

**S B**

**166**

POSITION PAPER

SB 166

INTRODUCTION

The process by which Medicaid and GRM reimbursement rates are established for health facilities includes a procedure called year end conformance. This procedure compares the Medicaid Rate Commission (MRC) approved rate with actual rate billed by the facility during the billing period. If a defined level of variance between the approved and actual charges exists, an adjustment is made to the facility's base for its future prospective rate.

In August, 1988, the MRC repealed regulations that allowed waiver of the year end conformance adjustment. After realizing that in at least two cases the regulations had an unanticipated, negative effect, the MRC adopted a regulation which allows the commission to waive all or part of the year end conformance adjustment under certain circumstances. This regulation will become effective March 25, 1989.

This bill makes waiver authority retroactive to January, 1989. Due to federal Health Care Financing Agency requirements, federal participation in the state's Medicaid Program would be jeopardized if we change any provision of rate setting for a period prior to January 1.

ANALYSIS

Section 1 of the bill defines the procedure, provides for a full or partial waiver of the adjustment in cases of manifest injustice, and clarifies the treatment of some technical questions associated with implementation.

Section 2 of the bill requires reanalyzing rates in effect on or after January 1, 1989, in accordance with Sec. 1 of the bill, requires the immediate payment of an amount due the facility as the result of reanalyzing rates if waiver is granted, and prohibits recoument by the state if reanalyzing rates in accordance with Sec. 1 results in an amount due the state.

Section 3 of the bill provides for an immediate effective date. To receive federal financial participation (FFP) for the period January 1, 1989 - March 31, 1989, the state Medicaid plan amendment must be submitted prior to March 31, 1989. Therefore, SB 166 would have to be enacted into law with sufficient time for the department to prepare and submit the state plan amendment. An effective date before March 31, 1989, is essential for the state to continue to meet the federal requirements of the Medicaid Program and grant this retroactive relief.

DISCUSSION

Health facilities will benefit from a possible waiver of the year end conformance procedure under situations of manifest injustice. Situations which have been brought to the attention of the MRC to date include at least two in which facilities can demonstrate that a prudent management decision such as a reasonable rate increase has triggered the application of the procedure, and where a series of patients requiring an extraordinary level of care has triggered the application of the procedure. Other facilities may also seek relief from the year end conformance requirement, but it is not known whether they will meet the conditions for waiver.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES' POSITION

The department neither opposes nor supports Senate Bill 166.

Recommended: Kim Busch  
Kim Busch, Director  
Division of Medical Assistance

Date: March 6, 1989

Approved: Myra M. Munson  
Myra M. Munson, Commissioner  
Department of Health and  
Social Services

Date: March 6, 1989

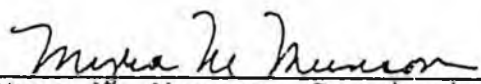
MAR 15 1989

REVISED ADDENDUM TO FISCAL NOTE ON CSSB 166

Although Sitka General Hospital has also been identified as a facility which could have year end conformance waived under SB 166, the financial impact to the Department of Health and Social Services from this waiver will not significantly impact the FY 89 budget.

Other facilities may be eligible to have year end conformance waived in accordance with SB 166, however, these facilities have not contacted either the Medicaid Rate Commission or the Department of Health and Social Services requesting such a waiver. Consequently, the potential financial impact from these facilities seeking a waiver has not been included in the fiscal note. If waiver is extended to the other possibly eligible facilities, the maximum anticipated fiscal impact in FY 89 would be <sup>AN ADDITIONAL</sup> \$250.0 total funds, \$125.0 general fund match and \$125.0 federal funds.

Approved:

  
Myra M. Munson, Commissioner  
Department of Health  
and Social Services

Dated:

March 15, 1989

(4) the disproportionate share payment is not subject to the payment limitations in 7 AAC 43.685(d).

(e) Disproportionate share payments will be phased in over a three year period. As of July 1, 1988, the adjustment will be one-third of the amount of the full payment adjustment. As of July 1, 1989, the payment will be two-thirds of the full payment adjustment. As of July 1, 1990, the payment will be the full payment adjustment. (Eff. 3/16/89, Register 109)

Authority: AS 47.07.040  
AS 47.07.070

**7 AAC 43.691. YEAR-END CONFORMANCE.** (a) The commission will determine whether the rates paid by the division of medical assistance are in conformance with the commission-approved rates as follows:

(1) The actual depreciation will be substituted for the approved depreciation when considering year-end conformance.

(2) For long-term care facilities and intermediate care facilities for mentally retarded, the commission will compare the actual costs per day to the approved rate, with actual ancillary costs substituted for the approved ancillary costs. Actual ancillary costs will be calculated based on the ratio of operating expenses, less revenue offsets defined in 7 AAC 43.685(b)(4), to charges in the applicable ancillary revenue center, not to exceed 100 percent of usual and customary charges. The following apply to the ancillary costs:

(A) If actual costs are less than two percent below or above the approved rate, adjusted for actual ancillary costs, no adjustments will be made.

(B) If actual costs are two percent or more below the approved rate, adjusted for actual ancillary costs, the actual ancillary costs will be compared to the approved ancillary costs. If actual ancillary costs are below the approved ancillary costs, 90 percent of the difference will be reduced from the rate as approved by the commission in the facility's next fiscal year. If actual ancillary costs are above the approved ancillary costs, 90 percent of the difference will be added to the rate as approved by the commission in the facility's next fiscal year.

(b) For acute care hospitals and specialty hospitals, the commission will compare the actual charges billed to the division of medical assistance with the approved rate per adjusted admission. If the actual charges to the division of medical assistance exceed the allowable costs as calculated in the approved budget and adjusted in (a) of this section, the percentage of charges will be adjusted downward in the facility's next fiscal year by the amount of the difference.

(c) Repealed 7/20/88.

(d) For rural health clinics, the commission will compare the actual costs for each visit to the approved rate and,

(1) if actual costs for each visit for medical assistance recipients are equal to or above the approved rate; no adjustments will be made;

(2) if actual costs or charges for each visit for medical assistance recipients are below the approved rate, the difference between the approved rate and actual costs or charges, whichever is less, will be deducted from the rate approved by the commission for the rural health clinic's next fiscal year.

(e) The commission will, in its discretion, waive all or part of the year-end conformance if the facility provides justification, to the commission's satisfaction, that manifest irreparable injustice will result if year-end conformance is strictly applied, and if the commission finds that

(1) the facility has taken effective measures to control costs in response to the situation upon which the waiver request is based;

(2) the waiver request does not contradict a prior action of the commission as to an element of the facility's rate established under 7 AAC 43.683, 7 AAC 43.685, or 7 AAC 43.686;

(3) the waiver request would result in payment for only allowable cost of services authorized by the division of medical assistance under state or federal laws, or both if applicable, or under regulations; and

(4) the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

(f) Outpatient surgical clinics and hospital outpatient laboratory services are exempt from all provisions of this section. (Eff. 8/9/86, Register 99; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/20/88; Register 107; am 3/25/89, Register 109)

Authority: AS 47.07.070

AS 47.07.071

AS 47.07.180

**7 AAC 43.709. DEFINITIONS.** In 7 AAC 43.670 — 7 AAC 43.709.

(1) "adjusted admission" means an adjustment to inpatient admissions that increases the number of admissions by outpatient revenue, at the rate of one additional admission for outpatient revenue equal to the inpatient rate;

(2) "ancillary costs" means, in the long-term care rate, patient-billed charges for additional services in long-term care facilities, such as pharmacy prescriptions, specific supplies, and physician-or-

STATE OF ALASKA  
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY  
LEGISLATIVE REFERENCE LIBRARY

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

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

SB 166

S-HESS

2/13/89

RECEIVED

FEB 10 1989

SENATOR TIM KELLY  
SENATE PRESIDENT

## SITKA COMMUNITY HOSPITAL

209 MOLLER AVENUE • SITKA, ALASKA 99835 • (907) 747-3241

February 10, 1989

Senator Tim Kelly  
Alaska State Senate  
P.O. Box V  
Juneau, AK 99811

Dear Senator Kelly:

I recommend favorable consideration of Senate Bill 166.

Senate Bill 166 will affirm an intent and an authority which reason dictates has always been present.

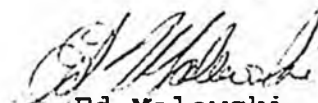
The Medicaid Rate Commission, for whatever reason, did not have a proviso in its rules and regulations after July 20, 1988 specifically stating it could waive its own rules for good reason. It appeared that it was their intent to have that authority. Nothing in their rules and regulations indicated that they did not have it.

Through a statistical quirk our reimbursement rate was calculated at 20%. Satisfactory justification was presented for the nonconformity and the rate was adjusted. The Commissioner of Health and Social Services had made several attempts to force the Medicaid Rate Commission to recant the adjustment and reset the rate at 20%. The Commissioner has not been successful to date, but continues to cry. A 20% reimbursement rate is not reasonable.

The Medicaid Rate Commission has in fact finally adopted rules and regulations which express their previous intent to have the ability to waive conformance for good reason.

Your support of SB 166 will be a vote for the affirmation of reason. Thank you. A similar letter has been sent to Senator Eliason, Representative Grussendorf and the other members of the Senate and House Health, Education and Social Services Committees.

Sincerely,



Ed Malewski  
Administrator

cc: HAA

EM:ck

**SITKA COMMUNITY HOSPITAL**

MAR 08 1989

209 MOLLER AVENUE • SITKA, ALASKA 99835 • (907) 747-3241

March 3, 1989

Senator Paul Fischer  
Alaska State Senate  
P.O. Box V  
Juneau, AK 99811

Dear Senator Fischer:

My staff and I have reviewed the Committee Substitute for Senate Bill No. 166, "an Act relating to conformance between actual payments and approved payment rates to health facilities for medical care under certain state medical assistance programs; and providing for an effective date."

The time and effort expended in the revision to ensure compliance with Federal dictates is appreciated.

Your support of the new Senate Bill No. 166 is encouraged and appreciated. We request that Senate Bill No. 166 be expedited so passage and implementation may be accomplished prior to 31 March 1989. If implementation takes place after 1 April 1989, the State loses a calendar quarter for implementation purposes.

Your interest and concern are appreciated. A similar letter has been sent to Senator Eliason, Representative Grussendorf and other members of both Senate and House Health, Education and Social Services Committees.

Sincerely,

  
Ed Malewski  
Administrator

cc: HAA

EM:ck

With file

FEB 13 1989

## SITKA COMMUNITY HOSPITAL

209 MOLLER AVENUE • SITKA, ALASKA 99835 • (907) 747-3241

February 10, 1989

Senator Paul Fischer  
Alaska State Senate  
P.O. Box V  
Juneau, AK 99811

Dear Senator Fischer:

I recommend favorable consideration of Senate Bill 166.

Senate Bill 166 will affirm an intent and an authority which reason dictates has always been present.

The Medicaid Rate Commission, for whatever reason, did not have a proviso in its rules and regulations after July 20, 1988 specifically stating it could waive its own rules for good reason. It appeared that it was their intent to have that authority. Nothing in their rules and regulations indicated that they did not have it.

Through a statistical quirk, our reimbursement rate was calculated at 20%. Satisfactory justification was presented for the nonconformity and the rate was adjusted. The Commissioner of Health and Social Services had made several attempts to force the Medicaid Rate Commission to recant the adjustment and reset the rate at 20%. The Commissioner has not been successful to date, but continues to try. A 20% reimbursement rate is not reasonable.

The Medicaid Rate Commission has in fact finally adopted rules and regulations which express their previous intent to have the ability to waive conformance for good reason.

Your support of SB 166 will be a vote for the affirmation of reason. Thank you. A similar letter has been sent to Senator Eliason, Representative Grussendorf and the other members of the Senate and House Health, Education and Social Services Committees.

Sincerely,

  
Ed Malewski  
Administrator

cc: HAA

EM:ck

Mc / TKs. -

Hearing Murdy 3/15 on  
SB 166.

~~The~~ The Senate HESS  
Committee has directed  
the Administration to  
work toward making  
The SJK a Community  
Hospital whole in this  
matter - I hope we can.



# SOUTH PENINSULA HOSPITAL

4300 BARTLETT • HOMER, ALASKA 99603 • [907] 235-8101

October 26, 1989

The Honorable Paul Fischer  
P. O. Box 784  
Soldotna, Alaska 99664

Dear Senator Fischer:

I appreciate being given the opportunity to participate in the Senate HESS meetings in Soldotna on November 1, 1989. I have two major areas of concern in regard to the functioning of the Medicaid Rate System since the advent of Executive Order 72. The first is with Senate Bill 166 and the year-end conformance process. The second is with the administrative appeals process.

Senate Bill 166 provided for the waiver of year-end conformance projects in situations where unusual circumstances produced rates that were manifestly unjust. This bill was prompted in very large part by the experience of Humana Hospital-Alaska. Humana was advised that it would receive reimbursement of only 30 percent of actual charges for treating Medicaid patients. An analysis of that problem revealed that Humana had treated an unusually high number of acutely ill Medicaid patients, whose average length of stay far exceeded the norm. When this situation occurs, the year-end conformance methodology produces artificially low reimbursement rates.

The major deficiency in the year-end conformance process that was identified was the fact that one single severely ill Medicaid patient could distort the entire year-end conformance process. Thus, the possibility existed that a facility that had not been over-reimbursed in any previous years would nevertheless be penalized by the year-end conformance process if it took care of an extremely ill patient who had a length of stay that exceeded the average for Medicaid patients. Senate Bill 166 was implemented to correct this deficiency.

In August, 1989, South Peninsula General Hospital was notified by the Medicaid Rate Advisory Commission that its proposed Medicaid reimbursement rate for acute care would be reduced by more than 16 percent, based on year-end conformance. This would result in a monetary reduction to South Peninsula in excess of \$87,000. The purpose of year-end conformance adjustments is to correct for past overpayments. An analysis of South Peninsula's prior years and the calculations of the MRAC staff shows that South Peninsula was underpaid in FY'88 by \$124,453 and in FY'87 by \$56,721. Nevertheless, South Peninsula's rates were lowered because of one critically ill cancer patient, whose length of stay was 25 times

The Honorable Paul Fischer  
October 27, 1989  
Page 2

higher than the average. This clearly should fall under the waiver provision of Senate Bill 166.

At the August 29, 1989 hearing, South Peninsula presented to the Medicaid Rate Advisory Commission a complete analysis of the extraordinary charges incurred by the single cancer patient who was hospitalized for almost two months. Had the statistics for this one patient been carved out of the calculations, there would have been no negative year-end conformance adjustment, and South Peninsula would have been reimbursed for 100 percent of its charges. Including the figures for that one patient led to the unjust result of a negative year-end conformance adjustment, and the facility sought the remedy established by Senate Bill 166 and asked for a waiver. The MRAC unanimously voted to waive year-end conformance for South Peninsula.

After the hearing, South Peninsula received an decision and order letter from MRAC Executive Director Jack Nielson in which its reimbursement rate for FY'90 was set at 87 percent of charges, which is a reduction of 13 percent. There was no explanation as to why the year-end conformance waiver was not upheld, nor any explanation as to how the 87 percent reimbursement figure was determined.

I have to tell you that it is extremely frustrating to go to Anchorage and present detailed information to the MRAC in support of South Peninsula's request for a waiver of year-end conformance, be granted that waiver by unanimous vote of the MRAC, and then have it arbitrarily overturned, with no explanation. What is particularly troubling is the fact that Commissioner Myra Munson's designated representative, Frank Hickey, voted to waive year-end conformance for South Peninsula Hospital. I do not understand why Commissioner Munson has designated someone to sit on the Medicaid Rate Advisory Commission to hear presentations, and then fail to follow the recommendations of that designee.

Senate Bill 166 was enacted in response to a specific situation where a health care facility has unusual circumstances that skew the year-end conformance results if this unusual circumstance is not taken into consideration. South Peninsula has an obligation to treat critically ill patients as diligently and with as much care as the less acutely ill. The consequence of that treatment, however, is that South Peninsula has been unfairly penalized by a lowered rate due to the year-end conformance process. We have attempted to avail ourselves of the designated avenue of relief, and have been thwarted by the system.

The second area of concern relates to the administrative appeals process. South Peninsula disagreed with its FY'88 rate

The Honorable Paul Fischer  
October 27, 1989  
Page 3

which was set on June 26, 1987, and appealed the decision of the then Medicaid Rate Commission. An evidentiary hearing was held in Anchorage on February 23, 1988. After the hearing, South Peninsula's attorneys presented a post-hearing brief. The attorneys for the Medicaid Rate Commission objected to our post-hearing brief and requested additional hearings. An additional hearing was held on January 31, 1989. Hearing Officer Elliott handed down a decision agreeing with South Peninsula's position that it had been under-reimbursed by the Medicaid system for its legitimate malpractice insurance costs. Mr. Elliott's decision was forwarded to Commissioner Munson early in July, 1989. Once Commissioner Munson received that decision, she simply refused to accept, reject or modify it for several months, and then finally rejected the decision and sent it back to Hearing Officer Elliott for further hearings.

Two things are especially troubling about this situation. First is the unconscionable delay in the resolution of the question under appeal. South Peninsula's rates for FY '88 were supposed to have been set as of June 30, 1987. It is now more than two years past that date, and South Peninsula still does not have a final decision on its appeal.

The second, and even more troubling, aspect of the administrative appeals process is the power that lies in the office of Commissioner of Health and Social Services to unilaterally overrule a well-reasoned decision of the hearing officer who has devoted substantial time to hearing evidence, reviewing exhibits and consideration of the merits of the appeal. Commissioner Munson did not attend the evidentiary hearings in February, 1988, or January, 1989. I have reviewed Commissioner Munson's orders on remand and find that they literally have nothing to do with the case that was presented to Mr. Elliott. The orders on remand make numerous assumptions, both factual and legal, which are simply incorrect.

As you may be aware, federal law requires that any state which participates in a Medicaid reimbursement program must provide its facilities with a prompt administrative review process. In all fairness, having to wait more than two years for a decision flagrantly violates the requirement for promptness. It also seems less than fair that a person who knows little or nothing about the specifics of an appeal has the final decision authority. Hearing Officer Elliott sat through days of testimony and reviewed numerous exhibits before he reached his 42-page decision. It seems to me there would need to be very strong evidence of the failure of his reasoning process to have it summarily overturned. Otherwise, the entire hearing process becomes a farce.

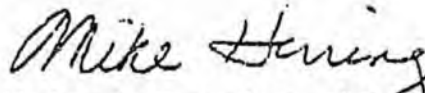
The Honorable Paul Fischer  
October 27, 1989  
Page 4

Prior to the effective date of Executive Order 72, all final decisions were rendered by the Medicaid Rate Commission. This was a fair process, because the Medicaid Rate Commission, having originally set the rates based on review of reports submitted, was familiar with the facts of a case and conducted hearings relating to the issues on appeal. Now, however, in South Peninsula's appeal, we have a situation where the appeals process allows someone who is not involved with the rate-setting process, and who is not involved with the formal hearing process, to make decision that is not based on fact. There has to be a way out of this dilemma. South Peninsula Hospital staff, and I as its administrator, are hopeful that through your inquiry, you can help us find a satisfactory solution.

I believe that the Medicaid Rate Advisory Commission should be reinstated to its former status as the decision-making body that sets reimbursement rates for health care facilities in Alaska.

I have been the administrator of South Peninsula General Hospital for over a decade. My facility does all that it can to provide quality care. The Medicaid program allows the frail, elderly and medically indigent of the State of Alaska to receive quality health care. We urgently need your help in establishing a Medicaid system within the State that fairly compensates health care givers for the care rendered.

Very truly yours,



Michael Herring, Administrator  
South Peninsula General Hospital

MH:nb

STATE OF ALASKA

MEMBER

TENTH ALASKA LEGISLATURE  
ELEVENTH ALASKA LEGISLATURE  
TWELFTH ALASKA LEGISLATURE  
THIRTEENTH ALASKA LEGISLATURE  
FOURTEENTH ALASKA LEGISLATURE  
FIFTEENTH ALASKA LEGISLATURE



SENATOR TIM KELLY

P. O. BOX V  
JUNEAU, ALASKA 99811  
(907) 485-3822

FEB 02 1989

P. O. BOX 210001  
ANCHORAGE, ALASKA 99521  
(907) 561-7612

February 2, 1989

MEMORANDUM

To: Senator Fischer, Chairman  
HESS Committee

From: Senator Kelly **TOK**

Re: Introducing a committee bill to correct a problem with health facility medical rate reimbursement.

I have attached a draft of legislation that would correct a problem inadvertently caused by a Medical Rate Commission action this last summer. In this action the commission repealed one of their own regulations that had a dramatic and unanticipated effect on certain health facilities year-end conformance determinations. I have talked with Commissioner Munson and everyone is in agreement that it was an unfortunate slip up. Last week the commission re-established the particular regulation.

The problem is that there appears to be no way for the commission itself to make this regulation retroactive, causing a disparate rate setting for those facilities whose conformance determination happened to occur in the time interval of the regulation's repeal. Humana hospital is particularly affected.

The proposed draft seems to be the only avenue for redress. It essentially puts the regulation language into law and retroactively applies the law. I have tried to make the title as tight as possible so that the bill does not attract other considerations. I would appreciate your consideration to introduce the bill as a committee bill.

1 IN THE SENATE

2 SENATE BILL NO.

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to conformance between actual pay-  
7 ments and approved payment rates to health facilities  
8 for medical care under certain state medical assis-  
9 tance programs; and providing for an effective date."

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

11 \* Section 1. AS 47.07.070 is amended by adding a new subsection to  
12 read:

13 (e) When actual payments made to a facility during a fiscal year  
14 are reviewed after the fiscal year has ended to determine whether they  
15 were in conformance with approved payment rates, all or part of the  
16 year-end conformance shall be waived if the facility provides satis-  
17 factory justification for the nonconformity. If a nonconformity is  
18 accepted, the corresponding adjustment that would have been made in  
19 rates for the succeeding fiscal year may not be made.

20 \* Sec. 2. The prospective payment rates determined under AS 47.07 for  
21 health facilities for fiscal year 1989, based on conformance reviews relat-  
22 ed to fiscal year 1988, shall be recalculated as if the provisions of  
23 AS 47.07.070(e), as enacted by sec. 1 of this Act, were in effect at the  
24 time of the conformance review and during the determination of prospective  
25 payment rates for fiscal year 1989. If the application of this section  
26 results in a higher prospective payment rate for a health facility for  
27 fiscal year 1989 than had previously been calculated for that facility, the  
28 difference shall be promptly remitted to the health facility, subject to  
29 appropriation. This section may not be applied to decrease payments to any

1 facility for fiscal year 1989. In this section, "conformance review" means  
2 the review undertaken after the end of a fiscal year to determine whether  
3 payments made to a health facility under AS 47.07 and AS 47.25.120 - 47.-  
4 25.300 conformed to the payment rate approved for that health facility  
5 under AS 47.07 and to determine whether prospective payment rates for that  
6 facility should be adjusted for the next fiscal year.

7 \* Sec. 3. This Act takes effect immediately under AS 01.10.070( ).  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

*Outdated*  
*Repealed 7/20/88*

7 AAC 43.691. YEAR-END CONFORMANCE. (a) The commission will determine whether the rates paid by the division of medical assistance are in conformance with the commission-approved rates as follows:

(1) The actual depreciation will be substituted for the approved depreciation when considering year-end conformance.

(2) For long-term care facilities and intermediate care facilities for the mentally retarded, the commission will compare the actual costs per day to the approved rate, with actual ancillary costs substituted for the approved ancillary costs. Actual ancillary costs will be calculated based on the ratio of operating expenses, less other operating revenue, to charges in the applicable ancillary revenue center, not to exceed 100 percent of usual and customary charges. The following apply to the ancillary costs:

(A) If actual costs are less than two percent below or above the approved rate, adjusted for actual ancillary costs, no adjustments will be made.

(B) If actual costs are two percent or more below the approved rate, adjusted for actual ancillary costs, the actual ancillary costs will be compared to the approved ancillary costs. If actual ancillary costs are below the approved ancillary costs, 90 percent of the difference will be reduced from the rate as approved by the commission in the facility's next fiscal year. If actual ancillary costs are above the approved ancillary costs, 90 percent of the difference will be added to the rate as approved by the commission in the facility's next fiscal year.

(b) For acute care hospitals and specialty hospitals, the commission will compare the actual charges billed to the division of medical assistance or Medicaid with the approved rate per adjusted admission. If the actual charges to the division of medical assistance exceed the allowable costs as calculated in the approved budget and adjusted in (a) of this section, the percentage of charges will be adjusted downward in the facility's next fiscal year.

(c) The commission will, in its discretion, waive all or part of the year-end conformance if the facility provides justification to the commission's satisfaction. (Eff. 8/9/86, Reg. 99)

Authority: AS 47.07.070  
AS 47.07.071  
AS 47.07.180

7 AAC 43.692. FUNDED DEPRECIATION. Repealed 8/9/86.

7 AAC 43.693. FACILITY AUDITS. (a) The commission will inspect the financial records of a facility receiving payments from the division of medical assistance. The commission will inspect financial records during normal business hours and will notify a facility of a proposed inspection of its records at least 10 working days before the inspection.

(b) If the commission directs, a facility receiving payments from the division of medical assistance for eligible state program recipients shall produce its financial records for inspection by the commission at a location within the state or at another place agreed upon by the commission and the facility.

(c) At the request of the commission, a facility shall send copies of financial records to the commission offices within 10 working days after the request is received.

(d) The commission will review the findings of facility audits. Audit findings that determine that the division of medical assistance has overpaid or underpaid will be acted upon in the following manner:

(1) If the audit findings relate to a facility's fiscal year already ended, the division of medical assistance will be notified of amounts due from or to the facility.

(2) If the audit findings relate to a facility's fiscal year in progress, the approved rate will be adjusted to reflect a correct payment rate. The level of adjustment will be prorated to ensure that the division of medical assistance will recoup all money by the end of the facility's fiscal year or that the facility will receive all

STATE OF ALASKA  
STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

STEVE COWPER, GOVERNOR

P.O. BOX H  
JUNEAU, ALASKA 99811-0601  
PHONE: (907) 465-3030

January 25, 1989

Medicaid Rate Commission  
P.O. Box 240249  
3601 "C" Street, Suite 592  
Anchorage, Alaska 99524-0249

Re: Year end conformance waiver  
regulation proposal

Dear Commission Members:

The Department of Health and Social Services offers the following comments regarding proposed regulation (7 AAC 43.691(c)) to waive year-end conformance in rate-setting by the Medicaid Rate Commission. \*/ The department supports the commission having authority to waive year end conformance, provided the authority is subject to conditions. The department recognizes the need for commission flexibility to respond to unique circumstances. The department opposes unlimited authority to waive year end conformance in any case. In addition, unlimited authority will very likely produce additional work for the commission and its staff and the facilities, since the facilities will have no guidelines to suggest what petitions are likely to be accepted and which ones are not. Truly prospective rate setting and responsible budgeting by the commission, department and facilities cannot occur if every facility can petition the commission at year-end for additional funds to balance its books.

The department offers the following alternative language:

\* Section 1. 7 AAC 43.691 is amended by adding a new subsection to read:

(e) The commission will, in its discretion, waive all or part of the year-end conformance, if the facility provides justification to the commission's satisfaction,

---

\*/ The department's attorney has checked with the staff of the regulations attorney and was informed that new subsection letter must be used even though the same language (as was repealed) is being proposed.

Health and Social Services Letter

that ~~immediate~~ <sup>a ill-reputable</sup> and manifest injustice will result if year-end conformance is strictly applied. All or part of year-end conformance will, in the commission's discretion, only be waived if the commission finds that:

(1) the facility has taken effective measures to control costs in response to the situation upon which the waiver request is based; and

(2) the waiver request does not contradict a prior action of the commission as to an element of the facility's rate contained in 7 AAC 43.683, 7 AAC 43.685, and 7 AAC 43.686; and


(3) the waiver request would result in payment for only allowed costs and services authorized by the division of medical assistance under state or federal laws or both if applicable, or regulations; and

(4) the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility, To provide patient care.

We urge the commission to adopt the department alternative language.

We appreciate the opportunity to offer comments on this important matter. Members of my staff will be available at the upcoming meeting to further elaborate on this position.

Sincerely yours,

  
Myra Munson  
Commissioner

*Wesleyan Nursing Home, Inc.*

*431 First Avenue*

*Box 430*

*Seward, Alaska 99664*

*(907) 224-5241*

October 26, 1989

The Honorable Paul Fischer  
P.O. Box 784  
Soldotna, Alaska 99669

Re: Department of Health and Social Services

Dear Senator Fischer:

In response to your request for Health Association members to participate in the Senate HESS meetings in Soldotna on November 1, 1989, I submit the following information.

I strongly urge the Senate to rescind Executive Order 72 and reinstate the Medicaid Rate Advisory Commission as the rate-setting entity for health care facilities in Alaska. I have served as the Administrator of Wesleyan Nursing Home since February, 1989, and during that short time have observed first-hand the following serious problems with the Medicaid reimbursement process as it currently functions.

Wesleyan is a long-term care facility primarily treating patients who are diagnosed as mentally retarded or mentally ill. Approximately 90 percent of Wesleyan's patients are Medicaid patients. Wesleyan has the lowest long-term care rate of any facility in the state -- 30 percent below the weighted average set by the MRAC for any other long-term care facility. Despite the fact that it is more costly to treat MR patients than geriatric patients, Wesleyan's rate is \$100 per day lower than Mary Conrad Center or Heritage Place.

Certification and licensing auditors from the Department of Health and Social Services conducted a review of Wesleyan's operations in December of 1988. As a result of that review, Wesleyan was placed on slow track decertification, citing the following deficiencies:

1. Deficient Ancillary therapy services;
2. Total absence of In-service training;
3. Failure to repair and maintain physical plant and facilities to such a serious extent that safety and sanitation standards were threatened;

Wesleyan was given 30 days to correct these deficiencies or be closed down by the state.

Wesleyan made dramatic improvements and avoided the threatened closure. The expenses incurred in upgrading the services and the facility in early 1989 (FY'89) would not ordinarily be taken into consideration in the rate-setting process for FY'90. The current Medicaid rate-setting system is a "history"-based system. The 1990 rate would therefore be based on 1988 expenses. Therefore Wesleyan requested an exception to the standard rate-setting methods in a hearing before the Medicaid Rate Advisory Commission on August 29, 1989. The exception request encompassed these areas:

1. Volumes rebase;
2. Ancillary therapy;
3. In-service training;
4. Repairs and maintenance;
5. Labor negotiation costs.

A copy of the exception request is enclosed for your information.

As was pointed out to the Advisory Commission, the State regulations and the State plan with the Federal Health Care Financing Administration require that the MRAC consider any unusual circumstances in determining whether to grant an exception to a facility's rate.

At the August 29 hearing, the MRAC voted unanimously to grant a volumes rebase, so that volumes used in the rate calculations would more accurately reflect current patient volume rather than using the higher history volumes that had resulted in a lower rate. Volumes are critical factors in determining rates. When base costs are divided by higher volumes than a facility is currently experiencing, patient day rates go down. When accurate current volumes are used in the calculations, the patient day rates correlate more reasonably to current costs.

The MRAC voted unanimously to reimburse Wesleyan for the mandated Medicaid ancillary therapy costs, and in-service training expenses. By a 3-1 vote, MRAC voted to grant the requested exception rate increase for repairs, maintenance, infection control and sanitation. The vote on the labor negotiations request was 2-2, resulting in no position being taken by MRAC on this issue.

The MRAC did not reach these decisions lightly, or based on superficial information. The hearing lasted more than three hours. Wesleyan brought its financial consultant, Donna Herbert, to the hearing to assist in the presentation and answer questions. During the presentation, the MRAC members and staff members, Jack Nielson and Mary Hilton asked numerous questions and there was a complete and thorough discussion of all exception issues. Commissioner Myra Munson did not attend the hearing, but was represented by her designee, Frank Hickey, who voted in favor on four of the five exception requests.

Wesleyan's representatives left the hearing feeling confident they would be allowed to continue to function as a viable health care provider, based on MRAC's granting of their requested

exceptions resulting in a reimbursement rate of \$152.71 per patient day. While this rate still left Wesleyan with the lowest reimbursement rate of any long term care facility in the state, it was adequate to cover base costs. When the decision and order letter was received, the rate was set at \$140.98 per patient day, which left Wesleyan with a \$239,795 shortfall for FY'90. No explanation for the rate reduction was given.

In a telephone conversation with Jack Nielson concerning the rate reduction, Donna Herbert was advised that Commissioner Munson had directed him to recalculate the rate based on Wesleyan's patient volume for 1987, 1988 and 1989. These were volumes much higher than Wesleyan's current volume. The three-year average of volumes for 1988, 1989 and the projected 1990 volume on which MRAC granted the \$152.71 rate at the August 29 hearing was the same formula followed by MRAC in granting recent rate exceptions to two other health care facilities. Commissioner Munson did not overturn those rate exceptions.

Commissioner Munson directed MRAC staff to disregard the entire hearing process, and to recalculate Wesleyan's rate based on arbitrary and unsubstantiated criteria; the formula she dictated has not been used in any other facility's rate calculation. She did not listen to any discussion of the important points affecting Wesleyan Nursing Home; however, she unilaterally overruled every single decision made by the MRAC. The five members of the MRAC are people with impressive credentials and with relevant expertise in the health care field. As required by statute, the MRAC membership includes a certified public accountant, a hospital administrator, a physician, an attorney and Commissioner Munson or her designee. If Commissioner Munson fails to attend a hearing, she has a moral responsibility to rely on the counsel and recommendations of her designee.

Wesleyan's request for a rate exception was not frivolous. In FY'86, Wesleyan's cash on hand was \$1.3 million (due in large part to generous church-affiliated support and donations, which are no longer available). Their operating loss in FY'88 was \$465,280; in 1989 it was \$896,981. These losses are the direct result of an inadequate reimbursement rate for more than three years, and have left Wesleyan with current cash reserves of less than \$150,000.

Wesleyan cannot continue to function with rates that do not cover its costs. If the facility is forced to close, its Medicaid patients must be transferred to other facilities in the state, any of whose rate is higher than even the \$152.71 rate granted by MRAC. Should Wesleyan close, the State of Alaska would be forced to pay approximately \$100 more per patient day than it pays Wesleyan to care for its patients.

Following Commissioner Munson's unilateral overruling of MRAC's recommendations, Wesleyan considered its options for relief. An appeal was considered, but the backlog of appeals is so great that the earliest time a decision could be expected would be two years away. Wesleyan cannot function for two years without adequate funding. The appeal process was disregarded, because Commissioner Munson has vetoed or otherwise remanded the vast majority of

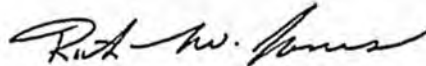
favorable decisions handed down by the appeals hearing officer for the past several months. It is clearly futile to force a facility to go through the arduous appeal process when the ultimate decision maker is the person who set the rates in the first place.

Seeing no alternative, Wesleyan has filed an action for relief in the Alaska Superior Court, asking only that the well-reasoned decision of the Medicaid Rate Advisory Commission be reinstated.

I believe that most, if not all of these deficiencies in the current system could be remedied if the Medicaid Rate Advisory Commission has restored to it the rate-setting decision powers it held prior to the enactment of Executive Order 72.

As a health care facility administrator, I take very seriously the responsibility of providing quality care for the Medicaid patients in the State of Alaska. I am grateful that you as a legislator have exhibited the concern for those patients, and are allowing an opportunity for health care providers to help explore remedies to this serious situation. I look forward to meeting with you in Soldotna on November 1.

Very truly yours,



Richard Jones, Administrator  
Wesleyan Nursing Home

RJ:ap

Enclosure

*Wesleyan Nursing Home, Inc.*

COPY

*431 First Avenue**Box 430**Seward, Alaska 99664**(907) 224-5241*

August 23, 1989

State of Alaska  
Medicaid Rate Advisory Commission  
PO Box 240249  
Anchorage, AK 99524-0429

Dear Commission Members:

When I appeared before you on June 29, I informed you that Wesleyan Nursing Home was in very serious financial condition. The cash reserves in 1985 of \$1,300,000 has been depleted to \$250,000 in 1989 and that we were losing \$60,000 per month. My concern was that the proposed rate of \$130.72 was so far below expenses, that the facility could not continue in this mode of operation.

At that time I also suggested that Wesleyan should consider classification as a MR and/or MI facility since the majority of residents treated at the facility are MR or MI rather than geriatric residents. Since I spoke to you on June 22, I have had a great deal of assistance and enlightenment from Karen Martz, Mary Hilton, Jack Nielson, Donna Herbert and a team from the Division of Mental Health and Developmental Disabilities. Each of them have worked closely with me to bring clarity into the current situation. They have each assisted me in identifying and recreating what problems in the past may have lead into the serious predicament that we face today.

It has been clearly reinforced to me by the Health Division (DMA) that Wesleyan historically and currently provides services to MR & MI residents appropriately within its ICF certification and license. Further, that due to the type of MR

and MI residents at Wesleyan a MR / MI unit should not be designated within the facility. The types of MR and MI residents located at Wesleyan receive "educational" therapy not restorative "active treatment" program therapy as is provided at API and Harborview. To illustrate by example, one of our MR residents is 38 years old. However, mentally she is 14 months old, is on a baby bottle, wears diapers and walks on her tip-toes (as would an infant at that stage of development). She is unable to communicate (as are several of our MR & MI residents), and requires constant attention on an almost one to one basis in a similar manner as you would expect to find in any home where an infant is present. Two of our residents are both MR and MI. The care planning and assessment process is much more involved, requires more staff time, and a broader spectrum of input in the interdisciplinary approach than is required for geriatric residents.

If a MR / MI designated unit were "created" the types of programs that would be required to be developed and provided would be "active treatment" programs. The costs associated with the new service program would be significantly higher than experienced with the current program. This would be viewed as an unnecessary duplication of service programs currently provided by API and Harborview. Residents needing "active treatment" program development are initially admitted to API or Harborview. Then, after improvement or stabilization of the residents' condition is achieved the resident is transferred to Wesleyan which provides a long term educational program in a less institutionalized or structured setting. Later, with continued progress, some residents are able to be transferred to shelter homes, foster homes, domiciles, sheltered educational workshop programs and near independent living in the residents home community. This

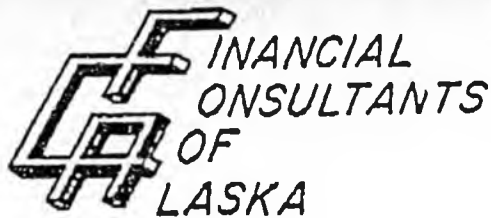
system is supported by all effected facilities, the Health Division (DMA) and the Division of Mental Health and Developmental Disabilities. The system currently in place works well, has appropriate goals including the active participation of community based mental health counseling services and the current system of utilizing Wesleyan as the second program step resource should not be changed.

As you are aware the Wesleyan Nursing Home rate is over 30% below the weighted average of the other free standing under 100 bed facilities. After reviewing past years records, staff reports and rates with your staff when they were kind enough to visit the facility, it appears that there were many reasons for the low rates that were set over the years that depleted all cash reserves.

A new management team is in place at Wesleyan. This new management team is supported and supplemented by the assistance of financial, planning and quality of care consultants and by a new open working relationship with the MRAC staff, Health Division and the Division of Mental Health & Developmental Disabilities.

Our facility has taken steps to correct the past deficiencies that were due to previous errors and omissions. However, under the current methodology, there is no mechanism to adjust base years. Therefore our costs are contained from base year even though the base years were incorrect. It is my understanding that corrections cannot be made for prior years, but there are two current problems that also effect the low rates:

1. That 1990 routine rates are being set using 1985 volumes from the "F" calculation.
2. A substantial portion of current costs, many of which are required by certification and licensing are not in our base year.



COPY

ATTACHMENT

Donna Herbert, owner

(907) 586-9565

174 S. Franklin St.  
Suite 229  
Juneau, Alaska  
99801

August 23, 1989

State of Alaska  
Medicaid Rate Advisory Commission  
PO Box 240249  
Anchorage, Ak 99524-0429

Dear Commission Members:

Wesleyan Nursing Home is bringing forward to the Commission a number of important issues for your consideration during the meeting of August 29, 1989.

The issues and their impact on Wesleyan's rate that we bring before you today are:

	<u>Exception Request</u>	<u>Staff Proposal</u>
Volumes Rebase	\$143.39	\$131.81
Ancillary Therapy	\$6.28	-0-
Inservice Training	\$1.24	-0-
Repairs & Maintenance	\$1.80	-0-
<u>Labor Negotiations</u>	<u>\$1.00</u>	<u>-0-</u>
Total Rate:	\$153.71	\$131.81

Thank you for your understanding and consideration of these issues, each of which has a significant impact on Wesleyan Nursing Home.

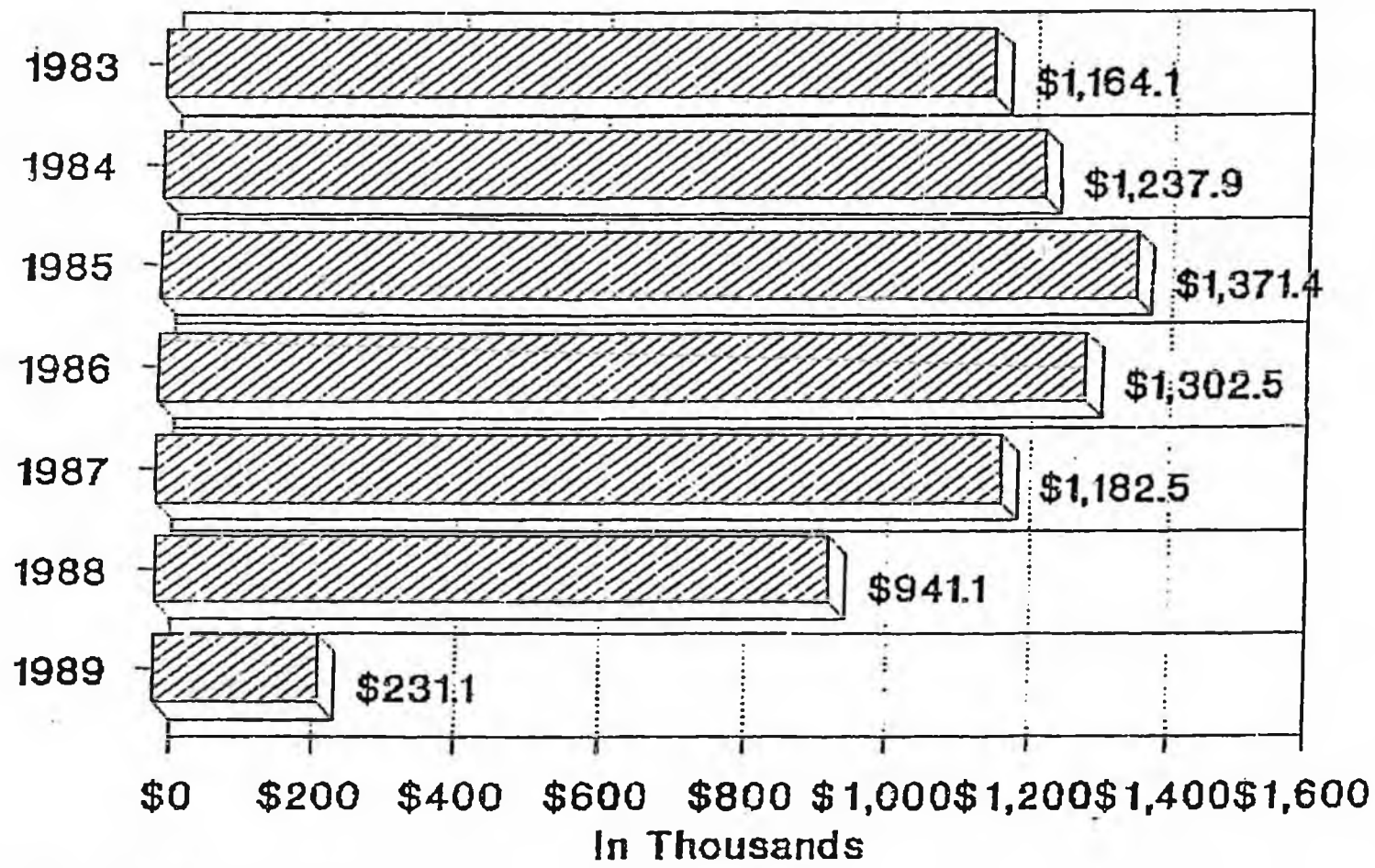
FOR WESLEYAN NURSING HOME:

Donna Herbert,  
Financial Consultants of Alaska

# WESLEYAN NURSING HOME

## Cash Position - '83 to '89

Fiscal Year



by: Financial Consultants of Alaska

WESLEYAN NURSING HOME  
Seward, Alaska

08/24/89

CASH and OPERATING LOSS POSITION

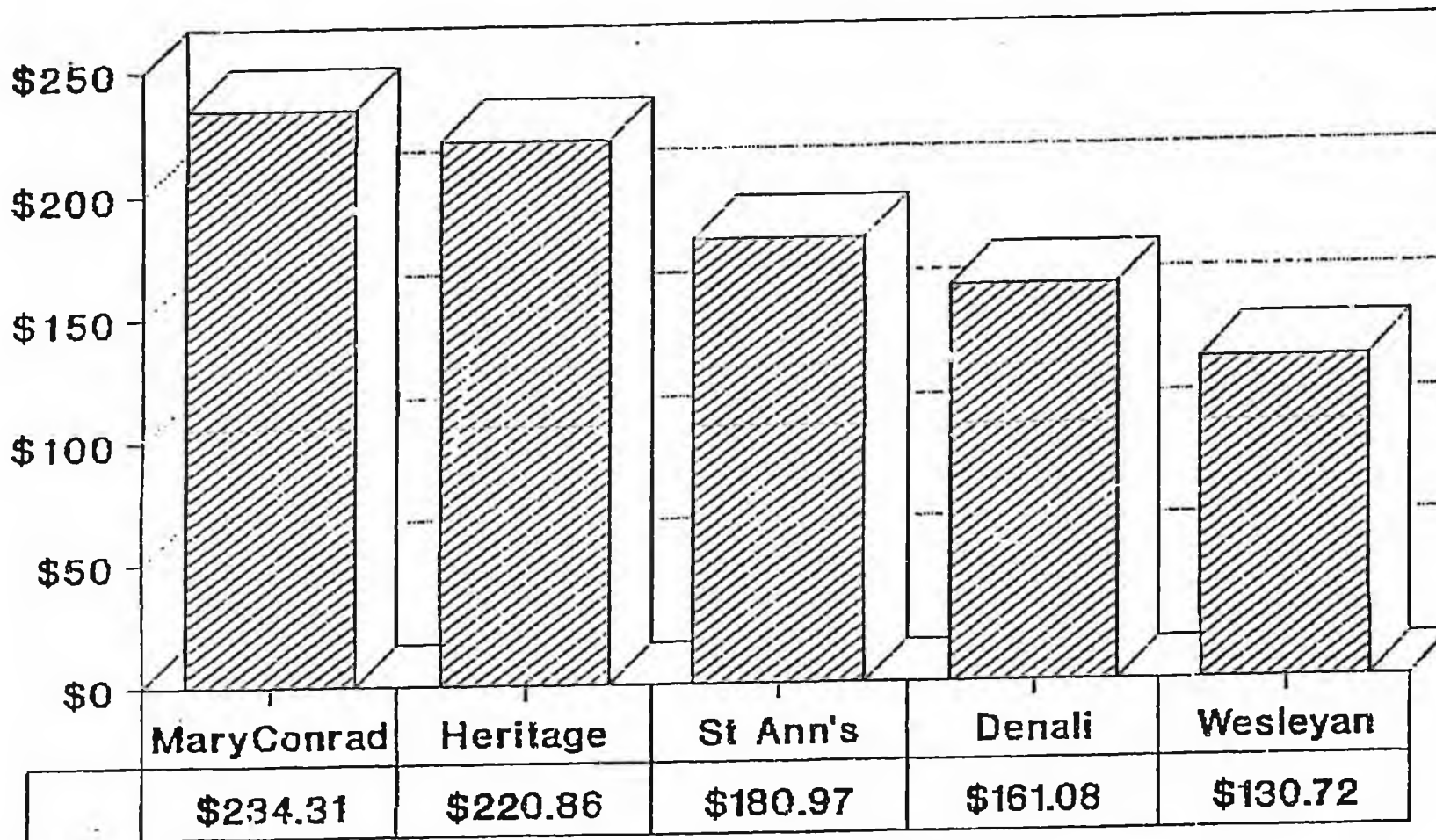
	F/Y 1983	F/Y 1984	F/Y 1985	F/Y 1986	F/Y 1987	F/Y 1988	F/Y 1989*	As of 08/15/89
Cash	\$1,164,087	\$1,237,918	\$1,371,411	\$1,302,510	\$1,182,448	\$941,051	\$393,981	\$231,118
Operating Loss	(\$12,818)	(\$168,836)	(\$161,757)	(\$184,479)	(\$291,760)	(\$465,290)	(\$714,056)	n/a
Other Sources of Revenue	\$209,156	\$228,361	\$227,808	\$228,635	\$177,691	\$154,056	\$124,056	\$69,937 **
Revenue over Expense	\$196,338	\$59,525	\$66,051	\$44,156	(\$114,069)	(\$311,234)	(\$590,000)	n/a

\*From General Ledger  
before final audit.

\*\*1990 Revenue Sharing

# 1989 REIMBURSEMENT RATES

## Free Standing Nursing Homes



**FACILITY & RATE**

by: Financial Consultants of Alaska

WESLEYAN NURSING HOME  
Seward, Alaska

08/21/89

EXPENSES vs REIMBURSEMENT

	F/Y 1984	F/Y 1985	F/Y 1986	F/Y 1987	F/Y 1988	F/Y 1989	F/Y 1990	TOTAL Over 7 Years
Total Facility Expenses:	\$1,997,846	\$2,136,860	\$2,244,725	\$2,311,184	\$2,673,871	\$2,948,896	\$3,243,786	
\$\$ Increase:		\$139,014	\$107,865	\$96,459	\$332,687	\$275,025	\$294,890	\$1,245,940
%% Increase:		6.96%	5.05%	4.30%	14.21%	10.29%	10.00%	62.36%
Total Patient Days:	23,029	23,340	22,682	21,298	21,465	18,440	19,710	
Rate Based on								
Actual Expenses:	\$86.75	\$91.55	\$98.97	\$109.93	\$124.57	\$159.92	\$164.58	
Approved Medicaid Rate:	\$81.40	\$85.25	\$90.09	\$97.14	\$103.21	\$117.52	\$130.72	
Rate Differential:	\$5.35	\$6.30	\$8.88	\$12.79	\$21.36	\$42.40	\$33.86	
Total Facility Expenses:	\$1,997,846	\$2,136,860	\$2,244,725	\$2,341,184	\$2,673,871	\$2,948,896	\$3,243,786	\$17,587,168
Reimbursement:	\$1,874,561	\$1,989,735	\$2,043,421	\$2,068,888	\$2,215,403	\$2,167,069	\$2,576,491	\$14,935,567
Other Revenue Sources:	\$223,361	\$227,808	\$228,635	\$177,691	\$154,056	\$124,056	\$90,400	\$1,231,007
REIMBURSEMENT EXCESS (SHORTFALL)	,076	\$80,683	\$27,331	(\$94,605)	(\$304,412)	(\$657,771)	(\$576,895)	(\$1,420,594)
	*****	*****	*****	*****	*****	*****	*****	*****

WESLEYAN NURSING HOME  
MEDICAID RATE ADVISORY COMMISSION PRESENTATION

PATIENT DAY VOLUMES

**SYNOPSIS:** Under the current rate-setting methodology, the routine component of the LTC rate is calculated using 1985 patient days as a base. A general statewide drop in census, along with the opening of Heritage Place, has resulted in Wesleyan volumes falling 27% since 1985. As an exception to normal practice, Wesleyan Nursing Home requests that a more realistic number of patient days be used in the calculation of the 1990 rate.

**DISCUSSION:**

PATIENT DAYS

	TOTAL	MEDICAID
1983	23,026	20,723
1984	23,029	20,956
1985	23,340	21,079
1986	22,682	20,243
1987	21,303	19,225
1988	21,465	19,298
1989	18,440	16,596
1990 - Based on 54 Patients	19,710	16,500
 1988-1990 3-Year Average:	 19,872	 17,465
1985-1989 Decrease:	-26.57%	

Please also refer to patient census and discharge data on page 15.

WESLEYAN NURSING HOME  
 MEDICAID RATE ADVISORY COMMISSION PRESENTATION

PATIENT DAY VOLUMES (Cont'd)

The patient day average over a three year period has been used previously by the Medicaid Rate Advisory Commission when granting volume exceptions.

	AS PROPOSED	VOLUME EXCEPTION
	<u>1985 DAYS</u>	<u>THREE-YEAR AVERAGE</u>
<u>ROUTINE</u>		
Patient Days	\$2,249,246 22,683	\$2,249,246 19,872
Routine Component	\$99.16	\$113.19
"F" Calculation Adj.	5.45	.54
Inflation Adj.	4.66	5.32
Total Routine Rate:	\$109.27	\$119.05
	<u>1988 DAYS</u>	<u>THREE-YEAR AVERAGE</u>
<u>CAPITAL</u>		
Patient Days	\$125,459 21,465	\$125,459 19,872
Total Capital Rate:	\$5.92	\$6.31
	<u>MEDICAID 1988 DAYS</u>	<u>MEDICAID THREE-YEAR AVERAGE</u>
<u>ANCILLARY</u>		
Net Cost	\$258,516	\$258,516
Patient Days	19,298	17,465
Total Ancillary Rate:	\$13.39	\$14.80
Wesleyan Rate Sub-Total:	\$128.58	\$140.16
Year-End Conformance:	\$3.23	\$3.23
FY'90 WESLEYAN RATE:	\$131.81	\$143.39

WESLEYAN NURSING HOME  
MEDICAID RATE ADVISORY COMMISSION PRESENTATION

PATIENT DAY VOLUMES (Cont'd)

PETITION TO THE COMMISSION:

Wesleyan Nursing Home requests the Commission to consider this critical volume issue and rebase the FY'90 "F" calculations using three-year average patient days, rather than 1985 patient days. Further, Wesleyan requests that the Commission instruct staff to calculate the ancillary component on the Medicaid three-year average volumes rather than the 1988 Medicaid days. This exception will add \$11.58 per LTC day to the proposed rate.

WESLEYAN NURSING HOME  
 MEDICAID RATE ADVISORY COMMISSION PRESENTATION

ANCILLARY THERAPISTS AND CONSULTANTS

**SYNOPSIS:** The state survey performed at Wesleyan Nursing Home in FY'89 cited the facility for the complete lack of occupational, physical, and speech therapists, lack of social workers, and inadequate recreational therapy department and programs.

**DISCUSSION:** In the table below, the therapy consultant and salaries for 1988 total \$2,079. Every LTC nursing home in the state is required to staff these ancillary departments with licensed consultants or licensed staff employees. Wesleyan has hired consultants and employees in each of the departments listed. There is \$109,733 of Medicaid Specific Ancillary Costs not included in their 1988 base rate. The partial Certification Report that is enclosed in the back of your packet has many of those deficiencies highlighted in yellow.

ANCILLARY THERAPIES NOT INCLUDED IN 1988 BASE

	1990 <u>Expenses</u>	1988 <u>Base</u>
OCCUPATIONAL THERAPY	55,253	1,640
PHYSICAL THERAPY	28,062	440
SPEECH	16,260	-0-
DIETICIAN	1,096	-0-
SOCIAL WORKER	1,696	-0-
RECREATIONAL THERAPY:		
2 Activities Aides	15,683	-0- <sup>1</sup>
1 Recreat. Therapist Consultant	<u>6,840</u>	<u>-0-</u>
<b>TOTAL ANCILLARY THERAPIES</b>	<b>124,890</b>	<b>2,079</b>
Less 1988 Costs in Base		
Plus 9.8% Inflation	<u>&lt;2,283&gt;</u>	
	122,607	
<b>MEDICAID SPECIFIC (@ 89.50%)</b>	<b>109,733</b>	
<b>TOTAL AVERAGED MEDICAID DAYS</b>	<b>17,465</b>	
<b>REQUESTED EXCEPTION FOR ANCILLARY THERAPIES -</b>	<b>\$6.28 PER DAY</b>	

---

<sup>1</sup> Recreational Therapy is a part of expanded services due to certification in FY-89.

WESLEYAN NURSING HOME  
MEDICAID RATE ADVISORY COMMISSION PRESENTATION

ANCILLARY THERAPISTS AND CONSULTANTS (Cont'd)

PETITION TO THE COMMISSION:

Wesleyan Nursing Home requests the Commission to consider the allowable therapy cost required by certification and by quality patient care logic and set a rate that includes an Ancillary Exception of \$6.28 per LTC day.

WESLEYAN NURSING HOME  
MEDICAID RATE ADVISORY COMMISSION PRESENTATION

REPAIR AND MAINTENANCE

**SYNOPSIS:** Wesleyan Nursing Home had many deficiencies for repair and maintenance in the 1989 certification report. Wesleyan demonstrated to staff in a walk through the facility that repairs have been sadly neglected.

**DISCUSSION:** For the entire 1988 fiscal year, Wesleyan had repair and maintenance costs of only \$3,348. In a building that is 37 years old, the lack of costs speaks to the many repairs that must be done to meet certification health and safety standards. The administrator has carefully inspected the facility and listed the deficiencies that must be corrected. I have enclosed a partial list of those repairs in the back of your packets. The partial certification report that is enclosed has many of those items marked in green.

The estimate of the repair costs is \$39,500. \$35,824 of those costs are not in the base year.

REPAIR AND MAINTENANCE

	<u>1990</u>	<u>1988</u>
REPAIR & MAINTENANCE EXPENSE	39,500	3,348
Less 1988 Costs plus Inflation in Base	<u>&lt;3,676&gt;</u> 35,824	
PATIENT DAYS	19,872	
TOTAL EXCEPTION REQUESTED	\$ 1.80	

The majority of the deficiencies on repairs, infection control and sanitation were cited on the state survey.

**PETITION TO THE COMMISSION:**

Wesleyan Nursing Home requests that the Commission consider the badly needed repair costs and grant an exception of \$1.80 per LTC day for repairs.

WESLEYAN NURSING HOME  
MEDICAID RATE ADVISORY COMMISSION PRESENTATION

INSERVICE TRAINING

**SYNOPSIS:** The 1989 Certification Review cited Wesleyan Nursing Home for a total lack of inservice training programs for the nursing staff. In 1988, Wesleyan recorded no inservice training costs.

**DISCUSSION:** Prior to the State's Certification Review, Wesleyan hired Whitman Nursing Consultants to review the facility before the State survey team's arrival. Marian Caudill performed the management certification survey and produced a 20-page report which delineated potential certification deficiencies that needed to be corrected before review.

Inservice training programs have been initiated and scheduled since the time of the State survey.

INSERVICE TRAINING

	<u>1990</u>		<u>1988</u>
STAFF IN SERVICE <sup>2</sup>	15,460	.78	-0-
BOARD AND ADMINISTRATION	5,000	.25	-0-
MANAGEMENT CERTIFICATION <sup>3</sup>	<u>4,177</u>	.21	-0-
	24,637		
PATIENT DAYS	19,872		
TOTAL EXCEPTION REQUESTED	\$ 1.24		

**PETITION TO THE COMMISSION:**

Wesleyan Nursing Home requests the Commission to consider the inservice training and allow an additional \$1.24 per LTC day.

---

<sup>2</sup> Cited in Survey.

<sup>3</sup> Hired prior to survey to correct deficiencies.

WESLEYAN NURSING HOME  
MEDICAID RATE ADVISORY COMMISSION PRESENTATION

LABOR NEGOTIATION FEES

SYNOPSIS: Wesleyan Nursing Home hired a labor negotiating firm to negotiate its labor-union negotiations. Failure to do so would have resulted in even higher salaries and benefits than the facility has been forced to comply with.

DISCUSSION:

LABOR NEGOTIATION FEES

	<u>1990</u>	<u>1988</u>
WILCOX (Law Firm)	19,822	-0-
Patient Days	19,872	
TOTAL EXCEPTION REQUESTED	\$ 1.00	

PETITION TO THE COMMISSION:

Wesleyan Nursing Home requests the Commission to grant a \$1.00 per LTC day increase in the rate for legal fees that were not included in base years.

WESLEYAN NURSING HOME  
Seward, Alaska

PATIENT CENSUS  
=====

	1985 =====	1986 =====	1987 =====	1988 =====	1989 =====
Jan	64	62	58	54	51
Feb	63	64	59	54	47
Mar	63	62	61	52	48
Apr	63	64	58	57	45
May	64	62	56	58	49
Jun	64	61	57	56	49
Jul	62	56	59	53	50
Aug	61	57	60	51	
Sep	63	57	62	51	
Oct	62	57	59	53	
Nov	63	61	60	52	
Dec	62	60	57	50	

PATIENT DISCHARGES  
=====

Home	4	8	5
Expired	5	11	6
OLOC	1	2	
Pioneer's			2
Heritage Place	2	2	1
HarborView		3	1
API	2	5	6
Other	1	1	3

Senator Fischer

SB 166

The Medicaid Rate Commission repealed one of its own regulations that had a dramatic and unanticipated effect upon certain health facilities year-end conformance determinations.

The problem is that there was no way for the commission itself to make this regulation retroactive, causing a disparate rate setting for those facilities whose conformance determination happened to occur in the time interval of the regulation's repeal. Humana and Sitka hospitals are particularly affected by this.

According to the department, if this bill is enacted it will partially reimburse the hospitals affected by the disparate rate setting.

As you can see by the fiscal note, this is a one shot deal to help correct an oversight .

This is only a partial reimbursement to help correct a wrong.

I urge your consideration of this bill.

(10) Interest, depreciation, and other capital costs will not be recognized on assets if a certificate of need was required and the facility did not secure one.

(11) Limits on operating costs provided by related organizations. Costs of services, facilities, and supplies furnished to a facility by organizations related to the facility are allowable costs only to the extent that these costs do not exceed the lower of

(A) the documented costs of the services, facilities, or supplies to the related organization; or

(B) the reasonable price of comparable services, facilities, or supplies offered by a vendor not related to the facility.

(12) Related organization cost documentation. A facility shall document the cost to a related organization for services, facilities, or supplies furnished to the facility by the related organization. The commission will permit the cost to be included in the operating base of a prospective payment rate only if the cost to be included is fully documented as prescribed in the manual. (Eff. 8/9/86, Register 99; am 7/20/88, Register 107)

Authority: AS 47.07.070  
AS 47.07.073  
AS 47.07.180

7 AAC 43.688. TOTAL FINANCIAL REQUIREMENTS. Repealed 8/9/86.

7 AAC 43.690. OPERATING COSTS. Repealed 8/9/86.

**7 AAC 43.691. YEAR-END CONFORMANCE.** (a) The commission will determine whether the rates paid by the division of medical assistance are in conformance with the commission-approved rates as follows:

(1) The actual depreciation will be substituted for the approved depreciation when considering year-end conformance.

(2) For long-term care facilities and intermediate care facilities for mentally retarded, the commission will compare the actual costs per day to the approved rate, with actual ancillary costs substituted for the approved ancillary costs. Actual ancillary costs will be calculated based on the ratio of operating expenses, less revenue offsets defined in 7 AAC 43.685(b)(4), to charges in the applicable ancillary revenue center, not to exceed 100 percent of usual and customary charges. The following apply to the ancillary costs:

(A) If actual costs are less than two percent below or above the approved rate, adjusted for actual ancillary costs, no adjustments will be made.

*B*

*Current regs*

(B) If actual costs are two percent or more below the approved rate, adjusted for actual ancillary costs, the actual ancillary costs will be compared to the approved ancillary costs. If actual ancillary costs are below the approved ancillary costs, 90 percent of the difference will be reduced from the rate as approved by the commission in the facility's next fiscal year. If actual ancillary costs are above the approved ancillary costs, 90 percent of the difference will be added to the rate as approved by the commission in the facility's next fiscal year.

(b) For acute care hospitals and specialty hospitals, the commission will compare the actual charges billed to the division of medical assistance with the approved rate per adjusted admission. If the actual charges to the division of medical assistance exceed the allowable costs as calculated in the approved budget and adjusted in (a) of this section, the percentage of charges will be adjusted downward in the facility's next fiscal year by the amount of the difference.

(c) Repealed 7/20/88.

(d) For rural health clinics, the commission will compare the actual costs for each visit to the approved rate and,

(1) if actual costs for each visit for medical assistance recipients are equal to or above the approved rate, no adjustments will be made;

(2) if actual costs or charges for each visit for medical assistance recipients are below the approved rate, the difference between the approved rate and actual costs or charges, whichever is less, will be deducted from the rate approved by the commission for the rural health clinic's next fiscal year.

(e) Outpatient surgical clinics and hospital outpatient laboratory services are exempt from all provisions of this section. (Eff. 8/9/86, Register 99; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/20/88, Register 107)

Authority: AS 47.07.070  
AS 47.07.071  
AS 47.07.180

7 AAC 43.692. FUNDED DEPRECIATION. Repealed 8/9/86.

7 AAC 43.693. FACILITY AUDITS. (a) The commission will inspect the financial records of a facility receiving payments from the division of medical assistance. The commission will inspect financial records during normal business hours and will notify a facility of a proposed inspection of its records at least 10 working days before the inspection.

(b) If the commission directs, a facility receiving payments from the division of medical assistance for eligible state program recipients

*Outdated regs**A*

**7 AAC 43.691. YEAR-END CONFORMANCE.** (a) The commission will determine whether the rates paid by the division of medical assistance are in conformance with the commission-approved rates as follows:

(1) The actual depreciation will be substituted for the approved depreciation when considering year-end conformance.

(2) For long-term care facilities and intermediate care facilities for the mentally retarded, the commission will compare the actual costs per day to the approved rate, with actual ancillary costs substituted for the approved ancillary costs. Actual ancillary costs will be calculated based on the ratio of operating expenses, less other operating revenue, to charges in the applicable ancillary revenue center, not to exceed 100 percent of usual and customary charges. The following apply to the ancillary costs:

(A) If actual costs are less than two percent below or above the approved rate, adjusted for actual ancillary costs, no adjustments will be made.

(B) If actual costs are two percent or more below the approved rate, adjusted for actual ancillary costs, the actual ancillary costs will be compared to the approved ancillary costs. If actual ancillary costs are below the approved ancillary costs, 90 percent of the difference will be reduced from the rate as approved by the commission in the facility's next fiscal year. If actual ancillary costs are above the approved ancillary costs, 90 percent of the difference will be added to the rate as approved by the commission in the facility's next fiscal year.

(b) For acute care hospitals and specialty hospitals, the commission will compare the actual charges billed to the division of medical assistance or Medicaid with the approved rate per adjusted admission. If the actual charges to the division of medical assistance exceed the allowable costs as calculated in the approved budget and adjusted in (a) of this section, the percentage of charges will be adjusted downward in the facility's next fiscal year.

(c) The commission will, in its discretion, waive all or part of the year-end conformance if the facility provides justification to the commission's satisfaction. (Eff. 8/9/86, Reg. 99)

Authority: AS 47.07.070

AS 47.07.071

AS 47.07.180

**7 AAC 43.692. FUNDED DEPRECIATION.**  
Repealed 8/9/86.

**7 AAC 43.693. FACILITY AUDITS.** (a) The commission will inspect the financial records of a facility receiving payments from the division of medical assistance. The commission will inspect financial records during normal business hours and will notify a facility of a proposed inspection of its records at least 10 working days before the inspection.

(b) If the commission directs, a facility receiving payments from the division of medical assistance for eligible state program recipients shall produce its financial records for inspection by the commission at a location within the state or at another place agreed upon by the commission and the facility.

(c) At the request of the commission, a facility shall send copies of financial records to the commission offices within 10 working days after the request is received.

(d) The commission will review the findings of facility audits. Audit findings that determine that the division of medical assistance has overpaid or underpaid will be acted upon in the following manner:

(1) If the audit findings relate to a facility's fiscal year already ended, the division of medical assistance will be notified of amounts due from or to the facility.

(2) If the audit findings relate to a facility's fiscal year in progress, the approved rate will be adjusted to reflect a correct payment rate. The level of adjustment will be prorated to ensure that the division of medical assistance will recoup all money by the end of the facility's fiscal year or that the facility will receive all

**FISCAL NOTE**

**REQUEST:**

Revision Date: \_\_\_\_\_ Agency Affected: Dept. of Health & Social Svs  
 Title An Act relating to conformance between BRU: Medical Assistance  
 actual payments and approved rates to facilities.  
 Sponsor: \_\_\_\_\_ Components: Medicaid Facilities  
 Requestor: Senate HESS Committee

**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	583.3					
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>583.3</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

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

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

**FUNDING: (Thousands of Dollars)**

GENERAL FUND	458.3					
FEDERAL FUNDS	125.0					
OTHER						
<b>TOTAL</b>	<b>583.3</b>					

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

**ANALYSIS :** (Attach a separate page if necessary)

See Attached

Prepared by: Kim Busch, Director *Kimberly Busch* Phone: 465-3355  
 Division: Medical Assistance Date: 3-9-89

Approved by Commissioner: Myra M. Munson *Myra M. Munson* Date: 3-10-89  
 Agency: Department of Health & Social Services

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

The Department is unable to retroactively secure federal financial participation for the period 7/1/88 - 12/31/88. Consequently, state general funds are calculated for this period. This fiscal note assumes passage of SB 166 prior to 3/31/89 and submission of a federally approvable state plan amendment prior to 3/31/89 to secure FFP for the period 1/1/89 - 3/31/89. This fiscal note further assumes regulations passed by the Medicaid Rate Commission giving it the authority to waive year end conformance become final on 4/1/89. Therefore, the impact on facilities is limited to the period 7/1/88 - 3/31/89. The Department has identified only one facility which would be impacted by this legislation.

## FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
 Title: Relating to Medicaid Facility  
Payment  
 Sponsor: Senate HESS  
 Requestor: \_\_\_\_\_

Agency Affected: Health & Social Services  
 BRU: Medical Assistance  
 Components: Medical Facilities

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	250.0					
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	250.0	-0-	-0-	-0-	-0-	-0-
<b>CAPITAL</b>	-0-	-0-	-0-	-0-	-0-	-0-
<b>REVENUE</b>	-0-	-0-	-0-	-0-	-0-	-0-

**FUNDING:** (Thousands of Dollars)

GENERAL FUND	125.0					
FEDERAL FUNDS	125.0					
OTHER						
<b>TOTAL</b>	250.0					

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

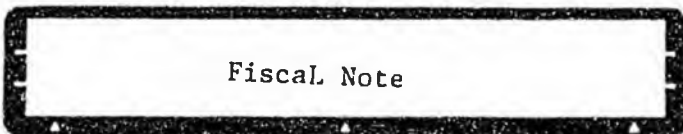
**ANALYSIS :** (Attach a separate page if necessary)

Fiscal impact is calculated based on impact to one identified facility.

Prepared by: <sup>Fon</sup> Kim Busch, Director *Kim Busch* Phone: 465-3355  
 Division: Medical Assistance Date: 3/6/89

Approved by Commissioner: Mura M. Murren *Mura M. Murren* Date: 3/6/89  
 Agency: Health and Social Services

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



STATE OF ALASKA  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
JUNEAU, ALASKA 99811  
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M

March 6, 1989

SUBJECT: Conformance Reviews  
CSSB 166 (HESS)

TO: Senator Paul Fischer, Chair  
Health, Education and Social Services  
Committee

FROM: Terri Lauterbach *TL*  
Legislative Counsel

Enclosed is a draft CS for SB 166, a bill related to the conformance reviews for medical facility payment rates.

I have used the language you submitted almost verbatim, considering that a specialized expertise is involved in this area, an expertise I cannot claim. However, I do have one question. I note that the last two sentences of section 1 cover two situations: (1) if both charges and costs are affected; and (2) if only charges are affected. What about the third possibility - that only costs are affected?

It may be that situation #3 is not at issue in this context, but I thought I would bring the matter to your attention in case it is important.

Let me know if I can be of further assistance.

TL:kb  
wkk2/104

Enclosure

6-0659E  
Lauterbach  
3/6/89

Original sponsor: Health, Education and  
Social Services Committee

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 166 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to conformance between actual pay-  
7 ments and approved payment rates to health facilities  
8 for medical care under certain state medical assis-  
9 tance programs; and providing for an effective date."

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

11 \* Section 1. AS 47.07.070 is amended by adding a new subsection to  
12 read:

13 (e) When an actual rate paid by the department is reviewed at  
14 the end of the year for which the approved rate was established and  
15 the review is conducted to determine whether the actual rate paid was  
16 in conformance with the approved rate under this section, all or part  
17 of an adjustment for year-end conformance may be waived for the facil-  
18 ity if the facility provides proof of manifest injustice resulting  
19 from application of the adjustment for year-end conformance. When the  
20 adjustment for year-end conformance of the base year is waived, in  
21 whole or part, for a facility under this subsection, the amount waived  
22 may not be included as part of the base upon which the prospective  
23 rate is determined if the nonconformity affects both costs and  
24 charges. When the adjustment for year-end conformance of the base  
25 year is waived, in whole or part, for a facility under this subsec-  
26 tion, the amount waived shall be included as part of the base upon  
27 which the prospective rate is determined if the nonconformity affects  
28 only charges.

1 after January 1, 1989, an approved prospective payment rate determined for  
2 a facility for fiscal year 1989, based on a conformance review of that  
3 facility's rate for fiscal year 1987 shall be recalculated as if the pro-  
4 visions of AS 47.07.070(e), as enacted by sec. 1 of this Act, were in  
5 effect at the time of the determination of the prospective payment rate in  
6 effect for the period. If the application of this section results in a  
7 higher prospective payment rate for a health facility than that which had  
8 previously been calculated for the facility, the difference shall be  
9 promptly remitted to the health facility. If the application of this  
10 section results in a lower prospective payment rate for a health facility  
11 for fiscal year 1989 than had previously been calculated for the facility,  
12 this section may not be applied to decrease a rate to a facility for fiscal  
13 year 1989 for any part of year-end conformance waived.

14 (b) In this section, "conformance review" means the review undertaken  
15 after the end of the year for which a facility's approved rate has been set  
16 to determine whether actual payments made to a health facility under AS 47.-  
17 07 and AS 47.25.120 - 47.25.300 conformed to the payment rate approved for  
18 that health facility under AS 47.07 and to determine whether the prospec-  
19 tive payment rate for that facility should be adjusted for the next rate-  
20 setting year.

21 \* Sec. 3. This Act takes effect immediately under AS 01.10.070(c).  
22  
23  
24  
25  
26  
27  
28

*Adopted*  
*DCM*

6-0659E  
Lauterbach  
3/6/89

Original sponsor: Health, Education and  
Social Services Committee

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 166 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to conformance between actual pay-  
7 ments and approved payment rates to health facilities  
8 for medical care under certain state medical assis-  
9 tance programs; and providing for an effective date."

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

11 \* Section 1. AS 47.07.070 is amended by adding a new subsection to  
12 read:

13 (e) When an actual rate paid by the department is reviewed at  
14 the end of the year for which the approved rate was established and  
15 the review is conducted to determine whether the actual rate paid was  
16 in conformance with the approved rate under this section, all or part  
17 of an adjustment for year-end conformance may be waived for the facil-  
18 ity if the facility provides proof of manifest injustice resulting  
19 from application of the adjustment for year-end conformance. When the  
20 adjustment for year-end conformance of the base year is waived, in  
21 whole or part, for a facility under this subsection, the amount waived  
22 may not be included as part of the base upon which the prospective  
23 rate is determined if the nonconformity affects both costs and  
24 charges. When the adjustment for year-end conformance of the base  
25 year is waived, in whole or part, for a facility under this subsec-  
26 tion, the amount waived shall be included as part of the base upon  
27 which the prospective rate is determined if the nonconformity affects  
28 only charges.

1 after January 1, 1989, an approved prospective payment rate determined for  
2 a facility for fiscal year 1989, based on a conformance review of that  
3 facility's rate for fiscal year 1987 shall be recalculated as if the pro-  
4 visions of AS 47.07.070(e), as enacted by sec. 1 of this Act, were in  
5 effect at the time of the determination of the prospective payment rate in  
6 effect for the period. If the application of this section results in a  
7 higher prospective payment rate for a health facility than that which had  
8 previously been calculated for the facility, the difference shall be  
9 promptly remitted to the health facility. If the application of this  
10 section results in a lower prospective payment rate for a health facility  
11 for fiscal year 1989 than had previously been calculated for the facility,  
12 this section may not be applied to decrease a rate to a facility for fiscal  
13 year 1989 for any part of year-end conformance waived.

14 (b) In this section, "conformance review" means the review undertaken  
15 after the end of the year for which a facility's approved rate has been set  
16 to determine whether actual payments made to a health facility under AS 47.-  
17 07 and AS 47.25.120 - 47.25.300 conformed to the payment rate approved for  
18 that health facility under AS 47.07 and to determine whether the prospec-  
19 tive payment rate for that facility should be adjusted for the next rate-  
20 setting year.

21 \* Sec. 3. This Act takes effect immediately under AS 01.10.070(c).  
22  
23  
24  
25  
26  
27  
28

0659A

Terry

Lauterbach

BY THE HEALTH, EDUCATION,  
AND SOCIAL SERVICES COMMITTEE

BY THE SENATE

COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 166

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to conformance between actual payments and approved payment rates to health facilities for medical care under certain state medical assistance programs; and providing for an effective date."

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

\* Section 1. AS 47.07.070 is amended by adding a new subsection to read:

(e) When an actual rate paid by the department is reviewed at the end of the year for which the approved rate was established and such review is conducted to determine whether the actual rate paid was in conformance with the approved rate under this section, all or part of any adjustment for year end conformance ~~shall~~ <sup>may</sup> be waived for the

facility if the facility provides proof of manifest injustice resulting from application of the adjustment for year end conformance. When the adjustment for year end conformance of the base year is waived, in whole or part, for a facility under this subsection, the amount waived shall not be included as part of the base upon which the prospective rate shall be determined if the non-conformity affects both costs and charges. When the adjustment for year end conformance of the base year is waived, in whole or part, for a facility under this subsection, the amount waived shall be included as part of the base upon which the prospective rate shall be determined if the non-conformity affects only charges.

\* Sec. 2. For the services provided on or after January 1, 1989, any approved prospective payment rate determined for a facility for this period, based on a conformance review of that facility's rate for fiscal year 1987 shall be recalculated as if the provisions of AS 47.07.070(e), as enacted by sec. 1 of this Act were in effect at the time of the determination of the prospective payment rate in effect for the period. If the application of this section results in a higher prospective payment rate for a health facility than that which had previously been calculated for that facility, the difference shall be promptly remitted to the health facility. If the application of

this section results in a lower prospective payment rate for a health facility for fiscal year 1989 than had previously been calculated for that facility, this section shall not be applied to decrease a rate to a facility for fiscal year 1989 for any part of year end conformance waived. In this section, "conformance review" means the review undertaken after the end of the year for which a facility's approved rate has been set to determine whether actual payments made to a health facility under AS 47.07 and AS 47.25.120 -- 47.25.300 conformed to the payment rate approved for that health facility under AS 47.07 and to determine whether the prospective payment rate for that facility should be adjusted for the next rate-setting year.

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

# FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
Title: Relating to Medicaid Facility  
Payment  
Sponsor: Senate HESS  
Requestor: \_\_\_\_\_

Agency Affected: Health & Social Services  
BRU: Medical Assistance  
Components: Medical Facilities

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	250.0					
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>250.0</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>
<b>CAPITAL</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>
<b>REVENUE</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

**FUNDING: (Thousands of Dollars)**

GENERAL FUND	125.0					
FEDERAL FUNDS	125.0					
OTHER						
<b>TOTAL</b>	<b>250.0</b>					

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

**ANALYSIS : (Attach a separate page if necessary)**

Fiscal impact is calculated based on impact to one identified facility.

Prepared by: <sup>FBI</sup> Kim Busch, Director *Kim Busch* Phone: 465-5355  
Division: Medical Assistance Date: 3/6/89

Approved by Commissioner: Myra M. Murren *Myra M. Murren* Date: 3/6/89  
Agency: Health and Social Services

**Distribution (by preparer):**

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