ASHNHA

ALASKA STATE **HOSPITAL &**
NURSING HOME ASSOCIATION

February 26, 2016

Senator Anna MacKinnon, co-chair
Senate Finance Committee
State Capitol, Room 516
Juneau, AK 99801

Dear Senator MacKinnon,

Thank you for the opportunity to testify at the Senate Finance Committee hearing on SB 74 on February 25. ASHNHA greatly appreciates the work of the Senate Finance Medicaid Reform Subcommittee on this bill and for allowing our association the opportunity to provide input. I wanted to expand on some of my comments at the hearing and to provide you with additional information and feedback on this important legislation.

This bill represents a significant step forward in Alaska's health care reform journey. States that have successfully managed health care costs have a long history of engaging in reform, so we view this bill as the start of a process that will lead us to a more sustainable health care system. We encourage the Legislature to continue the dialogue into future legislative sessions.

This bill articulates a reform vision for the Medicaid program, including payment reform, enhanced care management, telemedicine, public-private partnerships and short-term cost reduction. We support the broad vision for the health care system outlined in the legislation.

The bill establishes a framework for payment reform, beginning with demonstration projects. Changing the health care system takes time and we fully support the use of demonstration projects to test new payment and delivery models. We appreciate the flexibility given to the Department of Health & Social Services to solicit innovative demonstration proposals and we remain committed to the idea that innovation can come from within Alaska's provider community. One size does not always fit all in our diverse state and we appreciate that this bill recognizes the need to develop local and regional solutions to managing health care.

We support the efforts in the fraud and abuse sections of the bill to limit redundant audits. It is important for the state to have the tools to address fraud and abuse, but to ensure that in doing so we do not burden low-risk providers with unnecessary administrative work that will only drive additional cost into the system.

We concur with the focus on primary care, through developing a primary care case management system. We support strengthening primary care as a building block for system change.

Finally, I want to note that we are enthusiastic and willing partners with the State and the Alaska Chapter of the American College of Emergency Physicians in a project to reduce the

unnecessary use of emergency departments (EDs), not just for the Medicaid population, but for all ED users. ASHNHA and ACEP have advocated for this project for more than a year because we believe it will have a significant and positive impact on reducing unnecessary ED utilization, while improving care. Major components of the project include an electronic data interchange to better share information between EDs, enhanced case management, opioid prescribing guidelines and patient education. A similar project in Washington State resulted in an overall reduction in Medicaid ED visits of nearly 10% and a reduction of 25% in prescriptions of controlled substances from EDs. This kind of provider engagement and public-private partnership will be critical to ongoing success in managing health care costs.

The ability to negotiate shared savings on this project is an important step forward in payment reform. As providers look at moving from a volume-based system to one based on value, the ability to engage in shared savings and other forms of risk is important learning for us and for the state moving forward.

I'd like to highlight a few areas of concern. We appreciate the committee's effort to address fraud and abuse. As low-risk providers, hospitals and nursing homes have a significant stake in ensuring the integrity of the Medicaid program. We support giving the Departments of Law and Health & Social Services the necessary tools to combat fraud and abuse. However, every dollar spent in compliance or in litigation is a dollar added to health care costs. As you ask providers to reduce costs, we ask that you consider the administrative burden you are placing on them. This bill contemplates a significant structural change to our fraud and abuse statutes. Some of the provisions included in the committee substitute were introduced in SB 78 in late January, including the overpayment section and the private right of action section. We are concerned that many providers are not yet aware of these changes and have not had an opportunity to understand their impact.

The bill creates a new private right of action where private persons or entities can bring an action on behalf of the government and share in the monetary judgment. This has the potential of incentivizing frivolous lawsuits, costing providers time and resources as they defend themselves against unwarranted assertions. Even if a lawsuit is ultimately thrown out, providers will have spent time and attorney's fees in defending themselves.

The only place SB 74 clearly states that the new enforcement "action" (referenced in Sec. 09.10.075, page 2, Section 1) is limited to Medicaid (those involving medical assistance payment fraud) is in the header. This creates ambiguity.

In addition, the bill expands existing AS 09.10.120 to be more clearly linked to Medicaid-related claims. This statute was previously focused more on natural resource and property-related frauds, and raises a question -- why treat Medicaid fraud more harshly than other frauds under AS 09.10.120 (e.g., longer statute of limitations)? (Page 2, Section 2)

The proposed Section 3 (AS 09.58.010) contains a number of fairly onerous provisions unrelated to actions that result in a false payment. If the state were to adopt this approach we suggest at an amendment to subsection (a)(5) (in bold): *"(5) knowingly enter into an agreement, contract, or understanding with an officer or employee of the state for approval or payment of a claim under the medical assistance program knowing that the information in the agreement, contract, or understanding is false or fraudulent* ***[and is material to receipt of payment for medical assistance]****."*

Much of AS 09.58.010 and AS 09.58.020 through .040 appears to be based on the federal False Claims Act. The Federal FCA doesn't define "proceeds of the action" with the overly-broad definition in this Alaska proposal. As noted previously, duplicate or conflicting compliance obligations between state and federal statutes can be problematic, both for the state and for providers.

Sec. 09.58.090 creates a very low threshold ($5,500) for this new enforcement mechanism and penalties. We suggest a more material threshold of damage to the state before this type of enforcement kicks in.

The new statutory audit provision [Sec. 14 AS 47.05.200(a)] is extremely onerous and one-sided. It does not require the state to evaluate for over- and under-payments, and it is inconsistent with existing Alaska Medicaid approaches to audits. More specifically, the following language is problematic:

- The new obligation in Sec. 16 (AS 47.05.235) that each provider must do an annual self-audit "of all claims submitted" and report the overpayment within 10 days. This obligation is a substantial burden when providers have effectively attested to the accuracy of each claim when submitted. In addition, there is no mention of reporting or recovering underpayments, and no provision for the state to audit for or pay interest on underpayments.
- While we appreciate the inclusion of language that the department may not assess interest and penalties on overpayments identified by providers, this section does not appreciate the full complexity of identifying or repaying overpayments. The MMIS system does not always make it easy to "refund" payments, since adjusting line items can be problematic and Xerox has to accept adjustments. Some providers have old credit balances dating back many years that Xerox will not accept. Until the State and Xerox agree to accept all refunds initiated by providers, regardless of whether they are self-identified or identified through external audits, it is unfair to invoke a penalty.
- The term "overpayment" needs to be better defined. Overpayments can be relatively simple (e.g. a duplicate payment made by Medicaid or another payer is determined to be primary) or more complex. Payments for non-covered services are difficult for providers to identify and should not be the provider's responsibility to self-report. An example would be if the patient was authorized for a four day inpatient stay, stayed for five days

and the state paid the full five days. This should be the state's responsibility to identify, but under this legislation if an audit identified the overpayment, providers would be subject to interest and penalties. Fee schedule or rate payment errors are also very difficult for providers to identify and should be the state's responsibility. Finally, system defects should be excluded from penalties. The MMIS system currently has known defects that are resulting in consistent overpayments for certain claims. Until the system is paying claims accurately, it is not just to consider penalizing providers for overpayments.

- We also suggest that if this approach to enforcement is adopted it must include standards for uniform/fair audits, and limitations on audit contractors using extrapolations that create assumptions of additional overpayment.

Regarding other areas of the bill, in Section 18 on page 22, we suggest a wording change. Lines 24 – 27 of the bill say that a primary care case management system or managed care organization should "increase the use of primary and preventive care.... While decreasing the use of specialty care and hospital emergency department services." We suggest amending that section to read "...decreasing the use of **unnecessary** specialty care and hospital emergency room services." This reflects the intent of decreasing unnecessary care, rather than decreasing necessary care.

We fully support enhanced use of the prescription drug database and we support efforts to increase participation in the program. We are concerned that in some hospital-based contexts, it is not always possible for physicians, pharmacists or their agents to check the patient's prescription record before dispensing, prescribing or administering a controlled substance. A specific example would be emergent trauma care.

We suggest eliminating Sec. 19 (e) (page 23) as duplicative. Section 20 (47.07.039, page 25) addresses the projects contemplated in Sec. 19 (e) in much more detail. We appreciate the work that went into crafting the language in Section 20 and we fully support moving forward under this framework.

Again, I want to express our appreciation for the significant work done in crafting this legislation. We look forward to working further with the committee to continue the difficult, yet important work of health care reform.

Thank you for your time. I would be happy to answer any further questions.

Sincerely,

Becky Hultberg, President/CEO