Talking points on the DHSS proposed budget reductions

Nursing home/long-term care facility rate cuts and inflation freeze

- Long-term care facilities (nursing homes) cannot sustain rate cuts or to have inflation withheld. In most facilities, at least 85% of the residents are on Medicaid. Since Medicaid pays a cost-based rate that doesn't truly cover all costs, nursing facilities operate on very thin margins.
- Nursing homes do not have a significant volume of other payers to help absorb cuts. They operate with high fixed costs related to meeting patient care needs and regulatory requirements. The impact of rate cuts could be the closure of long-term care facilities in Alaska, fewer front-line caregivers or reduced quality of care.
- In past periods of budget reductions, long-term care facility rates were not cut, but inflationary adjustments were suspended. Even the suspension of inflation adjustments pushed many facilities to the edge of financial viability.
- Alaska already has one of the lowest rates of nursing home beds per capita in the country, and with a growing elderly population we can't afford to lose any existing capacity.

Hold Critical Access Hospitals (CAH) harmless from rate cuts and inflation withhold

- Current budget reduction plan presented by DHSS does NOT hold CAHs harmless.
- Utilize the small facility agreement payment methodology in regulation (7 AAC 150.190). Nearly all CAHs have signed small facility agreements with DHSS as part of the rate setting process. The agreement outlines the rate and inflationary increases the facility will receive each year for four years to provide 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.
- Most Alaska CAHs have co-located nursing home beds. Combining services under one roof achieves efficiencies and maximizes staff resources, spreading costs over more patients and helping to create a sustainable rural health system.
- A cut to the long-term care (nursing home) rate impacts CAH sustainability due to shared administrative and patient services. Close to 100% of care for residents in CAH long-term care facilities is paid by Medicaid.
- Cutting Medicaid rates or withholding inflation for either hospital acute care or long-term care risks destabilizing a fragile rural health facility.

Rate reductions for all other providers

- Provider rate cuts are the easiest lever for DHSS to pull to address Medicaid cost growth. However, cutting provider rates simply ratchets down the amount paid for services without addressing the underlying structure, organization or cost growth of health care. Reducing Medicaid rates merely shifts burden and risk from the state to other payers. Reducing provider rates is not innovative, forward-thinking or

transformational.

- 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. No impact analysis has been conducted to determine if a rate cut would disrupt services for patients.
- 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.
- 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.
- 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.

Withhold inflation for all other providers

- Withholding inflation is an additional rate cut for all facilities and providers.

Eliminating Medicaid adult preventive dental

- 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.

Hospital DRG payment system

- Changing payment methodologies is very complex. Moving to a DRG system requires the deep involvement of providers to set the rates correctly.
- Outlier payments and adjustments for low volume facilities are critical to protect sustainability of health care services.
- ASHNHA hired HMA, a reputable health care consultant, two years ago to look at several options for Medicaid cost containment. HMA looked at DRGs and estimated that it would take the state several years to make the transition, and that the state's staff and data capacity was insufficient at the time. The proposed timeline is aggressive and could have unintended negative consequences.
- DHSS should work with hospitals to have a smooth transition to a new DRG

payment system while maintaining access to care for Medicaid recipients.

Acuity-based nursing facility payment change

- Alaska's nursing homes are much smaller than the national average, have a low percentage of Medicare and private pay, high fixed costs and significant regulatory burden.
- Acuity based payments require volume over which to spread costs and risk. This payment change is not appropriate for very small nursing facilities that are part of critical access hospitals.
- Since Medicaid pays for over 85% of nursing facility care, 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.
- Moving to an acuity-based rate by Jan. 1, 2020 would require significant work at a time when facilities will be under financial stress. This is a significant change and requires deep involvement from the facilities that will be impacted; if not handled carefully could result in facility closures.
- The high fixed costs necessary to operate a facility offer little flexibility to change staffing or reduce costs based on a resident's acuity. 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.

Timely filing

- The proposal to shorten the timeframe allowed to file Medicaid claims from 12 months to six months has not been adequately discussed with providers.
- 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, but these are not related to timely filing. Filing a false claim is a serious legal violation, while a submission error is an unintentional billing mistake. 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, a shorter timeframe will lead to more submission errors.
- DHSS is often many months behind in reviewing eligibility applications and eligibility processing backlogs 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. We do not want providers penalized for the state's administrative delays.
- 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.

Honor the DHSS Small Facility Agreements to protect Critical Access Hospitals (CAH) from rate cuts and inflation withhold

- During the Department of Health and Social Service's (DHSS) presentations on Medicaid rate reductions, there is a slide saying that protecting small hospitals is a core principle in approaching rate adjustments. While it is accurate that 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/SNF rates will have a huge impact on the financial viability of small, independent CAHs.
- The best way to protect CAHs is to honor the small facility agreements that DHSS has signed with nearly every CAH as part of the rate setting process. This is a payment methodology allowed in statute (7 AAC 150.190). The agreement outlines the payment rate and inflationary adjustment the facility will receive each year for the four-year period of the agreement. This provides the CAH with a stable payment environment in which to plan for services to meet community needs.
- This year (SFY19) for the first time in four years DHSS is honoring these agreements. As recently as January 2019, DHSS has continued to enter into these agreements as part of the rate setting process (Providence Seward Small Facility Agreement signed 1/15/19) This has helped create financial stability for the CAHs.
- DHSS has not indicated if they intend to honor the Small Facility agreements moving forward beginning July 1, 2019. Presentations indicate CAH acute care rates will be held harmless but not the long-term care rates. This creates considerable uncertainty and places the CAHs in a vulnerable position.
- Although DHSS has been presenting to the legislature that CAHs will not be impacted by the rate cuts because the nursing facility operates under a separate license, this is not accurate. The CAHs operate both acute care and long-term care services under one administrative structure. The fact that DHSS signs one small facility agreement that includes rates for both acute care and long-term care demonstrates an integrated facility. A cut to one part of the facility will certainly impact the other part of the facility.
- CAHs had a 5% rate cut in hospital rates in FY2018. Fortunately, the CAH long term care rates were not cut, however both services had three years of no inflationary adjustments. As a result, Medicaid reimbursement declined by 10-12% during this period. Rates were restored during FY2019 which has helped them regain financial stability. During this period of rate cuts & no inflation adjustment, half of the CAHs had negative operating margins. If the nursing home/SNF rate was also cut the losses would have been even greater.
- Most Alaska CAHs have co-located nursing home beds. Combining services under one roof achieves efficiencies and maximizes staff resources, spreading costs over more patients and helping to create a sustainable rural health system. A cut to the long-term care (nursing home) rate impacts CAH sustainability due to shared administrative and patient services. Close to 100% of care for residents in CAH long-term care facilities is paid by Medicaid.