

HOUSE FINANCE COMMITTEE

April 10, 2015

9:04 a.m.

9:04:22 AM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 9:04 a.m.

MEMBERS PRESENT

Representative Mark Neuman, Co-Chair
Representative Steve Thompson, Co-Chair
Representative Dan Saddler, Vice-Chair
Representative Bryce Edgmon
Representative Les Gara
Representative Lynn Gattis
Representative David Guttenberg
Representative Scott Kawasaki
Representative Cathy Munoz
Representative Lance Pruitt
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Becky Hultberg, President and Chief Executive Officer, Alaska State Hospital and Nursing Association (ASHNHA); Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Jeff Jessee, Chief Executive Officer, Alaska Mental Health Trust Authority.

PRESENT VIA TELECONFERENCE

SUMMARY

HB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

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

#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."

9:06:14 AM

BECKY HULTBERG, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALASKA STATE HOSPITAL AND NURSING ASSOCIATION (ASHNHA), supported HB 148 and Medicaid expansion. She voiced that Alaskan hospitals provided over \$100 million each year in uncompensated care. She asserted that expansion would reduce the amount of uncompensated care and provided significant economic and fiscal benefits for the state. The cost of healthcare for the state was unsustainable and was "simply a math equation." She believed the problem was solvable and that expansion "might be part of the solution." She believed that the state's healthcare system must be "transformed." She stated that healthcare was different from any other industry in the state in service delivery, payment, magnitude of the costs, and the personal nature of the service. She thought that a different approach to the issue was necessary. She shared concern about policy debates that were based on sound bites, deceptive Facebook ads, and speculation in an attempt to "scare" the public. She stated that her purpose before the committee was to answer member's questions and address the idea of healthcare transformation.

Ms. Hultberg discussed the issue of the Medicaid Management Information System (MMIS) [Xerox contract with Department of Health and Social Services (DHSS)]. She stated her concern and shared that the association had dealt with the issue for over one and a half years. She related that the association was "deeply engaged" with the state and Xerox due to disruptions in payments. She indicated that currently ASHNHA's clients were receiving timely payments and the system's improvements were significant. She reported that back payments were still problematic from the time that the system was not functioning properly and would be resolved over time. The association was confident that the system could handle a "small number" of additional

recipients added to the system due to Medicaid expansion. She stated that from a provider's view point ASHNHA was not concerned with the status of the MMIS system in regards to Medicaid expansion.

Co-Chair Neuman disagreed with her characterization that "the policy debate was an attempt to scare people." Ms. Hultberg clarified that she believed that Facebook ads and soundbites were an attempt to scare people. She advocated for honest policy debates regarding healthcare reform and Medicaid expansion.

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Representative Gattis asked what amounted to a "small number" of people in regards to Medicaid expansion. Ms. Hultberg remembered that up to 20 thousand people out of the potential 40 thousand eligible could enroll in the program, which represented a small percentage of the total number of Medicaid recipients. She added that the "volume" would not overwhelm the system relative to what it currently handles. Representative Gattis requested specific numbers. Ms. Hultberg deferred to the department for the answer.

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, answered that approximately 160 thousand beneficiaries were expected to enroll in Medicaid next year. He expounded that the 20,000 new enrollees from expansion would represent a one-eighth increase in the Medicaid population or roughly 12.5 percent. The expansion population was not anticipated to be high utilizers similar to other populations already covered such as, people with disabilities therefore, the new claims volume was expected to be less than 12.5 percent.

Representative Gara agreed that the ads that Ms. Hultberg referred to were deceptive.

Vice-Chair Saddler cited Facebook ads by DHSS encouraging citizens to contact their legislator in support of Medicaid expansion. He strongly agreed that policy discussions should not be based on Facebook soundbites. He requested discussions focused on utilization rates and reductions in uncompensated care in addition to what other states experiences were.

Ms. Hultberg "sincerely regretted mentioning Facebook..." and would discuss the policy merits.

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Representative Pruitt referred back to the idea of small numbers regarding expansion. He wondered what happened in relation to the estimated number of new recipients versus the actual number of new enrollees, in other states that expanded Medicaid. He asked how a larger number than anticipated of new recipients would impact the system. Ms. Hultberg concurred that some states experienced a higher number of new enrollees than projected. She stated that ASHNHA had confidence in the department's projections but realized they could be inaccurate. The association expressed confidence that the MMIS system could handle additional volume over the 20,000 estimated new beneficiaries based on how the system was currently handling claims.

Co-Chair Neuman stated that the committee would hear from experts on the MMIS system from DHSS at a later date.

Representative Wilson wondered how expanding Medicaid was going to save the state money since the state paid much higher rates for medical procedures. She deduced that Medicaid recipients were being served and that the issue was about who was paying for the services. Ms. Hultberg responded that the short answer was that "structural change" in healthcare delivery and how and what was paid for was needed to lower healthcare costs. The healthcare system needed to pay for "value" instead of "volume." She felt that the necessary changes would be "significant and disruptive." She opined that making disruptive change in an established system "required both capital and confidence" and would be a huge challenge. She declared that "change was going to happen" due to the economics of the healthcare cost curve on federal and state levels. She pointed out that how the state responded to the change was the issue. If the state was not the "architect" of the change the state would be "victims" of any changes.

Representative Wilson declared that Ms. Hultberg's answer "made no sense." She thought that Ms. Hultberg was advocating for more government involvement in managing healthcare and thought that was a private matter. She believed that Medicaid expansion instituted over a short

time frame was "irresponsible." She stated that 30 percent of the state's population would be eligible for Medicaid and many new recipients would not have jobs. She did not believe expansion could happen without "a lot of government control."

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Ms. Hultberg answered that she could better answer the question if she could get through more of her presentation. She revealed that government currently paid approximately 50 or more percent of healthcare costs and was already a huge payer, which made the industry different than other business. She remarked that government and healthcare were linked in ways other industries were not. Representative Wilson felt like she was hearing a lot of rhetoric and had not heard statistics or facts. She wanted to hear about other states that did not choose expansion but utilized some other system of healthcare before hasty decisions were made on Medicaid expansion in Alaska.

Representative Edgmon thought that the committee had previously engaged in thorough discussions regarding expansion with representatives from medium sized hospitals from Kenai and Ketchikan (04/09/2015 08:37AM). He deduced that Medicaid expansion provided the "front-end capital" to initiate innovation. He cited the following from the previous meetings testimony, "Healthcare in Alaska is fragmented and lacked coordination..." He summarized that the only way to implement a payment restructuring system with accountability and information sharing was with the front-end capital that Medicaid expansion could provide. He believed that projections were not possible to predict exactly. He requested that the committee hear testimony from the large providers in Anchorage and the Matanuska-Susitna Borough who would be the primary beneficiaries of expansion. He felt that the healthcare industry was a business and Medicaid expansion was creating a new business model.

Co-Chair Neuman agreed to provide the requested testimony.

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Representative Guttenberg requested that Ms. Hultberg highlight the areas where ASHNHA thought savings could be achieved through expansion.

Co-Chair Neuman requested examples and comparatives and more information regarding a provider tax.

Vice-Chair Saddler referred to Representative Edgmon's comments and disagreed with his conclusions. He felt that the medium sized hospitals spoke about "what might be" through Medicaid expansion and "cherry picked" elements from a demonstration project they were involved in and not as part of a "systematic revamping expansion of Medicaid."

Co-Chair Neuman asked the committee to stay focused on the presentation at hand.

Ms. Hultberg moved the discussion to payment reform. She referenced the previous day's testimony regarding reform and summarized that tangible examples of feasible reform were currently taking place. She recounted that the Ketchikan hospital's current demonstration project resulted in better quality outcomes at lower costs. The project was funded by a \$3 million CMS (Centers for Medicaid Services) innovation grant but was not sustainable because of the way hospitals were reimbursed; they were incentivized to treat people in the hospital. She detailed that the project could continue through payment reform that financially rewarded hospitals for "keeping people out of the hospital" and improved margins that expansion would provide. The second reform project was a community care organization project modeled after a currently operating reform project in Oregon. She explained that the model paid a provider a "global payment" which was a fixed dollar amount payment based upon a number of people in a pool. If the costs of providing healthcare was larger than the payment the provider absorbed the loss. The provider gained financially if they provided better quality outcomes at a lower cost. She delineated that the benefit of a global payment was that every provider's financial incentives were "aligned." The goal was better care at a low cost versus more care at a higher cost. The Kenai (Central Peninsula) hospital would develop the model if they can make it financially viable. She voiced that Ketchikan's demonstration project required more capital. The Central Peninsula hospital did not have a grant source and were relying on the reduction in uncompensated care achieved through Medicaid expansion to implement its demonstration project. She thought that without Medicaid expansion the hospitals would still seek new models of delivering care, but the models would not be

as comprehensive and innovative without the expansion capital to implement them.

Representative Guttenberg understood the concept of global payment systems. He wondered what safeguards were in place in instances when a hospital was turning people away from the ER for treatment in a different facility. He asked whether the system was integrated and would ensure follow up care.

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Ms. Hultberg stated that integrated "IT" (Information Technology) systems were part of the model. She revealed that the model included multiple providers, along with hospitals uniting to form the healthcare system. The providers were paid based on quality benchmarks as well and had no incentive to deny care. They are incentivized to ensure that the care was delivered at the best location at the best value. She furthered that "by combining the financial incentives and the quality matrix" one could guarantee high standards of care at lower costs. Representative Guttenberg provided an example of a hospital discharging a sick patient due to cost factors. He asked whether the model would allow the patient to be treated at multiple facilities without penalizing one provider for not providing quality care on their end. Ms. Hultberg relayed that the patient would retain a primary care provider and had a choice of clinics within the system but that all providers were "on the same page" regarding the patients needs. She understood that at some point someone would stray outside the model's health system and would most likely be back in the Medicaid fee for service model. She stated that she needed more information regarding how that particular "dynamic" was handled in Oregon.

Representative Gattis remained fixed on the business model. She wanted to address the business model of private insurers. She thought that the private insurance companies would be interested in participating in the cost cutting models and weren't part of the conversation. Ms. Hultberg suggested that many of the models also had insurance partners. The exemplified coordinated care model in Oregon had insurance partners as part of the model due to the level of risk.

Co-Chair Neuman agreed with Representative Gattis and wondered whether the coordinated care model allowed the state to submit RFP's (request for proposals) from private insurance companies to manage a coordinated care system. Ms. Hultberg suggested that the managed care demonstration projects proposed in the legislation provided for wide ranging managed care opportunities besides the coordinated care model.

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Representative Gara stated that there were many questions about how Medicaid "produced savings." He noted that much of the testimony addressed multiple instances where Medicaid would cover costs that were currently being paid for by the state's general fund. He identified the additional Medicaid coverage in lieu of general funds as cost savings to the state. He reiterated that it cost more to treat people in an ER than in a clinic and was one area of potential savings. He reminded the committee that Medicaid coverage would decrease Alaska Regional Hospital's costs for uncompensated care which allowed the hospital to provide a primary care type clinic under Medicaid expansion. He asked whether the scenario could be widespread under Medicaid expansion to other hospitals in the state. Ms. Hultberg responded that he identified two types of savings. One saved general fund expenses by offsetting general funds through federal Medicaid expansion funding. The other savings were within the healthcare system through Medicaid expansion and payment reform. She hoped that other hospitals would choose the Alaska Regional model but could not speak for them. She emphasized that in general, the "highest likelihood for healthcare transformation" was through Medicaid expansion and payment reform.

Vice-Chair Saddler agreed with Representative Edgmon that hospitals were businesses and that the federal government was "squeezing" hospitals into reducing uncompensated care costs with a "stick" and that the carrot was Medicaid expansion which provided additional funding. He asked her to describe the efforts the association had done before the possibility of Medicaid expansion to accomplish payment reform or provide managed care.

Ms. Hultberg answered that Medicare was primarily driving payment reform throughout the country as well as private

payers in some states. Several large corporate private payers like Walmart and Boeing were driving larger change through alterations in their plans. She pointed out that the association's members were businesses and payment reform required risk to potentially lower revenue. Currently, forces aligned to "allow the conversation to occur." Some of the changes were being driven by the "future" realization of even higher costs without cost containment and some change was driven by the carrot and stick of Medicaid expansion. She shared that providers were aware that change had to occur and that changing the business model was disruptive and could potentially lead to loss in revenue. She believed that providers were currently "at the table" because it was the "right thing to do" and Medicaid expansion offered the carrot to do it. The financial incentives to lower costs had to accompany the need for change or hospitals and providers would act "rationally" as businesses facing losing profit and continue the current system "given the payment structure" even though it was not the "right thing to do."

Co-Chair Neuman understood Ms. Hultberg's opinion on the matter.

Vice-Chair Saddler restated his question. Ms. Hultberg replied that the association had not had the conversation of payment reform before because the financial incentives did not exist.

Co-Chair Neuman wanted to hear more about provider taxes and the differences between large hospitals and small office providers.

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Ms. Hultberg moved to the topic of provider taxes. She reported that a white paper produced by Alaska State Hospital and Nursing Home Association (ASHNHA) titled, "Provider Taxes - A comprehensive Overview" (copy on file) was included in the members backup packets. She explained that provider taxes were taxes imposed on providers by states. If a state wanted to use the proceeds of the tax as part of the Medicaid match then the state must adhere to certain federal requirements. The federal requirements delineated that the tax must be broad based and apply to all providers. The tax must be uniform to all providers within a class of providers and cannot hold the providers

harmless; in this case guarantee that the state was compensated for the entire amount the state paid in taxes. The requirements also included specific limits on how much a provider could be taxed. She noted that the provider tax was applied in 49 states. She voiced that often the tax worked for both the provider and the state; specifically when the Medicaid rate for services was below the Medicaid upper payment limit the tax can leverage additional federal reimbursement up to the upper payment limit. She summarized that the provider tax levied a tax on the provider and the state received the revenue. The federal government matched the revenue and the "pot of new money" was divided between the providers and the state. Providers received the funds in the form of increased rates or supplemental payments and the state gained tax revenue to help support the Medicaid program. She declared that it was not known whether the provider tax system would work in Alaska. The association's consultant would study the issue. The tax was typically levied on hospitals and nursing homes. However, under federal law, 19 classes of providers could be taxed which included physicians and ambulatory surgery centers. She expounded that one of the decisions in considering a provider tax would be assessing what type of providers the state wanted to tax. The broad based tax could be applied differently within a class by taxing similar types of facilities within one class differently. For instance within the hospital class large hospital could be taxed differently than small hospitals. She summarized that within the broad based requirement, classes of providers could be carved up based on specific criteria and taxed differently.

Representative Pruitt referred to Ms. Hultberg's comment that 50 percent of healthcare was paid for by government. He assumed that the majority of the 50 percent was derived from Medicare and Medicaid. He thought that if providers saw the benefit from expansion through increased enrollees, he wondered how long it would be before providers come forward to ask the state for "more" based on increasing the market for providers through expansion. He was concerned about rising costs for the state as Medicaid expansion grew. Ms. Hultberg clarified that her 50 percent comment only applied to hospitals and no other provider classes. She responded that "government was the worst payer for hospitals." She emphasized that her statements merely reflected the reality that at some hospitals the government paid for 50 percent of the bill. She revealed that

commercial payers were better payers. The association's intent was not to "crowd out" the private payers. The current business model of the legal mandate to provide free care in the form of uncompensated care was not optimal. She believed that the opportunity to reduce the uncompensated care costs at the same time as implementing changes to the entire system was compelling.

[9:52:56 AM](#)

Vice-Chair Saddler asked for clarification regarding taxing one classification of providers at different rates under the provider tax. Ms. Hultberg restated that the tax must be broad based within a provider group. She offered the example of physicians as a provider group and stated that "all similarly situated providers" must be treated equally within the broad based tax. However, classes of providers within a group were allowed to be taxed differently. She exemplified hospitals as an example. She elaborated that hospitals classified as "Perspective Payment System" (PPS) were large hospitals and "critical access hospitals" were small hospitals. Based on the two types of hospital providers, the tax could be differentiated within that same class of hospital providers.

[9:54:58 AM](#)

JEFF JESSEE, CHIEF EXECUTIVE OFFICER, ALASKA MENTAL HEALTH TRUST AUTHORITY, declared that the Alaska Mental Health Trust Authority (AMHTA) was interested in both Medicaid expansion and reform. The trustees believed that the current system was "unsustainable" and that drastic solutions were necessary. He thought that "reform was not an option or a destination" but was a process over time. He felt that restructuring healthcare payment and delivery systems would be necessary. He reported that over the last 6 years the trust successfully reformed the children's mental health system. He detailed that over \$40 million of state funding was reprogrammed to create a community based system of care within the state versus sending children and funding outside of the state. Currently, 92 children, down from a high of 438 remained out-of-state. The trust provided over \$16 million to assist in the reform effort. He reported that the trust was excited about expansion because of the potential capital opportunities offered via Medicaid expansion. In addition, the trust was charged with

reformation in certain areas of Department of Corrections (DOC) and the Criminal Justice System.

Mr. Jessee stated that the prisons were currently at 101 percent of capacity and reform efforts could not wait. He shared that the trust beneficiaries were either not being served or were served inappropriately at very high costs. Beneficiaries could not receive substance abuse treatment when necessary and ended up in jail or psych emergency rooms. He explored potential savings in DOC, particularly focused on 24 hour hospitalizations. He referred to the white paper and a distribution chart titled, "Alaska Inmate Hospitalization Costs FY 12-15" (copy on file) distributed by AMHTA and declared that the savings under Medicaid expansion in regards to 24 hour inmate hospitalizations were real.

[10:00:41 AM](#)

Mr. Jessee identified a critical point related to 24 hour hospitalizations; whether the inmates would have access to Medicaid when they were released from the hospital. He stressed the importance of providing support for sobriety and recovery when released from prison; 65 percent of inmates were AMHTA beneficiaries and over 80 percent of inmates had substance abuse problems. He elucidated that Medicaid eligibility was a critical piece of funding for criminal justice reformation due to the importance of providing services in order to keep recidivism down. The trust viewed Medicaid expansion as a way to accelerate providing services to beneficiaries at lower costs to the state. He thought that the work could be done, but it would be much more difficult without Medicaid expansion. He believed that without addressing substance abuse issues criminal justice reform and recidivism would be nearly impossible.

Representative Wilson referred to the 24-hour hospital stay and asked for verification that Medicaid expansion would apply "to the new group and not for the current group." Mr. Jessee answered that Medicaid expansion applied to anyone currently in prison that was eligible for Medicaid. Representative Wilson asked how many inmates currently stayed in the hospital longer than 24 hours. Mr. Jessee pointed to the inmate count on the chart titled "Alaska Inmate Hospitalization Costs FY 12-15" (copy on file).

Vice-Chair Saddler noted that one of Mr. Jesse's "underpinning" of support for Medicaid expansion was substance abuse treatment in order to reduce recidivism. He asked how many times an individual needed treatment and what obligation did the state have to keep sending an individual to expensive treatment services in order to reduce recidivism. Mr. Jesse answered that in his case it took one time in a treatment program to achieve sobriety and for others it varied. He delineated that the experience was not different than other diseases like diabetes where success of treatment and follow up also varied. He thought that follow-up played a major part in minimizing relapses. He emphasized that relapses were a common occurrence in addiction.

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Representative Pruitt asked for an interpretation of the graphs distributed by the trust. Mr. Jesse explained that in viewing the graphs moving from left to right the lines represented the numbers of individuals and what the costs were per person. He exemplified the 50 mark and extrapolated that 50 inmates hospitalizations for over 24 hours costs \$10 thousand per person and increased to \$50 thousand for the next 50 inmates and continued until the line spiked upward. He concluded that a relatively small number of inmates hospitalizations were very expensive. Representative Pruitt could not see the correlation with the graphs and the points that Mr. Jesse was making. Mr. Jesse deduced that the cost of inmates going into the hospital remained relatively stable from year to year and therefore the costs and savings were predictable.

Co-Chair Neuman related that up to 95 percent of the costs in Medicaid could be associated to 5 percent of the Medicaid recipients which were trust beneficiaries. He stated that managed care was broad ranging. He wanted Mr. Jesse to better define managed care in relation to beneficiaries and discuss the different services that could be provided.

[10:11:55 AM](#)

Representative Gattis asked why private industry could not provide services under managed care and why private insurers were not offering managed care services particularly if it realized savings for private insurers.

Mr. Jessee stated that private insurers were moving towards managed care services through health fairs and informational emails. He disliked the term managed care because for many it meant a set fee for service system of managing payment. He stated that the most important goal was to assist beneficiaries to become smarter utilizers of services because many were high users of mental health care as well as health care in general.

Representative Wilson asked why the trust had not offered a private insurance policy specifically for beneficiaries and used trust funding as an insurance policy. She wondered why the trust had not explored an insurance model. Mr. Jessee stated that the Trust had already invested in medical home pilot programs in partnership with the Department of Health and Social Services (DHSS) and was looking into that option. He furthered that the Trust was not in a financial position to become an insurance company and was proposing placing the beneficiaries into an insurance plan called "Medicaid expansion." Representative Wilson felt that he missed her point. She asked why the trust did not invest the millions of dollars that the trust had already spent in programs and provided beneficiaries insurance policies instead of investing in programs. Mr. Jessee replied that it would be too expensive for the Trust and "beyond its means" to provide insurance coverage for thousands of individuals. However, the Trust could provide some capital for system reformation.

[10:17:15 AM](#)

Vice-Chair Saddler stated that his son was a trust beneficiary and received a Medicaid waiver. He understood that the decision by the trust to cover the administrative costs of Medicaid expansion "diluted" the expenditure by including non-beneficiaries. He wondered whether the trust was concerned over the dilution of trust funds and who in the trust decided to pay for the administrative costs of expansion. He asked for clarification regarding the decision making process. Mr. Jessee reported that the trustees made the decision and would review it in May, 2015. The trustees were always concerned when an investment was made that benefited people outside of the beneficiary pool. He elaborated that if the reform was "systemic" and would benefit beneficiaries "over the long haul" the trustees would consider paying administrative costs a good investment even if it helped non-beneficiaries.

[10:19:15 AM](#)

Representative Edgmon wondered whether information was available that discussed what "the building blocks of the argument really are." He listed reform, costs, benefits, and structural changes; administrative and statutory as necessary for expansion. He wondered whether a white paper that distilled expansion issues into one or two pages was available.

Co-Chair Neuman remarked DHSS was taking notes on his request and would hopefully provide the information to Representative Edgmon.

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

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ADJOURNMENT

[10:21:11 AM](#)

The meeting was adjourned at 10:21 a.m.