ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

March 20, 2019

The Honorable Adam Crum, Commissioner
Department of Health & Social Services
350 Main Street
Juneau, AK 99801

Dear Commissioner Crum,

The Department of Health & Social Service's presentation to the House Finance Health & Social Services Budget Subcommittee on March 19 provided the first opportunity for us to understand how the Department plans to address the Governor's $714 million proposed Medicaid reduction.

We are concerned that so far these proposals have been developed without provider input and we hope the Department will now engage with providers in discussions. Productive changes to Medicaid require working together and we welcome the opportunity to work collaboratively on solutions to address the state's health care needs. ASHNHA has been part of Medicaid reform efforts and we want to continue to be part of the solution. General fund payments to hospitals were less in SFY18 ($42 million) then in SFY15 ($46 million) despite an additional 79,000 Medicaid recipients receiving care. Working together we have provided more care to vulnerable Alaskans at less cost to the state.

We have the following comments, questions and concerns about the items raised in the hearing and we welcome the opportunity to meet with your staff to discuss these issues further.

General comments on rate reductions: Provider rate cuts are the easiest lever for the Department to pull to address Medicaid cost growth. However, provider rates simply ratchet down the amount that the Department pays for services without addressing the underlying structure, organization or cost growth of health care. Medicaid already pays below cost, so reducing Medicaid rates merely shifts burden and risk from the state to other payers.

Many states have reduced provider rates, but cost growth in the Medicaid program has continued. Reducing provider rates is not innovative, forward-thinking or transformational. In fact, reducing provider rates could harm efforts to transform the delivery system to achieve a more sustainable growth rate moving forward. Much work has been done through SB 74 and the Alaska Healthcare Transformation project on moving Alaska's health care system toward a

delivery system that rewards value and promotes efficiency. Cuts of this nature could set the health care reform journey back, without demonstrating a long-term reduction in health care cost growth.

Skilled Nursing Facility (SNF) 5% cut and rate methodology change to acuity-based rate: We are very concerned about the impact of a 5% rate cut on SNFs as of July 1. As you are aware, the SNF payer mix is 85% or more Medicaid. Since Medicaid is a cost-based rate that doesn't truly cover all costs, SNFs operate on very thin margins. In past periods of budget reductions, SNF rates were not cut, but inflationary adjustments were suspended. Even the suspension of inflation adjustments pushed many SNFs to the edge of financial viability. The current line item budget shows a total reduction in SNF payments of $5 million. It is unclear if the current system can support such a reduction without facility closures. SNF closures could impact the viability of Critical Access Hospitals (see below) and the capacity and throughput in acute care hospitals which would no longer have safe discharge locations for patients needing 24-hour nursing care.

Moving to an acuity-based rate by Jan. 1, 2020 would require significant work of SNFs, at a time when facilities will be under financial stress. We are concerned that the timeline is too aggressive, and we hope that detailed analysis has been completed given the potential impacts on vulnerable SNFs. Further, as noted below acuity-based rates may not be appropriate for low-volume facilities.

Critical Access Hospitals (CAHs) "held harmless": While the budget exempts CAHs from the 5% inpatient cut, it does not exempt their co-located SNFs from a budget reduction. Many CAHs are supported financially by the co-located SNF, which provides economies of scope that allows the facility to maintain financial viability. SNF rates are as important, if not more important, than CAH inpatient rates. The reduction of SNF reimbursement could push several CAHs toward financial insolvency. Further, more information is needed to determine if the acuity-based rate system will be appropriate for CAHs operating low volume SNFs. The high fixed costs necessary to operate a facility offer little flexibility to change staffing or reduce costs based on a resident's acuity. We are concerned about the lack of analysis on the impact on small SNFs and we urge the Department to evaluate if this change will result in the closure of small rural facilities. Alaska already has one of the lowest rates of SNF beds per capita in the country, and with a growing elderly population we can't afford to lose any existing capacity.

Physician and other provider rate cuts: The Department proposes to reduce physician and other provider rates by 5%, holding primary care harmless. Physicians have previously received a 10% rate cut and have had inflationary adjustments suspended, making the cumulative reduction more than 20%. This reduction will affect other provider types as well, such as behavioral health providers, physical therapists, nurse practitioners and other critical non-physician providers. It is not clear if the Department has conducted an impact analysis on the proposed rate reduction and if it would disrupt services for patients. Before moving

forward, such an analysis should be completed. Behavioral health providers finally received a rate increase after nearly a decade of flat rates. Cutting rates now will stifle the development of much needed behavioral health programs and push those with needs to the highest cost setting.

Medicaid adult dental eliminated: Eliminating adult dental will result in an increase in emergency department use for dental problems that could have been prevented or treated in a less costly care setting.

Movement to diagnosis-related group payment methodology for PPS acute care hospitals: ASHNHA supports further investigation regarding moving to a DRG based payment methodology for Medicaid. However, we would appreciate a more complete understanding of the Department's research and analysis of this change. Finally, a start date of January 1, 2020 seems overly optimistic, so we would appreciate more information on the anticipated process.

Other administrative changes: While we appreciate the focus on administrative efficiency, we are concerned that the Department's projections are overly optimistic. For example, the Department projects a $26.5 million in savings from reducing the timely filing allowance, which simply means that providers will have less time to file claims. A second example is the implementation of a nurse advice line for Medicaid, which is projected to save $1 million, an aggressive target. We hope that the Department has done analysis and projections to verify these numbers, or the Medicaid program could end up with an unanticipated budget shortfall.

Medicaid expansion and other eligibility changes: While we appreciate that the current proposal does not include moving forward with any changes to eligibility, concerns remain about Medicaid expansion and overall Medicaid eligibility in the future. For hospitals to absorb these cuts and proposed changes, they need assurance that current eligibility will continue. The ability to achieve the proposed cost containment measures is contingent on maintaining eligibility. This is especially true for the shift from behavioral health grants to Medicaid funding. Without assurance of stable eligibility, providers will not make investments in behavioral health services. Similarly, managing a DRG payment structure requires sufficient volume of patients to allow for variability.

Impact of changes on other Medicaid reform:
The plan for cost containment is silent on key initiatives that have been underway for several years including the Coordinated Care Demonstrations (United Healthcare managed care demo) and the behavioral health Administrative Services Organization. How will the work that has been developed to date be impacted by the proposed measures? Will these efforts continue?

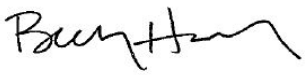
Finally, we are concerned that this plan only accounts for $100 million of the anticipated $225 million general fund cut for FY 20. The $225 million general fund cut represents a $714 million

cut when considering federal funds. Providers, like any other business or organization, need certainty for planning and management purposes. The lack of certainty is having a chilling effect on the ability of providers to invest in new facilities and services, as evidenced by the suspension of capital projects in Anchorage and the Mat-Su Valley. Included in these projects are badly needed inpatient psychiatric beds that serve a critical role in meeting Alaska's behavioral health needs.

While we continue to hear that the Department is in conversations with CMS about how to address future reductions, the lack of direction and vision is of serious concern to the providers responsible for caring for Alaskans. We have heard repeatedly that the Department is talking to CMS about innovations. To ensure success, we encourage you to involve stakeholders as part of the dialogue and process. We want to work together as good partners to improve and transform the Alaska health care system – and we look forward to the time when we can focus on that shared vision.

Thank you for your time. We look forward to further discussions.

Sincerely,



Becky Hultberg, President/CEO

Cc: Members of the Senate Finance Committee
Members of the Senate Finance HSS Subcommittee
Members of the House Finance Committee
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