patients with Medicaid is a frequent visitor to the emergency department because many physicians don’t accept that insurance. Trying to understand the inability of patients with insurance to see primary-care providers, I called

three local clinics, pretending to be a patient with Medicaid, and tried to make an appointment. The soonest I could see a primary-care doctor was two months. Primary-care physicians who accept Medicaid insurance are overwhelmed with patients...⁴⁸

It is little surprise, then, that the above-mentioned *Annals* study found Medicaid patients are twice as likely as those with private insurance to use the emergency room as a source of primary care.⁴⁹

The *Journal of the American Medical Association* reports that emergency rooms “are increasingly serving as the safety net for medically underserved patients, particularly adults with Medicaid.” The authors of that study found, “Adults with Medicaid accounted for most of the increase in ED visits” between 1997 and 2007, which was “almost double of what would be expected from population growth.” Indeed, adult Medicaid patients are three times more likely than the uninsured, and seven times more than patients with private insurance (which the expansion would crowd out), to use an emergency room for conditions that could have been addressed with primary care.⁵⁰

Medicaid Expansion May Increase Uncompensated Care

When Maine expanded its Medicaid program to cover childless adults, as the PPACA’s Medicaid expansion would do, uncompensated charity care by hospitals did not fall. It grew at an accelerated rate, increasing five fold.⁵¹

Tragic Consequences

One Medicaid enrollee who turned to an emergency room when he couldn’t find primary care was a 12-year-old Maryland boy named Deamonte Driver

. In 2007, Deamonte was suffering from a toothache, caused by an abscess. His mother struggled in vain to find a dentist who would accept the family’s Medicaid coverage. According to one account, “the Public Justice Center in Baltimore...made dozens of calls” on the family’s behalf to find a dentist who would accept the family’s Medicaid coverage.⁵²

Since only one in six Maryland dentists accepts Medicaid, the *Washington Post* reported, “By the time Deamonte’s own aching tooth got any attention, the bacteria from the abscess had spread to his brain . . . After two operations and more than six weeks of hospital care, the Prince George’s County boy died.”⁵³

“A routine, \$80 tooth extraction might have saved him,” the *Post* concluded. “If Medicaid dentists weren’t so hard to find.”⁵⁴

Would Expanding Medicaid Improve Health?

The Medicaid expansion may not even improve the new enrollees’ health at all. Oregon Health Insurance Experiment investigators published an article in the *New England Journal of Medicine* that found Medicaid had no discernible effect on measured physical health outcomes of

enrollees. Supporters thus have no reliable evidence to show the Medicaid expansion would improve enrollees' physical health at all, much less that it would deliver the largest gains in health per dollar spent.

Let's unpack that. Medicaid's effect on the health of enrollees is theoretically ambiguous. On the one hand, Medicaid will spend around half a trillion this year purchasing medical and long-term care services for around 60 million people.⁵⁵ It would be difficult to spend nearly half a trillion dollars on medical care without providing some benefits.

Yet Medicaid also has many effects that might negatively impact enrollees' health. The taxes that fund Medicaid—including both sales and income taxes—directly inhibit low-income families' ability to afford food, clothing, housing, and higher-quality educational options, all of which contribute to health. That tax burden also reduces incomes indirectly by decreasing economic activity and opportunity, making it more difficult for low-income workers to become self-sufficient. Medicaid further provides powerful disincentives to climb the economic ladder. If enrollees increase their earnings, they might lose a benefit worth thousands of dollars.⁵⁶ Medicaid also increases the cost of private insurance at the same time it lures people out of private insurance.⁵⁷

One would hope that before state and federal governments would spend half a trillion dollars per year on a program like Medicaid, they would establish whether the program will improve health *and* achieve the greatest health improvements per dollar spent. Yet no one bothered to measure Medicaid's effect on the health of enrollees in a reliable way until Oregon began a monumental new study in 2008—42 years and \$9 trillion after the program's inception. Indeed, Congress debated the PPACA's Medicaid expansion in 2009 and enacted it 2010 without even waiting until the first set of results from the Oregon study became available in 2011.⁵⁸

The Oregon Health Insurance Experiment is essentially a PPACA field test. The State of Oregon held a lottery that randomly assigned thousands of able-bodied Oregon adults earning below 100 percent of the federal poverty level—in other words, the most vulnerable group targeted by the PPACA's Medicaid expansion—either to receive Medicaid coverage or nothing. Economists then collected data on the lottery winners and losers. The use of random assignment makes the Oregon Health Insurance Experiment's results the most reliable information ever collected on the effects of Medicaid.

Congress should have waited for the results.

In 2013, Oregon Health Insurance Experiment researchers reported, “Medicaid coverage generated no significant improvements in measured physical health outcomes” for poor adults.⁵⁹ Medicaid did increase per-person medical spending from \$3,300 to \$4,400. But even after two years, Medicaid produced no discernible improvement in enrollees' blood pressure, cholesterol levels, blood sugar levels, or risk of heart attacks. All that additional spending should have had an immediate impact on these important and treatable health measures, especially among the poor. Medicaid's failure to do so casts doubt whether the additional \$1,100 of medical care it makes available to enrollees improves their health in other areas, or over the long term. Since government subsidies are less likely to improve health for people with higher baseline access to

care, the Oregon Health Insurance Experiment casts even greater doubt on whether the PPACA's subsidies for higher-income individuals will improve their health.

The results stunned and embarrassed supporters of the PPACA, who had portrayed the law's passage as a matter of life and death, particularly for the poor.⁶⁰ Some complained the sample size was too small, yet that's just another way of saying the disease burden among the expansion group is not as great as supporters have portrayed it. Others stressed the findings that Medicaid reduced depression and financial strain. While the effect on depression is unambiguously beneficial, it is unclear whether reducing the financial strain imposed by medical bills should be an indicator of success for a program like Medicaid. If Medicaid has no impact on health, one might prefer that the uninsured experience financial strain when they need expensive medical care. That risk might prod people to purchase insurance and thus reduce the number of people who experience financial strain.

Supporters of the Medicaid expansion have an obligation to show the \$1 trillion the PPACA would spend on new health care entitlements will actually improve the health of enrollees. They cannot meet that burden of proof. There is no reliable evidence that Medicaid saves lives, scant reliable evidence it improves health outcomes at all, and absolutely no evidence that it is a cost-effective way of improving health. In the absence of such evidence, there can be no urgent need to expand Medicaid.

Expanding Medicaid Would Destroy Jobs

The most vocal advocates of the Medicaid expansion are the Virginia hospitals and other health care providers who would receive its subsidies.⁶¹ As George Bernard Shaw noted, "A government which robs Peter to pay Paul can always depend on the support of Paul."⁶²

These providers claim the Medicaid expansion would create or save jobs. In reality, it would destroy jobs. Government spending does not appear out of thin air. The money spent is diverted from other job-creating uses, and the taxes that raise those funds reduce overall economic activity.⁶³ University of Chicago economics professor Casey Mulligan explains:

Medicaid is a transfer, so it creates jobs in the sectors where it is spent, but it destroys jobs at the source of financing (for example, someone fails to buy a new car because he or she is lending money to the government to finance the expansion)...

States therefore have a choice of depressing their employment rates by accepting the Medicaid expansion and the significant additional financing that goes with it, or forgoing the expansion and its employment-depressing effects...

If enough states [refuse to expand Medicaid], both state and federal taxpayers could save a lot, and the nation might avoid another depressing force on its labor market.⁶⁴

Indeed, treating Medicaid like a jobs program is dangerously counterproductive. A thought experiment can illustrate. Consider the following medical innovations:

- Artificial respirators that pump oxygen into patients' lungs.
- Oximeters, the small devices that attach to a patient's forefinger, that automatically measure the oxygen in her blood and display the results on a monitor.
- Blood pressure machines that automatically track the patient's blood pressure, and display that information on the same monitor.
- Dosage machines automatically that dispense the right amount of medication to the patient at the right time.
- Mechanical hospital beds that automatically and gently adjust to prevent bed-ridden patients from developing painful pressure sores.
- Electronic medical records that make patient information more secure and accessible, and can reduce administrative costs and duplicative testing.

If supporters believe the purpose of Medicaid is to create jobs, they should endorse legislation denying Medicaid reimbursement for these devices. Even better, they should endorse legislation banning these innovations outright. Think of all the jobs such a ban would create for the nurses, lab technicians, orderlies, and clerks who would then have to perform those tasks by hand! Of course, that would be foolish, because it would make health care more expensive.

"Treating the health care system like a (wildly inefficient) jobs program," two Harvard economists recently explained in the *New England Journal of Medicine*, "conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price."⁶⁵ Expanding Medicaid for the sake of creating or saving jobs would reduce incentives to find ways of delivering better health care at a lower cost, and soak up resources that could be put to better use. The day Medicaid becomes a jobs program, we should abolish it—not expand it.

Washington Plans to Rescind Medicaid "DSH" Cuts Anyway

State officials don't need to expand Medicaid to save hospitals from cuts in the federal government's Medicaid "disproportionate share hospital" payments. The federal government is already planning to rescind those cuts, a development that further weakens the case for the expansion.

Hospitals have lobbied for the expansion on the grounds that they need it to compensate for the PPACA's cuts to Medicaid DSH payments, which the hospitals receive from the federal government to cover the cost of treating patients who don't pay their medical bills. As a preliminary matter, if hospitals dislike those cuts, they should not have endorsed the PPACA in the first place. The hospital industry was nearly unanimous in its support for that law. Various hospital lobbies "strongly urge[d]" Congress to pass the PPACA "with or without bipartisan support" as a matter of "national security, equity and fairness." They hailed the law as "historic," "a giant and essential step forward," and a "major first step" full of "great improvements." If the Medicaid DSH cuts take effect, therefore, the hospital industry has no one to blame but itself.

As it happens, it appears those cuts will not take effect. The Obama administration and members of Congress from both parties have proposed eliminating them. In his budget proposal for fiscal year 2014, President Obama proposed to rescind the Medicaid DSH cuts the PPACA would impose in all states in 2015.⁶⁶ The Obama administration's Centers for Medicare & Medicaid Services has proposed to eliminate two years' worth of Medicaid DSH cuts.⁶⁷ Sens. Debbie Stabenow (D-MI) and Roy Blunt (R-MO) have introduced legislation to rescind those cuts.⁶⁸ The bipartisan support for rescinding these cuts means Virginia has even less reason to expand Medicaid.⁶⁹

Expansion Doesn't Solve the PPACA's Discrimination against Citizens

Arizona Gov. Jan Brewer (R) has claimed that not expanding Medicaid would result in discrimination against U.S. citizens. In some cases the PPACA would provide larger subsidies to legal immigrants (who would receive subsidized private insurance through an Exchange) than to similarly situated citizens (who would receive Medicaid or no subsidies). The source of this discrimination is the PPACA's Exchange subsidies, and expanding Medicaid would not eliminate it. States *can* eliminate this discrimination by refusing to establish an Exchange, as 34 states including Virginia have done.⁷⁰

Here's how the PPACA discriminates against U.S. citizens. Many states decline to cover certain legal immigrants through their Medicaid programs. The PPACA's authors therefore let those immigrants purchase subsidized health insurance through an Exchange. The practical effect is that if a legal immigrant and a U.S. citizen are both below the poverty level, the immigrant may receive government-subsidized private health insurance, while the citizen gets less – *regardless of whether her state expands Medicaid*. If her state expands Medicaid, she receives a subsidy in the form of Medicaid coverage, which is generally considered inferior to "private" Exchange coverage. If her state does not expand Medicaid, she receives no subsidy at all.

Note that expanding Medicaid does not end the discrimination against citizens, which occurs whether the state implements the expansion or not. The only way to prevent such discrimination is to block the Exchange subsidies, which the PPACA gives states the power to do.

The PPACA authorizes Exchange subsidies only in states that establish their own Exchanges. Virginia, along with 33 other states, has refused to establish an Exchange, which blocks those discriminatory subsidies.

Unfortunately, the IRS is trying to issue those subsidies in those 34 states anyway. The agency is attempting to tax, borrow, and spend more than \$500 billion without legal authorization, and indeed contrary to the plain language of the PPACA and congressional intent.⁷¹

State officials who want to stop discrimination against U.S. citizens must challenge these illegal subsidies in court, as Oklahoma attorney general Scott Pruitt has done.⁷² Stopping the IRS's \$800 billion power grab is the *only* way to stop such discrimination. Expanding Medicaid

would not end it, because many citizens would still receive Medicaid coverage while immigrants receive private insurance.

Expansion Would Not Eliminate Penalties against Employers

Some employers have endorsed the expansion because it would reduce the penalties they face under the PPACA's employer mandate. Yet the expansion would not eliminate penalties against employers. Refusing to establish an Exchange and stopping the IRS's illegal power grab, on the other hand, would eliminate *all* penalties against all employers under the PPACA's employer mandate.

Expanding Medicaid would protect some employers from some penalties. The PPACA's employer mandate penalizes certain employers up to \$2,000 per worker if (1) the employer fails to offer sufficient coverage to all full-time workers, and (2) one of those workers receives a subsidy through an Exchange. Workers who are eligible for Medicaid are not eligible for Exchange subsidies. If a state implements the expansion, therefore, workers with household incomes below 138 percent of the federal poverty level would not be eligible to receive Exchange subsidies, and their employers could not be penalized for failing to offer them coverage. Employers would still be penalized for failing to provide coverage to other workers, however, thus many employers would receive no relief at all.

If a state refuses to establish an Exchange, however, then by law all Virginia employers would be exempt from the employer mandate. The PPACA allows no Exchange subsidies through a federal "fallback" Exchange, and therefore authorizes no penalties against employers in Virginia and the 33 other states that have refused to establish Exchanges.⁷³ Virginia should join Oklahoma and Indiana in challenging the IRS's illegal Exchange subsidies in court.

No Exit

Supporters argue that if the cost proves too great, Virginia can simply back out of the expansion. Some have even proposed an automatic "sunset" provision that would automatically end the program on a specified date, thereby forcing the legislature to reauthorize it. A sunset provision, they argue, would guarantee that the program would become permanent only if it proves successful. In reality, even with a sunset provision, the expansion is a no-exit proposition. Once implemented, it will become permanent despite the inevitable cost overruns, the damage to the private insurance markets, and even if it fails to benefit enrollees. As Milton Friedman once quipped, "Nothing is so permanent as a temporary government program."⁷⁴

Automatic sunset provisions have next to zero chance of sunsetting the expansion. State officials are loath to cut Medicaid even under the "old" matching grant system, where Virginia gets to keep 50 percent of the savings. Even if all else were equal, future Virginia officials will be much less likely to sunset the expansion if the state can only keep 10 percent or less of the savings.

Moreover, all else will not be equal. By the time a sunset provision would take effect, the health care providers who are lobbying for the Medicaid expansion today will have grown

dependent on the “their” new subsidies. If you think providers are lobbying heavily for the Medicaid expansion today, just wait until you see their efforts to reauthorize it. That lobbying campaign will be augmented by years of new expansion revenues, plus a new constituency that does not exist today—i.e., new enrollees.

The fact that some states have proposed automatically shutting down the expansion on December 31, 2016, illustrates how unserious and cynical sunset proposals are. Who can imagine a state legislature dropping thousands of people from the Medicaid rolls just one week after Christmas?

Even if Virginia tries to sunset the expansion, the federal government could nevertheless block the exit. HHS Secretary Kathleen Sebelius could simply decree that states that implement the expansion may not opt out, but must continue to comply with its requirements or lose all federal Medicaid funds – even if the federal government reneges on its promise to shoulder 90 percent of the spending. The Congressional Research Service writes:

the [Supreme] Court did not address such matters as whether a state that chooses to expand its Medicaid coverage may later decide to “opt out” of that choice and of the expansion requirements...[T]hese practical ramifications of the Court’s ruling...will need to be addressed by the Secretary of HHS, who has overall authority to implement the provisions of the Affordable Care Act, taking into consideration the Supreme Court’s decision.⁷⁵

This would not be a stretch for Secretary Sebelius, who has taken much greater liberties than this in implementing the ruling in *NFIB* (see below). Some legal scholars argue the Court could uphold such a decree:

While the Supreme Court stated that the federal government cannot condition the first dollar of existing Medicaid coverage upon a state’s decision of whether to opt into the expansion, it did not say that those requirements of federal law would not apply *after* a state has opted into the expansion. As such...it is entirely likely that a court would find that the Secretary of Health and Human Services has the legal authority to condition first-dollar federal Medicaid spending on...continuation in the expanded program. In other words: the federal government may shift a greater portion of the financial burden to states, but if [a state] has agreed to the expansion, it is likely that it will be locked into the program with no meaningful way to exit without risking ALL federal Medicaid funds.⁷⁶

Is there a soul in Virginia willing to bet their own money that Sebelius would just let the Commonwealth walk away from the Medicaid expansion? Even if the Court ultimately rules against HHS, litigating the issue would be costly, not least because Virginia could have to keep funding the expansion while the litigation is pending.

Does the “Arkansas Plan” Make Sense?

Under a proposal put forward by Gov. Mike Beebe (D), Arkansas has requested and received approval to enroll the Medicaid-expansion population through the state’s Exchange.

That approach would increase the cost of the expansion; would strip even more Americans of their existing coverage by encouraging more employers to drop their health benefits; would violate congressional intent; is of dubious legality;⁷⁷ would make the PPACA even more of a giveaway to private insurance companies; and would add a new form of discrimination to the law—i.e., discrimination against low-income parents.

The Beebe plan would dramatically increase the cost of the expansion. MIT health economist Jonathan Gruber, one of the PPACA's architects, explains, "Medicaid coverage is less expensive than coverage in the exchange for this population."⁷⁸ The Congressional Budget Office estimates covering expansion enrollees through an Exchange would cost an additional \$3,000 per person, increasing the overall cost of the expansion by 50 percent.⁷⁹ Implemented nationwide, such a plan would increase the cost of the PPACA and federal deficits by more than \$50 billion over 10 years.⁸⁰

Opening the Exchanges to Medicaid-expansion enrollees would encourage even more employers to drop coverage. Gruber explains, "if the entitlement for low-income individuals is to an exchange, disruption of existing employer insurance arrangements will be higher than if it is to a Medicaid."⁸¹ Exchange plans will presumably offer better access to care than traditional Medicaid. If so, workers will be more willing to drop their employer's coverage to enroll in the expansion, and firms with low-wage workers will be more likely to stop offering coverage entirely. Under the Beebe plan, the share of expansion enrollees who would have had private insurance anyway would therefore likely be even higher than the 82 percent projected under the expansion.

The PPACA's authors forcefully and repeatedly rejected this proposal in two separate committees due to its cost. Shortly before the Senate's Committee on Health, Education, Labor, and Pensions voted down the idea, Sen. Jeff Bingaman (D-NM) said, "[F]or our committee to say...that anyone covered by Medicaid could opt to go into the [Exchange] and obtain subsidies I think would just add to the cost and I would have to oppose the amendment."⁸² Before the Senate Committee on Finance likewise voted down the proposal, chairman Max Baucus (D-MT), the lead author of the PPACA, was strident:

I must say that this is a very bad amendment...If you are concerned about affordability, you will reject this amendment outright immediately...this one just blows affordability out the window. We cannot accept this amendment...I cannot understand how anybody would vote for this amendment.⁸³

Given such a clear statement of congressional intent, it would be wrong, and likely unlawful, for HHS to spend up to \$50 billion or more on a proposal that Congress expressly rejected.

The main beneficiaries of those additional subsidies would be insurance companies. Since its introduction in 2009, left-wing critics have called the PPACA a giveaway to private health insurance companies because it forces nearly all Americans to purchase those companies' products. The Beebe plan would increase government spending by paying private insurers more to cover Medicaid enrollees *outside of Medicaid* than those insurers receive for covering them *through Medicaid*. It would therefore make the PPACA an even greater giveaway to private

insurers. Paul Krugman rightly calls Beebe's proposal "welfare for the medical-industrial complex."⁸⁴

Finally, the Beebe plan creates a new "marriage penalty" or "family penalty" because it would offer better coverage to low-income bachelors than low-income families. The Medicaid-expansion population consists primarily of childless adults below 138 percent of the federal poverty level. Meanwhile, families in that income range are often already covered through the traditional Medicaid program. Under the Beebe plan, those childless adults would receive private coverage through an Exchange, while low-income children and their parents would receive Medicaid, which is widely regarded as inferior.⁸⁵

States Can Decline All of the PPACA's Medicaid Provisions

States can further reduce their Medicaid outlays, and federal deficits, by refusing to implement any portion of the PPACA's Medicaid expansion. The Supreme Court's ruling in *NFIB v. Sebelius* gave states the power to reject not just the expansion's coverage for newly eligible adults, but all mandatory Medicaid provisions of the PPACA.

As originally conceived, the expansion mandated that states expand their Medicaid programs in numerous ways. States that failed to comply would lose all federal Medicaid funds, which amount to roughly 12 percent of revenues for the average state.⁸⁶ The Court found that mandate unconstitutionally coercive.

The Court then freed states to refuse all mandatory Medicaid provisions of the law, including mandatory eligibility for all adults and children below 138 percent of poverty, "maintenance-of-effort," the new "MAGI" income standard, eligibility determinations for Exchanges, and so forth.⁸⁷

Shortly after the Court issued its ruling, however, Secretary Sebelius arbitrarily narrowed the Court's remedy. In a letter to governors, Sebelius invented the interpretation that states may only opt out of providing coverage for newly eligible adults.⁸⁸ Failure to implement any of the provisions of the expansion would result in the same penalty as before *NFIB*: the federal government would revoke all federal Medicaid grants. In other words, Sebelius is continuing to threaten states with the loss of all federal funds—a penalty the Supreme Court held to be unconstitutional coercion—unless they implement provisions of the law the Court made optional. Maine ran afoul of Sebelius' rewriting of *NFIB* and has challenged HHS in federal court.⁸⁹ States can further reduce the cost of their Medicaid programs, and federal spending and debt, by following Maine's example.

Better Options

Americans' access to medical care is less secure than it should be, thanks to decades of government interventions like the PPACA. Blocking and repealing this Act are positive steps that will make health care more affordable and secure. For example, the CBO reports that repealing the PPACA would reduce premiums for many consumers by freeing them to purchase more affordable health plans.⁹⁰

Virginia and federal officials should not stop there. After rejecting both an Exchange and the Medicaid expansion, and stopping the Obama administration's attempts to ignore and rewrite the law, state officials should adopt reforms that make health care better and bring it within the reach of more patients.

A “Good Samaritan” Law

For example, Virginia should enact a “Good Samaritan” law like those enacted in Tennessee, Illinois, Connecticut, and Missouri.⁹¹ Such a law would increase access to care for the poor without costing taxpayers a dime or threatening other priorities like education.

Volunteer groups like Remote Area Medical engage doctors and other clinicians from around the country to treat indigent patients in rural and inner-city areas of various states. These volunteers are often turned away from providing free medical care to the poor, because—even though they have a valid license from their own state—they do not have a license to practice issued by the state they are visiting. Remote Area Medical has had to turn away patients or cancel clinics in California, Florida, Georgia, and other states due to these licensing restrictions. “Before Georgia told us to stop,” says founder Stan Brock, “we used to go down to southern Georgia and work with the Lions Club there treating patients.” After a tornado devastated Joplin, Missouri, Remote Area Medical arrived with a mobile eyeglass lab. Missouri officials prohibited the visiting optometrists from giving away free glasses.⁹²

Tennessee, Illinois, Connecticut, and Missouri have now enacted laws that allow out-of-state-licensed clinicians to deliver free charitable care in their states without incurring the considerable and unnecessary costs of obtaining a new license. To protect patients, visiting clinicians are still subject to the malpractice laws of whatever state in which they are practicing.

Let Patients and Doctors Reform Malpractice Liability

Virginia can also expand access to care for the poor, again without costing taxpayers a dime, by allowing patients and providers to enact their own “med mal” reforms via contract.

The cost of medical malpractice liability insurance increases the price of health care for patients, pricing many low-income patients out of the market. Some “med mal” reforms would reduce medical prices, potentially making medical care more affordable. On the other hand, to the extent that these reforms limit physicians' exposure to liability, they may reduce incentives to improve the quality of care, or prevent some injured patients from recovering the full cost of their injuries.⁹³ When these types of complicated tradeoffs exist, the best approach is to let patients choose the tradeoff that works best for them.

Virginia should allow patients and providers to adopt their own med-mal reforms via contract.⁹⁴ Patients who want caps on non-economic damages, mandatory binding arbitration, medical courts, or a “loser pays” rule could choose those reforms, and enjoy any concomitant reduction in their medical bills. Patients who prefer to have an unlimited right to sue could write one into contracts with their medical providers, and pay whatever markup comes with that added

protection. Where states have already imposed caps on noneconomic damages or other limitations on patients' right to recover, this freedom would allow patients to demand *greater* protection than those states currently allow. The resulting experimentation would inform all patients and providers about which med-mal reforms do the best job of protecting patients from the dual harms of negligent care and unnecessarily high prices.

The obstacle to such contracts is that courts will not enforce them. That unfortunate judicial trend denies care to low-income patients by denying them the opportunity to decide for themselves whether accessing medical care now is more important than an unlimited right to sue in the unlikely event they suffer an injury due to a provider's negligence. The General Assembly should direct courts to enforce such contracts. Such a law would expand access to care for the poor, again without imposing any costs on taxpayers.

Study Whether Medicaid Works

Most non-health care experts are surprised to learn, as discussed above, how little reliable evidence there is on whether Medicaid improves health, and how there is no evidence it is a cost-effective way to improve health.⁹⁵ Though the Oregon Health Insurance Experiment is a promising start, some observers complain it was too small⁹⁶ and Oregon officials have unfortunately halted that experiment.

Rather than expand Medicaid, Virginia should apply for a waiver to conduct an Oregon-like experiment with existing populations, to determine exactly what taxpayers are getting for the billions of dollars they are forced to contribute to the program. Such a study would reduce state and federal Medicaid spending while improving the state of knowledge about Medicaid's effects.

No doubt some will object to randomly assigning Medicaid slots among existing populations. Yet the Oregon Health Insurance Experiment showed that losing the lottery reduced average medical spending among study subjects by just 25 percent, with no indications of harm to their physical health. The truly unethical course would be to preserve or expand Medicaid without knowing whether that additional spending helps enrollees, or just harms taxpayers.

Conclusion

Twenty-six states argued before the Supreme Court that the PPACA coerced states into implementing an unaffordable Medicaid expansion. The Medicaid expansion remains unaffordable today given current projections, and its actual cost is likely to exceed those projections. Perhaps more important, expanding Medicaid conflicts with the goal of delivering affordable, high-quality health care. Virginia should wisely and politely decline to participate.

¹ Portions of this testimony are adapted from Michael F. Cannon, "50 Vetoes: How States Can Block the Obama Health Law," Cato Institute White Paper, March 21, 2013, <http://www.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper.pdf>.

² See Michael F. Cannon, "50 Vetoes: How States Can Block the Obama Health Law," Cato Institute White Paper, March 21, 2013, <http://www.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper.pdf>.

³ This \$1.2 trillion figure represents the total projected burden of the revenue-increasing provisions of the law. Douglas W. Elmendorf, "Letter to Rep. John Boehner on Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012," July 24, 2012, p. 6, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf>. As the CBO has not published updated projections for all such provisions, this estimate may not be directly comparable to subsequent projections.

⁴ Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Institute Policy Analysis No. 669, October 13, 2010, p. 8, <http://www.cato.org/pubs/pas/PA669.pdf>.

⁵ This \$1.6 trillion figure represents total projected spending under the insurance-coverage provisions of the Act, and does not include the budgetary impact of the non-refundable portion of the Act's premium-assistance tax credits, which further increase federal deficits. Congressional Budget Office, *Effects of the Affordable Care Act on Health Insurance Coverage—February 2013 Baseline*, February 5, 2013, p. 2, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf, and author's calculations; Douglas W. Elmendorf, "Letter to Rep. John Boehner," Table 2, pp. 5–6 (showing 78 percent of the budgetary impact of Exchange-related tax credits and subsidies is new spending, while only 22 percent is tax reduction); and author's calculations. The estimate also reflects the fact that certain states have refused to implement the Act's Medicaid expansion. That adjustment reduces projected Medicaid outlays, but increases the budgetary impact of Exchange-related tax credits and subsidies. The CBO's most recent projections based on all states implementing the Medicaid expansion (from March 2012, and adjusted for slower observed growth in Medicaid spending) yield a similar estimate: \$1.5 trillion. Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 11, <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>; Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023*, February 2013, p. 60, <http://cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf>; Elmendorf, "Letter to Rep. John Boehner," Table 2, pp. 5–6; and author's calculations.

⁶ Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 12, <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

⁷ U.S. Congressional Budget Office, "Appendix C - Labor Market Effects of the Affordable Care Act: Updated Estimates," *THE BUDGET AND ECONOMIC OUTLOOK: 2014 TO 2024*, February 2014, p. 127, available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf>. Supporters of the law object that the CBO will reduce labor-force participation by the equivalent of 2.5 million workers, not eliminate 2.5 million jobs. The two effects are essentially equivalent. See Michael F. Cannon, "Yes, ObamaCare Will Eliminate Some 800,000 Jobs," *Cato@Liberty*, November 2, 2011, <http://www.cato-at-liberty.org/yes-obamacare-will-eliminate-some-800000-jobs/>.

⁸ Board of Governors of the Federal Reserve System, "Summary of Commentary on Current Economic Conditions by Federal Reserve District," March 6, 2013, <http://www.federalreserve.gov/monetarypolicy/beigebook/beigebook201303.htm>.

⁹ Austan Goolsbee et al., "Non-Farm Payrolls Up 236,000 in February," *CNBC Video*, March 8, 2013, <http://video.cnbc.com/gallery/?play=1&video=3000153157>.

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ACA Impacts on Medical Care in Alaska, Exchanges and Medicaid Expansion

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Access to care

- ACA has added over 20,000 new pages of regulations to over 130,000 pages of pre-existing medical regulations before ACA. Makes care more expensive and more confusing to provide.
- 40% Providers opted out of Medicaid nationally creates more limited access (low reimbursement so less time with patient results in poorer outcomes, more rules, more restrictions, more audits)
- Estimates of up to 60% providers will retire or opt out of Medicare/Medicaid in next 3 years. Alaska has 80% participation in Medicaid now because of high reimbursement will fall if reimbursement cut and as more rules and regulations are released from committees set up under ACA.
- Many states really limit services/medications which causes poorer Medicaid outcomes. Medicare now won't pay for services ordered by un-enrolled providers. Exchanges-15- 60 page applications, limits on eligibility \$62,000/family of 2, expensive, limits on which insurance companies can participate, repayment if income higher than estimated
- More employers cutting back on employee hours <30/week or days <120/year of employment to avoid paying for rapidly increasing cost of health insurance premiums up over \$2000/year/family, or eliminating spousal coverage--Children covered up to 26 years. Severe penalties if do not supply insurance.
- HSAs modeled after Healthy Indiana Program much better option as lower costs, less fraud, better outcomes consider linking this to permanent fund could cover many more people less expensively putting patients back in charge of health care

Increasing Costs

- No state opt out once expand Medicaid. (see ACA)
- No federal funding guaranteed beyond first 3 years of Medicaid expansion
Federal government trillions in debt with (\$220?) trillion unfunded liabilities
Medicare, etc.(Baby Elephant model)
- Cost estimates range from \$68 to \$278 million/year just for cost to state for Medicaid expansion.
- CBO says 2014-2019 cost \$570 million to state of Alaska with cost increasing from 2014-2022 to \$987 million as federal reimbursement falls for Medicaid.
- Increasing premiums in private sector (Medicaid pays below cost- so costs shifted to private payers increasing the premiums especially for small businesses and individuals) as insurance premiums est. to increase by 30-70% and up to 200% for younger people. By 2018 est. 100% of private insurance plans in Alaska will be taxed at 40% level (More services mandated to be covered under ACA so premiums will go up)
- Expansion of Medicaid increases costs both to state and federal government paid for by increased taxes/fees/penalties on taxpayers and companies. (Block grants-RI which puts states in charge a better choice)

Problems with Medicaid

- Many who need help fall through cracks.
- Medicaid patients poorer outcomes (University of Virginia study 800,000 patients) than uninsured.
- Many not getting married or deliberately underemployed/unemployed to obtain Medicaid or coming from other states.
- 60% Alaskans now dependent on Fed government for services what about independence/freedom/personal responsibility? Small number actually paying the bill via taxes: federal government borrowing from foreign governments to pay bill is unsustainable!
- ACA transfers \$700 billion from elderly (Medicare) to fund younger healthier people (Medicaid/Exchanges) and requires everyone to pay for abortions and other elective procedures (sex change operations)
- Confusing rules/regulations fed/state takes decisions away from patients/providers and limits medications/services-- disallows charity care/ boutique practices! (providers are told they are committing fraud if discount services below Medicare rate)
- Low reimbursements/audits in many states forcing practices to close/sell to large corporations.

Exchanges

- Mandated under ACA --many from Medicaid may be forced into these exchanges- confusing requirements/60 page application!
- Expensive to run \$60 to 70 million to set up, \$6 million/year to run in Alaska alone before any care given --duplicate administrative costs Medicaid/exchange-- restrictive on who can participate people limited by income to 400% poverty level and insurance companies government controls which ones participate.
- No clear guidelines as Governor Herbert of Utah said unsure if their exchange will qualify!
- Federal exchange no penalties to private companies if do not meet insurance requirements as there are in state exchanges as ACA is currently written
- Many states giving money back!
- Unsure number of people who will benefit or of cost to run- if employers drop coverage and pay less expensive penalties may be tremendous demand from new uninsured or may be very little demand as people may find it less expensive to buy as they do now privately- unsure how new premium taxes will impact these exchanges.

Providers

- Shortage of primary care providers now 50% MDs over 50; need 32 new/year, average 8 new MDs. 60% MDs considering retiring/opting out nationwide 2014/2015 (67% in an Anchorage survey I did of 400 providers)
- EHR increased time and expenses and security concerns (25% less efficient) \$1.5 million in fines if security breach
- Coding changes in 2014 (10,000 to over 80,000 codes)
- Audits by 18 organizations now with increasing fines regular includes new RAC Medicaid/Medicare audits (commission based/extrapolate) mandated under ACA
- Bundling of payments(have to bill hospital if within 30 days of hospital admission)/ quality reporting/IPAB (Independent Physician Advisory Board sets rates and services allowed)
- Underpayment by Medicare, Medicaid ,Insurance, Large corporations(United ,etc. now buying up practices) US average 40% MDs not taking Medicaid; dramatic reduction in private practices since ACA passed selling to large corporations
- Federal mandates/limits on services or required unnecessary services (breast cancer screening/PSA testing/Pap smears, etc.) 50% of my breast cancer patients diagnosed before age 50 yet limit Mammograms to >50!

Abortion coverage; Formula restrictions; pre-authorizations; increasing regulations

Summary

- ACA is a very expensive tax and regulatory bill that is going to drive providers out of business, increase insurance premiums and have a very detrimental impact on the economy of Alaska.
- We need to limit Medicaid, encourage the use of HSAs, not fund state exchanges, limit rules and regulations that increase costs for all, limit punitive audits and make them educational, support programs for the training of medical providers, continue efforts toward liability reform, pass legislation to allow boutique practices, and support health care freedom acts that put the patient, not the government, back in charge of their health care.

Better Solutions than ACA

- Block grants for states for Medicaid (Rhode Island)
- Educational not punitive audits
- Preventive care and prevention of accidents, Internet and school educational programs on diabetes, blood pressure, lipids, diet. etc.
- HSAs to model after Healthy Indiana Program(67% reduction in expenditures)
- Allow tax right offs or waivers for charity care without accusations of fraud for providers; pass legislation to allow boutique practices
- Increase vocational education programs for home care for disabled/elderly, support WWAMI, PA, NP, Residency, Nursing, Dental programs
- Payment like VISA/debit cards
- Allow patients/providers to make decisions not government/insurance/committees/UN/court(tort reform!)
- Pass a Health Care Freedom Act