ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 16, 2016
3:04 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Neal Foster
Representative Louise Stutes
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool

MEMBERS ABSENT

Representative Liz Vazquez, Vice Chair

COMMITTEE CALENDAR

HOUSE BILL NO. 227
"An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 227
SHORT TITLE: MEDICAL ASSISTANCE REFORM
SPONSOR(s): REPRESENTATIVE(s) SEATON

01/19/16	(H)	PREFILE RELEASED 1/8/16
01/19/16	(H)	READ THE FIRST TIME - REFERRALS
01/19/16	(H)	HSS, FIN
02/02/16	(H)	HSS AT 3:00 PM CAPITOL 106
02/02/16	(H)	Heard & Held
02/02/16	(H)	MINUTE(HSS)
02/09/16	(H)	HSS AT 3:00 PM CAPITOL 106
02/09/16	(H)	-- MEETING CANCELED --

WITNESS REGISTER

BECKY HULTBERG, President/CEO
Alaska State Hospital and Nursing Home Association
Juneau, Alaska
POSITION STATEMENT: Presented a PowerPoint titled "Hospitals and payment reform," in conjunction with discussion on HB 227.

ACTION NARRATIVE

3:04:04 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:04 p.m. Representatives Seaton, Talerico, Stutes, Foster, and Tarr were present at the call to order. Representative Wool arrived as the meeting was in progress.

HB 227-MEDICAL ASSISTANCE REFORM

3:04:14 PM

CHAIR SEATON announced that the only order of business would be a presentation by Becky Hultberg on the landscape for hospitals and some of the demonstration projects in the proposed bill, HOUSE BILL NO. 227, "An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

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BECKY HULTBERG, President/CEO, Alaska State Hospital and Nursing Home Association, stated that she would discuss the broader concept of payment reform and the various models discussed in proposed HB 227, and other proposed bills. She stated that hospitals felt that payment reform was inevitable and had already started, both at the state and national levels. She declared that the Alaska State Hospital and Nursing Home

Association (ASHNHA) represented all but one of the hospitals and nursing homes in Alaska, employing more than 10,000 Alaskans. She noted that hospitals were often the largest private sector employer in the community, as well as the largest health care providers.

MS. HULTBERG introduced a PowerPoint, titled "Hospitals and payment reform," and directed attention to slide 3, "Definitions: concepts." She shared that one concept, managed care, was a confusing term as it was used in various context to mean many things, but it was really just a method of health care delivery that focused on collaboration and coordination to avoid unnecessary and duplicative care, and delays. There was an emphasis on timeliness and effectiveness of treatment. She declared that it was a system for actively managing health care to reach a desired outcome for quality, and possibly lower costs. She stated that the payment in this environment was not fee for service. She explained that fee for service, the current system in Alaska, was payment based on volume and the services were not bundled, but paid for separately. Each visit to a provider resulted in separate charges for each part of the visit.

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REPRESENTATIVE WOOL asked about the designation for payment of a flat rate for service.

MS. HULTBERG expressed her agreement that there were different iterations of managed care, and this was one type. She moved on to slide 4, "Types of payment: risk continuum," and explained that this risk continuum depicted the scale from a provider having no financial risk for outcomes, fee for service as the transaction was based on volume; to the other end of the spectrum wherein the provider was bearing full risk for outcomes, known as a partial or full capitation or global budget. She reported that providers would bear different levels of risk along this continuum. She reiterated that fee for service was defined as payment per unit, with the provider bearing no risk, whereas with pay for performance, although the payment may remain per unit perhaps the provider is incentivized based on quality outcomes. There could be a holdback of payment until certain quality objectives are met, or a bonus type structure based on outcomes. This would still be a fee for service although with built in incentives for different behavior. She explained that an example of a bundled payment would be for a knee replacement, as rather than pay for each

individual service, there would be one bundled payment for that person for that procedure, even as the provider was at a risk for whether the case cost more or less. She relayed that bundling was often used for discreet events that were easy to measure and providers typically know what the cost would be, even though the provider was at risk for the outcome and the cost of the procedure. She defined episode or case-based payment as a broader type of bundling for a service. The final payment listed on the continuum, slide 4, was for partial or full capitation, which she defined as a per member per month type of fee, based on the number of patients and the average patient cost. She pointed out that the provider was at risk for the health care cost of that population.

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MS. HULTBERG moved on to slide 6, "Definitions: types of payment," and paraphrased from the definition for capitation, which read: "a payment arrangement that pays a provider or group of providers a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care." She pointed out that the person receiving care under the capitation model could either receive no care or cost a lot more than the payment on any given month. Essentially, this was a mechanism by which the provider was taking risk for the population. She directed attention to the definition for global budget, which she defined as similar to capitation. She relayed that there were often very defined quality and outcome metrics built into the global budget contract environments. She offered as an example the Oregon Coordinated Care Organizations (CCOs) in which the State of Oregon had decided that it would manage its Medicaid population in a regional structure so, as these CCOs would get a set amount of money to take care of a defined Medicaid population, they would be at risk for the health cost of this population. This would create very incentivized care delivery at the lowest cost and highest quality. She reported that quality metrics were built into the contracts, as sometimes a lot of money could be spent without getting great quality. She offered an example for the purchase of an air conditioner for a patient with a heart condition living in a hot climate, in order to reduce repeated emergency room visits. She pointed out that heath conditions could be exacerbated by the physical environment or psychological or social needs. With the global budget or capitated environment, the providers were incentivized to do some things that could seem strange from a health care perspective, but actually impacted health care needs. She stated that capitation or

global budget environments allow the health care providers to address the underlying causes of health care spending whether they are health care or related to some other factors.

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REPRESENTATIVE TALERICO asked in which of the six categories of payment Alaska currently stood.

MS. HULTBERG replied that Alaska had fee for service. She offered her belief that there were some small projects beginning to be discussed or initiated that would move Alaska further along on the continuum. She listed a CCO pilot on the Kenai Peninsula, and a care coordination program in Ketchikan as "baby steps." She offered Ketchikan as an example of a hospital doing a great job managing care and keeping people out of the hospital even as it resulted in a loss of revenue through their fee for service system. She declared that there was not any incentive; even though it was a good outcome to not have someone in the hospital, the payment structure did not reward that, it rewarded volume and sickness.

REPRESENTATIVE WOOL mused about the quality and value differences, and whether the fee was disproportionate to the service provider.

MS. HULTBERG opined that the key to the organizations involved in global budget models was that providers were at the table as part of the risk sharing. She shared that an out of line physician fee brought a strong incentive to the hospital to negotiate that fee; whereas, a fee for service environment did not have the same pressure from providers to manage costs.

CHAIR SEATON asked what was the general driver for the assumption of risk.

MS. HULTBERG replied the short answer was that Medicare was driving the shift from volume to value right now. She noted that this complete shift in the business model to move from fee for service was really hard and that it required sophisticated data analytics to understand the health of your population and what could be impacted. She opined that it was important to keep in mind that this was a journey, and that, as providers needed to start down the path, it would take time and experience in learning how to do it well. She stated that this was a big shift to taking a financial risk.

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MS. HULTBERG moved on to slide 7, "Definitions: types of organizations," and stated that these were all organizations that managed care, even though the names were different. She reported that accountable care organizations (ACOs) were Medicare driven which tied provider reimbursements to quality metrics and reductions in the total cost of care, even as there could be different levels of risk bearing in the ACO. She referenced the aforementioned CCO models in Oregon, pointing out that there was a pilot program in the proposed bill. She relayed that managed care organizations (MCOs) were an umbrella term for health plans that provided health care for a predetermined monthly fee, and coordinated care through a network of physicians and providers. MCOs were a health plan that was bearing the risk, contracting with providers for the delivery of care and was not the model that ASHNHA would select as it did not necessarily change the payment structure between the insurer and the provider. She stated that the biggest thing to remember was that all these models were for active managed care, and for the organization to take some level of risk, so the interests of the provider and the payer were aligned.

MS. HULTBERG addressed slide 8, "Volume to value," and described the fee for service movement toward value, whereby payment was tied to cost and quality. She said that Alaska could remain a fee for service environment for a while, as part of the market could always be fee for service. However, nationally, she stated that "the train really has left station" and that Alaska will be forced to move to these models from a hospital standpoint, which would help drive the market.

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MS. HULTBERG pointed to slide 9, "Hospital trends: lower inpatient use." She stated that hospitals were seeing a lot fewer inpatients than previously; although, when revenue was related to volume and inpatient use, that was a significant trend over the 20 years depicted on the graph.

MS. HULTBERG moved to slide 10, "Reduced readmission rates." She reported that, as CMS was now penalizing hospitals for readmissions, thereby changing them from revenue to penalties, these rates were declining.

REPRESENTATIVE TALERICO asked if the hospital was able to participate in the evaluation of the readmission penalty as some

patients participated in activities that required readmission at no fault to the health care provider.

MS. HULTBERG replied that she would respond later with specifics, noting that these were typically for certain types of events and for certain defined time frames. She agreed that there was a concern among hospitals that they were not always responsible for what happened outside the hospital. CMS was saying that the hospital didn't quite take care of the patient, hence the readmission, although it could be related to something different. She reported that these were the pressures that hospitals were under, and these pressures would most likely increase.

REPRESENTATIVE WOOL pointed out that people sometimes became sicker in hospitals.

MS. HULTBERG acknowledged that these were called hospital acquired conditions, and the hospital was penalized. She declared that payments were now changing due to this. She offered that this was an example of tying payment to quality.

CHAIR SEATON asked if these were measured in a 30 day - 90 day admission rate for the same condition.

MS. HULTBERG stated her agreement.

3:28:12 PM

MS. HULTBERG shared slide 11, "Employer health insurance," and read that this was the cumulative increase in health insurance premiums compared to wage increases and inflation over 15 years. She shared that the take away from the chart was, as health insurance costs have gone up, employers were shifting more costs to the employee. She opined that it would become difficult to continue that cost shift. She stated that real wages were affected by this shift to employees paying more for their health insurance premium.

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MS. HULTBERG turned to slide 12, "Growth in high deductible plans." She pointed to the considerable growth in high deductible health plans since 2006, noting that there were two implications: one was that it really did provide employees with skin in the game and awareness of cost when shopping for health care so that patients were acting more like consumers; the

second was for bad debt, as the new amount of money was now cost shifted to consumers for payment. She reiterated that this was cheaper for employers. In Alaska, as the public sector had not moved in a meaningful way to high deductible plans, there was a disconnect between private and public health care plans.

REPRESENTATIVE TARR asked if there were high deductible plans within the Affordable Care and Patient Protection Act and whether these were higher risk.

MS. HULTBERG replied that the aforementioned would be within the parameters set by the Affordable Care and Patient Protection Act. She stated that some of the plans on the current health exchange were considered high deductible, and that self-insured employers would still need to meet the general parameters.

REPRESENTATIVE TARR asked if the currently required preventative health care changes were included in the high deductible plans, and if the high deductible was then applied for surgery and long term stay.

MS. HULTBERG replied that preventive care was still available with no out-of-pocket cost. She explained that the real difference with a high deductible plan was the size of the deductible compared to the traditional plan. She explained that often there was an employer contribution to a health savings account with a high deductible in a large self-insured employer plan, and that employees were often then more sensitive to spending as it was spent out of their account.

REPRESENTATIVE WOOL asked whether the growth in high deductible plans was connected to the price of health costs going through the roof, noting that a company would save money by offering a cheaper plan which had a higher deductible.

MS. HULTBERG expressed her agreement that one way to address more expensive plans was to buy a cheaper plan, which typically had a higher deductible, but that even larger employers were finding that their healthcare spending was growing at a lower rate under this aforementioned model structure because employees had more incentive to act like consumers.

REPRESENTATIVE WOOL observed that, with a high deductible plan, as soon as people reach their deductible, they "start consuming a lot more."

MS. HULTBERG expressed agreement that this "tends to be the case no matter the structure of the plan." She opined that the key takeaway for the provider, based on slide 12, was that it was becoming increasingly difficult for providers to cost shift to commercial pay, as employees could only take so much of the cost shifting and employers could only pay so much more.

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MS. HULTBERG moved on to slide 13, "Projected Medicare Spending, 2013-2023." She referenced a report which stated that the Medicare trust fund would be exhausted in 2026, which was driving a lot of activity on the federal level.

REPRESENTATIVE TALERICO asked about a graph showing Medicaid spending versus Medicare spending.

MS. HULTBERG replied that she did not have anything that compared the two.

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MS. HULTBERG returned to slide 13 and stated that, as the baby boomers aged into Medicare, there was a significant recognition that, absent some changes, the program would be very difficult to maintain.

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MS. HULTBERG referenced slide 14, "Medicare payment policies," which depicted Medicare cuts to nine of Alaska's larger hospitals, which would result in $591 million of reductions in payment over 15 years. She reported that an additional $400 billion reduction had been proposed in the recent budget by President Obama, although she stated that she did not know if this would be enacted. She declared that Congress had figured out that hospitals were piggy banks, and consequently there were cuts extended into the future to pay for current spending. She emphasized that this environment created a lot of stress on hospitals from Medicare payments.

REPRESENTATIVE TALERICO asked if Medicaid reimbursement was similar to Medicare.

MS. HULTBERG relayed that Medicaid reimbursement was structured completely differently than Medicare reimbursement. She said that Medicare pays more on an encounter basis whereas Medicaid

pays a daily rate based on cost, a completely different payment methodology.

3:37:34 PM

MS. HULTBERG addressed slide 15, "Medicare delivery system changes," a copy of a press release from January, 2015, which stated that Medicare was moving from volume to value. She paraphrased the article, stating that "the first goal is for 30 percent of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients instead of how much care they provide, and to do it by 2016." She went on to share that the goal was to get to 50 percent by 2018, and that the second goal was for virtually all Medicare fee for service payments to be tied to quality and value, at least 85 percent in 2016 and 90 percent in 2018. She reiterated that this was a move away from fee for service to value based payments, while recognizing that, although there would still be some fee for service, this would be tied to quality or other metrics.

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MS. HULTBERG pointed to slide 16, "Shrinking of Traditional Payment," which graphically depicted payment movement under Medicare fee for service, and the volume to value shift. She stated that this was important to hospitals as Medicare was a "huge part of a hospital payer mix" so hospitals did not really have any choice for whether to accept Medicare. Consequently, when Medicare stated that it was changing, the hospitals had to figure out how to manage this.

3:39:07 PM

MS. HULTBERG shared slide 17, "Move to Population-based Payment," which was another way of looking at the risk continuum, specifically for Medicare. This moved from fee for service to population based payment, similar to a capitated payment.

MS. HULTBERG explained slide 18, "Accountable Care Organizations," which showed the location of the ACOs, noting that there were not any in Alaska. She reported that more than 70 percent of the U.S. population lived in locations currently served by ACOs with almost 44 percent of the population living in areas served by two or more ACOs. The movement toward an ACO

model had accelerated in the last few years, from 154 ACOs in 2012 to 426 ACOs in 2015.

CHAIR SEATON asked if the majority were plans with seniors as the primary clients.

MS. HULTBERG clarified that these depicted were entirely the Medicare population, and that hospitals had to move with this shift.

REPRESENTATIVE WOOL asked for clarification that these were Accountable Care Organizations and entirely Medicare, and he questioned whether hospitals were treating non-Medicare patients in the accountable care format.

MS. HULTBERG explained that the slide represented Medicare ACOs, although there were others, noting that ACOs were a model, and were not restricted to Medicare as a payer.

CHAIR SEATON asked if ACOs could have two separate billing or payment systems, one for Medicare and one for other patients.

MS. HULTBERG asked for a specific organization.

CHAIR SEATON asked if the depicted ACOs existed parallel but independent from the other billings into that facility.

MS. HULTBERG opined that it depended on the organization and whether it was a Medicare ACO, while also seeing commercial patients as fee for service, then there would be different financial arrangements. She stated that with Medicaid billings, the ACO would not necessarily need to have different systems.

CHAIR SEATON asked specifically about Alaska, questioning whether an institution which had three payees, Medicare, Medicaid, and commercial patients, would have three separate payment systems.

MS. HULTBERG replied that, as many of the organizations already had different rules and system, she was not sure whether this would necessarily recreate a lot of different infrastructure, as many of the organizations were already billing Medicare, Medicaid, and commercial insurance. She opined that having to live within all the current payment systems would not necessarily be changed by reconfiguring the billing for any one of them. She declared that health care billing was already incredibly complex.

REPRESENTATIVE WOOL asked whether a Medicare mandate to providers for a certain percentage of patients under a managed care model would drive hospital physicians out, so it was not necessary to work under the mandate.

3:46:52 PM

MS. HULTBERG directed attention to slide 19, "Joint replacement comprehensive pay model," which clarified that Medicare was doing bundled payments as well as ACOs. She stated that this demonstration model required that all the payment in 75 geographic areas be 100 percent bundled payment for joint replacement. She allowed that Anchorage was not included, and that it was not ready for this bundled payment model, noting that it was necessary to first coordinate who got what part of the payment, among the hospital, physicians, and post-acute care. She pointed out that this model was a five year pilot that could become mandatory if it was successful.

MS. HULTBERG replied to Representative Wool, and considered slide 20, "SGR out, MACRA in." She explained that physicians were paid by Medicare under the Sustainable Growth Rate (SGR) formula, a formula which resulted in annual cuts, forcing Congress to pass a bill to restore payment so physicians did not take large payment cuts. She stated that there had been alignment to do away with SGR, and utilize a new payment system, Medicare Access and Chip Reauthorization Act (MACRA). She said that this would move the volume to value to physician practices, incentivizing them to participate in alternative payment models. If they chose to remain in a fee for service payment system, there would be bonuses or penalties based on outcomes. She declared that this would be a big issue in Alaska starting in 2018, as it would be difficult to operate under because there was already a problem with Medicare access.

MS. HULTBERG shared slide 21, "Volume to value: implications for the market." She relayed that volume to value was inevitable once Medicare had stated that it was moving. The goal was better health care, with the triple aim for improving the individual experience of care, reducing the per capita cost of care, and improving the health of the population. She stated that the volume to value transition was driving toward this triple aim goal. She offered an anecdote of moving from volume to value, as it was important for the state to consider the implications for this transition and how it would be navigated. She offered a recommendation to continue to review pilot

projects similar to those in proposed HB 227, in order to test some demonstration models for payment reform with hospital and physician providers willing to assume some risk. She pointed out that the Alaska population was not highly concentrated, so it could necessitate "some tweaks to any model we would want to adopt based on our unique geography and our unique provider community." She acknowledged that parts of the Alaska system could retain fee for service for some time; although the high likelihood was movement toward a new model, it was necessary to immediately start the deliberative process to determine which one was right for Alaska.

CHAIR SEATON asked if there were additional models which would be good to incorporate into the proposed bill.

MS. HULTBERG suggested a primary care model in Colorado and a similar Alabama model. She opined that the key was to create an environment for innovative projects from providers, possibly a CCO, and maybe a few others. She relayed that, as these could be regional, a strength of the pilot approach was for letting the regions come forward with suggested projects tailored to their unique needs.

CHAIR SEATON opined that there should not be limitation for any provider groups in the proposed bill.

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REPRESENTATIVE TARR asked about a hospital perspective, noting that the patient would be accessing Medicare services for chronic health conditions, otherwise they would be accessing their primary care provider. She asked about the relationship between Medicare cuts for those people who would now have Medicaid to access services to which Medicare had previously covered.

MS. HULTBERG shared that there had been a concern under Medicaid expansion about Medicaid patients crowding out Medicare patients and whether providers would take the Medicare patients. She reported that Anchorage used to have a Medicare access problem, and, in response, there were now two hospital based clinics seeing Medicare patients. She declared that private pay was following what Medicare was doing, as were states. She relayed that with the volume of Medicare, it was expected to see the commercial payers follow Medicare in the payment reform market. She declared that, as the goal was to keep people out of the hospital, when the providers became part of the risk bearing

entity, there became a financial incentive to keep people out of the hospital.

3:58:17 PM

REPRESENTATIVE TARR returned attention to slide 14, and asked if it was known whether a growing senior population with the accompanying increase in Medicare, and the cost shifting cuts from Medicaid expansion, would be represented by increased spending in Medicaid.

MS. HULTBERG replied that these were really cuts that were cuts and were not related to quality payment. She said that some cuts were related to the Affordable Care and Patient Protection Act, and some were a result of sequestration, a combined series of cuts that showed the increasing financial pressures on hospitals since 2010. She declared that there were increased efforts to improve processes and be more efficient, as Medicare was cutting reimbursement. She stated that this had a huge impact on the hospital business model. She noted that the first impacts would be on small community hospitals. She relayed that there had been a lot of response nationwide, focusing on rural hospital sustainability. She suggested that there was a need for payment policies to allow community hospitals to stay viable.

REPRESENTATIVE WOOL acknowledged the upcoming Medicare mandates, and he asked if fewer physicians would accept Medicare. He questioned whether other insurance payers also had these mandates, which would lead to physicians having a harder time for opting out.

MS. HULTBERG replied that the changes on the payment side to physicians should be watched, as there would be a significant administrative burden on them. If physicians remained in a fee for service environment, it would be necessary to collect and report the metrics on four different variables, including satisfaction, resource utilization, and quality. She opined that there was concern for this huge administrative burden, as some physicians would opt out from Medicare patients.

4:03:25 PM

CHAIR SEATON asked whether there were now more dual eligibilities with the expansion of Medicaid.

MS. HULTBERG replied that she did not have the data.

CHAIR SEATON asked if this had been rising to the surface regarding payment or reimbursement for dual eligibles system-wide.

MS. HULTBERG replied that she had not heard anything specific.

CHAIR SEATON declared that it was interesting to try to address this without trying to design it, and he expressed appreciation for the global perspective. He asked that any models be submitted for investigation.

REPRESENTATIVE WOOL expressed his agreement that this presentation had been very informative, and he suggested that this information would have been good to know prior to the last presentation.

REPRESENTATIVE TARR asked about the health care partnerships between hospitals and primary care providers. She surmised that a move from volume to value based would be of more interest for a hospital to become a primary care provider, and that a challenge would be that many hospital based primary care providers did not offer behavioral health services. She declared that this could be a shortcoming for that model, whereas a more traditional private practice doctor may be able to take that on.

MS. HULTBERG replied that she had not heard of any controversy between hospital based and non-hospital based physicians. She declared that hospitals were very aware of the need to integrate behavioral health services into primary care. She stated that acute behavioral health problems showed up in the emergency room, and that was not the place to deal with these issues. She emphasized that the organization was very supportive of models that would support and integrate behavioral health. She relayed that many hospital CEOs had very high concerns for behavioral health. She pointed out that when people did not have adequate community support and adequate follow up care for behavioral health issues, they ended up in the emergency rooms or in-patient hospitalization, which was not necessarily the best equipped environment for behavioral health care. She relayed that Alaska State Hospital and Nursing Home Association (ASHNHA) has gotten more involved in communication with Department of Health and Social Services for behavioral health issues, and expressed agreement with the need to integrate behavioral health. She opined that recognizing the importance of

behavioral health in the overall system of care was endorsed by ASHNHA, which supported this ongoing conversation.

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MS. HULTBERG reflected on her earlier comments, and clarified her earlier definition of "30 day readmissions" to be for all causes, that it did not matter for what, the hospital was still penalized.

REPRESENTATIVE WOOL mused that as hospitals and medical care improved and there was less need for medical care, the people in the hospital business suffered. He suggested that a balance needed to be met, as the incentive should be to keep people away from hospitals and doctors, but not to punish hospitals and doctors.

MS. HULTBERG opined that this was a core reason for the acceleration of payment reform, as currently there were not the right incentives. She suggested that the best scenario would be when the provider, the patient, and the payer all had the same incentives for a quality outcome at a reasonable cost.

4:11:00 PM

CHAIR SEATON recognized that this discussion was for better understanding to parts of proposed HB 227. He opened public testimony, and noted that it would also be open in the future.

[HB 227 was held over.]

4:12:41 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:12 p.m.