Medical Care Advisory Committee
September 3, 2020
Meeting Location: HCS Conference Room
240 Court Plaza Suite 202
Juneau, Alaska 99801

The public is invited to make public comments
On September 3, 2020 from 3:30p.m. To 5:00p.m.
240 Court Plaza Suite 202, Juneau, Alaska 99801
Either in person or by calling 1-800-315-6338 (pass code 55829#)

MINUTES September 3, 2020

10:30a.m. – 10:45a.m.

INTRODUCTIONS:
Tawnya Adams, Regional Operations Manager;
Susan Ohmer, Executive Director, Provider Behavioral Health, Provider Behavioral Health;
Victoria Kildal, Behavioral Health Director Kodiak Area Native Association;
Robert Rang, CEO/Administrator Providence – Seward Medical Care Center
Matthew Hirschfeld, MD/PhD, Director-Maternal Child Health, Provider Physician Alaska Native Medical Center/Licensed Physician;
Dane Lenaker, DMD, MPH, Dentist, SEARHC Medical Clinic;
Jeanie Monk, Senior Vice President, Alaska State Hospital and Nursing Home Association;
Mary Middleton, Executive Director Stone Soup Group; and
Susan Wheeler, Pharmacist, Provider/Licensed Pharmacist;

Members Not Present:
Bunti Reed, OCS Program Coordinator, Consumer/Senior advocate,
Philip Hofstetter, Au. D, CEO – Petersburg Medical Center, Hospital Administrator;
Katrina Wilson, Nursing Facility Administrator Yukon-Kuskokwim Health Corporation; and
Renee Gayhart, Division Director, Health & Social Services, HCS Director.

Guests:
Jason Ball, Medicaid Program Specialist V;
Clinton Lasley, Deputy Commissioner;
Gennifer Moreau-Johnson, Director Division of Behavioral Health;
Heidi Barnes, Medicaid Program Specialist IV;
Tony Newman, Divisions Operations Manger;
Heidi Lengdorfer, Data Processing Manager;
Adam Crum, Commissioner;
Erin Narus, Lead Pharmacist;
Al Wall, Deputy Commissioner;
Ted Helvoigt, Contract Economist;

Dr. Julius "Pepper" Goslin, Medicaid Medical Director and
Suzanne Cunningham, Special Assistant to the Commissioner II.

Minutes from September 3 – 4, 2020 reviewed and approved by all MCAC members.

Announcements:

- Renee Gayhart Director of Health Care Services is unable to attend the meetings.
- Bunti Reed is no longer able to participate in the MCAC any longer.
- Consumer/Senior Advocate position is now vacant.

10:45a.m. – 11:15a.m.

Jason Ball, Medicaid Program Specialist V – JSURS data analytics tool and Care management Plan.

- Quality Assurance – Ability and Responsibility to look after patience and providers as it relates to care and reimbursements.

- JSURS Analytic Tool – Used to create data profiles by looking at folks by geography, age or sex to learn patient population. Profiles are created that look at physician services, use of pharmaceuticals, use of dental services, travel patterns, and just about anything. Data profile is built to get a greater sense of what our patients experience is with the Medicaid program. It helps with identifying trends and patterns in utilization, helps with identifying trends and patterns as it relates to spending, as well as looking for gaps in care.

  Provider profiles can be looked at the individual level or at the practice level. It allows a user to look for patterns that are acceptable such as billing and practice patterns that are acceptable. It also allows a user to look a patterns and trends that are less desirable such as indicators of fraud or abuse, indicators the need for billing interventions and to work with billing staff to understand a little bit more of the Medicaid program rule. Those are the two main things we use with the JSURS tool.

  As we look to be a resource and partner better in the future, we are working towards a tool kit or data request form that will help us deliver better data that is closer to what you are looking for the first time. We are looking at enhancing and improving the process so that we give better data the first time. As we continue to develop that form and that request process it will help us set priorities, set process, set parameters and it's going to help you ask the right questions in line with what the system can do.

  Transition to the Care Management Program which is a real-life implementation program visualization of what we do with our JSURS data. Care Management program where we identify over utilizers of Medicaid service at the patient level, So it's individual patients that have been identified to be using a Medicaid item or service that is more on a frequency of front Medicaid application. Medicaid regulations 7AAC 105600 that directs this program that basically says go find people who are overusing or abusing the Medicaid program and

intervein. We use our JSURS tool to look at emergency room use, travel patterns where we are not seeing medical visits, but we are seeing travel. We are looking at prescription and narcotic use. As we do that we end up with a list of people who are likely candidates for this program. The programs assign a primary provider and primary pharmacy to the member. It's not a voluntary program. This is a state decision and members have appeal rights of course.

At this point we have to gather a whole host of medical records to support this decision as it relates to putting a person into the Care Management Program and assigning a primary provider and primary pharmacy. Our records total for the last physical year that we received 2 million pages of records on behalf of the patients that we are working towards putting into this program. It's labor intensive at the division level as we need to read and review all the documents.

We are working on a regulation change that will help shift some of that record burden off of the provider. It reduces some of the record burden from the state and takes a data base approach to the identification of potential services that were received that weren't necessary. We would try to identify certain data behaviors and data pattern that would make someone eligible without having to go through that full record burden.

Right now, the program sits at about 400 people. We would like to expand that out and offer it to more people. One of the things that the program offers is health care navigation. It engages patients and helps them understand the important of primary care relationships, the importance of working with their local pharmacy and having active dialogue between all of their health care providers vs what we see most often is a very disconnected set of health care providers and pharmacies. What we're looking to do is by promoting and ensuring continuity of care leading to better health care outcome that actually cost less. That is what we're doing with our real-life example through the care management program supported by our JSURS analytics tool.

Open for Questions:

- Dane - Are you seeing an increasing demand from various partners or departments?

- Jason – yes we are seeing an increase inquiries into how we can support different departments and programs. We are trying to work this form so that can understand the priority of the request. The intent of the form is to help the inquiring body to help guide them through steps that make it easier and cleaner to pull that data. We have ongoing relationships with Program Integrity, the Medicaid Fraud Control Unit our sister division, SPS, Behavioral Health, Office of Rate Review and we're also doing some work with some of the specialty folks in Department of Administration as they want to take a look at Medicaid data. We're approaching it two-fold where we can train other division to some of this themselves we're absolutely doing so but we do have some capacity and we would love to continue to partner and grow the partnership with the MCAC.

11:15a.m. – 11:30a.m.

Jeannie Monk, MCAC member (Private/Non-Recipient Citizen) and Dane Lenaker, MCAC Chair – Yearly review of Bylaws. Highlight of changes were:

- Previous Bylaws had specific and detailed qualifications and responsibilities. It was one of the areas MCAC members felt were too much, so we streamlined qualifications and responsibilities. It about placing the statewide interest above individual concerns.

- Streamlined the officers and committees, as well as subcommittee structure.

- Withing the Bylaws now there are now only two official subcommittees. An executive committee and Bylaws committee.

- There is also a process where other subcommittees can be appointed. Those subcommittees will always have the Chair that is a member of the MCAC but committees may include other members of the public.

- Changes to the committee and subcommittee process. If a subcommittee wants to make a recommendation, they can provide recommendations back to the full MCAC for review and if those recommendations are approved by the full MCAC then they can be forwarded on to DHSS Commissioner.

MCAC Roundtable Updates

- Topic to be discussed later depending on what public comment looks like – Differentiation between workgroup and subcommittee.

- MCAC Group votes to reconvene reviewing the Policy and Procedure until September 4 meeting to allow all MCAC members ability to review.

- Tawna - Informs group cost of gloves in United States are skyrocketing and will soon exceed Medicaid allowable. Soon providers will be unable to provide. PPE and other mask prices are coming down in price, but gloves are not.

- Susan Ohmer – From a local perspective we've now reached a point at our agency where can not meet all the requirements to run an organization like I feel we need to do that a behavioral health center does so we're in the process of looking for another physical agent that can take on comprehensive behavioral health services in Petersburg because a small independent nonprofit just can't do everything that is required for comprehensive behavioral health with the amount of grant money that we get and the amount of Medicaid revenue we can bring in. There are very few independent nonprofits that provide comprehensive behavioral health in southeast.

Announcement to Public to Disclose Who is on – Michael Balwin announces he's online.

11:30a.m. – 12:00p.m.

Clinton Lasley, Deputy Commissioner, Department of Health and Social Services – Overview of covered Division. OCS, DJJ, API, Pioneer home update.

- Introduction in role and organizational structure and projects being worked - Deputy Commissioner for Family, Community & Integrated Services within Division of Health & Social Services. As a department we're broken up into two separate sections. Medicaid side which Deputy Commissioner Al Wall is in charge of and myself which is Family, Community & Integrated Services.

- Beginning of this calendar year we did a little bit of reorganization. We used to have Behavioral Health with Family, Community & Integrated Services but we moved Behavioral Health to the other side, so we are primarily focused on having all of our facilities and service providers on one side under one organizational structure. All of our payments, programs and Medicaid programs on the other side. So that is how our overall structure is. Under Family, Community & Integrated Services I have the Division of Juvenile Justice, the Office of Children Services, the Alaska Pioneer Home and the Alaska Psychiatric Institute. The Alaska Psychiatric Institute used to be under the structure of Behavioral Health but after the restructure we separated it. I have about 2,000 staff members within the four Divisions.

- Division of Juvenile Justice Services - has six facilities across the state which are: Bethel, Fairbanks, Juneau, Kenia, Matsu and Anchorage. Anchorage is our largest which has 220 beds, 435 employees and with a budget of 59 Million dollars, which are decided for youth services.

- Division of Alaska Pioneer Homes - has six facilities across the state which are: Ketchikan, Sitka, Juneau, Anchorage, Palmer and Fairbanks. The Pioneer home systems is probably one of the oldest running organization systems within the state government. It is a little over 103 years now. Alaska Pioneer homes has about 600 staff members with a budget of 65 million dollars that is for 498 elders within the state. Average age within the homes are 87. People with dementia are about 67%.

- Alaska Psychiatric Institute (API) - located in Anchorage has 87 beds, 346 staff and a budget of 55 million dollars. Alaska Psychiatric Institute provide emergency court ordered psychiatric services for the state. Juneau, Fairbanks and Matsu have facilities that can provide some for evaluation and treatment.

- Office of Children Services (OCS) - is not a facility where we provide direct services to families. We have various offices throughout the state that has the widest coverage. We have 585 positions in the Office of Children Services with an annual budget of 170 million dollars. OCS provides a wide array of services from the intake of an investigation for reports of harm all the way through to adoption and guardianship with the goal of reunification. We also have a working relationship with our tribal partners.

- Items that we are working on are keeping census at the facility of Alaska Psychiatric Institute and building the infrastructure, culture and leadership team. We currently have 50 beds of the 80 beds that we are able to take patients. We are working towards of the goal in upping that to 65 beds in October. At the end of the year we hope to open the youth beds which are 10 beds.

- I brough in former representative Tammy Wilson as a special assistant in my office. She has a passion for child services. She has been helping me understand the layers and understanding what is working.

MCAC Roundtable Updates Continued

- Robert – Concerns is that the State of Alaska is looking at contracting a 3rd party vendor looking at how long-term care facilities are being reimbursed for their services. It is pretty vague at how it's working out. We are only paid for cost. There is not a profit margin in long-term care services. There is concern in the long-term care facilities in what this is going to mean in the end and if some of the long-term facilities maybe viable after that.

Heidi Barnes, Medicaid Program Specialist IV – Overview of Alaska Medicaid Access Monitoring Review Plan.

- Alaska Medicaid Access Monitoring Review Plan - was initiated by CMS to all states to insure equal access for Alaska Medicaid members as the rest of the community. It is important to remember this. Example, if I lived in Barrow then I would have the same access to the same types of medical providers regardless if I was on Medicaid or if I was not on Medicaid.

- Alaska is different than any other state as far as population, geography, size, and road systems. Most of the lower 48 states use measures such as time or distance to get to a provider. In Alaska that doesn't make sense because of our unique situation and because of so many areas not accessible by road. We can't compare ourselves to highly populated areas or densely populated areas. What we looked at is the adequacy of the providers we do have. A consistent number of providers that can support people in all areas. Do we have the rates to support keeping those providers on? Do we have members that use services from all different areas? One of the questions that someone sent was, "How do we determine our areas to look at?" When we originally worked on this report, we looked at several different ways to look at our areas. We looked at census areas, economic region, individual villages and cities but we also had to consider the HIPAA privacy act and protect our members. With some of our areas and villages that are small as far as population goes or the areas are spread out that that they can tell a certain person might have 14 services for dental. They might be able to figure out who that person was just by looking at the area so after much consideration under the Executive Director at that time we went ahead with Alaska Economic Region.

- We look at the total population in these regions ranging from 400,000 down to 300 in different areas. So, we have a big group of people in one small areal theoretically and we have a small community spread out throughout the state. Consistently we have found that

Alaska Medicaid does offer equal access and more because we travel our patients frequently. There is adequate services available to anyone in the state of Alaska especially our Medicaid members.

- When we are looking at the services and providers and who provide the services. We're looking at where the patient reported they lived. We're not looking at where the provider is because we know that we travel people and we know the specialty people, the specialty services we're going to find in the hub not in the villages. We look at where they are living, what type of services they're getting by looking at their claims.

- The project started with CMS wanting focus on 5 areas which are: Behavioral Health, Home Health, The Physician Specialty Services, Pre-impost natal and the Primary Care Services. Later the rule expanded to add at any service where the provider rate was reduced, and it affected the state plan. At the time of a state plan change and for the next 3 years our AMRP report would need to review these services as well as the initial areas of service. The Department has added several more categories of services: ambulatory surgical centers, in-patient and out-patient hospital, nursing facilities, and the professional services which covered quite a few areas. The AMRP Data is always pulled in 3-year increment to provide a trend.

- The current AMRP cycle is looking at 46 provider types, based on how the provider enrolled, instead of the original service categories. Due to the increased provider rate reductions, it has made the report more manageable to break apart the service groups into smaller more specific provider types.

- If a service or provider type has dropped by 10 percent or more, we investigate and report on our findings. We look to see if the provider has retired, if the provider has been providing services for the past 18 months, if the provider was bought out by another provider, restructuring, if there is a change in the enrollment policies... We can usually tell why the providers are leaving. The other piece is the number of Medicaid members, how our membership is changing and the type of memberships over the course of the 3 years. It is broken down into eligibility categories: children, adults, age and disabled. We look at who's using the most services, where they are located, if people are moving.

- CMS proposed a change to the AMRP rule last year, major changes in how we look at access and the base of the report. The final rule was supposed to come out on August 1, we are still waiting. We will continue to complete the 2019 report as we have done the past 3 or 4 reports.

12:00p.m. – 12:45p.m.

Gennifer Moreau-Johnson, Director of Behavioral Health – Update on 1115, update on optum and update on new regulations for Phase II.

- Division has been expanding services with Behavioral Health during the COVID pandemic. The Division has applied for federal grants with short turn arounds in as short as 9 days. Division was awarded a little over $2 million dollars for COVID grants for Behavioral Health services in Alaska. The Division has been utilizing the CARES Act (Coronavirus Aid Relief Economic Security Act funding in a variety of ways such as expanding youth and adult access to the statewide crisis call center. CARE line number is 1-877-266-4357. The CARE line provides technical assistance and consultation directly to communities around suicide and behavioral health issues relating to COVID-19 pandemic. The other targeted areas is assisting people in communities after a suicide event has occurred. The Division has also opened up a second line due to the heavy strain on Alaska healthcare and emergency response system targeting first responders. The people who are on the front line with emergency response systems and health care are experiencing a great deal of duress. Being on the front line during the pandemic has put a lot of stress on people. The Alaska Responders Relief Line number is 1-844-985-8275.

- We have leveraged federal regulatory flexibility to increase the availability of telehealth services. We have seen an increase in usage of telehealth by new providers and we are seeing an increase in telehealth reimbursements. We are using federal and state flexibilities and some flexibilities in existing policies. We have temporarily lifted service authorization requirements to make sure folks are accessing care with the least amount of administration burden. We are also waiving prior authorization requirement during this crisis. Our goal is to reach more Alaskan's in need of behavioral health services by creating those flexibilities.

- The Division has made COVID response individualized service program funding available to behavioral health providers. The goals is to stabilizing and successfully maintaining community based per client.

- 1115 Medicaid Waiver Update – Key change is leveraging federal financial participation. It is up to 90% federal match. Another key themes to the waiver is rebalancing of care fittings. The idea that by providing early intervention services you can avoid acute services…getting the right services to the right person at the right time.

- To date we have authorized 23 mental health agencies, 45 substance abuse disorder agencies, operating at 174 sight locations and with over 755 individual rendering providers to deliver these waiver services. A thing to remember is that the state does not deliver the services but our providers. The intention of the state is to put these services out to achieve our goal of advocacy but to engage our providers. We are dependent on our providers to provide these services to achieve our goal.

- One of the things we are monitoring very closely is the impact of the refinancing from General Fund grant to Medicaid. Medicaid can't cover the cost of everything that grants

might have more flexibility in covering. One fun fact about the 1115 waiver is that states are required to have an independent evaluator so through an RFP process the State of Alaska Division of Behavioral Health has awarded the Health Services Advisory Group the independent evaluator contract for the 1115 waiver. The evaluators will be evaluating the full scope of the waiver such as: what we committed to, timelines, financing, as well as clinical outcomes

- ASO Administration Services Organization (ASO) Update – A deliverable for the ASO is assisting the Division by providing care management to ensure the right services are provided at the right time, that the appropriate level of services are provided and that early interventions are available. Another deliverable is that the ASO will assist the division by conducting quality improvement activities and financial accountability. Deb Etheridge is the COO Optum and CEO is Shelia Jorgenson. The contract was executed in 2019 taking the phased approach phase one going live with the processing of 115 claims in February. July 1st is when Phase II was implemented with ASO paying claims for all of Behavioral Health Claims.

- The items that were not moved over from Conduent to the ASO was the few provider types that tend to bill medical codes as well. The thought process was not to disrupt a process that is working for them and a year from now the final migration can occur.

Motion to recess until 2:00p.m.

2:00p.m. – 2:30p.m. Tony Newman, Division Operations Manager, Division of Senior and Disabilities Services – Update on EVV

- Electronic Visit Verification (EVV) is a system that electronically captures information about a visit between a healthcare services provider to a consumer. The electronic verification can occur through a telephone, GPS system, an app on a smart phone, and box that sits in a consumer home. The reason why it's being done is that in 2016 congress passed the 21st century CURES Act requiring states to implement EVV systems for Medicaid funded personal care services that require an in-home visit by a provider. Its intended to be a Medicaid fraud reduction technique insuring people are really delivering the services that they say they're delivering.

- The EVV is going to start out for personal care services. By 2023 it supposed to be expanded under the federal law to include home healthcare services. If electronic visit verifications are not done by 2021 for Personal care services and Home Health Care services by 2023 the feds will impose a penalty on our Medicaid match until we do implement EVV.

- Appendix K – is an appendix in the federal law around the 1915C waivers (the Home and Community-Based Services Waivers) that are offered at the Division in emergency situation. It gives the ability to ask for flexibilities under the standing Home and Community-Based Waivers authority in order to respond to the emergency that COVID poses. The Appendix K lifetime is until March 10, 2021. Appendix K allows the ability to temporarily provide alternative settings and distance delivery methods for things that would normally be done in

person such as CPR. It also allows some flexibility in paying services that normally were not allowed such as a husband providing services to a child. The division is monitoring all aspects of the flexibilities to see what may want to be kept after the pandemic such as tele-assessments.

12:45p.m. – 1:30p.m.

Heidi lengdorfer, Chief Data Officer – Discussion on Decision Support System and Health Information Exchange, Planning documents for Support Act.

- Support Act – temporary pot of money at 100% FFP. It's 100% federal funding. We have an approved funding request from CMS as of February to work on a decision support system and we have used it on our system drug monitoring plan. The Support Act is about reducing opioid overdose death.

- Decision Support Systems – Working with Retirement & Benefits on a RFP for a decision support systems that will allow us to have better access to the Medicaid claims data, as well as the state employee health data. This will help save money.

- HIE – Since January/February a Behavioral Health landing page has been put integration. A social determinants of health data module has been completed. Completed the connection with the PMP and completed Youth Exchange Data which will provide national healthcare data as they move across the healthcare data and not just in Alaska.

- Looking to the future there will be two types of API. One will be a provider API and the patient API which will be HIPPA compliant where the patient has access only. The goal for API will allow a patient to have access claims going back to 6 years. The compliance deadline is set for July of 2021.

MCAC Roundtable Updates Continued

- Matt – Issues with Genetic clinics and genetic testing. A workgroup was created to come up with some guidelines and what Medicaid will pay for. The ultimate goal is to get better genetic services for kids by the state by improving the reimbursement for genetic testing. A final draft was sent to Carrie Silver for review.

- Other bigger project is the Pediatric subspeciality project which is being put on by the All-Alaskan Pediatric Partnership. Over the past 2 years there was some instability in pediatrics for various reason such as aging staff and small population of kids. Alaskan Pediatric Partnership received funding for a project to provide a 2-year consulting plan to come up with a system that will actually work for all kids in the state. The goal is to build a board that specializes in Pediatric Specialty that makes sure all services are covered, all the contracts are covered and looking at providing services in a new way by utilizing telemedicine with general pediatricians with additional training in subspecialty that provides the first line of care that establishes a good relationship with a Children's Hospital down in the lower 48. We may have nurse practitioners with PA's doing the same thing. We got great buy-in from all the organization in the state and Preston Simons from Providence is our main

representative. We got Kathy the Director of Children's Hospital from Providence. We got Doug Eve involved from AMC so we got some really big people involved. Suzan Trick, who is the consultant, is the one driving this and a lot of partners working on it. We are hoping that by 6 months from now we will have the plan more established.

- What we need is the system that we have now that doesn't work at all that great, but it is working. We need it to remain stable for a year or two until we get this new plan up and running. It potentially can be a role model for the country that has rural area that has a low population of kids that needs services. We might be able to give them advice in their state as well such as places like Idaho and Montana or South Dakota.

- The last thing we are working on is with Kate Hudson and other members from the State of Alaska has put together a small workgroup that will be reporting to the MCAC probably next meeting. They're looking at what happens with Medicaid special rules around reimbursement for telemedicine during the times around COVID. So like the telephone calls reimbursements, some of the increase in codes that can be reimbursed by Medicaid for video telemedicine. The group is looking at those codes that was done around COVID and looking at what other states have done around COVID, trying to decide to do those should continue or do we make recommendations to the MCAC. The group will try to determine if it helps people and if its what people want or if it will decrease cost.

- Dane – Dental work with the subcommittee has been paused. Once COVID hit pretty much the dental community has stopped doing dentistry for quite a while and then it was heavily restricted. People have not wanted to dive back into dentistry because of COVID. Dentistry has always been an area of concern and as recently as August the World Health Organization has said that if you don't need dental care to hold off on it. There is a growing body of evidence that suggesting that folks that are under privilege or are under served or have Medicaid or public insurance they are the most vulnerable and most likely to be impacted by some of the changes with COVID. It is something we're monitoring and taking a close look at.

- Jeannie – ASHNA is partnering with the State on a maternal health project and we're specifically looking at severe maternal morbidity. So this is developing a toolkit for providers and since many of the women that give birth in Alaska are covered by Medicaid this group might be interested. There is a Maternal Child and Death Review Committee meets a couple times of the year that review every maternal child and death to see what the underlying factors and was it preventable. In order to make improvements it's good to look at things in short of death that cause a serious incident. We are in the process of developing a tool kit that will then be rolled out providers across the state on the morbidity issue and then on the mortality issue we are developing a series of briefing paper on some of the different factors that are involved in the maternal death.

- Hospitals and nursing home update the main topic and issue is COVID. It's challenging in the long-term facilities, but we are fortunate that if we have a resident that tests positive that the facility is able to react quickly avoiding a high mortality rate. This still comes at a cost of nursing home staff members, residents and resident family members because of the heavy

restrictions on visitations. Residents and resident family members seem like they are really losing their patience and getting tired of the strict guidelines. This is particularly important in Alaska because we have low capacity in long-term care. Alaska has among the lowest number of beds per capita in the country and lower number of beds over 65. We have no specialty long-term care facilities such as Alzhymers care or geriatric sights. This causes a problem as hospitals have to hold onto patients for much longer than is medically necessary sometimes weeks or months because there is nowhere to discharge patients to. This issue even though not new is becoming more and more of an issue due to COVID. There are concerns about how the department is looking at a new Medicaid reimbursement method for nursing phones because it can result in many nursing homes to close that have a high percentage of Medicaid.

3:00p.m. – 3:30p.m.

Adam Crum, Commissioner, Department of Health and Social Services – Budget overview, COVID-19, Disaster Relief and Emergency Operations, cost containment.

- Budget overview status is the recent closure of FY20. First time in a long time that we have lapsed some Medicaid funds across the board. One big help on that was the increase of 6.2% of FMAP from the Feds for the Medicaid program due to the COVID response. As we are looking towards our FY21 budget, one thing should be noted is that the cost containment items that were put into place for FY20 which included 5% rate reduction for facilities as well as withholding inflation have all gone away and are not in place as of July 1, meaning the rates have been made whole. One thing that we are very aware of as we move forward towards this next fiscal year is we want to make sure that our hospitals maintain good fiscal health. We are putting projections together for FY22. We are talking with the hospitals seeing where they are at. A lot of them have been able to recover quite a bit since the elective procedures were delayed due to COVID response. Ongoing efforts for system changes and rates include the DRG (Diagnosis Related Groups) analysis as well as the Skilled Nursing acuity case-mix analysis, which are both being led by the Office of Rate Review. ORR is working with facilities and ASHNHA as our contractor finishes their analysis.

- COVID-19 response has changed a lot of behaviors throughout health care facilities and how PPE is used, as well as how visitors come in-and-out of facilities. They are also encouraging staff members in their off time to be doing the right thing, by avoiding exposure to the virus in the community and then bringing it back into the facilities. The state has done a great job at protecting its vulnerable population as our mortality rate is amongst the lowest in the world.

- Status of Disaster relief and emergency side is that we're working to get some funds available for hospitals and skilled nursing facilities using CARES relief funds allocated to DHSS to support the COVID-19 response.

MCAC Roundtable Updates Continued
Chair – Announcement on elections needed for upcoming meeting. Chair is vacant. Matt announces he can continue as Vice Chair.

3:00p.m. – 3:30p.m.

Public Comment - Laura calling about the recommended COVID-19 Nursing home guidelines concerning residents and relatives of residents. Situation is a family member is in a nursing home and due to the strict COVID guidelines they are unable to see each other without a glass separating each other and has been going on for 6 months. Laura explains that her spouse feels like he's in a prison as he's confused why he must hold a device to speak to visitors and is unable to sit in a wheelchair for prolong period of time. Laura would like the MCAC member to propose that each resident be allowed 1 family member in the facility signing a waiver acknowledging the risks.

Michael – is thankful for all the hardwork and recommendations the MCAC group is doing and looking forward to hearing and seeing all the information from the MCAC.

5:00p.m.

Meeting Adjourns.

Medical Care Advisory Committee
September 4, 2020
Meeting Location: HCS Conference Room
240 Court Plaza Suite 202
Juneau, Alaska 99801

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MINUTES September 4, 2020

Jeannie – Announces to the MCAC group that she is open to being the Chair and will discuss the process with Dane.

Members Not Present:
Bunti Reed, OCS Program Coordinator, Consumer/Senior advocate
Susan Ohmer, Exec. Director Public Mental Health Services, Inc., Provider Behavioral Health,
Philip Hofstetter, Au. D, CEO – Petersburg Medical Center, Hospital Administrator;
Katrina Wilson, Nursing Facility Administrator Yukon-Kuskokwim Health Corporation; and
Renee Gayhart, Division Director, Health & Social Services, HCS Director.

8:00a.m. – 8:15a.m.

Erin Narus, Lead Pharmacist, Division of Health Care Services – Update of regulation changes. Upcoming projects focus on additional efficiencies.

- The pharmacy program is responsible for overseeing the programmatic responsibilities for covered outpatient drugs as they're defined by CMS. The reimbursement model as it was confided in 2017 by CMS is to reimburse at an actual ingredient at physician cost at a professional dispensary. What goes into a professional dispensary is a variety of factors that are not related to the drug product itself but to the professional services by pharmacists, by technicians and other inquiry staff within the pharmacy. Reimbursement overhead, building equipment, bottles and labels are also included. Through the regulatory process it guides states to perform what is considered professional dispensing surveys to determine the appropriate reimbursement rate. The last time this survey was performed was in 2012 and the regulations that the state put forward in 2014 utilized that reimbursement. We just finished up the final report coming out march in this year was our 2019 dispensing survey.

- The ingredient cost reimbursement the pharmaceutical product apposition starts at the manufacturer level and goes through a wholesaler. The cost that the a manufacture sells a product to a direct buyer such as a wholesaler or sometimes a pharmacy directly is at a wholesale apposition cost so that is one of our pricing bench marks that we use to help us identify what the pharmacy actual apposition cost will be. The pharmacy acquisition cost

plus professional dispensary results in the gross reimbursement to the pharmacy by the state utilizing both state and federal dollars. There is a phenomenal copay that is required for certain types of prescriptions 50 cents for those that are less than $50 dollars and $1.50 for those that are greater than $50 dollars.

- There are special out pricing that are used to make sure that your paying as close as to the acquisition cost as possible without imposing on whose burden on the pharmacy to maintain or update the files on a daily basis. One of those is the national average drug acquisition cost. It results to a 20 million cost avoidance on the front end of the prescription cost. The ACAFUL went into effect in April of 2016. Previously the older federal of the limit was based off an antiquated formula and it under-reimbursed pharmacies so this is a welcome change in 2016.

- The physician cost is another benchmark place that was currently used and its based off of manufacturers list price to direct purchasers.

- Trends from Quarter 3, 2018 to Quarter 3, 2019 costs have only increased to 1.6 to 1.7% which in the pharmaceutical realm is very good considering a lot of expensive drugs have just come to market which have been beneficial to patients.

- Drug class that drive our net spend is opioid dependence treatment do top the list of unique drug classes followed by hemophilia. One hemophilia patient treatment costs just for hemophilia factor in one-year ranges from $400,000 to a $1 million dollars per person. From the period of October of 2018 through end March of 2019 we had approximately 12,000 individuals who had filled an opioid prescription during that time. In the first half of 2020 we had a 22% decrease resulting in only 9,400 individuals.

8:15a.m. – 8:30a.m.

Ted Helvoigt, Contract Economist - Update on annual reporting.

- Overview of the MESA forecast which is the long-term forecast of Medicaid Enrollment and Spending in Alaska. The MESA forecast provides a benchmark for future initiatives. It provides insights into how individual factors affect spending such as: healthcare price inflation, intensity of use of Medicaid services, Medicaid enrollment and Population growth & demographic change.

- MESA relies on published data and statistical modeling such as: long-term population projections, enrollment in Medicaid programs, utilization of Medicaid services, intensity of Medicaid use and spending on Medicaid.

- Our findings show Medicaid enrollment grew by 51% between FY2015 to FY2019. Federal spending grew by 93% and GF spending grew by 6%. Medicaid expansion coinciding with Alaska's recession has increased the relative importance of the healthcare sector. Alaska's population has slowed and is projected to grow slowly with Alaska senior's population to

grow throughout our 20-year projection. It is estimated that there will be 300,000 more Medicaid enrollment by 2040 with a projected Medicaid services increasing an average of 4.6% per year.

- Most Medicaid recipients don't have a diagnosed chronic condition, but chronic conditions drive spending on Medicaid services. In FY2018, spending on Medicaid recipients with one or more diagnosed chronic conditions averaged $25,700, while recipients without a diagnosed chronic condition averaged only $3,900. Spending on Medicaid recipients with one or more diagnosed chronic conditions varied little by age, however, the prevalence of chronic conditions increases with age. In FY2018, 73% of Medicaid spending was on beneficiaries diagnosed with one or more chronic conditions and we expected this to grow to 78% by 2040.

****from 8:30a.m. forward recorder ran out of memory****

8:30a.m. – 9:00a.m.

Al Wall, Deputy Commissioner, Department of Health and Social Services – Overview of Medicaid Division. DBH, DHCS, DPA, SDS

9:00a.m. – 9:30a.m.

Dr. Julius "Pepper" Goslin, Medicaid Medical Director, Division of Health Care Services - Subcommittee/Advisory group discussion.

- Summarized the MCAC Subcommittee/Workgroup process
- Presented P&P to MCAC members for review at which time was set aside because MCAC didn't have a quorum.

9:30a.m. – 11:00a.m.

MCAC Member update and Roundtable - Subcommittee

11:00a.m. – 11:30a.m.

Suzanne Cunningham, Specialist Assistant to the Commissioner, Legislative Liasion, Commissioners Office – Legislative update

11:30a.m. – 2:30a.m.

Committee Recommendations Draft Time – Final recommendations for the following year.