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STATE OF ALASKA THE LEGISLATURE

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POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H HESS	3-17-88	8:30 a.m.
H HESS	3-15-88	8:30 a.m.
H SA	3-2-88	3:00 p.m.
H SA	3-11-88	3:00 p.m.

HOUSE COMMITTEE REPORT

(11)

Date referred: 3/14/88

FURTHER REFERRALS: Judiciary

DATE: 3-17-88

The Health, Education and Social Services Committee has considered HB 348

"An Act relating to the composition of the Medicaid Rate Commission."

RECOMMENDS:

- replace with CS HB 348 (HESS) the same title
- attached amendment(s) a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S):

- fiscal impact same as previous fiscal note published _____
- zero fiscal note same as previous zero fiscal note published _____
- zero with analysis

SIGNING DO PASS:

[Signature]
[Signature]
[Signature]
[Signature]

SIGNING OTHER RECOMMENDATIONS:

[Signature]

[Signature]
 Co-Chairman's signature
[Signature]

FISCAL NOTE

REQUEST:

Revision Date: 3/17/88
Title: "An Act Relating to the Medicaid Rate Commission"
Sponsor: House HESS
Requestor: _____

Agency Affected: Health & Social Services
BRU: Medical Rate Commission
Components: Medical Rate Commission

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Karen Perdue

Prepared by: Karen Perdue
Division: Office of the Commissioner

Phone: 465-3030
Date: 3/17/88

Approved by Commissioner: *Wpa He Munem*
Agency: Health & Social Services

Date: 3/17/88

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

TABLE OF MEDICAID PRIORITIES - AS 47.07.035

112

(Lowest to Highest)

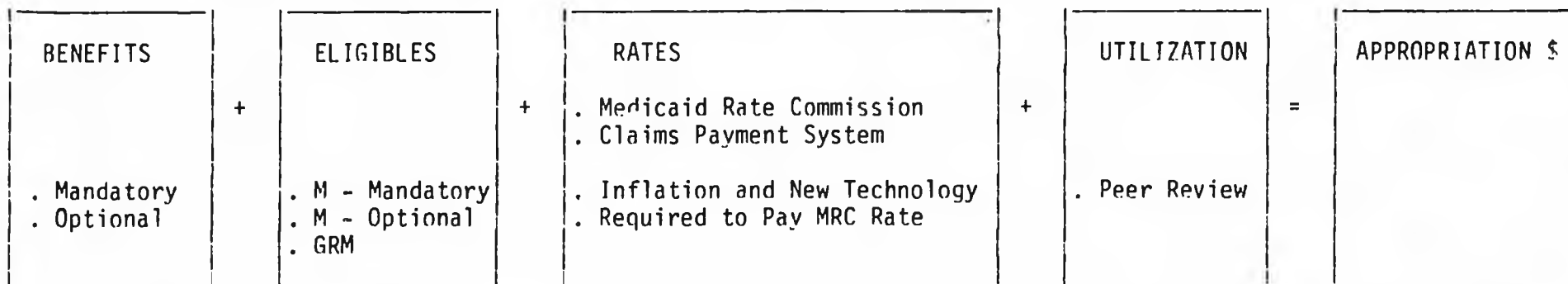
Service	Recipients	FY88 Annual Amount		
1. Chiropractic	600	410.0	BENEFIT	
2. Adult Dental	2,032	571.2	}	
3. Emergency Hospital Services	-0-	-0-		
4. Speech, Hearing & Language Disorders	298	113.0		
5. Optometrists Services & Eyeglasses	4,543	984.0		
6. Occupational Therapy	36	53.4		
7. Prosthetic Devices	198	679.8		
8. Medical Supplies & Equipment	330			
9. Clinic Services Includes Mental Health Clinics	1,384	3,979.2		
10. Physical Therapy	224	255.4		
11. Personal Care	96	526.8		
12. Non-Institutional Long Term Care	-0-	-0-		
13. Inpatient Psychiatric Services	69	5,570.5		
14. Intermediate Care for the Mentally Retarded	116	10,566.1		
15. Intermediate Care Services	400	17,108.6		40%
16. Individuals Under 21 Not Eligible for AFDC (RIBICFF KIDS)	1,500	1,785.0		ELIGIBLE GROUP
17. Skilled Nursing Services for Individuals under 21	14	786.3		}
18. Aged, Blind and Disabled Individuals IN AN INSTITUTION	2,766	19,824.8		
19. Individuals in a Hospital, Skilled or Intermediate Care Under 300% SSI level	49	2,800.2		
20. Individuals Under 21 Under Supervision of the Department - FOSTER CARE	500	595.0		
		<u>\$66,609.3</u>		

13 Includes Alaska Psychiatric Institute

14 Includes Harborview Developmental Center

16-20 Are Eligibility Groups. The costs shown are included in the above optional services as well as the mandatory Medicaid services.

FY89 MEDICAL ASSISTANCE



PROGRAM INCREMENTS:

- . No new benefits/services
 - . 4.2% in Medicaid Facilities
 - . 4.5% in all other programs
 - . Healthy baby bill implement SOBRA option
 - . 3.8% for all programs
- . No adjustment for Change in Utilization Patterns
- . Base Adjustment for Unmet Need

ADMINISTRATIVE INCREMENTS FOR COST MANAGEMENT

- | | |
|--|--|
| <ul style="list-style-type: none"> . Hearing Officer 2.0 . Auditors 94.6 | <ul style="list-style-type: none"> . Physicians Services 99.5 . Pharmacists Services 103.5 . Continue Pre-Admission Screening 211.8 . Continued Third Party Liability Recoveries 0 |
|--|--|

Implementation of the Medicaid Management Information System impacts each of the four areas above.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

STEVE COWPER, GOVERNOR

PO BOX H
JUNEAU, ALASKA 99811-0601
PHONE (907) 465-3030

March 11, 1988

The Honorable Fran Ulmer
Chairperson
State Affairs Committee
Alaska State House
P.O. Box V
Juneau, AK 99811

Dear Representative Ulmer:

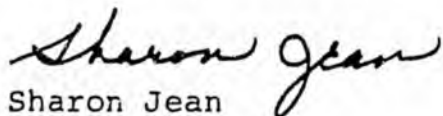
As you know, the Governor's Interim Commission on Health Care was convened in November to study a variety of questions regarding the provision of health care in Alaska. A primary focus of these deliberations has been the provision of long-term care services in Alaska, including both institutional and non-institutional care. As part of its study of institutional services, the Commission, through its Long-Term Care Committee, has been reviewing the mechanism used in Alaska to set medicaid rates for long-term care facilities and acute care hospitals.

The Long-Term Care Committee has recently learned that the current rate setting process has resulted in rates which may have put the State in jeopardy of non-compliance with Federal Medicaid guidelines. (See attached memoranda from Mary Benson and Norman Meyer). As these documents indicate, the Federal government contends that the State has paid, and is continuing to pay, rates which exceed the Federal upper limits. Failure to correct this situation could result in a considerable financial penalty accruing to the State, and possibly, the termination of federal participation in Alaska's Medicaid program. The Health Care Commission is very concerned with these possibilities and this concern has prompted us to alert you to this problem.

The Long-Term Care Committee is currently discussing alternatives to the present rate setting structure. Although that committee has not yet made recommendations, the attached issue paper (Facility Rate Setting) suggests several options under consideration. The recommendations of the Commission regarding this and other health care issues will be available in draft form by the middle of April.

If the Health Care commission can provide you with additional information regarding this or other issues, please do not hesitate to contact me. Thank you for your consideration.

Sincerely,



Sharon Jean
Chairperson
Governor's Interim
Commission on Health Care

Enclosures

cc: Governor Steve Cowper
Representative John Sund
Representative Niilo Koponen
Representative Johnny Ellis
Representative Al Adams
Representative Pat Pourchot

FACILITY RATE SETTING

ISSUE

Facility rate setting. Alaska's system for setting medicaid reimbursement rates for private health care facilities is unique. It is the only state that entrusts the rate setting process to a volunteer commission that is wholly outside the control of the executive or legislative branches. The Medicaid Rate Commission (MRC) thus has no legislative mandate to keep facility rates within amounts budgeted by the Department of Health and Social Services and appropriated by the legislature. Aspects of this issue include: mechanisms utilized for rate setting; policies that drive the rates; and potential sanctions by the federal government, which participates in funding through Title XIX of the Social Security Act (medicaid).

HISTORY

The Medicaid Rate Commission was established by the Alaska Legislature in 1984, AS 47.07.110. It consists of five members, including: the chief executive officer of an health facility licensed by the state but not owned or operated by the state or federal government; either the commissioner of administration or health and social services or a designee of either commissioner; a physician licensed to practice and actively practicing medicine in Alaska and not employed by the state; a certified public accountant with relevant experience; and a representative of health services consumers who does not have a direct or indirect interest in an entity providing health care services. *Id.* The members are appointed by the governor and serve at his or her pleasure for three-year terms, which are staggered. AS 47.07.130-140. The commission's duties are to "review proposed payment rates and budgets of health facilities and establish payment rates for health facilities...." AS 47.07.180. The commission is required by statute to "determine prospectively the rate of payment to a health facility...based on a fair rate for reasonable costs incurred by the facility." AS 47.07.070. The statutes detail various factors which must be considered in determining the rate. *Id.*

Since its inception, the Medicaid Rate Commission has set rates at ever-increasing levels. In FY 84, \$21.7632 million was expended by the Department of Health and Social Services in medicaid payments to long-term care facilities. In FY 88 the projected expenditure for long-term facilities medicaid payments is \$29.6313 million, which is 30.1% of the entire medicaid budget. Percentage increases in rates paid to long-term care facilities between FY 83 and FY 88 are provided in the attachment. The lowest percentage increase in that period is 12.93%; the highest is 131.95%. The average increase is 42.45% in that period. *Id.* The average daily rate paid to private long-term care facilities in FY 1988 is \$212.11. *Id.*

The dramatic increase in medicaid rates has not resulted in large numbers of seniors being served by medicaid-funded long-term care. In FY 86, the total general fund medicaid expenditures for seniors (age 65 or over) were \$14,823,000. Of that total, \$3,823,000 was expended for non-long term facilities, which served 2,123 seniors at an average expenditure of \$1,801 per recipient. A total of \$11,000,000 was expended for medicaid long term care, which served 539 seniors at an average expenditure of \$20,408 per recipient. See *Halterman Report*, table 1.

The increased rates authorized by the MRC are due to a combination of factors. The prospective rate setting system is based on costs incurred by the facilities during

a base year, which in practice has meant their previous fiscal year plus an inflation factor. The statutes set out the costs to be considered in setting rates and the MRC has, at the legislature's direction, promulgated regulations enumerating the rate-setting factors. In formulating rates, the MRC evaluates various components of facility costs during their base year, including: costs of current operation, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other operating expenses; education; research; and appropriate capital development. AS 47.07.070; 7 AAC 43.685. In practice, the rate has been based on the actual historical costs of operating facilities. Alaska, unlike most states, does not impose an upper limit on reimbursement amounts to facilities.

The only statutorily-imposed standards require that the rate of payment be based on a fair rate for reasonable costs incurred by the facility. AS 47.07.070(a). Additionally, the MRC, in determining a rate, "may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility." AS 47.07.070(c). Other than the generic cost items specified in the statute creating the MRC, the "fair rate for reasonable costs" language, and a statutory directive that the MRC "consider the appropriation limit set by the legislature for the department's programs under [portions of Title 47] and available federal revenue" (AS 47.07.070(d)), there are no statutorily-imposed restrictions on what rates the MRC sets. However, the purpose section of the statute authorizing the Department of Health and Social Services to participate in the medicaid program is instructive. It provides that: "It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing." AS 47.07.010.

Ninety percent (90%) of residents in long-term care facilities received medicaid coverage in April 1987, which is a typical month. See *Halterman Report* at 6. Since medicaid is a system which reimburses providers directly, every dollar of the approved rate flows directly to the institutions rendering the long-term care services. The national average cost of long-term care is \$56 per day; the average daily rate in Alaska as of FY 88 is \$212. *Id.* at 13-14; attachment. Thus, Alaska's daily rate is almost 400% of the national average. The higher cost of living in Alaska has been alluded to numerous times by the health care industry. See *A Study of Factors Influencing Acute and Long Term Care Costs in Alaska*. However, the 400% differential in daily rates is well above the increased cost of living in Alaska. The justification that it costs more because it costs more is no justification at all.

The overriding factor identified in the exorbitant rates paid to facilities in Alaska is the rates set by the MRC, which reimburse for almost all costs, no matter how inefficient a facility may be. The current rate structure does not reward thrift and ingenuity in administering a facility nor does it consider the fact that many of the co-located and long-term facilities were originally constructed with state grants. The MRC's rates thus allow facilities to obtain reimbursement for capital costs and depreciation, both of which were originally funded from state dollars. In essence, the rates reward higher and higher expenditures and does not provide an offset for capital costs originally incurred by the state. The medical industry knows full well that whatever it spends, it will likely be reimbursed through the medicaid rate. The medical industry's response has been that there is a higher level of service in Alaska. One doubts that any level of service could justify such a cost differential in daily rates.

Has the MRC, through its prospective rate setting process, in effect discriminated against non long-term medicaid eligible Alaskans by setting rates so high that funding for other needy Alaskans is greatly reduced? Have the high medicaid payment rates resulted in high rates being charged to people ineligible for medicaid, so that retired persons living on modest retirement incomes are unable to afford institutional care? It appears so. The next question is, why? If the true purpose of Alaska's participation in the medicaid program is to ensure all needy recipients of access to medical care, why does the legislature continue to permit the MRC to operate as an independent body with no external and only few internal controls? If, instead, Alaska's public policy is to use the medicaid program to subsidize long-term care facilities which have small occupancy rates and inversely high daily rates, it should be so stated.

The MRC, viewed in a historical context, has operated quite well to insure facility survival. However, such is not the purpose of the federal medicaid statute, which was enacted by Congress to ensure that all categories of eligible needy persons receive needed medical care. The effect of the MRC prospective rate setting system is becoming clear to not only Alaskans, but to the federal government, which currently matches Alaska's medicaid contribution. The federal government has recently advised the Division of Medical Assistance that although there is no upper limit on reimbursements in state law, there is an upper limit under federal criteria, which the state is exceeding. Thus, there very well may come a time, and soon, when the federal government refuses to match the State of Alaska's facility medicaid costs or matches only the 50% it deems reasonable. The state would then be liable to use general fund monies to make up the difference. Loss of federal dollars would be a heavy price to sustain an unstated policy of ensuring facility survival no matter how cost ineffective the facility may be.

POPULATION AFFECTED

All Alaskans are potentially affected by this issue. Eligible medicaid populations may not receive funding for their medical needs if facility reimbursements continue not only to soak up the largest share of the DMA's total budget, but to require large annual increases in that budget. The Legislature has already signaled its unwillingness to fund DMA at requested levels. Two years ago, the state was forced to eliminate many services previously funded through the general relief medical program, which is solely a state funded medical program for the truly needy. In addition, no funds have been appropriated for the catastrophic illness program for the past two fiscal years. The Department of Health and Social Services has recently submitted a supplemental request of \$18.3 million for the remainder of FY 88, basically to cover the ever-increasing costs of payments to facilities. Medical assistance for the needy cannot continue to depend on ever-increasing emergency requests to the Legislature.

Everyone is suffering during these times of fiscal austerity. As the economy continues to bottom out, many Alaskans are finding themselves in need of medical care. However, due to decreasing funding, those needs could go unmet. It is against this backdrop that the fundamental unfairness of the current medicaid reimbursement system must be viewed. Should the state, as a conscious or unconscious public policy decision, fund ever-increasing private facility costs while the medical needs of other deserving Alaskans go unmet?

OPTIONS TO ADDRESS THE ISSUE

The following are two options to consider:

1. Abolish the MRC and authorize the DHSS to perform the rate setting function; the DHSS could therefore ensure that the total facility reimbursement rate does not drive its entire budget and could ensure that the rate paid is not a subsidy to the facilities at the expense of all other classes of medical consumers served by DHSS.
2. If the MRC continues to exist in statute, there must be statutory criteria to limit facility reimbursement, including authority to impose a ceiling on reimbursement rates.

Myra A. Munson, Commissioner
Department of Health and Social Services
P. O. Box 11-07
Juneau, Alaska 99811

Dear Ms. Munson:

During a recent meeting, members of your staff requested an explanation of how the disapproval of a state plan amendment would affect Alaska's Medicaid program. They also expressed an interest in learning what actions HCFA would take if the State chose to implement the changes contained in the disapproved amendment.

A state electing to receive payments under Title XIX of the Social Security Act must submit and receive approval of its state plan for medical assistance. Once the Medicaid state plan has been approved, it can only be changed via the state plan amendment process. This process requires the state to thoroughly describe the proposed change in the form of a state plan amendment and submit the document to HCFA for approval. If the amendment is approved, it becomes part of the approved Medicaid state plan and the change is effectuated. If HCFA disapproves the amendment, the proposed change cannot be implemented and the state plan remains unchanged.

A state may choose to ignore HCFA's disapproval and implement the proposed change. This course of action would result in the state being out of compliance with the approved state plan and could have significant financial ramifications. The exact extent of the financial consequences would depend on the substantiality of the non-compliance but could range from the disallowance or deferral of the FFP associated with the disapproved change to the termination of FFP for the state's entire Medicaid program.

If you have any questions concerning this matter, our contact person is Bob Grauman. Bob can be reached at (206) 442-0443.

Sincerely,

Norman V. Meyer
Associate Regional Administrator
for Program Operations

cc: Kim Busch

BG 1138k

File Code: SMO-1

MEMORANDUM

State of Alaska

TO Norma Lundy
Governor's Interim Health
Care Commission

DATE March 11, 1988


FILE NO

TELEPHONE NO

THRU.

SUBJECT State's Potential
Liability to Federal
Government on Medicaid

FROM


Mary K. Bensen
Executive Director
Medicaid Rate Commission

In response to your Committee's questions concerning the state's potential liability to the federal government on Medicaid, I have prepared the following summary.

The state has a variety of issues concerning Medicaid payments to hospitals and long term care facilities. Attached is a memorandum outlining issues as of February 17, 1988. Since that time several other issues have developed increasing the state's potential liability.

In late February, the federal government identified an upper limit issue with acute care services for 1984, 1985, and 1986. We have been notified approximately \$2.0 million will be requested back from the state. It appears this argument will continue into 1987 and 1988. I estimate we will be arguing another \$2.0 million in 1987 and \$1.0 million in 1988. The state does not agree with the federal finding. We anticipate we will prevail or partially prevail.

The second issue involves litigation with Cordova Hospital challenging the Medicaid Rate Commission's ability to apply audit findings prior to August 1986. The facility's contention is the state could only audit prior to that time but had no ability to recoup funds based on audits. I was notified Monday, the Alaska Health Association is planning to join the suit on behalf of all members facilities. Regardless of who prevails, the federal government will take its half from the state. Based on current audit findings, it appears there will be at least \$1.0 million in audit findings for 1985 and 1986. This will result in \$500,000 in payments to the federal government. We feel the state will prevail.

The outstanding issues are recapped as follows:

FY 87 Long Term Care Upper Limit	\$ 2,055,000
FY 88 Long Term Care Upper Limit	2,515,000
FY 89 Long Term Care Upper Limit	<u>2,800,000</u>
Potential Federal Claim	\$ 7,370,000
FY 89 Proposed Regulation	\$ 2,900,000
Outstanding Appeals	<u>7,000,000</u>
Total Contingent Liability	\$17,270,000
1984/5/6 Hospital Upper Limit	\$ 2,000,000
1987 Hospital Upper Limit	2,000,000
1988 Hospital Upper Limit	1,000,000
Audit Finding	<u>500,000</u>
Total	\$22,770,000

Attachment

**STATE OF ALASKA 1988 LEGISLATIVE SESSION
FISCAL NOTE**

NO. 1

BILL VERSION: HB 348
PUBLISH DATE: HOUSE 1/11/88

REQUEST

Bill Resolution No. : _____
 Title : An Act Relating to the Membership
 of the Medicaid Rate Commission
 Sponsor : Rules Committee
 Requestor : Governor
 Date of Request : _____

FISCAL DETAIL

Agency Affected : Health & Social Services
 BRU : Medicaid Rate Commission
 Components : Medicaid Rate Commission

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		-0-	-0-	-0-	-0-	-0-
TRAVEL		-0-	-0-	-0-	-0-	-0-
CONTRACTUAL		-0-	-0-	-0-	-0-	-0-
SUPPLIES		-0-	-0-	-0-	-0-	-0-
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-

CAPITAL						
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REVENUE						
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FUNDING : (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

The proposed language changing the membership of the Medicaid Rate Commission would have a net zero impact on the Medicaid Rate Commission budget.

Prepared by: Randy Super For: Kim Busla Phone: 465-3355
 Division: Medical Assistance Date: 12/8/87

Approved by Commissioner: [Signature] Date: 12/8/87
 Agency: _____

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

MEMORANDUM

State of Alaska

TO: Norma Lundy
Governor's Interim Health
Care Commission

DATE: March 11, 1988


FILE NO:

TELEPHONE NO:

THRU:

SUBJECT: State's Potential
Liability to Federal
Government on Medicaid

FROM:


Mary K. Bensen
Executive Director
Medicaid Rate Commission

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Audit Finding	<u>500,000</u>
Total	\$22,770,000

Attachment

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE COMMISSION

STEVE COWPER, GOVERNOR

PC BDP 240245
360 C STREET SUITE 597
ANCHORAGE ALASKA 99524-0245
PHONE (907) 562-1896

February 17, 1988

The Honorable Myra Munson
Commissioner
Department of Health & Social Services
Pouch H-01
Juneau, AK 99811

Dear Myra:

Today, I received correspondence from Region X concerning the upper limits issues for our FY84 and FY85 fiscal years.

I want to keep you fully informed of the potential liability the state faces with this and other issues. While the state needs to require federal participation based on our approved State Plan, the upper limit issue is a problem for the state of Alaska.

Currently, we have approved State Plans through June 30, 1987. The 1988 State Plan is not approved. Our aggregate calculations for hospital services indicate the approved rates are under the upper limit for FY87 and FY88.

The long term care rates continue to be the major issue for state. I am listing an estimate of the contingent liability the state faces on several issues including the federal upper limit, regulations pending before the Medicaid Rate Commission, and appeals in process. All the issues listed below will likely be all general state funds. The appeals from providers request payments for expenses not included in the State Plan. While I do not believe the facilities will prevail, it is important to consider the appeals as contingent liabilities against General state funds. The outstanding issues are as follows:

FY87 Long Term Care Upper Limit	\$ 2,055,000
FY88 Long Term Care Upper Limit	\$ 2,515,000
FY89 Long Term Care Upper Limit	<u>\$ 2,800,000</u>
Potential Federal Claim	\$ 7,370,000

FY89 Proposed Regulation	\$ 2,900,000
Outstanding Appeals	<u>\$ 7,000,000</u>
Total Contingent Liability	\$17,270,000

RECEIVED

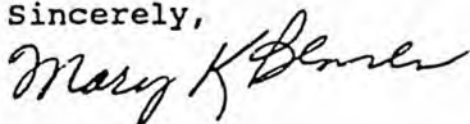
FEB 19 1988

Budget & Finance
Director's Office

If any of the contingencies become a reality, the impact will be in the FY89 appropriation. As you consider the appropriation request for FY89, you may want to consider requesting funding for some of the contingencies. As a note, the federal upper limit issue and the chart above reflect only the federal portion. I estimate excess above the upper limit for the 3 three years is approximately \$14,645,000 in actual payments to the health care facilities or just under 20% of the rate.

If you wish to discuss any of these issues or I can be of any assistance, please do not hesitate to contact me.

Sincerely,



Mary K. Bensen
Executive Director

cc: -Commission Members, Medicaid Rate Commission
Karen Perdue, Deputy Commissioner DHSS
Kim Busch, Medical Assistance
Harlan Knudson, Health Association of Alaska
Robert Bilden, Legislative Audit

Myra A. Munson, Commissioner
Department of Health and Social Services
P. O. Box 11-07
Juneau, Alaska 99811

Dear Ms. Munson:

During a recent meeting, members of your staff requested an explanation of how the disapproval of a state plan amendment would affect Alaska's Medicaid program. They also expressed an interest in learning what actions HCFA would take if the State chose to implement the changes contained in the disapproved amendment.

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If you have any questions concerning this matter, our contact person is Bob Craunan. Bob can be reached at (206) 442-0443.

Sincerely,

Norman V. Meyer
Associate Regional Administrator
for Program Operations

cc: Kim Busch
BG 1138k
File Code: SMO-1

STEVE COWPER
GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 11, 1988

The Honorable Ben Grussendorf
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Representative Grussendorf:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill that would change the composition of the Medicaid Rate Commission, which was established in the Department of Health and Social Services in 1983.

Currently, the Medicaid Rate Commission has four public or provider representatives and one state government representative. The latter is either the commissioner of health and social services or the commissioner of administration (or the appointed designee of either). The purpose of the Medicaid Rate Commission is to establish the rates for payments made to hospitals, nursing homes, and a variety of other health care facilities for services provided to Medicaid and general relief medical assistance recipients. The commission currently commits the state to a distribution of over \$80,000,000 yearly. With the present composition of the commission, the state lacks budgetary control because it cannot contain the growth of the rates approved by the commission.

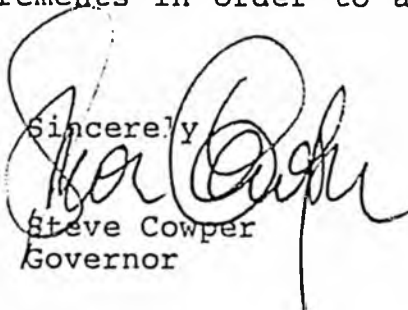
Historically, boards with the authority to commit the state to some level of expenditure or indebtedness have had a voting majority of cabinet or top-level administrative officials. This bill brings the composition of the commission into conformance with other rate-setting bodies by placing a total of three department heads (or, in place of the third department head, one of the division directors of the office of management and budget) on that rate-setting body. Two other governor-appointed members would represent health care providers and consumers, respectively. The commission would, of course, continue to make its decisions based upon presentations made to it by health care providers.

The Honorable Ben Grussendorf

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This proposed change would also help assure that the Department of Health and Social Services maintains the Medicaid program within federal requirements in order to allow maximum use of federal money.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve Cowper", written over the typed name and title.

Steve Cowper
Governor

STATEMENT
HEALTH ASSOCIATION OF ALASKA

March 15, 1988

House Committee on State Affairs
HB 348 - MEDICAID RATE COMMISSION

The Health Association of Alaska, representing acute and long term health care facilities, is opposed to H.B. 348, an act relating to the composition of the Medicaid Rate Commission.

Purpose of Medicaid Rate Commission:

The purpose of the Commission is to establish a fair rate of payment to health facilities for services rendered to Medicaid and General Relief Medical (GRM) beneficiaries.

The major activities of the Commission are to develop and implement a new rate setting system, audit facility data, prepare and negotiate the State Plans with the Federal Government for federal funding, and report proposed Medical Assistance expenditures for current and subsequent state fiscal years. The rate setting is a public process wherein the Commission deliberates the proposed rates and sets the rates.

Current Composition of Medicaid Rate Commission:

1. Licensed Health Facility CEO
2. Commissioner of Administration or Commissioner of Health and Social Services or their designee
3. Licensed physician
4. Certified Public Accountant
5. Consumer

Intent of HB 348:

Replace licensed health facility CEO, physician, and CPA with a health care provider, Commissioner of Administration, Commissioner of Health and Social Services, and/or a third Commissioner or a director of a division of the Office of Management and Budget.

Reasons Why Health Association of Alaska Opposes HB 348:

1. The intent of HB 348 is to control health care facility costs by having three of the five members of the Commission represent state government.

That is contrary to legislative intent. Hospital and long term health care facility rates established by the Commission should not be budget driven, but should reflect a fair rate of payment for services rendered.

State government and the public need to have the data compiled by the Commission, and know that fair and equitable rates are established by utilizing that data.

(MORE)

Concern is that needed rate increases will be denied solely for the reason that the Department of Health and Social Services will be required to seek additional funding from the Legislature to underwrite such increases. The fact that health facility costs, generated by people in need, must compete with other health and social service programs is recognized, but it does not negate the fact that hospitals cannot subsidize state programs.

It should be noted that a recent survey (by providence Hospital) showed that hospital uncompensated care (bad debt/charity) costs increased from \$5,339,000 in 1982 to \$10,368,000 in 1986. Medicaid paid hospitals only \$20,978.00 in 1986. Liability insurance premium costs increased from \$3,147,000 in 1986 to \$5,377,000 in 1988. (Data from Medicaid Rate Commission.)

2. The Certified Public Accountant, physician, and licensed health facility CEO are needed on the Commission, as is the consumer and the representative of the Department of Health and Social Services.

Establishing health facility costs is extremely complex, and the involvement of individuals who are in the everyday business of providing health services and cost accounting contribute significantly to the deliberations of the Commission.

#

FOR: Harlan Knudson
Health Association of Alaska
319 Seward Street, #11
Juneau, AK 99801
586-1790



Official Business

Alaska State Legislature

House of Representatives

Al Adams

Chairman

Committee on Finance

WHILE IN SESSION
P.O. Box V
State Capitol
Juneau, Alaska 99811
(907) 465-3706

OUT OF SESSION
P.O. Box 333
Kotzebue, Alaska 99752
(907) 442-3320

1024 W. 6th
Anchorage, Alaska 99501
(907) 274-0615

March 2, 1988

Representative Fran Ulmer
Chairman
House State Affairs Committee
P.O. Box V
Juneau, AK 99811

Re: HB 348

Dear Representative *Fran* Ulmer:

I would like to take this opportunity to voice my support for House Bill 348 "An Act relating to the composition of the Medicaid Rate Commission."

As I am sure you are aware, the entitlement programs in general and the Medicaid budget in particular represent an ever increasing portion of the Department of Health & Social Services Budget. From FY 86 - FY 88, a period when the vast majority of state funded programs were sustaining double-digit percentage budget reductions, state general funds for Medicaid increased by 12.2%. If you add the FY 88 request for supplemental funding pending before the House Finance Committee, the increase is approximately 37.1%. I have attached a spreadsheet which more clearly demonstrates the growth in this program during this period.

While some of these increased costs can be attributed to expansion of services and increased caseloads, it is also true that a significant

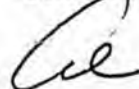
portion of the increased costs are directly related to the rate increases awarded to Medicaid eligible facilities by the Medicaid Rate Commission.

Under current law, the rate commission operates outside the normal policy/budget process and the composition of the commission further aggravates the problems inherent in this situation. House Bill 348 would provide for a majority of the members of the commission to be state policy-makers and presumably more sensitive to the overall policy and budget priorities of the state.

To illustrate just how out of step with the normal budget process the current commission appears to be, I have attached a copy of a notice of proposed changes in the regulations of the Medicaid Rate Commission which came across my desk last week. If the commission adopts these regulations as written, the state will be obligated for an additional \$2.9 million for FY 89 with further increases in succeeding years. These funds are not in the current Governor's FY 89 budget request nor will the regulations likely be approved in time for submission as a budget amendment. As a practical matter what we have here is a FY 89 supplemental request. We are set-up for a FY 89 Medicaid supplemental before we have even approved the original FY 89 budget!

In conclusion, I urge the State Affairs Committee to give favorable consideration to HB 348. I am under no illusions that this will solve all our Medicaid funding problems; but I am convinced it is a worthwhile step in the right direction. In the absence of additional cost containment measures in this area, I fear that further erosion in funds for other vital health & social services programs is inevitable.

Sincerely,



Al Adams
Chairman

House Finance Committee

cc Rep. Mark Boyer
Chairman
House Finance HESS Budget Subcommittee

ATTACHMENT A MEDICAID BUDGET FY 87 ACTUAL-FY 89 (GENERAL FUNDS ONLY)

	A	B	C	D	E	F	G	H	I	J
1	COMPONENT	FY 87 ACT	FY 88 AUTH	FY 88 SUPP	FY 88 TOTAL	FY 89 GOV	FY 89 REGS	FY 89 TOTAL	FY 89 V FY 87	FY 89 V FY 87
2									AMOUNT	%
3										
4	MEDICAID-NON FACILITY	12,556.1	10,972.6	4,970.0	15,942.6	17,213.2	0.0	17,213.2	4,657.1	37.1%
5	MEDICAID-FACILITY	22,822.4	26,598.2	3,375.0	29,973.2	33,112.1	2,900.0	36,012.1	13,189.7	57.8%
6										
7	TOTAL	35,378.5	37,570.8	8,345.0	45,915.8	50,325.3	2,900.0	53,225.3	17,849.8	50.4%

FY 88 TOTAL=AUTHORIZED PLUS PROPOSED SUPPLEMENTAL; FY 89 TOTAL=FY 89 GOVERNOR PLUS PROPOSED NEW REGULATIONS

EL

NOTICE OF PROPOSED CHANGES
IN THE REGULATIONS
OF THE MEDICAID RATE COMMISSION

Notice is given that the Medicaid Rate Commission, under authority vested by AS 47.07.070 and AS 47.07.073, proposes to amend regulations in Title 7 AAC 43 of the Alaska Administrative Code, dealing with establishment of a rate setting process for payment of services for Medical Assistance programs to facilities, to implement AS 47.07, as follows:

1. 7 AAC 43.685(b)(2) is proposed to be amended by identifying capital and various insurance and employee benefits costs as passthrough costs.
2. 7 AAC 43.685(b)(3) is proposed to be amended by adding various insurance and employee benefits costs as facility budgeted costs for rate setting.
3. 7 AAC 43.691(a)(1) is proposed to be amended to substitute actual passthrough costs for budgeted passthrough costs when calculating year end conformance.

Notice is also given that any person interested may present oral or written statements or arguments relevant to the proposed action at a hearing to be held in Room 336 of the Frontier Building, 3601 "C" Street, Anchorage, Alaska at 1:30 p.m. on March 18, 1988.

This action is expected to require an increased general fund appropriation of \$2,900,000 in fiscal year 1989, \$3,500,000 in fiscal year 1990, and \$4,300,000 in fiscal year 1991.

DIVISION OF MEDICAL ASSISTANCE

BUDGET INCREASE FACTORS

	<u>Dept. Request</u>	<u>FY87 Authorized</u>	<u>Actual</u>	<u>National CPI</u>	<u>Dept. Request</u>	<u>FY88 Authorized</u>	<u>Projected</u>	<u>FY89 Dept. Request</u>
Medicaid Facility								
Price	3.7%	0.0%	5.0%	15.7%	3.5%	2.5%	5.5%	3.8%
Utilization	3.1%	3.1%	7.5%		0.0%	0.0%	6.5%	0.0%
Eligibles	8.5%	8.5%	6.0%		6.3%	6.3%	6.0%	4.2%
Medicaid Non-Facility								
Price	3.7%	0.0%	15.7%	15.7%	2.8%	0.0%	5.5%	3.8%
Utilization	3.1%	3.1%	Unk.		0.0%	0.0%	6.5%	0.0%
Eligibles	10.4%	10.4%	6.0%		6.3%	6.3%	6.0%	4.5%

Changing the Medicaid Rate Commission to Advising the Department on
Medicaid Facility Rates.

Purpose

This proposed amendment would change the focus of the Medicaid Rate Commission from a rate setting body to one giving advice to the Department of Health and Social Services. Upon consideration of that advice and review of available funding, the department adopts fair facility rates for Medicaid based on federal requirements and state statutes.

Section 1. AS 47.07.040 is amended to read:

Sec. 47.07.040. State plan for provision of medical assistance. The department shall prepare a state plan in accordance with the provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan, The department [, INCLUDING THE MEDICAID RATE COMMISSION,] may make those arrangements or regulatory changes, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United State Department of Health and Human Services to secure for the state the optimum federal payment under the provisions of 42 U.S.C. 1396-1396p (Title XIX, Social Security Act, Medical Assistance). In addition, the department shall provide a report to the legislature no later than March 15 of each year concerning the status

of this program and recommendations, with supporting fiscal data, as to any changes in the coverage of eligible persons or services to be provided.

* Sec. 2. AS 47.07.070 is amended to read:

Sec. 47.07.070 Payment to Health Facilities. (a) The commission shall advise the department on the prospective [DETERMINE PROSPECTIVELY THE] rate of payment to a health facility under this chapter and AS 47.25.120-47.25.300 based on a fair rate for reasonable costs incurred by the facility. The department shall set the rates of payment to a health facility. The department [COMMISSION] shall by regulation list the factors it considers in making its rate determination under this section, after consultation with the commission.

(b) In determining a rate of payment to a health facility under this section, the department [COMMISSION] shall consider the proportionate share of the facility's financial requirements for patient care for

(1) cost of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the department [COMMISSION] may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility.

(d) In determining a rate of payment to a health facility under this section, the department [COMMISSION] shall consider the appropriation limit set by the legislature for the department's programs under this chapter and under AS 47.25.120-47.25.300, and available federal revenue.

* Sec. 3. AS 47.07.073 is amended to read:

Sec. 47.07.073 Uniform Accounting, Budgeting, and Financing Reporting.

(a) The department [COMMISSION] by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for reporting revenues, expenses, assets, liabilities, and units of service. The department [COMMISSION] shall specify the date the system become effective for each health facility.

(b) In adopting regulations as under this section, the department [COMMISSION] shall consider

(1) accounting, budgeting, and financial reportings procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) the size and organizational structure of health facilities;

(4) the methods used by health facilities to obtain payments; [AND]

(5) other factors the department [COMMISSION] considers relevant; and [.]

(6) the recommendations of the commission.

(c) The department [COMMISSION] may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Notwithstanding other provisions of this section, the department [COMMISSION] may, by regulation, modify the system of accounting, budgeting and financial reporting required under this section for a health facility having fewer than 25 acute care beds in order to reduce the operating costs of that facility.

Sec. 4. AS 47.07.075 is amended to read:

Sec. 47.07.075. Application of Administrative Procedure Act. Action of the department [COMMISSION] under AS 47.07 and AS 47.25.120-AS 25.300 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

Sec. 5. AS 47.07.110 is amended to read:

Sec. 47.07.110. Medicaid Rate Advisory Commission established. The Medicaid Rate Advisory Commission is established in the Department of Health and Social Services.

Sec. 6. AS 47.07.180 is amended to read:

Sec. 47.07.180. Duties. (a) The commission shall review proposed payment rates [AND MAY REVIEW BUDGETS] of health facilities and advise the department on [ESTABLISH] payment rates for health facilities under this chapter and AS 47.25.120-47.25.300.

(b) The commission shall advise [CONSULT WITH] the department on the state plan as it relates to health facilities. [THE COMMISSION MAY NOT CHANGE THE UNIT OF PAYMENT WITHOUT THE WRITTEN CONSENT OF THE DEPARTMENT.]

(c) When the department enters into a substantially revised state plan under AS 47.07.040, and when, as part of the the revised state plan, the department [COMMISSION] adopts regulations which substantially change

the methods used or the factors considered in determining the prospective payment rates, the commission may, at its discretion, recommend the department redetermine the prospective payment rates for all facilities from the effective date of the new regulations forward. Each redetermined rate will be effective from the date of the department's [COMMISSION'S] new order as to each facility.

[(D) BY MARCH 1 OF EACH YEAR, THE COMMISSION SHALL DEVELOP FOR THE FISCAL YEAR STARTING THE NEXT JULY 1 AN ANNUAL ESTIMATE OF MEDICAL ASSISTANCE PROGRAM EXPENDITURES IN HEALTH FACILITIES UNDER THE JURISDICTION OF THE COMMISSION. THE ESTIMATE SHALL CONSIDER ANTICIPATED UTILIZATION AND PAYMENT RATES FOR EACH FACILITY. THE METHODOLOGY USED BY THE COMMISSION TO DEVELOP THE ESTIMATE SHALL BE CONSISTENT WITH THE REGULATIONS GOVERNING THE COMMISSION'S RATE-SETTING PROCESS.]

Sec. 7. AS 47.07.190 is amended to read:

Sec. 47.07.190. Employment of personnel. The department [COMMISSION] may employ and determine the salary of an executive director, who shall provide staff assistance to the commission. With the approval of the department [COMMISSION], the executive director may select and employ additional staff. The commission shall be assisted by the officers and personnel of the department as the commissioner of health and social services shall direct. The executive director of the commission is in the exempt service under AS 39.25.

Sec. 8. AS 47.07.900(4) is amended to read:

(4) "commission" means the Medicaid Rate Advisory Commission;

Sec. 9. Sections 1-7 of this Act take effect immediately under AS
01.10.070(c).

CS#2

Linking Medicaid Rate Commission Set Facility Rates to Approval of Federal State Plan to Ensure Continued Federal Funding

Purpose

This proposed amendment would require any rate set by the Medicaid Rate Commission to comply with federal Medicaid program requirements. The amendment links the effect dates of changes in regulations to the approval of the Medicaid state plan by federal funding authorities. If the rates do not meet with federal requirements and the state plan is not approved, federal funding for the Medicaid program is jeopardized. If the rates for hospitals and other facilities go into effect prior to the federal approval of the plan, the state Medicaid program is at risk whether the federal government will participate in federal funding for these facilities.

* Section 1. AS 47.07.070(a) is amended to read:

The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120-47.25.300 based on a fair rate for reasonable costs incurred by the facility. The rates of payment must be in accordance with provisions of 42 U.S.C. 1396p(Title XIX, Social Security Act, Medical Assistance). The commission shall by regulation list the factors it considers in making its rate determinations under this section. Regulations that require modification of the state plan become effective only after federal approval of the state plan or the amended state plan, except with the prior written approval of the department.

* Sec. 2. AS 47.07.180(c) is amended to read:

When the department enters into a federally approved substantially revised state plan under AS 47.07.040, and when, as part of the federally approved revised state plan, the commission adopts regulations which substantially change the methods used or the factors considered in determining the prospective payment rates, the commission may, at its discretion, redetermine the prospective payment rates for all facilities from the beginning of the first quarter in which the federally approved revised state plan is in effect [THE EFFECTIVE DATE OF THE NEW REGULATIONS FORWARD]. Each redetermined rate will be effective from the date of the commission's new order as to each facility.

* Sec. 3. Sections 1 and 2 of this Act take effect immediately under AS 01.10.070(c).

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FACILITY RATE SETTING

ISSUE

Facility rate setting. Alaska's system for setting medicaid reimbursement rates for private health care facilities is unique. It is the only state that entrusts the rate setting process to a volunteer commission that is wholly outside the control of the executive or legislative branches. The Medicaid Rate Commission (MRC) thus has no legislative mandate to keep facility rates within amounts budgeted by the Department of Health and Social Services and appropriated by the legislature. Aspects of this issue include: mechanisms utilized for rate setting; policies that drive the rates; and potential sanctions by the federal government, which participates in funding through Title XIX of the Social Security Act (medicaid).

HISTORY

The Medicaid Rate Commission was established by the Alaska Legislature in 1984. AS 47.07.110. It consists of five members, including: the chief executive officer of an health facility licensed by the state but not owned or operated by the state or federal government; either the commissioner of administration or health and social services or a designee of either commissioner; a physician licensed to practice and actively practicing medicine in Alaska and not employed by the state; a certified public accountant with relevant experience; and a representative of health services consumers who does not have a direct or indirect interest in an entity providing health care services. *Id.* The members are appointed by the governor and serve at his or her pleasure for three-year terms, which are staggered. AS 47.07.130-140. The commission's duties are to "review proposed payment rates and budgets of health facilities and establish payment rates for health facilities...." AS 47.07.180. The commission is required by statute to "determine prospectively the rate of payment to a health facility...based on a fair rate for reasonable costs incurred by the facility." AS 47.07.070. The statutes detail various factors which must be considered in determining the rate. *Id.*

Since its inception, the Medicaid Rate Commission has set rates at ever-increasing levels. In FY 84, \$21.7632 million was expended by the Department of Health and Social Services in medicaid payments to long-term care facilities. In FY 88 the projected expenditure for long-term facilities medicaid payments is \$29.6313 million, which is 30.1% of the entire medicaid budget. Percentage increases in rates paid to long-term care facilities between FY 83 and FY 88 are provided in the attachment. The lowest percentage increase in that period is 12.93%; the highest is 131.05%. The average increase is 42.45% in that period. *Id.* The average daily rate paid to private long-term care facilities in FY 1988 is \$212.11. *Id.*

The dramatic increase in medicaid rates has not resulted in large numbers of seniors being served by medicaid-funded long-term care. In FY 86, the total general fund medicaid expenditures for seniors (age 65 or over) were \$14,823,000. Of that total, \$3,823,000 was expended for non-long term facilities, which served 2,123 seniors at an average expenditure of \$1,801 per recipient. A total of \$11,000,000 was expended for medicaid long term care, which served 539 seniors at an average expenditure of \$20,408 per recipient. *See Halterman Report, Table 1.*

The increased rates authorized by the MRC are due to a combination of factors. The prospective rate setting system is based on costs incurred by the facilities during

a base year, which in practice has meant their previous fiscal year plus an inflation factor. The statutes set out the costs to be considered in setting rates and the MRC has, at the legislature's direction, promulgated regulations enumerating the rate-setting factors. In formulating rates, the MRC evaluates various components of facility costs during their base year, including: costs of current operation, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other operating expenses; education; research; and appropriate capital development. AS 47.07.070; 7 AAC 43.685. In practice, the rate has been based on the actual historical costs of operating facilities. Alaska, unlike most states, does not impose an upper limit on reimbursement amounts to facilities.

The only statutorily-imposed standards require that the rate of payment be based on a fair rate for reasonable costs incurred by the facility. AS 47.07.070(a). Additionally, the MRC, in determining a rate, "may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility." AS 47.07.070(c). Other than the generic cost items specified in the statute creating the MRC, the "fair rate for reasonable costs" language, and a statutory directive that the MRC "consider the appropriation limit set by the legislature for the department's programs under [portions of Title 47] and available federal revenue" (AS 47.07.070(d)), there are no statutorily-imposed restrictions on what rates the MRC sets. However, the purpose section of the statute authorizing the Department of Health and Social Services to participate in the medicaid program is instructive. It provides that: "It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing." AS 47.07.010.

Ninety percent (90%) of residents in long-term care facilities received medicaid coverage in April 1987, which is a typical month. See *Halterman Report* at 6. Since medicaid is a system which reimburses providers directly, every dollar of the approved rate flows directly to the institutions rendering the long-term care services. The national average cost of long-term care is \$56 per day; the average daily rate in Alaska as of FY 88 is \$212. *Id.* at 13-14; attachment. Thus, Alaska's daily rate is almost 400% of the national average. The higher cost of living in Alaska has been alluded to numerous times by the health care industry. See *A Study of Factors Influencing Acute and Long Term Care Costs in Alaska*. However, the 400% differential in daily rates is well above the increased cost of living in Alaska. The justification that it costs more because it costs more is no justification at all.

The overriding factor identified in the exorbitant rates paid to facilities in Alaska is the rates set by the MRC, which reimburse for almost all costs, no matter how inefficient a facility may be. The current rate structure does not reward thrift and ingenuity in administering a facility nor does it consider the fact that many of the co-located and long-term facilities were originally constructed with state grants. The MRC's rates thus allow facilities to obtain reimbursement for capital costs and depreciation, both of which were originally funded from state dollars. In essence, the rates reward higher and higher expenditures and does not provide an offset for capital costs originally incurred by the state. The medical industry knows full well that whatever it spends, it will likely be reimbursed through the medicaid rate. The medical industry's response has been that there is a higher level of service in Alaska. One doubts that any level of service could justify such a cost differential in daily rates.

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Has the MRC, through its prospective rate setting process, in effect discriminated against non long-term medicaid eligible Alaskans by setting rates so high that funding for other needy Alaskans is greatly reduced? Have the high medicaid payment rates resulted in high rates being charged to people ineligible for medicaid, so that retired persons living on modest retirement incomes are unable to afford institutional care? It appears so. The next question is, why? If the true purpose of Alaska's participation in the medicaid program is to ensure all needy recipients of access to medical care, why does the legislature continue to permit the MRC to operate as an independent body with no external and only few internal controls? If, instead, Alaska's public policy is to use the medicaid program to subsidize long-term care facilities which have small occupancy rates and inversely high daily rates, it should be so stated.

The MRC, viewed in a historical context, has operated quite well to insure facility survival. However, such is not the purpose of the federal medicaid statute, which was enacted by Congress to ensure that all categories of eligible needy persons receive needed medical care. The effect of the MRC prospective rate setting system is becoming clear to not only Alaskans, but to the federal government, which currently matches Alaska's medicaid contribution. The federal government has recently advised the Division of Medical Assistance that although there is no upper limit on reimbursements in state law, there is an upper limit under federal criteria, which the state is exceeding. Thus, there very well may come a time, and soon, when the federal government refuses to match the State of Alaska's facility medicaid costs or matches only the 50% it deems reasonable. The state would then be liable to use general fund monies to make up the difference. Loss of federal dollars would be a heavy price to sustain an unstated policy of ensuring facility survival no matter how cost ineffective the facility may be.

POPULATION AFFECTED

All Alaskans are potentially affected by this issue. Eligible medicaid populations may not receive funding for their medical needs if facility reimbursements continue not only to soak up the largest share of the DMA's total budget, but to require large annual increases in that budget. The Legislature has already signaled its unwillingness to fund DMA at requested levels. Two years ago, the state was forced to eliminate many services previously funded through the general relief medical program, which is solely a state funded medical program for the truly needy. In addition, no funds have been appropriated for the catastrophic illness program for the past two fiscal years. The Department of Health and Social Services has recently submitted a supplemental request of \$18.3 million for the remainder of FY 88, basically to cover the ever-increasing costs of payments to facilities. Medical assistance for the needy cannot continue to depend on ever-increasing emergency requests to the Legislature.

Everyone is suffering during these times of fiscal austerity. As the economy continues to bottom out, many Alaskans are finding themselves in need of medical care. However, due to decreasing funding, those needs could go unmet. It is against this backdrop that the fundamental unfairness of the current medicaid reimbursement system must be viewed. Should the state, as a conscious or unconscious public policy decision, fund ever-increasing private facility costs while the medical needs of other deserving Alaskans go unmet?

DRAFT

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OPTIONS TO ADDRESS THE ISSUE

The following are three ^{recommendations} ~~options~~ to consider:

1. Abolish the MRC and authorize the DHSS to perform the rate setting function; the DHSS could therefore ensure that the total facility reimbursement rate does not drive its entire budget and could ensure that the rate paid is not a subsidy to the facilities at the expense of all other classes of medical consumers served by DHSS. Staff of the MRC should be left in place and become employees of the Department of Health and Social Services.
2. Continue the MRC within the Department of Health and Social Services in an advisory capacity to the Commissioner. The Department would enact regulations providing the policies under which the MRC would propose rate setting regulations.
3. If the MRC continues to exist in statute, there must be statutory criteria to limit facility reimbursement, including authority to impose a ceiling on reimbursement rates.

EXPLANATION OF COMMITTEE SUBSTITUTES FOR HB 348

CS #1 - Changes to the Medicaid Rate Commission to Advising the Department on Medicaid Facility Rates.

CS #2 - Links Medicaid Rate Commission Set Facility Rates to Approval of Federal State Plan to Ensure Continued Federal Funding.

CS #3 - Eliminates the Medicaid Rate Commission

Original sponsor: Rules/Governor

1 IN THE HOUSE

2 CS FOR HOUSE BILL NO. 348 ()

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the Medicaid Rate Commission and
7 prospective payments to health facilities for certain
8 medical services; and providing for an effective
9 date."

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

11 * Section 1. AS 39.25.120(c) is amended by adding a new paragraph to
12 read:

13 (21) executive director for prospective payments to health
14 facilities in the Department of Health and Social Services.

15 * Sec. 2. AS 47.07.040 is amended to read:

16 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL ASSISTANCE.
17 The department shall prepare a state plan under [IN ACCORDANCE WITH]
18 the provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social Security
19 Act, Medical Assistance) and submit it for approval to the United
20 States Department of Health and Human Services. The plan shall desig-
21 nate [THAT] the Department of Health and Social Services as [IS] the
22 single state agency to administer this plan. The department shall act
23 for the state in [ANY] negotiations relative to the submission and
24 approval of the plan. The department [, INCLUDING THE MEDICAID RATE
25 COMMISSION,] may make those arrangements or regulatory changes, not
26 inconsistent with law, as may be required under federal law to obtain
27 and retain approval of the United States Department of Health and
28 Human Services to secure for the state the optimum federal payment
29 under the provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social

1 Security Act, Medical Assistance). In addition, the department shall
2 provide a report to the legislature by [NO LATER THAN] March 15 of
3 each year concerning the status of this program and recommendations,
4 with supporting fiscal data, as to [ANY] changes in the coverage of
5 eligible persons or services to be provided.

6 * Sec. 3. AS 47.07 is amended by adding a new section to read:

7 Sec. 47.07.065. PROSPECTIVE PAYMENT SYSTEM. The department
8 shall adopt regulations necessary to implement a system of prospective
9 payments to health facilities under this chapter.

10 * Sec. 4. AS 47.07.071 is amended to read:

11 Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than
12 120 days after the end of the [EACH] fiscal year of a health facility,
13 the facility shall submit to the department [COMMISSION] a report on
14 the facility's financial performance during the fiscal year.

15 * Sec. 5. AS 47.07.072 is amended to read:

16 Sec. 47.07.072. REPORT BY THE DEPARTMENT [COMMISSION]. Not
17 later than September 30 of each year, the department [COMMISSION]
18 shall submit to the governor a report on the prospective payments made
19 under this chapter during the current fiscal year and an estimate of
20 the prospective payments that will be made during the remainder of the
21 current fiscal year and the next fiscal year. The report shall state
22 the assumptions that are used as a basis for the estimates.

23 * Sec. 6. AS 47.07.190 is amended to read:

24 Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commissioner
25 [COMMISSION] may employ and determine the salary of an executive
26 director for prospective payments to health facilities. With the
27 approval of the commissioner [COMMISSION], the executive director may
28 select and employ additional staff. [THE COMMISSION SHALL BE ASSISTED
29 BY THE OFFICERS OR PERSONNEL OF THE DEPARTMENT AS THE COMMISSIONER OF

1 HEALTH AND SOCIAL SERVICES SHALL DIRECT.] The executive director [OF
2 THE COMMISSION] is in the partially exempt service under AS 39.25.120
3 [AS 39.25].

4 * Sec. 7. AS 47.07.900 is amended by adding a new paragraph to read:

5 (11) "commissioner" means the commissioner of health and
6 social services.

7 * Sec. 8. AS 47.25.195(b) is amended to read:

8 (b) A health facility receiving a payment under this chapter is
9 subject to the requirements of AS 47.07 [AS 47.07.070 - 47.07.075].

10 * Sec. 9. AS 47.25.195(d) is amended to read:

11 (d) If insufficient money is appropriated to fund medical assis-
12 tance under AS 47.25.120 - 47.25.300 when taking into consideration
13 projected use and the health facility payment rates established under
14 AS 47.07 [IN ACCORDANCE WITH (b) OF THIS SECTION], the department may,
15 by regulation, establish at any time in the fiscal year a prospective
16 pro rata reduction of the facilities' established payment rates that
17 will be paid by the department for services provided by facilities
18 under AS 47.25.120 - 47.25.300;

19 * Sec. 10. AS 47.25.195(e) is amended to read:

20 (e) Notwithstanding (a) - (d) of this section, the department
21 may enter into agreements with any facility to provide services at a
22 payment rate lower than the rate established under AS 47.07 [IN ACCOR-
23 DANCE WITH (b) OF THIS SECTION].

24 * Sec. 11. AS 39.25.110(23); AS 47.07.070, 47.07.073, 47.07.074, 47.-
25 07.075, 47.07.110, 47.07.120, 47.07.130, 47.07.140, 47.07.150, 47.07.160,
26 47.07.170, 47.07.180, and 47.07.900(4) are repealed.

27 * Sec. 12. This Act takes effect immediately under AS 01.10.070(c).
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Alaska State Legislature

Please enter into the record my testimony to the HES (HOUSE HESS)
 committee name
 committee on HB 348, dated 15 MARCH 88
 bill/subject

MY APOLOGIES TO THE COMMITTEE, I MISUNDERSTOOD THE QUESTION OF ELIGIBLE PATIENTS REQUESTING CARE. SITKA COMMUNITY HOSPITAL HAS AN EXCELLENT RECORD AND TO THE BEST OF MY KNOWLEDGE SITKA COMMUNITY HOSPITAL HAS HAD NO DENIALS OF ELIGIBILITY FOR CARE, INDICATING AN EFFICIENT SCREENING PROCESS FOR BENEFICIARIES OF SPECIFIC PROGRAMS AND A NON ABUSE OF THE SYSTEM HERE IN SITKA.

Signed: Edward Malewski EDWARD MALEWSKI
 Testifier

SITKA COMMUNITY HOSPITAL

Representing (Optional)

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