ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
October 27, 2015
10:08 a.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Liz Vazquez, Vice Chair
Representative Neal Foster
Representative Louise Stutes
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool (via teleconference)

MEMBERS ABSENT

All members present

OTHER LEGISLATORS PRESENT

Representative Andy Josephson

COMMITTEE CALENDAR

OVERVIEW(S): MEDICAID REDESIGN AND THE PROVIDER TAX

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

MONIQUE MARTIN, Healthcare Policy Advisor
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Provided a PowerPoint presentation entitled, "Medicaid Redesign & Expansion Technical Assistance Contract Update," and dated 10/27/15.

BECKY HULTBERG, President and CEO
Alaska State Hospital and Nursing Home Association
Juneau, Alaska
POSITION STATEMENT: Provided comments on Medicaid redesign from the providers' and stakeholders' prospective.

JARED KOSIN, Executive Director
Office of Rate Review
Division of Health Care Services
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Provided an overview and update on the Health Care Provider Tax Feasibility Study and Recommendation.

BECKY HULTBERG, President and CEO
Alaska State Hospital and Nursing Home Association
Juneau, Alaska
POSITION STATEMENT: Provided comments regarding the health care provider tax.

ACTION NARRATIVE

10:08:28 AM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 10:08 a.m. Representatives Stutes, Talerico, Vazquez, Tarr, Foster, Wool (via teleconference), and Seaton were present at the call to order. Representative Josephson was also present.

OVERVIEW(S): MEDICAID REDESIGN AND THE PROVIDER TAX

10:09:43 AM

CHAIR SEATON announced that the only order of business would be to receive updates on the various reform and redesign projects currently underway relating to Medicaid. The purpose of the updates is to ensure that members of the committee have access to the process in order to contribute to Medicaid reform as the meetings and draft [proposals] are taking place. The three main topics are a report from the National Conference of State Legislatures, Medicaid redesign, and the Health Care Provider Tax Feasibility Study and Recommendation.

10:11:02 AM

REPRESENTATIVE VAZQUEZ reported that in August [2015], several members of the legislature, representatives from the executive branch, and representatives from the provider community attended meetings sponsored by the National Conference of State Legislatures (NCSL) on the topic of "State Strategies to Improve Health System Performance." [In the committee packet was a

document from the National Conference of State Legislatures entitled, "State Strategies to Improve Health System Performance, Monday, August 17-Wednesday, August 19 - Denver, CO, Alaska Team Report."] Attending the conference from Alaska were: Margaret Brodie, Director of Health Care Services, Department of Health and Social Services (DHSS); Jay Butler, Chief Medicaid Officer, DHSS; Senator Cathy Giessel; Anita Halterman, Chief of Staff, Office of Representative Vazquez; Senator Anna MacKinnon; Nancy Merriman, Executive Director, Alaska Primary Care Association; Representative Paul Seaton; Heather Shadduck, Chief of Staff, Office of Senator Kelly; and Representative Liz Vazquez. At the conference the following vision and action plan were discussed:

> Vision: To be focused on health, not healthcare. All goals, strategies and action steps need to ultimately keep people and families healthier (not just a better sick system).
>
> Action Plan Goal 1: Better Family Health Outcomes by Utilizing Services Appropriately to Reduce Public-Payer System Cost.

- Better use of state data will improve health, create efficiencies, and reduce cost
- Better address the social determinants of health into primary care
- Including referrals to social services
- Demonstration(s) for coordinated care for better health outcomes and reduced costs
- Evaluate need for integration of behavioral health and primary care
- Braiding services into K-12 education. Outreach to schools, starting fall 2015
- Need a State Plan Amendment for regulatory change for lower-level behavioral providers
- Anita Halterman, Margaret Brodie, and Heather Shadduck will convene meeting to discuss collaboration, re: behavioral health and primary care integration
- Update group on Dec. 17

REPRESENTATIVE VAZQUEZ advised there is a shortage of behavioral health providers and thus a need to review the regulations in order to make changes to increase access to mental health and primary care services under Medicaid. She returned to the goals of the action plan.

Goal 2: Better Use of State Data Will Improve Health, Create Efficiencies, and Reduce Cost.

- Begin with a focus on claims data
- Inventory what data is currently present in Alaska - task commitment from Representative Vazquez's office and Ms. Brodie
- Communicate to policymakers why data (on a broader scale) is important
- Include what data is important, more than just claims data, - population health data and health outcome measures
- Screen data vendors by end of November 2015
- Ms. Brodie will meet with vendors at the National Association of Medicaid Directors meeting and report back Dec. 17th
- Use prescreen vendor data to pull together Alaska-specific examples
- Engage current fraud, misuse, and abuse activities (to look at cost savings potential) and collect anecdotal examples
- Communicate to this meeting group
- Make case to Finance Committee on the need for a request for proposal (RFP) (April 2016)
- Not more money, but a reallocation of resources
- Issue RFP IF ...
- Outsourcing is more effective
- Proven return on investment
- RFP includes strong evaluation and accountability
- Ability to withhold funds if vendor does not meet contract obligations

10:18:15 AM

REPRESENTATIVE VAZQUEZ said that after discussions at the conference, each state prepared a presentation. She directed attention to the Alaska Team's PowerPoint presentation entitled, "Innovations in Health Care Payment and Delivery - Alaska," and dated 8/17/15-8/19/15, which was also provided in the committee packet. Areas addressed in the presentation were: accountability; sustainability; transparency; person-centered care across the continuum; data analytics; Tribal/non-Tribal equity [slide 2]. Representative Vazquez referred to the previously stated vision statement and pointed out that it is

more compassionate to have better health care, and it is also more cost effective. The following reachable goals were identified: to reduce cost in the system by moving people off of government health programs; to talk about health in plain English to engage stakeholders; to ensure reform is sustainable, particularly as pertains to Medicaid [slide 3]. She directed attention to Goal 2 of the previously mentioned action plan, Better Family Health Outcomes by Utilizing Services Appropriately to Reduce Public-Payer System Cost, and restated the steps to attain the above goal [slides 4, 5, and 7]. Representative Vazquez closed, observing that the work of the group is an ongoing process.

10:22:39 AM

CHAIR SEATON suggested that the committee provide ideas to Representative Vazquez who is taking the lead for the state team. He added that the NCSL meeting brought several states together, and the discussion of the various models for Medicaid reform would be very helpful when determining what is best for Alaska.

REPRESENTATIVE VAZQUEZ recalled at the NCSL conference in Seattle [2015] there was keen interest in Medicaid presentations; in fact, it is estimated that Medicaid [cost] comprises 20 percent of most state budgets.

CHAIR SEATON introduced the presentation on Medicaid Redesign by the Department of Health and Social Services (DHSS).

10:24:49 AM

MONIQUE MARTIN, Healthcare Policy Advisor, DHSS, informed the committee the Medicaid Redesign & Expansion Technical Assistance Contract was awarded in June, 2015, to an Alaska firm, Agnew::Beck Consulting, which has subcontracted to Health Management Associates (HMA) and Milliman, Inc., an actuarial firm. She advised that the original contract was amended and both the contract and amendment are posted on the DHSS website. The amendment related to additional stakeholder processes; a webinar to follow each Key Partner Work Session and sector engagement sessions with stakeholders - such as the Alaska State Hospital & Nursing Home Association and the Alaska Primary Care Association - were added to the contract [slide 2]. Ms. Martin said the first component presented under the contract was an environmental assessment that examined the current U.S. health care delivery system and key factors to improve the health care

delivery system in Alaska, including financing authorities, models of care, and Medicaid experiences in other states. Next presented were alternative models for the expansion population, including actuarial analyses, what other states have done, a private option, costs, and wellness incentives. In general, looking at the Medicaid program's traditional population revealed opportunities for reform. A recommended package of reforms incorporating information from all sources is due to DHSS 1/15/16, and - at the end of the contract - action and evaluation plans are due to DHSS 5/16/16 [slide 3].

10:30:58 AM

MS. MARTIN provided a list of key partner organizations that included community and advocacy organizations, and many providers [slide 4]. Round 1 meetings began with an informational webinar on 7/27/15; a Key Partners Work Session was held 8/18/15, followed on 9/2/15 by a webinar with updates on the topics that were previously discussed. The August and September Round 1 meetings included a presentation of the draft environmental assessment, models of care, and financing opportunities. Also, there was discussion on the vision of a high-functioning health care delivery system in Alaska, and discussion about a "meeting in a box" which allows the department's partners to present to their audiences independent of DHSS [slide 5]. To describe models of care, DHSS created a chart to compare the present system of health care in Alaska to other approaches, from primary case management to full-risk managed care [slide 6]. Round 2 meetings began 10/9/15 and the contractor has compiled a list of potential initiatives that change daily as more analyses are received; the proposed initiatives include descriptions, key features, federal requirements, information technology (IT) needs, rates and payment structures, statutory/regulatory changes, actuarial analysis, and questions from stakeholders [slide 7]. Reform initiatives under consideration include a primary care improvement initiative, and others that already had priorities established in Round 1 [slide 8]. Ms. Martin said important dates remaining in the contract are the Key Partners Work Session 11/10/15 and a webinar on 11/19/15, followed by further actuarial analyses. During this time, DHSS will continue its presentations to keep interested parties informed. On 1/15/16, the final report is due to DHSS, and the contractors will be available for legislative hearings any time after that, and then the report will be followed by a final webinar on 1/21/16 [slide 9].

10:37:48 AM

MS. MARTIN stressed that key partners and stakeholders want to continue to work with DHSS on Medicaid reform; she displayed a graphic with many reforms that are currently underway at DHSS beginning in 2014, and proposed to extend to 2020 and beyond [slide 10]. She explained that DHSS wants to hear from vendors, providers, and stakeholders on the many ways to reform the Medicaid program. Slide 11 listed many public presentations that have been made or are planned, and she pointed out that Alaskans can stay informed by accessing meeting materials and webinar recordings on the DHSS website, by subscribing to email updates, and by requesting a presentation by the department [slide 12]. Ms. Martin closed, noting that other reform efforts concern the Tribal health system partnership 1115 waiver, related to transportation and referral, for Medicaid beneficiaries who are also Indian Health Service (IHS) beneficiaries. The department initially sought an ll15 waiver; however, the administration was notified in August of a pending Centers for Medicare and Medicaid Services (CMS) policy change. In addition, there is another contract underway regarding home and community based services 1915(i) and 1915(k) waivers that is also pending CMS implementation.

10:43:14 AM

CHAIR SEATON asked for a definition of a "meeting in a box," and also how legislators could organize a town hall meeting for those interested in Medicaid reform and redesign.

MS. MARTIN explained a meeting in a box is a tool that allows anyone to present - to those who are not technical experts - the models of care and the financing authorities called for in the contract. The contract is moving quickly, and DHSS wants to provide the most current information; she offered assistance in this regard.

CHAIR SEATON inquired as to whether the initiatives depicted on slide 10 are separate presentations.

MS. MARTIN said the initiatives are grouped by category; for example, "Process and Infrastructure Improvements" is connected to "Telemedicine Initiative" "Data Analytics and IT Infrastructure Initiative" and to "Medicaid Business Process Improvement Initiative" [slide 10].

CHAIR SEATON questioned whether there are separate presentations focused on each category.

MS. MARTIN said yes; webinars can delve into specific initiatives, or all of them. In further response to Chair Seaton, she confirmed that she can provide updated information at any time.

10:46:48 AM

REPRESENTATIVE TARR observed from the presentation that there is ample provider and stakeholder engagement in this regard. She asked how consumers are reached for their perspective.

MS. MARTIN explained that the reforms are at a technical stage involving financing, waivers, and care models; however, DHSS has talked with providers, advocates, and recipients. It is envisioned that as initiatives are recommended, there will be another stakeholder process to examine how user groups are affected, although some suggestions have already been received from recipients.

REPRESENTATIVE TALERICO surmised that after the analysis is received from the actuary, all of the initiatives shown on slide 10 will have a breakdown of costs and variables.

MS. MARTIN said a representative from Milliman - the actuarial firm in the contract - participates in the Key Partners Work Sessions and webinars, thus the firm is aware of the hurdles to delivering care in Alaska. However, some of the report will build actuarial analysis, and some actuarial analysis will drive final recommendations. For example, for primary care, some models have "per member per month" fees, and there are regional differences between costs and care.

CHAIR SEATON noted that one of the goals is to provide better service at a cheaper price, and he expected that to be a part of the actuarial analyses.

10:52:24 AM

MS. MARTIN agreed that the actuarial analyses will look at reforms to manage health conditions and provide preventative services, in order to avoid costly hospitalizations and catastrophic illnesses.

CHAIR SEATON referred to the Behavioral Health and Primary Care Integration Initiative, and opined that in some cases, such as the immunological basis of depression - as opposed to just psychological interactions - primary care would easily transition into the care of "a huge number of" behavioral health problems.

MS. MARTIN responded that there was extensive dialogue among stakeholder and public groups regarding a health home model of care. A health home is not just a typical doctor's office setting; a behavioral health provider can serve as a patient's health home, so that one with behavioral health needs and a chronic health condition - such as diabetes - can also have his/her primary behavioral health needs addressed.

CHAIR SEATON then referred to a document found in the committee packet entitled, "The Response of an Expert Panel to Nutritional Armor for the Warfighter: Can Omega-3 Fatty Acids Enhance Stress Resilience, Wellness, and Military Performance?" and urged that the committee consider these and other factors in its study of the integration of providers. Furthermore, another issue that has been identified is the shortage of professionals who supply services, and he suggested that Alaska could join a state compact on medical and nursing licensing to help those who want to perform a residency in Alaska, but who cannot due to a lack of licensing. He asked whether the aforementioned points are part of the redesign and expansion process.

MS. MARTIN acknowledged that workforce has been discussed; for example, the Behavioral Health Access Initiative addresses opening licensure or other opportunities. She said recommendations from the committee will be considered.

CHAIR SEATON encouraged DHSS to consider participating in a state licensing compact.

REPRESENTATIVE JOSEPHSON urged DHSS to examine technical redundancy in state licensure; in fact, his constituents view the state licensing system as needlessly slow.

11:00:20 AM

CHAIR SEATON observed that budget issues mean workforces are constrained and without employees to fill in for absences. He cautioned that state personnel reductions may impact the private workplace as well. Chair Seaton encouraged the committee to

review the materials and submit comments to DHSS on the presentation.

11:03:49 AM

BECKY HULTBERG, President and CEO, Alaska State Hospital and Nursing Home Association, informed the committee she would provide a brief update of Medicaid redesign from the providers' and stakeholders' perspective, and share observations. She stressed that Medicaid redesign is really health care system redesign. There are three sources of payment for health care: Medicare, Medicaid, and commercial or private payers. Medicare is spurring the transformation of the health care system by moving away from traditional payments based on volume and toward payments that are based on value. Medicaid also has a huge impact on the health care system and - from the stakeholders' perspective - redesign is difficult, expensive, and will take time; in fact, DHSS and stakeholders are involved in a process that is constrained by a lack of time and resources. Ms. Hultberg urged for realistic expectations of the consultant and the department. Although the process in Alaska has just started, the federal Centers for Medicare and Medicaid Services (CMS) have enabled other states to take steps. For example, she described a $65 million grant funded by CMS for a five-year initiative in Washington, and other funding received by Oregon and Colorado. She pointed out that transforming a decades-old health care system is "hard work," and the contract in Alaska will advance work that has been done. She advised that CMS is investing in reform because a reduction of "1 to 2 percent off your cost-curve, that is hundreds of millions, if not billions of dollars in the future, of savings." The Alaska State Hospital and Nursing Home Association (ASHNHA) is very supportive of the department's effort and recognizes that the contractor needs to produce an immediate action plan, given the state's fiscal situation, and also a longer-term reform plan to shape the future.

11:10:13 AM

MS. HULTBERG said a coalition of groups known as AK Health Reform is working towards a mutual understanding of health care reform and focused its first work session on the Colorado Regional Care Collaborative Organizations (RCCO) model. The second work session focused on the Oregon Coordinated Community Care Organizations model, which generated interest. The third session will hear from the Washington State Health Care Authority on the topic of managed care and, in December, there

will be a report from consultants. She stated the intent to continue the dialogue and to share the group's vision with the legislature. Ms. Hultberg observed that ASHNHA and the partners in AK Health Reform support the following: 1.) A stronger and enhanced role for primary care in the health care delivery system; 2.) The fastest-growing expense in the Medicaid budget is long-term services and support; 3.) Behavioral health integration needs to be a goal; 4.) Managed care organizations - when management of services is outsourced to an insurer - need to be thoroughly understood; 5.) Change takes time and a prepared infrastructure. She said ASHNHA and AK Health Reform strongly encourage DHSS and its consultants to consider pilot projects to demonstrate and test new models of care for use in Alaska. Finally, long-term reform must align financial incentives because as health care is moving from volume to value, CMS wants to pay based on quality and value, even though for providers the current model is to "do more, make more." Now the system is moving to a different model, "do less, make more," which means using incentives so that keeping people healthy, not treating them when they are sick, becomes the goal. She characterized this as a fundamental and profound change for which the present infrastructure is unprepared.

11:17:52 AM

REPRESENTATIVE TARR asked whether there is an opportunity to incentivize organizations so that they will move more quickly and implement pilot programs.

MS. HULTBERG said that depends. For example, by reducing the use of emergency rooms, shared savings would be an appropriate first step. She suggested that pilot programs should be encouraged.

REPRESENTATIVE TARR surmised that because hospitals function when people are sick, [reform] will fundamentally change the business model for hospitals. She asked whether hospitals would provide more primary care, or if primary care providers would become more integrated with hospitals.

MS. HULTBERG said these are unanswered questions that are being discussed by hospitals, physicians, and health care systems in other states; however, Alaska is a different market due to its small population and geography. In fact, Alaska may not fit in the new models of value. She cautioned, "... we need to be exploring them, but it's not time to jump yet, because we don't know if this model, if these models, are going to translate

here, like they have, like they do in Los Angeles." However, Alaska will not be able to continue exactly as it has in the past.

REPRESENTATIVE VAZQUEZ asked what groups are ready to proceed with pilot projects.

MS. HULTBERG responded that Central Peninsula Hospital is willing, and Ketchikan General Hospital has innovative programs. Provider groups other than hospitals, and communities, may be ready as well.

11:22:46 AM

CHAIR SEATON recalled that HB 148 authorizes two demonstration projects: One project is on a global payment model, and one project is on reducing preterm births in Alaska. He said that if other providers are ready with models, the committee is interested.

MS. HULTBERG added that a shared savings project, on which ASHNHA is willing to work with the state, is a hospital-based project in the Railbelt regarding emergency room (ER) care. In Washington, the project reduced Medicaid fees for ER visits by 10 percent.

CHAIR SEATON advised some of the projects may require legislative authorization.

REPRESENTATIVE TARR inquired how the resources available to DHSS will affect the speed at which some of these initiatives will be accomplished.

MS. HULTBERG opined that DHSS is capacity-constrained right now, and the costs of change in other states is illustrative of how this issue is not only hard, but resource-intensive. She warned that the ability to progress will be significantly affected by a lack of resources, noting that other states received funds through federal State Innovation Model (SIM) grants, which Alaska did not seek.

REPRESENTATIVE JOSEPHSON asked for more information on the availability of SIM grants.

MS. HULTBERG said, "... at this point I think the more, more critical issue is not, is not there was an opportunity foregone,

... but the critical issue is what do we do now? How do we move forward now?"

11:30:21 AM

JARED KOSIN, Executive Director, Office of Rate Review, Division of Health Care Services, DHSS, provided an overview and update on the Health Care Provider Tax Feasibility Study and Recommendation. Mr. Kosin said DHSS awarded its contract for a feasibility study to Myers and Stauffer, Certified Public Accountants, in June [2015]. Key goals of the project are a feasibility study and recommendation, a draft tax proposal, a public presentation, and subject matter expertise. The feasibility report and recommendation, and the draft tax proposal, are due 12/1/15, and must include stakeholder input. He stressed that stakeholder input in this type of issue is critical, so DHSS held a series of in-person meetings and webinars. Mr. Kosin explained there is a need for stakeholder engagement in the health care provider tax because federal law directs that there are nineteen possible tax classes, with numerous provider types within each class. In an effort to focus the study, DHSS first asked the contractor to determine whether some classes were unfeasible, and the contractor was able to identify classes in which providers do not do annual financial reporting, or are not licensed by the state, such as stand-alone imaging facilities. Immediately after the review, twelve of the classes were determined "probably not feasible." This narrowed the scope of the project to seven classes, which allowed more effective engagement with providers who may be affected. He said of the classes remaining, nursing home services and hospitals are the most obvious tax categories that are likely to be feasible and come under full consideration in Alaska. The second scheduled stakeholder meeting focused on nursing homes and hospital services only, and the next two webinars will be opportunities to hear responses from providers and the general public on the remaining possible tax types. At the present time, the contractor is building and testing tax models in order to run scenarios; using a scenario for each particular tax, the models will reveal educated conclusions regarding feasibility and economics. Although unfinished at this time, the models are Excel templates with different sections; the first section is the assessment basis, or what is being assessed with a tax. For example, at a hospital or nursing home, the model looks at whether to tax the number of beds, a flat fee per entity, resident patient days per year, or a percentage of revenue. The models can run scenarios with each possibility and glean a lot of information from each outcome.

The second section is compliance, and by federal law providers cannot be held harmless, which means that with health care services, the state can collect revenue from the provider tax, retain a portion of the revenue and, as many states do, take a portion of that revenue and invest it back into Medicaid payments. The portion invested back into Medicaid payments draws down the federal match, thereby funneling some of the money back to the providers, which is beneficial in that reimbursements can go up for services that would otherwise need higher reimbursement. In order to prevent abuse, the federal government ruled that states cannot hold providers harmless, but created a safe harbor provision whereby if provider tax and Medicaid repayments are limited to 6 percent of the providers' revenue, it is presumed to not violate the hold harmless provision. Mr. Kosin cautioned that the federal government may reduce the limitation to 3 percent or 3.5 percent, therefore, DHSS does not want to build a model on the existing limit. Also in the compliance section, the model looks at whether or not the tax is broad-based, although the state can apply for a broad-based waiver, using the P1/P2 test to qualify for an exemption. This is important to Alaska because the state has very small hospitals in remote areas providing critical access to care, and it may not make sense to include them in a provider tax. The model will show if Alaska can pass the P1/P2 statistical test for a waiver. In addition, provider taxes must be uniformly imposed in a tax class; if Alaska seeks a tiered tax rate for smaller entities, another waiver would be needed, and a B1/B2 statistical test would be required to qualify for an exemption. The final section in the model is the financial analysis, which will reveal the hypothetical revenue collected under each scenario, and will allow DHSS to evaluate whether the state should reinvest funds into its Medicaid payment through supplemental payments. He restated that the reinvestment of collected revenue can draw down federal match dollars, and in some cases, result in a net gain for providers, and benefits to the state. Although this is common in other states, Alaska must use its model to determine if it has the numbers and capacity to utilize this approach.

11:45:03 AM

MR. KOSIN closed, noting that DHSS is finalizing the tax classes, which are now down to six, allowing more consideration of each. He thanked ASHNHA for its participation, and that of its contractor. After the models determine whether a provider tax is feasible in Alaska, DHSS will submit recommendations to the legislature.

REPRESENTATIVE VAZQUEZ asked for the six classes of providers that have been identified as eligible for the provider tax.

MR. KOSIN answered the six classes include: inpatient hospital services, outpatient hospital services, nursing facilities or nursing homes, outpatient prescription drugs, ambulatory surgery centers, and others such as residential psychiatric treatment centers, personal care attendant agencies, waiver agencies, and behavioral health services. In further response to Representative Vazquez, he said the contractor has concluded - from looking at other states - that even though it is called a health care provider tax, the provider tax is viewed as an assessment or fee, and therefore can be applied to nonprofit and for-profit entities. He cautioned that any proposal introduced to the legislature would have to be reviewed by the Department of Law regarding constitutionality.

REPRESENTATIVE VAZQUEZ then asked whether providers that do not accept Medicaid would be required to pay the tax.

MR. KOSIN explained that would depend on which tax classes are deemed feasible. The attention at this time is on nursing homes and hospitals, all of which are subject to state rate settings and receive Medicaid. This question may be relevant to other categories, however, and the answer would be yes. The threshold is not whether a provider is a Medicaid participant, but whether a provider is in an identified class.

REPRESENTATIVE TARR surmised there are three categories, nonprofit, for-profit, and publically-owned.

MR. KOSIN explained DHSS distinguishes between all three types of entities regarding enhanced Medicaid payments because hospitals and nursing homes are subject to another federal law, the upper payment limit. The upper payment limit dictates that Medicaid cannot pay more than Medicare pays for the same or similar service. This calculation distinguishes between state-owned and non-state-owned facilities. He expressed doubt that the state would assess a fee against a state-owned facility, but the answer is unclear.

11:52:33 AM

REPRESENTATIVE TARR asked:

> Are you saying that the provider tax dollars that would be brought in could be ... bundled with your state dollars, and then you know, because of your percentage match, you would get more federal dollars that way? Or are you saying there's a mechanism by which you participate in that, and then your actual [federal medical assistance percentage (FMAP)] changes?

MR. KOSIN answered:

> ... you had it right the first time. We would obviously generate revenue, and then it would be up to the legislature to figure out - if they wanted to - a portion of that revenue could go back into Medicaid payments .... Instead of somebody paying a fee for service right now, for a hospital, we pay on a daily basis, you can actually pay an enhanced payment, on top of that, that just kind of goes along with your daily payment. That enhanced payment could be funded using some of the revenue you collected from the prior tax, it would then be bundled, with a federal match with Medicaid. So you had it exactly right the first way you said it.

CHAIR SEATON opined that these will be dedicated taxes.

REPRESENTATIVE TARR surmised that the provider tax dollars can be dual purpose because they enhance the federal match and provide an opportunity for supplemental payments.

MR. KOSIN said yes, limiting his response to drawing down the federal match, which is common in other states. However, how the funding is dedicated is a legislative issue.

CHAIR SEATON commented on the complexity of this issue.

REPRESENTATIVE VAZQUEZ asked whether there has been an estimate of the amount of tax that could be collected from the identified classes.

MR. KOSIN answered no.

CHAIR SEATON informed the committee that the average provider tax across the U.S. is 2 percent, but it is not known whether said 2 percent relates to all medical costs, or to the provider's revenue.

MR. KOSIN said he was unaware of the aforementioned 2 percent estimate. Last year, the legislature inquired as to the safe harbor provision, and asked for an estimate of 6 percent of hospital outpatient revenue. He warned that the estimate would not reflect what the tax may generate because the percentage is uncertain. The key concern is that the federal government may reduce the safe harbor provision from 6 percent to 3 percent, or 3.5 percent, and the tax base would have to be known. He stated that the contractor will have a better answer at a later date.

11:58:25 AM

BECKY HULTBERG, President and CEO, Alaska State Hospital and Nursing Home Association, acknowledged that the topic is very complex. She pointed out that provider taxes are almost always hospital and nursing home taxes; in fact, forty-nine states tax hospitals or nursing homes primarily as a mechanism to enhance provider payments, even though this tax can generate revenue for the states. She clarified that it is a tax used to leverage supplemental payments, and the big question will be what will be done with the revenue: What portion is returned to providers and what portion is kept by the state? Ms. Hultberg relayed that whatever tax basis is selected, the tax will result in "winners and losers." Some provider groups - such as ASHNHA - are happy about taxes, and some are not, and she warned that a poorly conceived health care tax could be a negative for the health care industry and the state. Consultants representing both sides need to find consistent data, so ASHNHA can run its models and take a position. Further, Ms. Hultberg expressed concern about the timeline in early December for the completion of the contract, given that the data for the models is uncertain, and she encouraged DHSS to take the time that is needed.

CHAIR SEATON returned attention to incentives and the change from a "fee for service model to a value model." He asked if the value model relates differently to the tax than does a fee for service model.

MS. HULTBERG advised that California has integrated systems, and also has provider taxes. As CMS pays for care, it is also looking at provider taxes.

12:04:31 PM

CHAIR SEATON cautioned against designing a tax based upon fee for service.

REPRESENTATIVE TARR asked whether other organizations - not affiliated with nursing homes or hospitals - are looking at possible tax classes.

MS. HULTBERG advised that the ASHNHA consultant is focused primarily on hospitals.

CHAIR SEATON observed that the committee's focus is on promoting health as a way to lower health care cost. He said there will be further discussion, not on the Medicaid system, but on practical initiatives to have a healthier population resulting in fewer costs to the Medicaid system. He directed attention to an additional document found in the committee packet entitled, "Reducing Negative Health Outcomes Through Prevention" and dated 10/8/15. Both documents will be posted on the House Health and Social Services Standing Committee website.

REPRESENTATIVE TALERICO announced a presentation regarding a safety message used in the private sector to avoid injury at the workplace.

CHAIR SEATON solicited other initiatives to save costs, not by restricting access to health care, but by reducing the need.

12:09:56 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 12:09 p.m.