ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

April 2, 2019

Members of the Senate Finance HSS Budget Subcommittee
Senator Natasha von Imhof, Chair
Senator John Coghill
Senator Lora Reinbold
Senator Elvi Gray-Jackson

Dear Chair von Imhof and members of the committee,

Following the Department of Health & Social Services' (DHSS) Medicaid presentation to the Senate Finance Health & Social Services Budget Subcommittee on April 1, I want to clarify several points raised in testimony from ASHNHA's perspective.

Long-term care rate cuts would be damaging

Thank you for noting concerns with cuts in long-term care rates. Many long-term care facilities (nursing homes) cannot sustain rate cuts. Nursing homes are 75% - 100% funded by Medicaid, which does not cover the full cost of care. The economics simply do not work for some facilities if a 5% rate cut is enacted and inflationary adjustments are withheld. Their ability to cost shift to other payers to absorb cuts if Medicaid does not pay the full cost of care is limited. In addition, they have high fixed costs related to meeting patient care needs and regulatory requirements. The impact of rate cuts could be the closure of some long-term care facilities in Alaska, fewer front-line caregivers or reduced quality of care. There is no other safe alternative in Alaska for long-term care residents, who would be forced to leave the state for care.

Hospitals rely on long-term care facilities as locations to safely discharge patients. If capacity is reduced, hospitals will be forced to hold patients in inpatient units, backing up the acute care system and putting significant financial stress on hospitals. Some payers do not reimburse for the time a patient is held in the hospital if it is no longer medically necessary, adding to the hospital's uncompensated care and placing Critical Access Hospitals in jeopardy of violating their federal length-of-stay limitations.

Critical Access Hospitals not held harmless

Critical Access Hospitals are rural hospitals with 25 beds or fewer.

Slide 12 of the Department's presentation stated that protecting small hospitals is a core principle in approaching rate adjustments. While it is accurate that Critical Access Hospital (CAH) inpatient and outpatient rates have been held harmless, it is not accurate to say that they will not be impacted by cuts. DHSS' proposal to cut long-term care rates will have a huge impact on the financial viability of small, independent CAHs. Most Alaska CAHs have co-located nursing home (long-term care) beds. Combining services under one roof achieves efficiencies and maximizes

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staff resources, spreading costs over more patients and helping to create a sustainable rural health system. A cut to the long-term care rate impacts CAH sustainability due to shared administrative and patient services. In small hospitals, up to 100% of care for nursing home residents is paid by Medicaid. Cutting Medicaid rates for either hospital acute care or long-term care risks destabilizing a fragile rural health facility. Reductions could also impact hospitals' ability to provide community benefits and important health care services at a loss as part of their charitable mission.

One of the simplest ways to protect Critical Access Hospitals is for DHSS to honor the small facility agreement payment methodology allowed in regulation (7 AAC 150.190). Nearly all CAHs have signed small facility agreements as part of the rate setting process. We would be glad to provide a sample agreement if requested. The agreement outlines the rate and inflationary increases the facility will receive each year, providing the CAH with a stable payment environment in which to plan for services to meet community needs. DHSS has failed to honor these agreements three of the last four years. This creates uncertainty for vulnerable rural facilities. Attached is a one-page summary of Alaska's hospitals and long-term care facilities, showing the number of CAHs with a co-located long-term care facility and the bed counts.

Concerns with lack of analysis on moving to diagnosis-related groups (DRG) payment system for large hospitals and acuity-based system for long-term care

Changing payment methodologies is very complex. Moving to a DRG system can take years of work and requires the deep involvement of providers. ASHNHA contracted with a health care consulting firm to analyze the feasibility of DRGs two years ago. The consulting firm recommended against moving to DRGs because of the lack of staff and data capacity at the Department, indicating that such a change could take several years. We are concerned that DHSS's aggressive timeline for implementation of DRGs could have unintended negative consequences.

We are also concerned about the ability for small nursing homes to succeed under an acuity-based rate, which requires volume over which to spread risk. If the acuity-based rate fails to cover the fixed cost of providing nursing home care to Medicaid recipients, the facility will not be sustainable. Further, the Department is showing a cost reduction associated with these rates prior to conducting any modeling to see if this is a feasible rate structure for Alaska's nursing homes.

Concerns with characterization of hospital costs

Deputy Commissioner Donna Steward expressed concerns that hospital costs would double from FY 15 to FY 19 (projected) without the Department taking action. To provide additional context, Medicaid expansion provided coverage for previously uninsured individuals, so it is not a surprise that costs increased related to that population. However, most of that cost is born by the federal government. State general fund dollars expended on hospitals were less in SFY 18 than in SFY 15, while more than 49,000 new enrollees have received Medicaid coverage since inception

of Medicaid expansion. Regular Medicaid enrollment increased as well. It is also not a surprise that general fund costs jumped in SFY 19, since in prior years hospitals had taken a 5% rate cut and absorbed three years of no inflationary adjustments. The restoration of those cuts in SFY 19, due to some small hospitals experiencing severe financial distress, increased expenses. Finally, as noted in the committee hearing, the SFY 19 projection includes SFY 18 funds pushed into SFY 19.

Concerns with proposed filing timeframes

The Department proposes to shorten the timeframe providers have to file Medicaid claims from 12 months to six months. Many payers, including Medicare, have a 12-month standard for filing claims. False claims and submission errors are cited as reasons for the reduced timeframe and we are concerned that in testimony these two issues have been conflated. Filing a false claim is a serious legal violation, while a submission error is an unintentional billing mistake. Further, the length of time it takes to file a claim has nothing to do with filing a false claim or a submission error. In fact, we expect a shorter timeframe will lead to more submission errors.

The Division of Public Assistance (DPA) is often many months behind in reviewing eligibility applications and eligibility processing backlogs at DPA result in significant billing delays. Currently, the state is six months behind in reviewing second level appeals. Delays will likely increase should they change the timely filing limits. Until Medicaid eligibility determinations can be done timely, expecting providers to complete claim filing in a shorter timeframe is unrealistic. Providers should not be penalized for the state's administrative delays. Finally, decreasing the timely filing period will require providers to increase staff which will result in higher health care costs. It will also put undue hardship on smaller facilities with fewer staff resources.

Thank you for your time. We look forward to working with the Legislature and the Department to make smart changes to Medicaid that will protect access to care while improving the long-term financial sustainability of the program.

Sincerely,

Becky Hultberg
President/CEO

CC: The Honorable Adam Crum, Commissioner, Department of Health & Social Services

Hospitals and Nursing Homes in Alaska 2019

Community	Facility Name	Acute Beds	Long-term Care Beds	Swing Beds	Tribally Operated
Critical Access Hospitals					
Cordova	Cordova Community Medical Center	13	10	13	No
Dillingham	Kanakanak Hospital	16	0	2	Yes
Homer	South Peninsula Hospital	21	28	21	No
Ketchikan	PeaceHealth Ketchikan Medical Center	25	29	0	No
Kodiak	Providence Kodiak Island Medical Center	25	22	25	No
Kotzebue	Maniilaq Health Center	17	18	0	Yes
Nome	Norton Sound Regional Hospital	18	18	18	Yes
Petersburg	Petersburg Medical Center	12	15	12	No
Seward	Providence Seward Medical & Care Center	6	40	6	No
Sitka	SEARHC/Mt Edgecumbe Hospital	25	0	15	Yes
Sitka	Sitka Community Hospital	12	15	12	No
Utqiaġvik	Samuel Simmonds Memorial Hospital	10	0	10	Yes
Valdez	Providence Valdez Medical Center	11	10	10	No
Wrangell	Wrangell Medical Center	8	14	8	No
Rural/Sole Community Hospitals					
Bethel	Yukon-Kuskokwim Delta Regional Hospital	50	18	0	Yes
Juneau	Bartlett Regional Hospital	73	0	0	No
Palmer	Mat Su Regional Medical Center	74	0	4	No
Soldotna	Central Peninsula Hospital/Heritage Place	49	60	34	No
Fairbanks	Fairbanks Memorial Hospital/Denali Center	152	90	0	No
Acute Care Hospitals					
Anchorage	Alaska Native Medical Center	167	0	0	Yes
Anchorage	Alaska Regional Hospital	250	0	0	No
Anchorage	Providence Alaska Medical Center	401	0	0	No
Other/Specialized Hospitals					
Anchorage	Alaska Psychiatric Institute	80			
Anchorage	North Star Behavioral Health	140	60 residential beds		
Anchorage	St. Elias Specialty Hospital	59			
Elmendorf	Elmendorf – USAF 673rd Medical Group	59			
Fort Wainwright	Bassett Army Community Hospital	43			

Standalone Nursing Homes		
Anchorage	Prestige Care and Rehabilitation Center	102
Anchorage	Providence Extended Care	96
Anchorage	Providence Horizon House	90
Anchorage	Providence Transitional Care Center	50
Juneau	Wildflower Court	61