HOUSE FINANCE COMMITTEE
April 9, 2015
8:37 a.m.

8:37:12 AM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 8:37 a.m.

MEMBERS PRESENT

Representative Steve Thompson, Co-Chair
Representative Dan Saddler, Vice-Chair
Representative Bryce Edgmon
Representative Les Gara
Representative Lynn Gattis
Representative David Guttenberg
Representative Lance Pruitt
Representative Tammie Wilson

MEMBERS ABSENT

Representative Mark Neuman, Co-Chair
Representative Cathy Munoz
Representative Scott Kawasaki

ALSO PRESENT

Matt Eisenhower, Director, Community Health Development, PeaceHealth Ketchikan Medical Center, Ketchikan; Rick Davis, CEO, Central Peninsula Hospital, Kenai; Bruce Richards, External Affairs/Marketing, Central Peninsula Hospital; Representative Dan Ortiz.

SUMMARY

HB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

HB 148 was HEARD and HELD in committee for further consideration.

Co-Chair Thompson addressed the agenda for the meeting.

#hb148

HOUSE BILL NO. 148

"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."

8:38:05 AM

MATT EISENHOWER, DIRECTOR, COMMUNITY HEALTH DEVELOPMENT, PEACEHEALTH KETCHIKAN MEDICAL CENTER, KETCHIKAN, shared his intent to provide a "boots on the ground" perspective on population health and work the center had done through an innovation program funded by a Centers for Medicare and Medicaid Services (CMS) grant. He provided a PowerPoint presentation titled "Envisioning Better Care, Better Health, a Better You!" (copy on file). He relayed that Ketchikan had a population base of approximately 16,000. He addressed the CMS Demonstration Project on slide 3. He relayed that in 2010 the Affordable Care Act (ACA) had given over $10 billion to CMS over a ten-year period to look at demonstration population health improvement models; some of the models were related to payment reform and care delivery changes. PeaceHealth had been a recipient of one of the initial grants, which was awarded for a three-year period at a total of $3.1 million. The project at PeaceHealth had functionally started in January 2013 and had touched about 3,300 lives in the community (approximately 20 percent of the community residents).

Mr. Eisenhower addressed that CMS was trying to accomplish part of the "Triple Aim," which was a per capita reduction of cost for patients receiving care and some confidence in population health (slide 4). PeaceHealth had looked at payment reform related to how numbers were tracked, which was largely a new concept in healthcare. Additionally, the project had focused on how to shift some care. He relayed that for the past 50 years the healthcare delivery system had been experts on how to fix people, but were by in large not very good about keeping people healthy. He opined that it should more appropriately be called "sick care" due to the way clinicians were trained and the way providers were paid for fee-for-services. He explained that providers only got paid when they worked with patients, typically when they were fixing a problem; they did not typically get paid

when helping patients to stay healthy. He spoke to various ways to reduce the cost of care: 1) reduce readmission rates; 2) reduce unnecessary utilization of certain procedures that may not be necessary if patients are given the preventative treatment they needed; 3) increase care for chronic disease surrounding hypertension, high blood pressure, and diabetes (cost of care for these issues dramatically decreases when treated properly at an early age); 4) increase community understanding and encouraging ownership in patients' healthcare; and 5) increase access to care.

8:42:19 AM

Mr. Eisenhower highlighted outcomes on slide 5. Examples of outcomes illustrated on the slide included controlling diabetes (especially for patients with out of control diabetes, which lead to complications), emergency room (ER) clinic referrals when a patient should be seen in a primary care physician setting, hypertension improvement, and how to provide better follow up after a patient leaves the hospital. He addressed readmission rates on slide 6. He stated that typically if a patient needed to return to a hospital within 30 days for the same diagnosis something was wrong (either they were not properly treated or their post-acute care was not accurately handled). He addressed that based on other hospitals of a similar size, the facility's readmission rate should be approximately 8.87 percent. Prior to the work PeaceHealth had done, its historical rate had been 9 to 9.5 percent over the past five years. He pointed out that raw data for an 18-month period showed a decrease in readmission over the period. He noted that the facility's current adult readmission rate was 5.93 percent compared to the expected 8.87 percent readmission rate. He continued that as some of the interventions had been refined over a six-month period, readmission rates had dropped from 7.42 percent down to 4.86 percent, which represented a 45 percent reduction (slide 9). There were about 1,200 hospital admissions in Ketchikan annually, which equated to approximately 50 patients who did not need to return to the hospital unnecessarily. He estimated that the savings was approximately $500,000.

8:45:14 AM

Mr. Eisenhower discussed that CMS wanted hospitals and caregivers to improve per beneficiary per encounter cost reduction (slide 10). He detailed that the cost for Medicare (patients over the age of 65) and Medicaid (federal/state entitlement for people with needs) had gone from $536/encounter in FY 12 to $457/encounter in FY 13 (a reduction of 15 percent). All payers (private insurance companies) had also seen the same savings. He addressed the lower portion of slide 10. Hospital data for 2012 and 2013 was shown on the right and clinic data was shown on the left. He pointed out that the clinic data represented regular doctors providing preventative care; the payment dollars for all payers was approximately $200. He remarked that the payment dollars for Medicare and Medicaid had not changed significantly; the numbers may actually rise if providers were doing their jobs properly. He pointed to the "all payers" under the hospital columns and noted that the deep costs resided in this area. He pointed to a dramatic reduction for hospitals per beneficiary per encounter from $1,373 in 2012 to $1,028 in 2013. From a prevention standpoint costs were expected to remain about the same or rise, with a cost or payment reduction on the inpatient and hospital side.

Mr. Eisenhower provided an example related to transitional care on slide 11. He explained that when a patient left the hospital the discharge report was provided to care coordinators (social worker, licensed practical nurse, and registered nurses) who discussed next course of treatment and medication reconciliation with patients. He elaborated that medication reconciliation was used for certain diseases such as heart failure; understanding and taking medication was a key component of reducing readmission rates. He emphasized that there were many non-medical hurdles to healthcare that resulted in medical failures.

8:48:32 AM

Co-Chair Thompson noted that Representative Gara had joined the meeting.

Vice-Chair Saddler asked for a definition of medication reconciliation. Mr. Eisenhower replied that medication reconciliation was helping the patient with medications they were taking, what they should be taking, and how much they take. For example, it boiled down to telling a patient

to take one blue pill in the morning and two pink pills at night.

Vice-Chair Saddler asked for clarification on what was being reconciled. Mr. Eisenhower replied that reconciliation referred to whether a patient was doing what the doctor prescribed. He emphasized that frequently a patient either did not understand the discharge planning or failed to pick up their prescription because they could not afford it, they did not have transportation to pick it up, or other. He reiterated that patients ended up back in the hospital due to many hurdles that were not necessarily from a scientific or medical standpoint.

Mr. Eisenhower continued to discuss a snapshot of the process on slide 12. The hospital employed social workers and primary care physicians for transitional care; it also worked with financial educators and community organizations. The hospital followed up with patients two days after they were discharged to provide post-acute care. He addressed the transition of care call template on slide 13. He explained that the template was easily replicated for other organizations if needed. Slide 14 showed examples of things a nurse did prior to making a phone call. The nurse reviewed a patient's experience in the hospital and looked for red flags that may result in readmission. For example, if a person went in for knee surgery the nurse would not find it important to check their ear; the preparation was specifically related to the patient's recent procedure. The preparation also included a medication review, follow up appointments, home health, other community support, and supplies. He looked at slide 15 and addressed the importance of motivational interviewing and active listening with patients. Care coordinators aimed to ensure that the patient did not return to the hospital and provided their recommendation.

8:51:52 AM

Representative Wilson asked if Mr. Eisenhower was referring to the ER when he discussed the hospital. Mr. Eisenhower replied in the negative. He explained that he was referring to discharged patients leaving the hospital after they had been admitted. He detailed that frequently a patient's visit began in the ER and ended up in the hospital. However, similar procedures were used for ER patients as well. He continued that once a person was admitted their

level of acuity or difficulty was typically higher than the emergency room. The goal was to keep patients from using the ER repeatedly if the environment was not appropriate.

Representative Wilson recalled visiting Unalaska a few years earlier. She discussed that the Unalaska clinic was also the emergency room. She explained that the clinic's model focused on steps it could take to prevent patients from unnecessarily using the emergency room. She surmised that the model used by PeaceHealth focused on following up with discharged patients to reduce readmission rates.

Mr. Eisenhower replied in the affirmative. He clarified that on a federal Medicare level the items were starting to be paid for with fee-for-service. The Medicaid world did not currently have the tools from a payment standpoint. He continued addressing psychosocial hurdles that resulted in expensive medical care (slide 15). For example, a patient may not fully understand their insurance or their coverage, may be concerned with pricing transparency, and other. He discussed that often times homelessness could contribute to a lack of healing. Other issues included adequate caretaking at home, transportation challenges (access to food and basic needs), disabilities, general medical literacy challenges, and other (slide 16). He believed that addressing the issues was part of the medical community's responsibility. He stated that the only way it would happen and would be incentivized was through payment reform and by holding hospitals and clinics responsible for their patients. He continued that medical facilities should be given the financial tools of payment in order to hire people who could help (i.e. social workers and care coordinators).

Co-Chair Thompson noted that Representative Guttenberg had joined the meeting.

Mr. Eisenhower addressed the final slide "Questions and Discussion" (slide 17):

- 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 caregivers.

Mr. Eisenhower elaborated that there was a net $2.2 million loss the hospital was realizing. He stated that the hospital did it in part because it had a grant to cover operational costs and philosophically it was the right thing to do; however, the model was not sustainable. He believed capital for the upfront startup costs of similar programs was missing. Additionally, confidence that it would work in communities was lacking. PeaceHealth had been fortunate to receive capital from a grant. He added that the care coordination required local knowledge by caregivers. He noted that based on the facility's experience, it was not practical to use a call center in Chicago to help with the items the organization found to be successful.

8:58:11 AM

Representative Gara wondered if Medicaid expansion had any bearing on the Ketchikan community. He referenced previous testimony from the Alaska Regional Hospital that with expansion it could reduce ER costs by constructing a clinic to provide needed services for a much lower price.

Mr. Eisenhower replied that the scenario described by Representative Gara was called a "fast track" in the medical system; where a person came into the emergency room, but was fast tracked through a different level of services. He stated Medicaid expansion would help PeaceHealth provide self-payers with a tendency to use the ER with more optimal clinic or fast track options. He added that from a researcher standpoint, the cost really resided in preventable expensive readmissions to hospitals. For instance, the hospital costs to the ER may be a few thousand dollars, whereas a readmission of a heart failure patient could be $30,000 or $40,000. He discussed that in smaller communities like Ketchikan, the hospitals averaged about 24 patients in the ER every 24 hours. He elaborated that even if the number was reduced, the hospital's staffing and cost for the ER did not change. He detailed that PeaceHealth could not really adjust its staffing to realize savings due to the facility's volumes. He stated that from a patient perspective it was about quality of care - getting a person in the right place, which was often not the ER.

Representative Gara wondered if uncompensated costs sent to private insurance payers would be reduced if ER care was reduced through Medicaid expansion. He asked if expansion would have a side benefit for Alaskans with private insurance who had their premiums hit due to uncompensated care.

Mr. Eisenhower deferred the question to another party. He remarked that there was a widely understood perspective that the whole trend of healthcare was changing to population health; there was an understanding that hospitals would have a different role in the future. From a hospital standpoint, there were many things that could be prevented. He continued that the cost based on volume would reduce through a combination of good population health management (keeping people out of the hospital) as well as ensuring patients in the hospital could pay their bills through Medicaid expansion. He recognized that PeaceHealth would have to redeploy many of its resources and move away from the acute setting towards the preventative world. He believed the perspective was widely understood. However, there was currently not much incentive to make the change based on a payment perspective; he could not get paid for much of the preventative work that was currently being done. He explained that the prevention was actually decreasing the revenue in the hospital setting.

9:03:37 AM

Co-Chair Thompson liked the idea of improving wellness and working to prevent people from coming back to the hospital repeatedly; however, he believed for larger hospitals the scope of the increased work would be very difficult.

Mr. Eisenhower answered that his presentation represented a small sliver of population health. He communicated that CMS and Medicare provided chronic care management, which allowed the hospital the enrollment of patients on a monthly basis in a registry. As long as the patients went through the preventative components dictated by CMS, the hospital was paid for the work. Currently traditional care and chronic care management were the two options available to the hospital. He agreed with Co-Chair Thompson. He continued that often in the Lower 48 the work was segmented; there were staff who only worked with discharge patients, while others worked only with chronic management. He discussed that it was doable; for every $1 the hospital

spent it was saving $2. The hospital knew improvement was possible, that it was the wave of the future, and the right thing to do.

Vice-Chair Saddler asked if PeaceHealth was a for-profit hospital. Additionally, he wondered if the facility was the only hospital in Ketchikan and if it was part of a national association. He asked for detail on the facilities. Mr. Eisenhower responded that PeaceHealth was part of a system of eight hospitals in the Northwest. He furthered that PeaceHealth was the only hospital in Ketchikan; it had one clinic in Craig. PeaceHealth was a critical access hospital with 25 beds; the facility offered a wide array of specialty services including obstetrics and orthopedic and general surgery. He remarked that a lot of Alaska had a closed system, including PeaceHealth. He elaborated that within its system, most of the physicians were employed by PeaceHealth; therefore, the facility had a very close relationship with the inpatient world, which was not the case everywhere. He was not opposed to clinics remaining independent, but he believed there needed to be a closer collaboration; in the past much of the patient care had been siloed.

Vice-Chair Saddler asked how many hospitals were in Ketchikan. Mr. Eisenhower replied that there was only one. He detailed that there was not significant incentive for the hospital to compete for patients due to the lack of competition. People had questioned why the hospital was paying money to lose money; the hospital was doing it to be a leader, because it believed it was the right thing to do, and because ultimately it would benefit.

Vice-Chair Saddler asked about the hospital's current funding stream. He asked for the number of Medicare, Medicaid, and other payers.

9:08:40 AM

Mr. Eisenhower replied that public payers accounted for 50 percent (Medicare at 21 percent/Medicaid at 18 percent), 8 percent were dual payers, 37 percent private payers, and 12 percent were uninsured or self-pay.

Vice-Chair Saddler pointed to slide 16 related to hurdles to follow up care. He believed addressing patients' housing needs, family support, transportation, and food was a broad

mandate of care. Mr. Eisenhower replied in the affirmative. He did not believe it was the hospital's responsibility to handle the items, but he did believe the hospital needed to take some ownership to help patients navigate the items to some degree. He furthered that the hospital did not have to provide housing, but in many cases it needed to help patients figure out housing through other organizations.

Vice-Chair Saddler asked if the hospital needed to help patients figure out housing out of a sense of social obligation or because it was good for the business.

Mr. Eisenhower answered that it was good for public health. He believed the days were gone where a payer was agreeable to continue paying every time a patient showed up to the hospital; the payers wanted true capitation and population health. He elaborated that hospital organizations took responsibility for a life and would negotiate what that life cost would be. For PeaceHealth the scenario was 10 to 15 years down the road; however, there were affordable care organizations in the Lower 48 that had a capitative agreement.

Vice-Chair Saddler asked for a definition of capitative.

Mr. Eisenhower explained that a capitative agreement meant that a hospital would receive one allocated payment amount per year for a patient. For example, PeaceHealth would receive $6,000 per year to take care of a patient. The structure incentivized PeaceHealth to make sure prevention was done because any cost above $6,000 would cost the hospital, whereas if the hospital did a good job and the patient only cost $4,000, the hospital would net the remaining $2,000. He remarked that there had been waves of the scenario through the 1980s through managed care and other. Ultimately, the consumer would drive the change through the expectation to receive good care. He opined that outside of capitation, it was difficult to see how the situation would change.

Vice-Chair Saddler believed Mr. Eisenhower was saying that people would be willing to give up more control of their lives to the influence of the healthcare system in order to receive healthcare at a lower cost. He thought it was an interesting trend to have a healthcare system take over more responsibility for food, disabilities, housing, family support, and social work.

9:12:57 AM

Representative Edgmon referred to Mr. Eisenhower's statement that healthcare should be more appropriately called sick care due to the high number of patients who returned prematurely. He pointed to Mr. Eisenhower's thorough discussion about all of the things PeaceHealth did to reduce readmission rates to 8.7 percent. He surmised that the takeaway was more about payment reform and the fact that if healthcare providers received the proper resources they could provide better care, increase efficiency, and reduce readmissions.

Mr. Eisenhower agreed. He detailed that most providers understood what needed to be done to keep people out of hospital. He relayed that there was currently not the incentive to do so. He believed payment reform was the incentive.

Representative Edgmon asked for verification that payment reform was more important than expanding Medicaid. Mr. Eisenhower believed the two went hand in hand. He elaborated that Medicaid expansion would provide more revenue to the hospital because of the reduction in uncompensated care. However, what he was referencing would not be accomplished primarily with Medicaid expansion without some payment and Medicaid reform.

Representative Wilson referred to the 12 percent who were uninsured or self-payers. She asked if the hospital received any federal funds that offset the 12 percent if they could not pay. Mr. Eisenhower did not believe so. He added that there were self-payers who paid their bills.

9:16:05 AM

Representative Wilson stated that many people had gone through the exchange in the past year. She commented that individuals had been given the choice to buy health insurance or take the federal tax penalty. She wondered if the 12 percent figure had declined when the exchange had been implemented.

Mr. Eisenhower prefaced that he was not a chief financial officer. He answered in the first quarter of FY 14 the

percentage of self-payers had been 17 percent at PeaceHealth; the number was currently 12 percent.

Representative Wilson asked how much of the 12 percent had no funds to offset their costs. Mr. Eisenhower would follow up with the information.

Vice-Chair Saddler asked about the specific Medicaid reform requirements needed to accomplish the triple aims care coordination process. Mr. Eisenhower replied that the hospital's experience had demonstrated that capital was needed to start up a program, get the training in place, and to ensure tracking is done properly. He shared that capital was necessary for the first step in Alaska, which would lead to confidence in policy makers to do even more payment reform. True payment reform would mean ensuring the hospital was compensated for its work from a fee-for-service standpoint (which was not currently occurring).

Vice-Chair Saddler asked about elements of payment reform needed. Mr. Eisenhower answered that payment could be provided to the hospital by a private insurance company, Medicaid, or Medicare. He detailed that for over 50 years it had been a fee-for-service. He stated that payment reform could come in many forms. He used true capitation as an example of an extreme payment reform that he did not foresee the state seeing in the next few years. Clearly in payment reform models, the fee-for-service would be shifting or adding fees for services the hospital was providing that it was not currently paid for. For example, the hospital was not currently paid for transitional care; there was no fee structure that enabled the hospital to bill for the service.

Vice-Chair Saddler asked for verification that payment reform would be separate from Medicaid expansion. Mr. Eisenhower replied that it was possible.

9:21:04 AM

Vice-Chair Saddler referred to the hospital's $3.1 million grant for three years. He asked how much capital would be needed for the facility. Mr. Eisenhower replied that PeaceHealth would need approximately $700,000 per year to implement all of the population health benefits. He explained that PeaceHealth had received more than the $700,000 because a piece of the project was to track the

data and conduct the research; most facilities would not need that extra layer.

Vice-Chair Saddler asked if it would be fair to divide the $700,000 by the hospital's 1,200 patients to determine the cost per patient. Mr. Eisenhower replied in the negative. He detailed that it was only one piece of what the hospital was doing. He could provide the information. The transitional care management piece represented in the presentation was only one facet of the broader work being done.

Vice-Chair Saddler appreciated seeing what care coordination and cost containment could be. He also understood that the items were exclusive of Medicaid expansion. Mr. Eisenhower agreed.

Co-Chair Thompson referred to discussion that Alaska was the only state that had no medical provider tax. He asked for comment. Mr. Eisenhower replied that the topic was out of his expertise.

9:23:16 AM

Co-Chair Thompson noted that the following presenters were working on a coordinated care project in Kenai.

RICK DAVIS, CEO, CENTRAL PENINSULA HOSPITAL (CPH), KENAI, read from a prepared statement:

> Central Peninsula Hospital is a 49-bed acute care hospital in Soldotna. It is owned by the Kenai Peninsula Borough and leased to a nonprofit board CPGH Inc. I'm testifying today in support of Medicaid reform and Medicaid expansion. In addition I'm going to cover a demonstration project that we've been working on that could help put Medicaid on a predictable and sustainable glide path. Reform is necessary for Alaska and expansion is necessary for those Alaskans who can't afford coverage. When I talk about reform I'm really talking about both delivery and payment reform combined. Because CPGH is a standalone community hospital, we must figure out a glide path on our own. There isn't a big health system behind us or a corporate swat team to call in to help us navigate the rapidly changing healthcare environment.

Some of you on the committee may have hospitals in your districts that operate under the same circumstances and pressure. As a result, we are left to our own devices to survive the ongoing transformation while continuing to provide those high quality services that make sense for our populations we serve. The process and timeline for us to change and how we deliver and pay for care has now been accelerated due to the current fiscal climate we find in Alaska today. For our part CPH began developing a pilot demonstration over a year ago for the Medicaid population on the peninsula. The demonstration is a managed care plan model that is risk baring, locally governed provider network that we call a community care organization or CCO for short. It would provide all Medicaid beneficiaries with physical health services and potentially behavioral health and dental services in one benefit package. The CCO would be paid under a single global budget for these services that can only grow at a fixed rate per year. That stability should be attractive from a state budget architect's standpoint as it eliminates the peaks and valleys that occur from year to year with the budget.

The CCO would be held accountable by the state to meet performance metrics and quality values that align with industry standards, new systems of governments, and payment incentives that reward improved health outcomes. Healthcare in Alaska is fragmented and it lacks coordination and efficiency, which reduces quality and increases unnecessary care. Currently Alaska does not utilize managed care organizations or managed health plans, but I understand there is language in nearly every bill the legislature is considering that provides for elements of the Medicaid population to be enrolled in a managed health plan.

I support making this necessary step. We must begin structural payment reform in Alaska now because it's clear to me that this will be the next stop in the road to reform. We're talking about global payment as a payment reform mechanism here.

I view our CCO as the step beyond payment reform. My belief is simply based on the funding structure and risk baring nature of the program. More importantly

> providers will no longer be paid for treating illness, but instead for a highly coordinated system that prevents illness and the high costs associated with it.

9:27:55 AM

Mr. Davis continued reading a prepared statement:

> As a hospital administrator I see things almost every day which do not make much sense with regard to patient care. The reason for this is because of the way providers are reimbursed or to take it a step further, the way incentives in our business are misaligned. An example, a terminally ill person who has managed to stay at home until their condition or pain has deteriorated to a point that their family could no longer provide the level of care necessary to manage their loved one's pain. What happens next for that patient? Probably many of you are thinking the next logical step would be hospice care. That would seem to make the most sense, but in our community you won't find a robust hospice program. We have a volunteer hospice program that does their best loaning out equipment providing some home health visits with the limited donations that they currently receive. But most patients still come to the hospital for those final days of their life. As a hospital, we're not incentivized to provide home hospice care simply because we're not paid for it. But I would like the flexibility to do that. So what happens instead? The patient's admitted to the hospital where they're most likely to spend their last days receiving care, but in the wrong high-cost environment.
>
> Under the CCO model a global budget would allow the organization flexibility to develop a more robust hospice program that would provide this pain management, palliative care, and respite services for the family in a less expensive home environment.

Vice-Chair Saddler asked for a definition of the term global payment. Mr. Davis replied that it could be called capitation, per diem, or other; it was a mechanism of payment. For example, on the Kenai Peninsula Borough there had been a given number of Medicaid beneficiaries who paid a given amount for service. The concept would be to present

a global budget for the population for the following year, capped at a certain level; it would then be the organization's responsibility to manage the care of the given population under the defined global budget. He believed it had to be done through a coordinated effort between the physicians, hospitals, post-acute care, insurance, and other.

Vice-Chair Saddler surmised that it [global payment] looked at history to determine how much it cost to provide care for a population and then limiting the organization to the historical average to eliminate outliers.

9:31:44 AM

Mr. Davis continued to read a statement:

> I would like for us to have the flexibility to be able to put these care models in place, but if we do divert our current resources to non-paying services it jeopardizes our other services that we do provide for our residents. It sounds ridiculous because it is. We need to restructure our payment system so that we can do what is best for the patient at a sustainable cost. The demonstration project we're building would allow us to do that. You may be wondering what the coordinated care organization looks like. It's a model based on a clinically integrated care and population health management model. It includes the hospital employed and independent primary care physicians, behavioral health providers, specialists, and an insurer. And they all work together instead of against each other, which is kind of the way our current system is built. This structure requires a great deal of frontend work to bring the stakeholders together, agree on a payment structure within the organization, and we would need to form a network, a shared savings distribution program, and develop quality targets and metrics for accountability.
>
> We're currently in the process of analyzing our current Medicaid population to better understand our needs. Under traditional managed care health plans the system separates physical health, behavioral, and other types of care. That makes things more difficult for the patients and providers and more expensive for the state. A CCO would have the flexibility to support

new models of care that are patient centered and team focused, and reduce health disparities.

I'm not guaranteeing we can provide all of these benefits together just yet. We're doing that assessment now. We believe a CCO would be better able to coordinate services and also focus on prevention, chronic illness management, and person-centered care. We would have the flexibility within our budget to provide services along with medical benefits with the goal of making and meeting the triple aims of better health, better care, and lower costs for the population we serve. There's not a better time in Alaska to consider implementing these models in combination with authorizing Medicaid to expand. Transforming newly eligible members into the managed care delivery system and our global budget model would help ensure sustainability in the state funding of the expansion when that time comes.

Alaska should strongly consider moving into the care coordination organization model to stabilize Medicaid funding, prevent future reductions in Medicaid coverage and benefits for Alaska's most vulnerable constituents, and begin working towards providing the preventative care needed for a healthier Alaska.

Mr. Davis relayed that there was an upfront cost to developing a program like the one under discussion. The organization had some employed physicians, but the majority were independent. He communicated that integrating all of the providers into a system was a substantial project with associated costs. He explained if the project was successful, reimbursement at the hospital would decrease. For example, recently there had been nine psychiatric patients. He emphasized that CPH was not a psychiatric hospital and was not the best place for the care to occur. Additionally, there had been a waiting room full of sick and injured patients. He communicated that there was no safety net system in the community to help the people before they reached a point of suicidal tendency or other that brought them to the emergency room. He elaborated that the state paid the hospital for the very expensive care; some of the patients ended up being admitted to the hospital and others were helicoptered to the Alaska Psychiatric Institute. He furthered that a global budget would allow the hospital to begin putting hospice, home

health, and other services in place. Expanding Medicaid would allow the hospital to fund the program. He stated that without a grant, there had to be a revenue stream from somewhere to help develop the innovations.

9:37:16 AM

Vice-Chair Saddler asked if CPH was the only hospital on the Kenai Peninsula. Mr. Davis replied in the affirmative. He elaborated that South Peninsula Hospital was approximately 80 miles south in Homer. Central Peninsula Hospital was a 49-bed facility; it received approximately 50 percent of its payment from Medicare/Medicaid, 35 percent commercial, 6 percent self-pay, and 7 or 8 percent federal pay (Indian Health Services and the state Department of Corrections).

Vice-Chair Saddler asked if there was a trend towards consolidation. He heard Mr. Davis saying that if the providers and follow up could all be coordinated there would be more control over the system and costs would be reduced. He wondered if it was the long-term trend in healthcare. Mr. Davis was looking at integration rather than consolidation moving forward. For instance, the contracts the hospital was working on for participation in the CCO involved transparency of data and sharing of electronic health information between all of the CCO members. Part of the problem with the current system was the absence of primary care-centered case management; a patient could visit the ER and go see a specialist, but was lost outside of the system. The clinically integrated coordinated care model was based on patient-centered primary care medical homes; the primary care medical home model was where the coordination began. He furthered that there was access to outcomes data from specialists, the organization knew where the good care was found and was able to keep them within the system to keep sight of their healthcare.

Vice-Chair Saddler could see the clear benefits. He asked about physicians and healthcare providers who were not part of the CCO. Mr. Davis answered that the goal was to better coordinate the care. He expounded that if a physician chose to not participate in the network, it did not exclude them from being part of a patient's care.

Vice-Chair Saddler remarked that "resistance is not futile." Mr. Davis agreed. He explained that a patient would be referred to a physician who would provide the best care (whether they were inside or outside the network). He continued that ideally there would be better access to outcomes data for someone in the network because they had already agreed to share the data and meet certain outcomes criteria. The goal would be to have everyone involved with more data transparency.

Vice-Chair Saddler understood that CPH supported Medicaid expansion. He wondered if the CCO was dependent on Medicaid expansion.

9:41:26 AM

Mr. Davis replied that the CCO was dependent on Medicaid expansion.

Vice-Chair Saddler asked for verification that the CCO could not currently be accomplished. Mr. Davis replied in the negative. He detailed that the hospital could not afford the upfront cost of developing the program without Medicaid expansion. He explained that if the project was successful its ER volumes would drop. He shared that recently the hospital had 7 patients at one time who had been over the age of 87. He relayed that the patients would probably have been better served at home through hospice or a palliative care program, but because the community did not have the service, the patients had come to the hospital for their final days. He remarked that the hospital was not the best place to go for a lot of the individuals; however, there was currently no alternative. He communicated that there was a cost associated with developing the program. The hospital's goal was to help fund some of the post-acute care and pre-acute care programs for the psychiatric patients. He noted that PeaceHealth had received a $3.1 million grant to get its feet on the ground, but CPH did not have any grants available to help.

Vice-Chair Saddler did not see how the reforms the hospital wanted to accomplish were dependent on Medicaid expansion. He believed they were money dependent.

Mr. Davis replied that it was the uncompensated care that would become eligible for Medicaid expansion that would backfill the holes in the hospital's revenue stream. He

furthered that as the Medicaid ER population dropped due to improved coordination of care, the hospital would be able to replace the patients with newly covered Medicaid expansion patients.

Vice-Chair Saddler commented that Medicaid expansion was one way to provide the hospital with the money it needed.

9:44:10 AM

Representative Guttenberg thought CPH may be the largest unaffiliated hospital in the state. He mentioned the Fairbanks and Ketchikan hospitals that were a part of a larger system. He remarked that CPH had problems that others did not have. He wondered how easy it would be to change the culture inside the hospital. He wondered if change of culture inside the hospital was governed by the way the hospital managed care and assigned doctors, nurses, and physician's assistants. He wondered if it was difficult to align people with the different missions and whether there was an additional cost.

Mr. Davis answered that it was difficult to change the culture within an organization. He did not believe the model's focus was about changing the culture within an organization because doctors were trained to perform procedures to heal people and nurses were there to care for people. The model pertained more to the management of population health in the community that was not currently taking place. The incentives were for everyone to do what they were trained to do (i.e. procedures, visits, or other). He explained that a global budget for population health management incentivized the cultural shift to a clinically integrated network coordinated care-type model where people became incentivized to provide preventative care, psychiatric safety net care, or to coordinate with the appropriate caregiver (as opposed to a person trying to do it all themselves because of payment incentive). He added that value-based purchasing was a large component of the overall picture.

Representative Guttenberg asked for detail on value-based purchasing. Mr. Davis replied that value-based purchasing meant being paid for outcomes as opposed to procedures. Currently hospitals were incentivized do more MRIs, procedures, and volume. He furthered that the model would

incentivize the hospital to provide valuable care instead of just more care.

Representative Guttenberg shared that his most recent experience with hospice had been dramatically different than the previous experience. He addressed what had changed. He explained that the hospice culture had changed in the Fairbanks medical community. He elaborated that one doctor had taken the operation of the whole program under his wing. He observed that hospitals were not getting fees to deliver an adequate program such as hospice. He asked for further detail.

Mr. Davis answered there was no payment incentive for the scenario described by Representative Guttenberg. He referred back to the elderly patients who had been in the hospital recently; some of the patients would have been served better and more cost-effectively at home. The global payment model would provide incentive for the hospital to put a more robust hospice program in place to help keep similar patients at home. He furthered that the global payment would enable the hospital to prepare a hospice program more cost-effectively. He summarized that under a global payment model the hospital would be incentivized to develop a hospice program, whereas under a fee-for-service model it was incentivized to admit them and to bill Medicare.

9:49:53 AM

Representative Guttenberg asked for verification that Medicaid expansion would be necessary for the hospital to make the changes described. Mr. Davis replied that the hospital could make the changes currently if it chose to invest significant funds into a program that would bring it no reimbursement. However, CPH was community owned and he did not believe the community would support the idea.

Co-Chair Thompson noted that Representative Dan Ortiz was present in the committee room.

Vice-Chair Saddler asked how much it would cost to make the changes Mr. Davis had described. Mr. Davis answered that he did not currently have a dollar estimate. He explained that the real cost for the hospital would be in reduced services it was providing for the current Medicaid population (i.e. services provided when individuals inappropriately used the

high-cost emergency room). He reasoned that the development of the network, legal costs, manpower, and consulting costs would be expensive. He relayed that the hospital was working with the Rural Policy Research Institute, under the University of Ohio [correction: University of Iowa]; the institute had received federal grant funds for rural innovative healthcare model studies. He elaborated that the institute was working with CPH along with four other hospitals nationwide to help the entities come to terms with how to establish making the changes discussed. He reiterated that CPH was a standalone entity; it did not have the manpower to make the changes on its own. He relayed that there would be quite an expense going into the undertaking.

Vice-Chair Saddler appreciated the complexity of the challenge, but did not know if some of the costs described by Mr. Davis to achieve cost reductions had been included in the public discussion about what Medicaid expansion would bring. He asked if the Rural Policy Research Institute was housed under the University of Ohio. Mr. Davis corrected his earlier statement and relayed that the institute was housed under the University of Iowa.

Co-Chair Thompson referred to an earlier statement by Representative Guttenberg about the Fairbank's hospital. He stated that the Fairbanks hospital was privately owned; it was operated by Bannister Health. He wondered if the CPH management was leased to a large corporation. Mr. Davis replied in the negative. He explained that CPH was managed by an 11-member, local community board.

9:53:43 AM

Representative Edgmon stated that one of the bigger criticisms of Medicaid expansion was the inability to find Medicaid providers. He wondered if the issue would be a challenge for CPH.

Mr. Davis answered that the savings pool associated with the global payment model had built-in incentives to compensate the primary care physicians at a level that was slightly higher than at present. The increase would come from shared savings achieved by a reduced volume of Medicaid patients coming into the hospital and from better coordination of specialty care services. He elaborated that there was a risk pool associated with the payment structure

that was reallocated back to members with a higher percentage going to primary care providers to incentivize the primary care medical home model development. The primary care providers then became the care coordinators for the population and helped to steer patients to the right care and the right place at the right time. The organization had employed and non-employed primary care physicians who were very interested in the project and had been participating in the early stages of development. He believed there would be adequate coverage in the region.

Representative Edgmon reasoned that the current conversation was a business discussion. He elaborated CPH was in the business of helping people and making sure they get the necessary medical services. He stated that those in support of Medicaid expansion often discussed the economic multiplier effect it would have. He asked how the economic multiplier effect would impact the Kenai Peninsula.

BRUCE RICHARDS, EXTERNAL AFFAIRS/MARKETING, CENTRAL PENINSULA HOSPITAL, answered that there would be a significant impact. There was impact when economic expansion occurred; new physicians came to the hospital and provided a service that had not been offered before. He cited a new spine surgeon as an example. He continued that there were significant jobs that followed a new service line into the community (e.g. new nurses, assistants, and other). He elaborated that sometimes individuals had to come in from out-of-state to help a new surgeon with an opening. He did not know the exact numbers, but the economic multiplier was significant. He noted it was important to keep in mind that the economic multiplier was not always the main objective; the goal was to get people covered with the right care in the right place for a reasonable cost. He remarked on the complexity of making the improvements. He highlighted that the movement away from a fee-for-service system to a system based on value and quality where people were held to measurements and outcomes. He concluded that there would be positive economic impacts as a result of the changes.

Representative Edgmon referred to prior testimony from the commissioner of Department of Health and Social Services that the state was looking at $1 billion in benefits over a six-year period, including $146 million in FY 16 alone and an additional 4,000 jobs scattered around the state. He noted that the statistics were all on a macro level; he did

not have detail on what it would mean to various regions of the state. He stated that the discussion was about economics; better economics provided better services, saved money, and made people healthier. He thought it was worthy for the hospital to have stronger numbers to substantiate that better benefits would come to the region from Medicaid expansion.

10:00:12 AM

Representative Wilson wondered if Medicaid was being done in the right direction. She remarked that under the pay-as-you-go system a patient had to come in [to a hospital or other] before someone [the hospital or other] got paid. She discussed that there was no incentive to provide wellness care because it did not bring in any money. She wondered if it was possible to change the way the Medicaid system worked to include preventative services and reduce costs. She surmised that grants were pushing hospitals in the direction of making the changes; however, if the grants were successful there would be no money to replace them in the future.

Mr. Davis replied that CPH had not received any grants. From CPH's perspective, the Medicaid expansion population would help provide the needed funding. He relayed that the global payment model would incentivize CPH to provide the preventative care programs. He had looked at the Eastern Oregon coordinated care organization; one of the facets of its program was a coordinated care model. The program targeted the high utilizers of the ER and offered them the ability to participate in a coordinated care model (similar to the project at PeaceHealth in Ketchikan) that taught the individuals to learn better habits or steered them towards mental health services. He stated that the model would incentivize CPH to provide many kinds of wellness and preventative programs because of a global budget payment, whereas, at present the hospital was paid when individuals inappropriately came to the ER.

10:02:57 AM

Representative Wilson remarked that Medicaid expansion would offer a different payment method. She thought Mr. Davis was saying that expansion would incentivize hospitals to offer [preventative or wellness] programs that were not possible under the current Medicaid system.

Mr. Richards replied that the demonstration project was included in the legislation in order to utilize and try the new payment system. He asked for clarification on the question.

Representative Wilson restated her question, which did not assume the passage of the legislation. She wondered if the model used in Ketchikan could be used under the current Medicaid system. Mr. Richards responded that there was not currently the payment system in place for hospitals to get paid for the work.

10:04:26 AM

Representative Wilson wondered if one year would be sufficient to know whether the model was successful. She was interested to learn how to take care of the current Medicaid recipients before expanding to a larger population. Mr. Davis replied that any global payment model would help the medical system achieve better care for patients. Expansion of the program would be partially determined by the associated revenue or revenue that was lost. He explained that there would be some benefit to a global payment model for the current Medicaid population; however, uncompensated care costs would continue and the population benefitting would be smaller. He did not know how long it would take to implement the model, but he hoped it would not take long. He added that the hospital was working hard on the project.

Representative Wilson did not have a good understanding about whether some of the issues were related to how the system was worked and how much flexibility there was to change the current system in order to increase cost savings to hospitals and lower costs for payers. She believed there was opportunity the state could utilize that did not relate to Medicaid expansion.

Co-Chair Thompson noted that the committee would end at 10:20 a.m. He relayed that the committee would meet at 9:00 a.m. the following day to continue the conversation.

Vice-Chair Saddler referred to testimony given by Mr. Eisenhower and Mr. Davis about the complexity of setting up coordination and other. He asked if the bill would enable the hospital to take advantage of coordination at the start

of the upcoming fiscal year in July. Mr. Davis answered that CPH was currently in the beginning stages of setting up the program. He did not know where the precise start and finish lines would be.

Vice-Chair Saddler remarked that Mr. Davis had testified that the project could not be done without Medicaid expansion. He asked for verification that CPH was working on the project anyway. Mr. Davis answered that the hospital was working on a coordinated care organization. He explained that the model would be much more robust and better if an estimated 4,100 people below 100 percent of the federal poverty level with no coverage in the region could be incorporated. He elaborated that CPH wanted to achieve population health management; it could not do a good job without including the 4,100 individuals in the Medicaid population.

Vice-Chair Saddler stated that Mr. Davis had testified that the hospital could not do the project without Medicaid expansion; however, he observed that CPH was moving forward without it. He asked for clarification.

Mr. Davis replied that CPH was working on healthcare reform in some form or other. The system he had described earlier would not be possible without Medicaid expansion to help fund it. He furthered that the hospital would try to do something regardless of the passage of a bill. He explained that what the changes would look like and the effectiveness of the hospital's efforts would depend on whether Medicaid expansion and reform or Medicaid reform were enacted.

Vice-Chair Saddler asked for clarification that the organization was going forward with the CCO currently without a commitment for Medicaid expansion. Mr. Davis answered that the hospital was exploring the idea, but it could end at any time.

Vice-Chair Saddler asked if the establishment of the CCO was conditional. Mr. Richards answered that CPH had started designing the program in anticipation of Medicaid expansion, which had been passed under the Affordable Care Act.

Vice-Chair Saddler asked if the program would be continued if the bill did not pass. Mr. Richards did not know;

however, the demonstration project in the bill was based on Medicaid expansion.

Vice-Chair Saddler asked how long it would take to continue setting the project up. Mr. Richards answered that it would probably be sometime in the fall, but he did not want to guess at a precise timeline.

Vice-Chair Saddler asked if the timeline was 6 months, 2 years, or 5 years. Mr. Richards replied that the hospital would want to begin sooner. He thought it could potentially be in the next 12 months.

10:12:09 AM

Representative Gara spoke to the testimony that with Medicaid expansion the hospital could provide increased preventative care, decrease costs, divert people from the ER, and increase the economic multiplier in the region. He wondered if the same savings and other benefits could be achieved without Medicaid expansion.

Mr. Davis replied that the hospital would have to spend significant money in order to lose money to improve the care of its community. Without Medicaid expansion CPH would be asked to spend money to lose money on the Medicaid only population. He did not know where it ended up and surmised that it was only possible to spend money to lose money for so long. He believed the Medicaid expansion population would help backfill the beds in the hospital. Currently, if the hospital was successful it would save the state money on the current Medicaid population, but the money came out of the pockets of the community.

Vice-Chair Saddler about disproportionate share hospital payments at CPH. He wondered how much the hospital received in a year. Mr. Richards replied that CPH did not receive disproportionate share hospital funding. He believed the total coming into the state was about $22 million. He approximated that the state's General Fund match was about half; the other half was returned to the federal government.

Vice-Chair Saddler asked about the amount of uncompensated care the hospital provided through its emergency program. Mr. Davis answered that in 2014 CPH had $20 million in bad debt and charity care.

Co-Chair Thompson thanked the testifiers for their presentations. He addressed the agenda for subsequent meetings.

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ADJOURNMENT

10:16:29 AM

The meeting was adjourned at 10:16 a.m.