ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
5085 HSTA HB 348

657

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE COMMISSION

STEVE COWPER, GOVERNOR

PO BOX 240249
3601 C STREET SUITE 590
ANCHORAGE ALASKA 99524-0249
PHONE (907) 562-1996

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	$ 2,800,000
Potential Federal Claim	$ 7,370,000
FY89 Proposed Regulation	$ 2,900,000
Outstanding Appeals	$ 7,000,000
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

Official Business

Alaska State Legislature

House

COMMITTEE ON STATE AFFAIRS

P.O. BOX V
State Capitol
Juneau, Alaska 99811

March 21, 1988

William Selvey, Jr.
Administrator
Bartlett Memorial Hospital
3260 Hospital Drive
Juneau, AK 99811

Dear ~~Bill~~ Bill:

On Friday, March 11, The State Affairs Committee passed out HB 348, An Act relating to the composition of the Medicaid Rate Commission.

I had offered a committee substitute which attempted to balance the administration members and the public members a little more equally. However, none of the other committee members supported this compromise. They preferred the original bill. Copies of both are attached. I have also attached the committee report to indicate how members feel about the bill.

Although I wish we could have struck a different balance, I want you to know that the administration put together a persuasive case for changing the way the commission currently operated.

Sincerely,

Fran Ulmer, Chair

HOUSE STATE AFFAIRS COMMITTEE

NEXT COMMITTEE: HESS

BILL: HB 348

CURRENT VERSION:

SCHEDULED: MARCH 2, 1988

SPONSOR: GOVERNOR

PHONE NO:

CONTACT FILE: ________________

BILL SUBJECT: RELATING TO THE COMPOSITION OF THE MEDICAID RATE COMMISSION

SPONSOR BACKUP: TRANSMITTAL LETTER

AFFECTED AGENCIES:

DEPARTMENT	CONTACT/PHONE	COMMENT
H&SS	LIVEY/3030	NOTIFIED 2/24/88
ADMIN	PUSHPENDER/2200	NOTIFIED 2/24/88

SISTER BARBARA HAAS, KETCHIKAN GENERAL HOSPITAL, 225-5171 (TELECONFERENCE) NOTIFIED 2/24/88

ALASKA HOSPITAL ASSOCIATION/586-1790 NOTIFIED 2/24/88

FISCAL NOTES

AGENCY	REQUESTED	DATED	FY 88 AMT	FY 89 AMT
H&SS		12/8/87	-0-	-0-

ACTION

DATE	COMMENT
3/2/88	HEARING: HELD FOR MORE INFORMATION FROM H&SS AND HOUSE RESEARCH
3/11/88	PASSED FROM HOUSE STATE AFFAIRS

(7)

HOUSE COMMITTEE REPORT

Date referred: 1/11/88

FURTHER REFERRALS: HESS
Judiciary

DATE: 3-11-88

The State Affairs Committee has considered HB 348

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

RECOMMENDS:

[ ] replace with ______________ [ ] the same title
[ ] attached amendment(s) [ ] a new title

[X] 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
[ ] zero fiscal note
[ ] zero with analysis

[ ] same as previous fiscal note published ______________
[X] same as previous zero fiscal note published 1-11-88

SIGNING DO PASS:

[signatures]

SIGNING OTHER RECOMMENDATIONS:

[signature] - no rec

[signature]
Chairman's signature

Introduced: 1/11/88
Referred: State Affairs,
Health, Education & Social
Services and Judiciary

go00268h

1 IN THE HOUSE

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

2 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 composition of the Medicaid
7 Rate Commission."

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

9 * Section 1. AS 47.07.120 is repealed and reenacted to read:

10 Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission
11 consists of the following members:

12 (1) the commissioner of administration, the commissioner of
13 health and social services, and a third commissioner or a director of
14 a division of the office of management and budget (AS 44.19.141)
15 designated by the governor, or the appointed designees of these com-
16 missioners or the director;

17 (2) one person appointed by the governor representing the
18 health care provider community;

19 (3) one person appointed by the governor representing
20 health care consumers.

21 * Sec. 2. AS 47.07.140 is amended to read:

22 Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the
23 commission appointed under AS <u>47.07.120(2) or (3)</u> [47.07.120(1), (3),
24 (4), or (5)] is three years. A member may not be appointed to a
25 successive term. The terms of the members shall be staggered. A
26 member appointed to fill a vacancy serves for the unexpired term of
27 the member. A term shall be measured from January 1 of the year in
28 which the term of the vacant position begins, regardless of when the
29 vacancy is filled.

1 * Sec. 3. TRANSITION. Upon the effective date of this Act, all po-
2 sitions on the commission, except that of the commissioner of health and
3 social services, become vacant, and the governor shall appoint new members
4 in accordance with AS 47.07.120 and 47.07.140, as amended by this Act.

go0268hB
Utermohle
3/8/88

Original sponsor: Rules/Governor

1 IN THE HOUSE BY THE STATE AFFAIRS COMMITTEE

2 CS FOR HOUSE BILL NO. 348 (State Affairs)

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 composition of the Medicaid
7 Rate Commission."

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

9 * Section 1. AS 47.07.120 is repealed and reenacted to read:

10 Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission
11 consists of the following members:

12 (1) the commissioner of administration and the commissioner
13 of health and social services or their designees;

14 (2) one person representing the health care provider commu-
15 nity;

16 (3) one person representing health care consumers;

17 (4) one person who is a licensed certified public accoun-
18 tant in the state and who is familiar with health care financing.

19 * Sec. 2. AS 47.07.140 is amended to read:

20 Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the
21 commission appointed under AS 47.07.120(2), (3), or (4) [AS 47.07.-
22 120(1), (3), (4), OR (5)] is three years. A member may not be ap-
23 pointed to a successive term. The terms of the members shall be
24 staggered. A member appointed to fill a vacancy serves for the un-
25 expired term of the member. A term shall be measured from January 1
26 of the year in which the term of the vacant position begins, regard-
27 less of when the vacancy is filled.

28 * Sec. 3. TRANSITION. On the effective date of this Act, all positions
29 on the commission, except those of the commissioner of administration and

of the commissioner of health and social services, become vacant. The governor shall appoint new members under AS 47.07.120 and 47.07.140, as amended by this Act.

DIVISION OF MEDICAL ASSISTANCE

BUDGET INCREASE FACTORS

	FY87				FY88			FY89
	Dept. Request	Authorized	Actual	National CPI	Dept. Request	Authorized	Projected	Dept. Request
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%

POSITION PAPER

HOUSE BILL 348

"Relating to the Composition of the Medicaid Rate Commission"

Purpose

HB 348 would modify the membership of the Medicaid Rate Commission (MRC). Currently, AS 47.07.120 requires the following membership on the MRC:

1. The chief executive officer of a health facility licensed by the state but not owned or operated by the State or federal government and that is subject to the budget review process of the Commission.

2. The Commissioner of Administration, Commissioner of Health and Social Services or the appointed designee of either commissioner.

3. A physician licensed to practice medicine in the State who is actively engaged in the practice of medicine and who is not employed by the State.

4. A certified public accountant with relevant experience.

5. A person representing consumers of health services who does not have a direct or indirect interest in any entity that provides health care services.

HB 348 changes the membership of the MRC to the following:

1. Commissioner of Administration or designee;

2. Commissioner of Health and Social Services or designee;

3. A third Commissioner or designee or director of a division office of management and budget designated by the governor;

4. A representative of the health care provider community appointed by the governor;

5. A representative of heath care consumers appointed by the governor.

Discussion

The MRC which was created by the legislature in 1984 is nearly unique in the nation in its rate setting authority. The MRC sets all the rates for inpatient care in hospitals and nursing homes

and for some other kinds of care provided in facilties. The total medicaid funds paid to providers through the MRC exceeded $65 million last year.

The MRC sets rates by adopting regulations over which the executive or legislative branch have no approval or disapproval authority. This creates a situation in which the State has the obligations, without the needed authority , to (1) manage within its budget, (2) meet all Federal medicaid standards concerning maximum rates, (3) ensure the greatest access to health care within our appropriation, and (4) try to manage ever escalating costs of health care. This is mpossible to do without authority over the activities of the MRC.

AS 47.07.070 requires the Medicaid Rate Commission to determine prospectively the rate of payment that the medicaid program will apply to health care facilities as reimbursement for the treatment of medicaid eligible individuals. Principals used in determining this rate are provided in statute while specific factors which are considered in determining the rate are adopted in regulation. HB 348 will neither change the scope of the MRC's authority to set rates nor alter the statutory basis upon which rates are determined.

However, HB 343 will (1) associate the MRC more closely to the development of health policy by the legislature and the executive branch and (2) provide more administrative control over an agency which has the authority to obligate the state to expenditures of over $65 million per year.

The MRC has the authority to control the amount of general funds which are paid to health facilities. The rates which are established by the MRC have the force of law; once established, they must be paid by the medicaid program as the health services are provided. The MRC obligates the State to pay these rates. and because Medicaid is an entitlement program. the State must pay for all eligible individuals who receive service, based on the service priority as established by law.

why not just advisory?

It is unique in Alaska to invest a body composed of a majority of non-State members with the authority to indebt the State. Boards with similar or comparable powers, such as the Alaska Housing Finance Corporation (AHFC), the Alaska Power Authority and the Alaska Public Utilities Commission, contain majority representation from the executive branch. The five member AHFC board, for example, has two public members and three cabinet officials.

The State's incurs obligations as a result of MRC decisions even though only one of the members of the MRC is a representative of State government (four are public members). The MRC, as currently established, sets rates, and consequently expends general

POSITION PAPER/Department of Health & Social Services

funds, independently from either the legislature or the executive branch. HB 348 would alter the composition of the MRC so that a majority of the members of the Commission would be representatives of the executive branch, thereby providing more policy control over t Commission's decisions, and, bringing the Commission's membership more in line with other State boards of comparable responsibility.

Although the MRC obligates the State to payments which exceed 50 percent of the State's medicaid budget of $121 million, the MRC is not charged with making rate decisions within the context of health care policy. The MRC establishes rates within the context of a methodology which considers facility cost data but not the impact of the rate and subsequent expenditure on other health programs. However, by not considering the impact of the rate on the overall health care policy, and by virtue of the amount of medicaid dollars obligated by the commission, the MRC is implicitly involved in establishing priorities for the provision of medicaid services.

For example, the MRC is currently considering adoption of new regulations to allow budgeted costs of certain expenses to be included in the rate, even when the budgeted amount exceeds inflation and, may have been, or be, driven by management practice or decision. This rate change, which could cost the State up to $3 million, is proposed even though the State is currently in jeopardy of having the Federal government reject the current State medicaid plan because rates exceeds the federal upper limits.

Each year, the legislature appropriates general fund dollars to fund the medicaid program. This apropriation is based on projections of utilization (the degree to which each individual requires medical services), the number of eligible individuals who require service, the benefit or particular service which the State chooses to provide each eligible individual and the price of services. Should the combination of utilization, eligibles and price require the expenditure of more funds than appropriated, the department may request supplemental appropriations to maintain the program.

If the supplemental apropriation is not forthcoming, the program must, by statute, eliminate services such as dental care and care for the developmentally disabled, and reduce the number of eligible individuals to the extent necessary to meet budget limitations. The proposed $3 million regulation change currently being considered is not budgeted in the FY 89 request. If the regulations go into effect and the money is not provided by the legislature through a supplemental, services would have to be eliminated.

POSITION PAPER/Department of Health & Social Services

As the cost and quantity of institutional care continues to increase, health care policy choices which require favoring one set of services over another become more complex and difficult for legislators and other policy makers to make. If prevention services are to be reduced, or new community services which enhance life outside institutions cannot be developed because of institutional costs, then policy makers will be unable to formulate health policies which respond to the needs of the society as a whole. The restructuring of the MRC as proposed by HB 348 will integrate the decisions of the MRC with other aspects of health care policy.

Position

The Department strongly supports the passage of HB 348 as an effective means of integrating the MRC into state policy and as a way for the State to gain control of an agency which has the authority to obligate state general fund dollars.

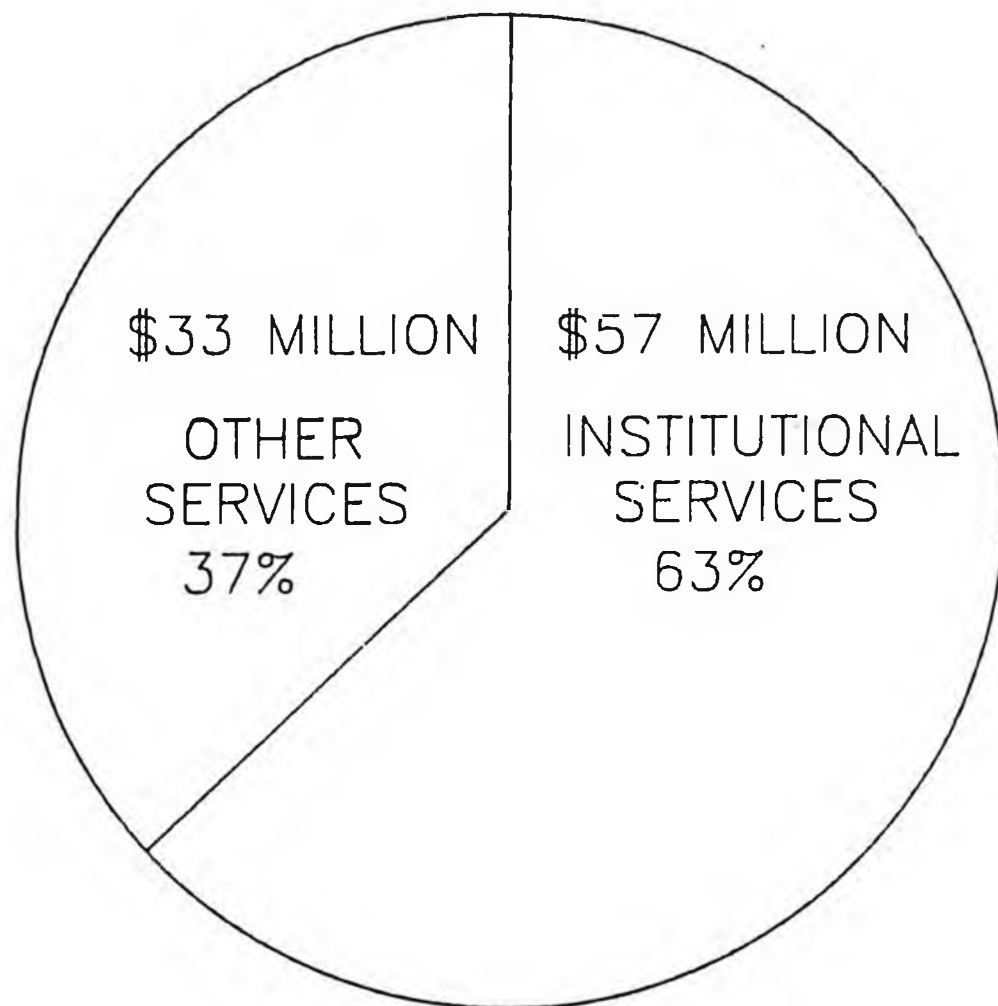
Approved by: Myra Munson

Myra Munson,
Commissioner

Date: March 2, 1988

A

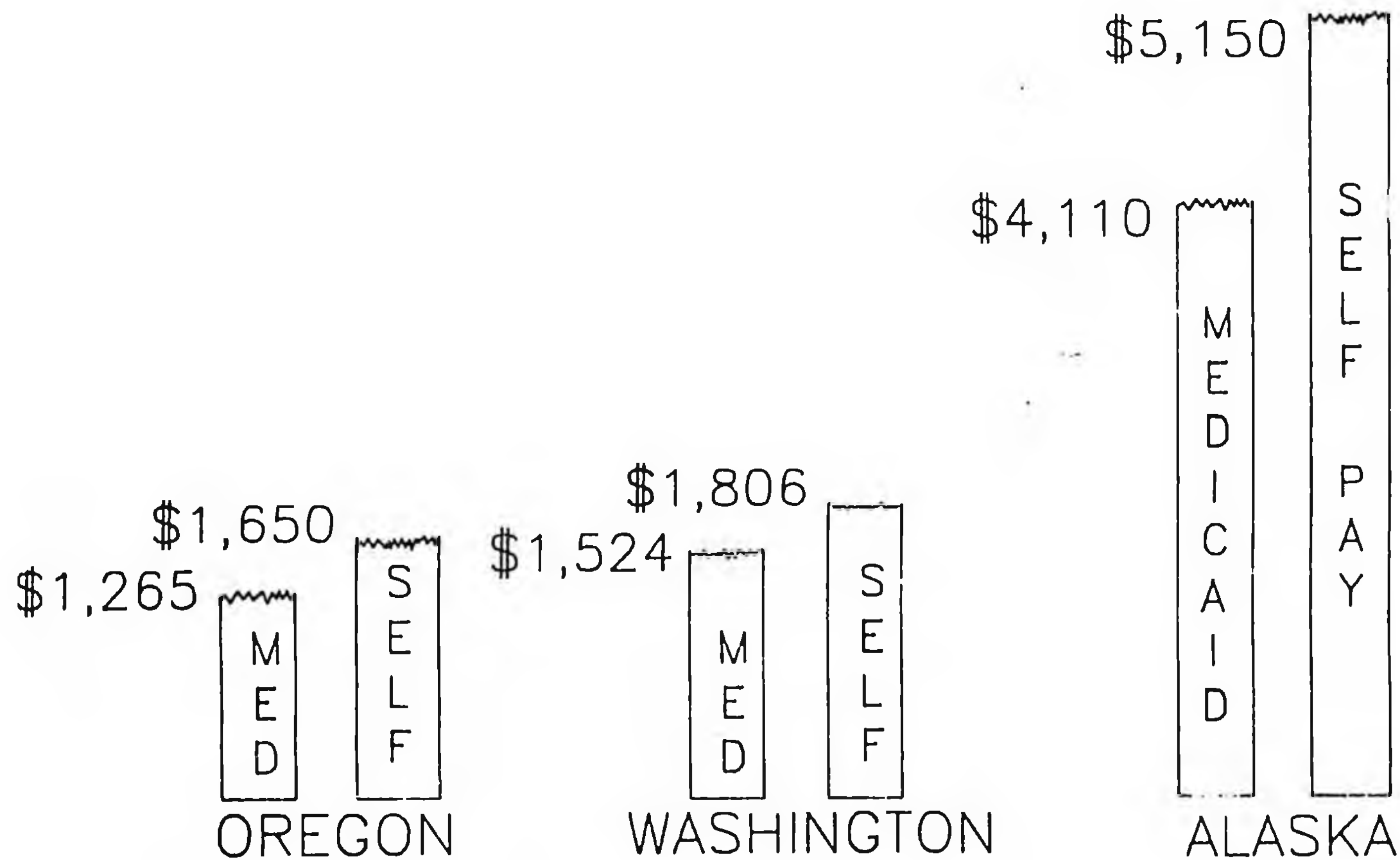
MEDICAID EXPENDITURES
BY TYPE OF SERVICE
FISCAL YEAR 1987



B

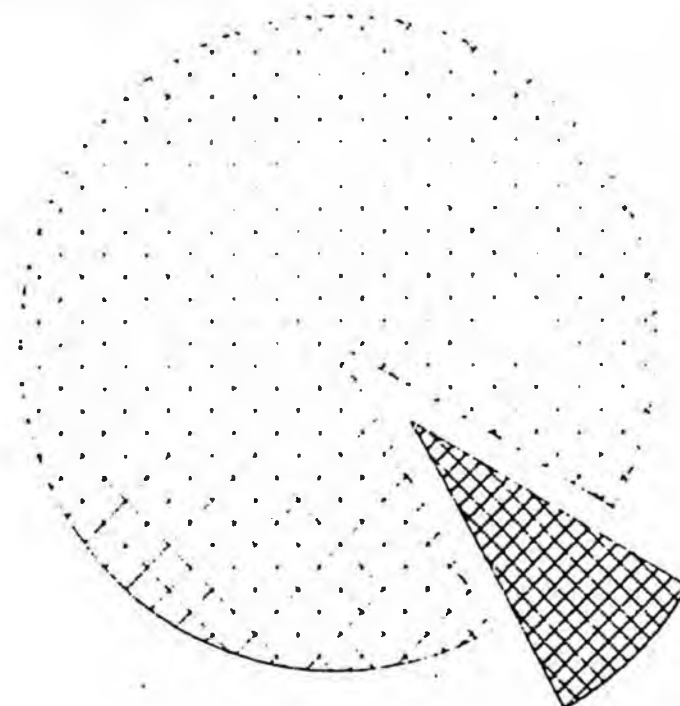
NURSING HOME CARE

TYPICAL MONTHLY COST TO MEDICAID AND SELF-PAYING PATIENTS



PERCENTAGE OF PATIENTS
MEDICAID AND NON-MEDICAID

INTERMEDIATE AND SKILLED NURSING
1982 THROUGH JUNE, 1987

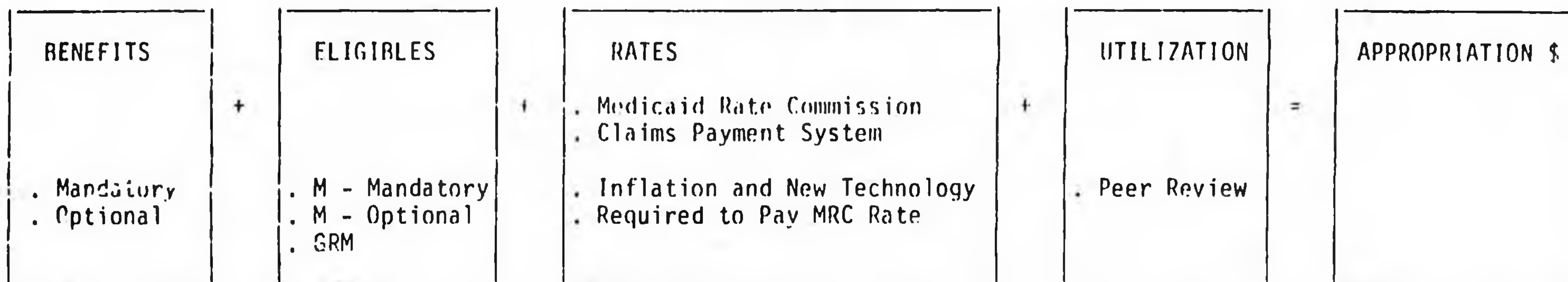


CALENDAR	ANNUAL AVERAGES			PERCENT
YEAR	OCCUPIED	MEDICAID	NON-MEDICAID	MEDICAID
1981	476	450.7	25.2	94.7%
1982	469	439.4	29.5	93.7%
1983	474	442.8	30.8	93.5%
1984	492	444.4	47.8	90.3%
1985	507	454.4	52.6	89.6%
1986	508	449.7	58.1	88.6%
1987	530	469.8	60.5	88.6%

ONLY THE FIRST SIX MONTHS AVERAGE IS GIVEN FOR 1987

D

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 Unm Need

ADMINISTRATIVE INCREMENTS FOR COST MANAGEMENT

. Hearing Officer 2.0
. Auditors 94.6

. Physicians Services 99.5
. Pharmacists Services 103.5
. Continue Pre-Admission Screening 211.8
. Continued Third Party Lability Recoveries

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

COMPARISON OF OREGON TO ALASKA

	ALL DEPTS	ALL DEPTS-NO NURSING	NURSING
AVERAGE WAGE PER HOUR			
ALASKA FACILITIES	$10.85	$10.98	$10.75
OREGON FACILITIES	$7.18	$7.56	$7.03
ALASKA RATIO TO OREGON	1.51	1.45	1.53
AVERAGE HOURS PER PATIENT DAY			
ALASKA FACILITIES	6.95	3.08	3.86
OREGON FACILITIES	5.01	1.42	3.59
ALASKA RATIO TO OREGON	1.39	2.17	1.08

COMPARISON OF OREGON'S HIGHEST COST FACILITIES TO ALASKA'S AVERAGE PER PATIENT DAY COSTS

FACILITY	WAGE PER HOUR	ALL-HRS. PER DAY	NURSING WAGE PER HR.	NURSING - HRS. PER DAY	NON-NURSING WAGE PER HR.	NON-NURSING HRS. PER DAY
ALASKA FACILITIES						
DENALI	$10.91	7.32	$11.27	4.12	$10.45	3.20
HERITAGE	$11.40	6.85	$11.63	3.53	$11.16	3.32
OUR LADY	$10.55	7.56	$10.20	4.25	$11.00	3.31
ST. ANN	$10.22	7.90	$9.55	4.43	$11.08	3.47
WESLEYAN	$11.17	5.10	$11.12	2.99	$11.24	2.11
AVERAGE	$10.85	6.95	$10.75	3.86	$10.98	3.08
OREGON FACILITIES						
CAPITOL VIEW	$6.70	4.74	$7.12	3.46	$5.56	1.28
FRIENDSHIP	$8.10	6.66	$6.81	4.70	$11.19	1.96
MT. VIEW CONV.CTR.	$6.60	3.72	$6.78	2.63	$6.17	1.09
PORTLAND ADVENTIST	$7.14	4.56	$6.99	3.63	$7.73	0.93
ROBISON	$7.34	5.39	$7.44	3.54	$7.15	1.85
AVERAGE	$7.18	5.01	$7.03	3.59	$7.56	1.42

legislature of the ultimate effect of the bill on the foundation program.

Discussion ensued concerning choices under the bill and the impact of last best offer provisions. Senator Josephson advised that the governor, through the legislation, is attempting to promote order and finality to the process.

Senator Ferguson raised concern that teachers and employees do not appear to be "giving up" anything under procedures proposed in the bill. Senator Josephson advised that by supporting the bill, employees are agreeing to the last best offer approach to settlement. In a last best offer situation, the employer may win as much as it loses.

Co-chairman Bennett advised that in the interest of time, SB 78 would be scheduled for further hearing at the next meeting.

SB 85

Co-chairman moved that SB 85 (ACT REPEALING THE CERTIFICATE OF NEED PROGRAM) be brought briefly on for hearing since Mr. Ron Pavellas, Chairman of the Alaska State Hospital Association was present to testify. Mr. Pavellas advised that the Association represents 22 long-term and acute care institutions throughout the state. He noted that SB 85 has undergone numerous revisions and now contains only one provision of a previously multipart bill. Mr. Pavellas explained that provisions relating to payment of Medicaid and other programs are noncontroversial.

The Association supports pending motions dealing with raising the limits on certificates of need from $150.0 to $1 million, as well as repeal of AS 29.90. Senator Josephson advised that he had circulated three amendments; one of which raises the certificate of need exemption to $1 million. The second amendment contains language approved by the House repealing automatic hospital construction funding. To protect facilities entitled to receive state aid as of this date, the third amendment adds a new section which grandfathers these projects. New projects, however, would no longer be automatically funded, since AS 29.90 would be repealed.

Co-chairman Bennett advised that SB 85 would be brought before committee for continued discussion at the next meeting.

ADJOURNMENT

The meeting was adjourned at approximately 10:00 a.m.

The next bill before the committee was SB 85, AN ACT REPEALING THE CERTIFICATE OF NEED PROGRAM; AND PROVIDING FOR AN EFFECTIVE DATE. Senator Josephson reminded the committee that the last time the bill was up, two amendments were passed out. The first raises the threshold of a certificate of need application to $1,000,000 and the other addresses 29.90 of the capital construction program and are pending before the committee.

Mr. Dennis DeWitt from the Alaska Hospital Association testified before the committee. Mr. DeWitt said the proposed committee substitute would create a prospective payment system for the medicaid program which changes from a payment system based on restrospectively determining costs in the medicaid program to prospectively determining what the level of payment will be. In moving from a restrospective to a prospective program, both the payor (State) and the payee (Hospital or other health facility) would both know going into their fiscal year what they might expect in the level of payment. Currently in the program the state does not know precisely what its expenditures are going to be nor does the provider have any idea how many of the expenses which they incur will be reimbursed by the state. The Association believes moving to a prospective payment system will enhance the ability of the state to budget more appropriately. It will also help the provider in terms of determining the level of services that a provider can provide and will be reimbursed for. The first amendment regarding increasing the threshold is one which the Association would support. Raising the threshold makes economic sense.

The second amendment, regarding the repeal of Section 29.90, is one which the Association has great difficulty with. To repeal 29.90 without the repeal of certificate of need seems to be a "quid without quo". The Senate did pass a resolution to establish a hearing on the Certificate of Need process. The Association intends to participate in those and are confident that next year there will be a study available to the legislature.

In answer to Senator Ferguson's question, Mr. DeWitt said that the Lake Otis issue has been resolved in terms, in fact the Department has recended that certificate of need. The language that is in this bill would not impact the Lake Otis situation because this does not repeal certificate of need.

Senator Ferguson asked what would happen in the case of a hospital in a rural area and the state wanted to build it? Mr. DeWitt said under the terms of the proposal before the committee, if the cost of the hospital, nursing home, etc., was less than $1,000,000 the proposer of the project could proceed. If it cost over $1,000,000 it would require a certificate of need. Of course, the chance of that happening is very slim.

Senator Ferguson asked where does the certificate of need for the Kotzeoue hospital tnat he had been working on come from. Mr. DeWitt said in Kotzebue if the state was to replace the hospital through federal funds, it would be exempt from certificate of need. If the state approached it on the basis of a community hospital replaced with a mixture of funds, similar to Dillingham, then there is some question as to whether there would be a certificate of need. If it is clearly a non-federal activity, clearly a certificate of need is necessary. In order to receive a certificate of need, an application must be filed with Health and Social Services.

Senator Josephson summarized that first the Senate passed a resolution for the study of the certificate of need program, the proposal for a $1 million threshold is designed to relieve some of the problems for those who have to present their request for a new boiler or new hot water system through the certificate of need program, the prospective payment element is designed to allow the state to better plan its expenditures and will also relieve Alaska from being under national payment schedules.

Mr. Mason Anderson, Acting Chief of Medical Assistance, was available to the committee to answer any questions regarding prospective payment.

Senator Faiks asked what the rationale was for repealing 29.90?

Senator Josephson said under the existing statute hospital construction projects automatically qualify for state assistance. It is an effort to get a better handle on all state substidies. The repeal would still allow the legislature to appropriate for specific capital projects in the hospital field on a case by case .

Senator Josephson MOVED the three amendments. No objection having been raised, the amendments were ADOPTED. Senator Josephson MOVED CSSB 85 (Fin) with the amendments with individual recommendations. No objection having been raised, the MOTION PASSED. All members on the committee signed DO PASS, except Senators Bennett and Sackett who signed NO RECOMMENDATION.

SJR 24

SJR 24, REQUESTING THAT ALASKA BE EXEMPTED FROM LEGISLATION ALLOWING ABROGATION OF EXISTING NATURAL GAS CONTRACTS, was assigned to Senator Josephson. He stated that this resolution was approved by the Resources Committee and the committee action was unanimous. The information provided indicates that the Regan Administration introduced legislation amending the natural gas policy act of 1978. The proposal attempts to combine phase decontrol of gas prices with measures enabling gas pipelines, and producers to get out of long-term contracts that are believed to be keeping prices so high. SJR 24 asks Congress to exempt Alaska

hf0624830830

HOUSE FINANCE COMMITTEE
June 24, 1983
8:30 A.M.

(Tape HFC 83-81, Side 2, #212)

CALL TO ORDER

Chairman Adams called the meeting to order at 8:30 A.M. and informed members they would be considering SB 85, SB 260 and SB 314.

PRESENT

All members of the committee were present except Representative Hurlbert and Ward. ALSO PRESENT: Rod Betit, Director, Division of Public Assistance, Dennis Dewitt, President, Alaska State Hospital Association, Sam Keto, Ancorage, and Representative Jack McBride.

SB 314 - Making a supplemental appropriation for the operation of the legislature.

Chairman Adams stated SB 314 would provide $403,500 supplemental funding for the operation of the legislature from the 150th day to the 165th day of the session. This amounts to approximately $26,900 per day with the lapse day being August 31, 1983 allowing legislative affairs time to close out the books for this fiscal year.

Representative Martin MOVED to Report Out of Committee CSSB 314, and asked UNANIMOUS CONSENT. There being NO OBJECTION, it was so ordered.

CSSB 314 was Reported Out of Committee.

SB 85

SB 85 - Amending or repealing provisions related to state aid for health facilities, certificate of need, Medicaid and general relief medical assistance.

Chairman Adams stated SB 85 was very similar to the House Finance Committee version of HB 19 which was passed out of committee two months ago. He said the bill provides that the only capital expenditures for health facilities of $1 million or more require a certificate of need. It also institutes a perspective payment plan system for the reimbursement providers of health care under the medicaid and medicaid programs. It repeals revenue sharing for hospital construction but grandfathers those facilities currently receiving the funds until they receive their 25% share

as established in the current law. Chairman Adams stated . had prepared a fiscal note which was the same as the fiscal note passed out in HB 19.

ROD BETIT, Director - Division of Public Assistance, stated SB 85 was a priority piece of legislation not only for the Department but also for the Governor's office. He stated the provisions contained in the bill were highly acceptable to the Department. He stated the prospective reimbursement package in the bill was extremely important as without it they would have to, under the advice of the Attorney General's office, reduce rates to hospitals and nursing homes around the state. This he stated would cause a severe financial impact, causing some to receive a 30 % reduction in revenues received from the Department. Mr. Betit stated the nursing homes in Alaska receive approximately 95% of their funding from the Medicaid program.

Representative Martin asked if the Alaska Medical Association was in concurrance. Mr. Betit said they have agreed to the system. Representative Martin referenced the revenue sharing stating they had lost $25 million in contruction costs, and asked if there was a provision from the Department that if a private party would buy up the hospitals they pay the state back, refencing the Teamsters Hospital. Mr. Betit stated to his knowledge there was no such provision, but would look into it.

Representative Zharoff referenced page 2, the reports by Health Facilities, and asked if actually takes 120 to put the reports together. Mr. Betit stated that had been the standard time-line they had given the facilities to get their books closed etc. He stated that was an adequate time for them to put them together and still give the Commission an opportuinity to look at them and come in with an amended buget and any variations by facility before the legislature would convene. Representative Zharoff asked if all the Health Facilities were on the same fiscal year as the state. Mr. Betit stated they were not, some being on the calander year and some on the state fiscal year, and some on an April through March fiscal year. Representative Zharoff asked if that created any problem. Mr. Betit stated that it did in that everybody does not come into the commission at the same time with their cost reports, but they have not had any great difficulty with it.

DENNIS DEWITT, President of the Alaska State Hospital Association, stated the Association was asking for a DO PASS recommendation on the bill and a YES vote on the floor.

Representative Bettisworth MOVED to Report Out of Committee CSSB 85 (Fin), and asked UNANIMOUS CONSENT. There being NO OBJECTION, it was so ordered.

CSSB 85 (Fin) was Reported out of Committee with a DO PASS recommendation.

Alaska State Legislature

Senate

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April 5, 1983

TO: Senate Community and Regional Affairs Committee Members

FROM: McKie Campbell, Committee Staff

SUBJECT: CSSB 85

Attached is a brief history of the certificate of need in Alaska prepared by staff to the Committee and an accompanying excerpt from a paper prepared by the Alaska Health Coalition that very briefly describes how the C.O.N. process works in Alaska.
Immediately beneath these is a position paper and fiscal note from the Department of Health and Social Services. These documents are the only new additions to the informational packet since last Tuesday's meeting.

gislature

Pouch V
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Juneau, Alaska 99811

April 5, 1983

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Committee on
Community & Regional Affairs

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BRIEF HISTORY OF ALASKAN CERTIFICATE OF NEED

In the early 1970's, Certificate of Need appears to have been a topic much on the minds of hospital administrators and other health care professionals.

In Alaska the issue mainly centered on the situation in Anchorage. Providence Hospital was trying very hard to become a major referral hospital where patients from Alaska with serious medical problems could be referred instead of being sent down south. Anchorage Community Hospital was in the process of transforming itself into Alaska Hospital while at the same time coping with a relatively high vacancy factor.

In this same period the federal government had passed PL 93-641, the federal C.O.N. law, and plans for Lake Otis Hospital were being discussed. There was strong feeling among the administration at Providence Hospital that it needed to achieve a certain size or critical mass to be able to support the special programs and attract the doctors necessary to be a major referral hospital. This feeling was mixed with concern that the creation of a new hospital (Lake Otis) would seriously hinder Providence's effort to reach the size it felt necessary. There was speculation that the C.O.N. process might prevent the creation of Lake Otis.

In 1976 Alaska's C.O.N. statute (18.07.031-18.07.111) was proposed. This was in response to the potential cutoff of federal health care aid if Alaska did not enact such a law. During this period the C.O.N. process was vigorously supported by the Carter Administration.

Representatives of the Hospital Association state that the Association was opposed to C.O.N. when Alaska passed its bill in 1976, but felt that federal pressure made passage of the bill inevitable. Senators who were here in 1976 can evaluate this assertion. Because of this perceived inevitability, the Association says it supported the C.O.N. bill in an attempt to get the most favorable bill possible. Even with its present C.O.N. law Alaska is not in full compliance with federal law.

In 1981 the Board of Directors of the Alaska Hospital Association passed a motion committing the Association to working towards the repeal of C.O.N. in Alaska. It is worth pointing out that a change in the national political climate had occurred with the Reagan administration in office and strongly opposed to the C.O.N. process. The threatened cutoff of federal health care funds (approximately five million dollars for Alaska) had also been suspended by a continuing resolution of Congress. Though it is certainly a gamble, many observers are convinced that the cutoff of federal funds will not be imposed if Alaska repeals its C.O.N. law.

Today a number of changes have taken place in Alaska and particularly in Anchorage that affect the Hospital Association's views on C.O.N. Providence has become a major referral hospital for Alaska. Anchorage Community Hospital became Alaska Hospital and is now Humana Hospital. Lake Otis, contrary to some expectations, received the first C.O.N. issued in Alaska. Lake Otis still has its C.O.N. but due to financial and legal problems has not yet been built.

If C.O.N. is repealed it appears likely that financing to construct Lake Otis would be extremely difficult to obtain.

CERTIFICATE OF NEED PROGRAM

Coalition, 2/83

PURPOSE

The most controversial aspect of the health planning effort, in Alaska and nationwide, has been the Certificate of Need (CON) program. Borrowed from public utility regulations, the earliest CON program was enacted by New York in 1964. Twenty-six other states instituted CON programs in the next ten years, and, with the passage of Public Law 93-641, CON was mandated for all states. Alaska's Certificate of Need statute (18.07.031-.111) was enacted by the State Legislature in 1976 and amended in 1981.

As originally designed, the CON program was implemented to curb rapidly escalating costs of health care by stemming uncontrolled capital investments in new health-care facilities, services, and high-technology equipment. To accomplish this goal, the CON program had several primary objectives: 1) to prevent unnecessary duplication of services and facilities; 2) to reduce the number of available hospital beds or at least not allow the growth of hospital beds to exceed guidelines established in the State Health Plan; 3) to promote an equitable and efficient allocation of resources; and 4) to determine if less costly alternatives to expensive capital expenditures were available to accomplish the same purpose.

CON

WHO MUST APPLY

The State of Alaska requires approval of capital expenditures for projects which meet or exceed certain thresholds:

1. Capital expenditures in excess of $150,000 toward building, improving, or purchasing a health care facility, including lease or purchase of equipment, costs of any study surveys, designs, and site acquisitions and preparations.

2. Any change within a two-year period in the licensed bed capacity of a health care facility amounting to 10 beds or 10 percent, whichever is the lesser, which increases or decreases the number of beds or redistributes beds among different categories of service.

3. Any addition or elimination of a major type of service offered in or through the health care facility.

A project meeting or exceeding these thresholds is required to obtain a Certificate of Need from the State of Alaska prior to implementation.

THE PROCESS

An applicant enters the CON review process by su
of Intent" to the Department of Health and Social Ser
the appropriate health systems agency describing brie
the proposed activity. If the DHSS determines that t
subject to CON review, the applicant develops a forma
submits it to the State agency and the regional healt
In most cases, a pre-application conference is schedu
applicant to minimize any potential misunderstandings
agreement on what would represent a successful applic
State agency certifies that the application is "compl
contains sufficient information necessary to conduct
-- the agency has 90 days to review the application
analysis to the Commissioner of DHSS for final action
90-day review period, the regional health planning a
review and seek public comments on the appropriatenes
application. The HSA submits its findings and recom
Commissioner. Once the Commissioner has considered
has been submitted, he decides whether or not to iss
Need to the applicant. The Commissioner notifies th
writing of the decision. Copies of the decision are
Systems Agency and are published in regional newspap

THE PROCESS

An applicant enters the CON review process by submitting a "Letter of Intent" to the Department of Health and Social Services (DHSS) and to the appropriate health systems agency describing briefly the scope of the proposed activity. If the DHSS determines that the project is subject to CON review, the applicant develops a formal application and submits it to the State agency and the regional health systems agency. In most cases, a pre-application conference is scheduled with the applicant to minimize any potential misunderstandings and to achieve an agreement on what would represent a successful application. Once the State agency certifies that the application is "complete" -- that it contains sufficient information necessary to conduct an objective review -- the agency has 90 days to review the application and to submit an analysis to the Commissioner of DHSS for final action. Within the 90-day review period, the regional health planning agency has 60 days to review and seek public comments on the appropriateness of the proposed application. The HSA submits its findings and recommendations to the Commissioner. Once the Commissioner has considered the information that has been submitted, he decides whether or not to issue a Certificate of Need to the applicant. The Commissioner notifies the applicant in writing of the decision. Copies of the decision are sent to the Health Systems Agency and are published in regional newspapers.

Official Business

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MEMORANDUM

TO: Norma Lang
Legislative Liaison
Department of Health &
Social Services

DATE: 31 March 1983

FROM: McKie Campbell
Professional Assistant
Senate Community & Regional
Affairs Committee

SUBJ: CSSB 85(HESS)

This is a written follow-up of my request of April 24 for a fiscal note and position paper on CSSB 85(HESS). This bill will be in front of committee again on Tuesday, April 5, 1983.

It would be most helpful if the Department would detail the fiscal impact of this bill by section, showing potential savings to the state as well as costs.

In last Tuesday's committee meeting Senator Sackett requested a history of Certificate of Need. Senator Sackett also said it was his impression that in the late 1970's and very early 1980's Providence Hospital and the then Alaska Hospital had supported the C.O.N. process. Both Providence and Humana hospitals are now supporting the repeal of the C.O.N. Senator Sackett requested an explanation of this apparent reversal of policy. Any assistance you can provide the committee on this history or explanation would be appreciated.

ALASKA STATE SENATE

JOE P. JOSEPHSON
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JUDICIARY (VICE-CHAIR)
FINANCE
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MAR 23 REC'D

21 March 1983

Hon. Frank Ferguson
Chairman
Committee on Community & Regional Affairs
Alaska State Senate
Juneau

FOR HAND DELIVERY

Dear Frank:

The HESS Committee considered SB 85, relating to the Certificate of Need program, and voted to replace SB 85, whose original sponsor was Senator Faiks, with CSSB 85, which is now in possession of your Committee on Community and Regional Affairs.

The HESS committee substitute has widespread support, including support from the Alaska State Hospital Association and the administration. In addition, the committee substitute will save considerable money, as described in the attached exhibit entitled "Fiscal Effects of CS For SB 85 (HESS)".

I would be glad to explain this rather complex legislation to you and your staff, or to appear at a committe hearing. Because of the need of health care facilities to know whether or not they must proceed with certificate-of-need processes for planned construction, I would urge the earliest possible consideration of the bill in your committee.

With best wishes,

Sincerely,

Joe P. Josephson

enclosure

cc: Senator Faiks

FISCAL EFFECTS OF CS FOR SB 85 (HESS)

SUSPENSION OF HOSPITAL CONSTRUCTION FUNDING -AS 29.90

$46.4 million dollars of state hospital construction funding will be saved for the $185.6 million expansion of Providence Hospital, and untold millions of dollars for any other hospital expansion project during the period of suspension.

CAP ON HOSPITAL REVENUE SHARING

By limiting available revenue sharing to 250 acute care beds per facility, the state will save a yearly amount of $150,000 on the planned expansion of Providence Hospital - 150 beds.

PROSPECTIVE PAYMENT PROGRAM

Projected to save 1-3% of growth in Medicaid and General Relief Medical Programs, Prospective Payment would save the state between $437,000 and $1,311,700, based on FY 84 payment levels of these programs to hospitals and nursing home facilities ($43,726.2 from the Governor's proposed budget).

Position Paper
C.S. for Senate Bill 85

An Act suspending the certificate of need program, amending provisions related to assistance for health facility construction, Medicaid and general relief medical assistance, and providing for an effective date.

I. General Overview

Hospital and Nursing Home rates in Alaska have traditionally been established retrospectively, that is, costs are estimated at the beginning of a fiscal year and an "interim payment" determined. At the end of the fiscal year, the total of interim payments made is compared to the allowable costs of the facility. The difference is either collected from or paid to the facility. This process is referred to as "cost settlement".

Prospective payment, on the other hand, provides for establishment of the payment rate prior to the fiscal year as a result of discussions between each facility and the State, each facility must then operate and provide care at this predetermined rate for the fiscal period.

While the retrospective method assures providers that all of their allowable costs will be reimbursed, a fundamental weakness of these retrospective systems is the lack of incentives to control staffing levels, equipment purchases, wage increases, and service expansion.

In view of reduced federal revenues and a new state spending limit, Alaska needs improved cost containment and predictability from its medical reimbursement system. The system must not only consider price, but also eligible groups and service coverages before the budget year commences. It also must consider the differences in "rural" and "urban" health delivery problems.

II. Problems with Retrospective Cost-Based Reimbursement Systems

- Tendency toward ineffective cost containment -- The key problem with a retrospective system is the lack of incentives to control expenditures so that unnecessary costs are avoided.

- Dependence upon auditing and monitoring procedures -- A retrospective system must have a tight, effective auditing system to monitor costs in order to curb abuses of the system.

- Tendency of the system to become inflexible -- Decisions are often made by accountants based on "generally acceptable accounting principles" rather than on the merits of each individual facility's situation.

- State is uncertain of total program costs until the fiscal period is well over -- Final cost figures may not be known to the State until 6 months after a fiscal year ends.

POSITION PAPER/Department of Health & Social Services

- Cost Shifting occurs where unallowable costs under Medicaid are borne by other payors (insurance and private payors).

III. Advantages of a Prospective Payment System

- **Based on the principle that predetermined rates will result in lower costs.** A 1982 study by THE URBAN INSTITUTE concluded that prospective systems lower the rate of increase in hospital spending by several percentage points a year, after an initial start-up period.

- Predictability of costs to the State. Prices are agreed upon by the facilities and the State before the fiscal period starts.

- Predictability of revenues to the facilities. The industry can negotiate wages, purchases and other business decisions with a set service price in mind.

- The technique encourages development of more sophisticated budgeting and cost monitoring capabilities. These are desirable management tools and will permit the State to see how a facilities' budget is built and discuss their assumptions in each of the major cost categories.

IV. Disadvantages of a Prospective Payment System

- Administrative costs are generally greater than those of a retrospective system. However, administrative costs vary greatly according to the design of the system, and as such, this factor is not of significant concern when compared to the total dollars being monitored in the health area.

- Arbitrary cost limiters ("FREEZES", "LIDS") may be introduced into the prospective system to balance costs versus revenues. This eventually places hospitals and nursing homes in a "no win" situation since the rates do not fairly reflect efficiently run facilities' costs.

- If rates are not applied industry wide, cost shifting can still occur if Medicaid rates are set unrealistically low by the State based on arbitrary limiters.

V. Operation of a Prospective Payment System

There are a wide variety of prospective payment systems operated in the acute-care and long-term care sectors around the nation.

A common element of a prospective rate payment setting mechanism is an allowable rate of increase in per diem cost for the following year. This percentage is normally calculated through application of economic indicator such as U.S. Department of Labor wholesale and consumer price

indexes. The percentage is then routinely applied to actual cost from the previous period to arrive at the prospective rate. Determination of allowable rates of increase can be undertaken either on an individual facilities or groups of facilities.

Another element of a prospective payment system is more precisely defined cost categories combined with a uniform method of reporting costs to the State. A common cost breakdown would be labor vs. non-labor with further categorization inside these areas. The following example uses "natural" expense categories in reporting facility costs.

- Labor expenses
  - physician's fees
  - management
  - clerical
  - technical (e.g., LPNs'; therapists)
  - registered nurses
  - household services (e.g., dietary, housekeeping workers)
- Non-labor expenses
  - food
  - utilities
  - drugs and supplies
  - maintenance of personnel
  - other

While some level of categorization is necessary to assure accuracy of prediction, the model outlined above may require an excessive level of accounting time and expertise for some of Alaska's smaller facilities. The compromise approach shown below may suffice:

- Salaries and fringe benefits
- Non-labor expenses
  - administrative and general
  - household and maintenance
  - dietary
  - professional care

VI. State Reimbursement Trends

To date, approximately thirty-four states have instituted a prospective system of reimbursement for nursing home services under Medicaid, and sixteen states have instituted a prospective system of reimbursement for hospital services under Medicaid. These prospective systems have taken many forms, each state's structure is a little different. However, they share the same philosophical purposes: "to encourage economy and efficiency, and to establish a uniform system of accounting, budgeting, and reporting in determining a health facility's future reimbursement".

VII. Why Alaska Should Consider Prospective Payment Now

1. Total overall spending is growing at 20% each year in Medicaid/GR Medical.

   In any period, total spending is always a function of, 1) the number of recipients, the volume of services used, and the unit price of service. With an automatic cost-of-living increase that expands Alaska's eligible population, coupled with no unit price control or volume limits, Alaska currently has no ability to effectively control growth in medical costs.

   According to a recent study by THE URBAN INSTITUTE, Medicaid payments rose at an annual rate of 15.5 percent from FY73 to FY79 nationally. Alaska had the highest annual rate of increase at 41.8 percent during this same period. Since FY79, costs have increased in excess of 20% annually in Alaska.

   These three factors (recipients, volume, and unit price) need to be considered collectively in any fiscal year. Currently, critical decisions concerning eligible populations, service coverages and unit price are handled independent of each other and do not produce a final cost figure until the fiscal year is past. If total spending is to be contained at a level below 20%, these factors must be considered collectively before each fiscal year starts.

2. Federal funding for Medicaid is reduced in FY84 and later years. The State is facing an unknown dollar cutback in federal funding for FY84. Unless additional State funding replaces these lost federal revenues, critical decisions must be made to bring program spending in line with available resources.

3. Prospective Systems reduce costs in the long term. The Urban Institute recently concluded that "a consensus is now developing that prospective rate setting is effective in lowering the rate of increase in hospital spending by several percentage points a year, at least in mature rate setting programs after an initial start-up period".

VIII. Why Doesn't the Department of Health and Social Services Simply Adopt Prospective Payment by Regulation?

The Legislature must specifically endorse adoption of a prospective system in Alaska. The Alaska Attorney General has ruled in a 1982 opinion that present Alaska Statutes prevent adoption of a prospective payment system by regulation. The legislature must change Alaska Statutes to clearly authorize the Department to adopt a prospective system.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER/Department of Health & Social Services

IX. What Options Exist?

1. Do Nothing. This strategy would leave reimbursement in the present retrospective environment and require the Department to pass reductions in federal revenues on to hospitals and nursing homes through reduced rates. Most recent calculations place Hospital and nursing home revenue reductions at 8% and 24% respectively for FY84. This strategy would not require any additional funds beyond the FY84 Governor's request for Medical Assistance but would severly impact Alaska facilities.

2. Remain on retrospective system and replace lost federal revenues with State funds, if State law permits. This strategy will require replacement funds and may require a statute change as well. There is some doubt whether the present statutes would permit the Department to pay rates in excess of the federal limits.

3. Same as option #2 but reduce persons eligible and medical services available. Under existing Alaska law, the Department is empowered to eliminate certain medical services and certain eligibility groups if funds were deemed inadequate for FY84. If it were determined that the Department could pay in excess of new federal limits with all State funds, or legislation were passed to permit this, the Department could make reductions in services and eligible groups to stay within its FY84 request.

4. Adopt Prospective System and replace lost federal revenues with State funds. This strategy will cost roughly the same as Option #2 but FY84 costs could be predicted with greater certainty. Assuming no changes were made in medical services covered or persons eligible, this option would save the State from 1 to 3% annually compared to Option #2 after the initial start-up period.

5. Adopt Prospective System but reduce persons eligible and medical services available. Herein lies the true value of a prospective system. Once the prospective rules are established and the rates (unit price) for services agreed upon for the fiscal year, eligible groups and medical services are then balanced against unit price to operate within the available appropriation. If no changes were made in persons covered or services offered, the price for this option would be the same as Option #4. If major reduction in eligibles or services were made, the costs for this option could be reduced proportionately.

6. Seek Relief from Congress. This is always an option but not one with as much potential in light of Alaska's present financial image. Nonetheless, there is provision within the new federal changes for special negotiation with the Secretary of Health and Human Services regarding "rural" hospitals. Alaska could pursue this option in conjunction with one of the strategies described in Option 1 through 5 above.

POSITION PAPER/Department of Health & Social Servic

XI. MAJOR PROVISIONS OF SB 85

Section 1: An excellent declaration of policy.

Section 6: Deletes that portion of AS 29.89.030 that provides payment of $1,000 per bed to a municipality that has the power to provide hospital facilities and services, but leaves the alternative payment of $250,000 per hospital in place. The provision of a $250,000 payment is primarily based upon the premise that most Alaskan hospitals are small in size with significant occupancy problems and, consequently, significant financial shortfalls.

Section 7: Provider authority to the Medicaid Rate Commissioner to determine prospectively a rate of payment to health facilities and establishes factors that must be considered in setting rate.

Section 8: Provides for Uniform Accounting, Budgeting and Financial Reporting, requires. Requires reports by the health facilities and the Rate Commissioner and provides for audits and appeals.

Section 10: Establishes the Medicaid Rate Commission, its composition, appointment of members, term of membership and employment of personnel.

Section 12: Provides authority for the Department to establish an interim system of prospective payments for the period 7/1/83 to 6/30/84.

Section 14: Suspends the operation of the certificate of need program for a period of seve years. The Administration has previously supported legislation which would repeal the certificate of need program. The Department views the provision in CSSB85 as an alternative which is similar to repeal.

Section 15: Repeals the definition of "Cost settlement" in AS 47.07.080(1).

Section 17: Establishes an effective date.

POSITION PAPER/Department of Health & Social Servic

Department's Position

The Department of Health and proposed.

4/4/83
Date

4/4/83
Date

4/4/83
Date

4/4/83
Date

POSITION PAPER/Department of Health & Social Services

Department's Position

The Department of Health and Social Services supports this legislation as proposed.

Date 4/4/83 — Robert London Smith, Ph.D., Commissioner, Department of Health and Social Services

Date 4/4/83 — John Pugh, Deputy Commissioner for Social Services, Department of Health and Social Services

Date 4/4/83 — Dan Meddleton, Director, Division of Planning, Policy and Program Evaluation

Date 4/4/83 — Rod Betit, Director, Division of Public Assistance

Bill/Resolution No.:
Title: Prospective Rate Setting
Sponsor:
Requestor:

EXPENDITURES/REVENUES: (Thousands

OPERATING
100 PERSONAL SERVICES
200 TRAVEL
300 CONTRACTUAL
400 COMMODITIES
500 EQUIPMENT
600 LAND & STRUCTURES
700 GRANTS, CLAIMS, ETC
TOTAL OPERATING

CAPITAL

REVENUE

FUNDING: (Thousands of Dollars)
GENERAL FUND
FEDERAL FUNDS
OTHER (Specify Source)

POSITIONS:
FULL-TIME
PART-TIME
TEMPORARY

III. SOURCE OF FUNDS TO OFFSET FISCAL

IV. ANALYSIS: Attach a separate pa

Prepared By:
Division: Public Assistance

Approved by Commissioner: X
Department: 4/6 83

Distribution:
Original to Legislative Finance
Copy to Office of Management a
Copy to Department (for Govern
Copy to Sponsor

POSITION PAPER/Department of Health & Social Servic

Position Paper

on

Senate Bill 85

"For an Act repealing the certificate of need program; and providing for an effective date."

Senate Bill 85 repeals those portions of AS 18.07.021 which provide the statutory authority for the Department to administer a certificate of need program and repeals references to certificate of need in other sections of the Statute as well.

The Administration supports Senate Bill 85 as it is currently written.

The Department recommends that the Committee review statutory provisions which relate to health facility development including the following:

Medicaid Program

The state's participation in the Medicaid program (State dollars fund approximately 52 percent of total program costs) has grown from $1 million in 1972 to nearly $38 million in FY 82 and total costs including federal participation have grown from $2 million to nearly $74 million in this same period. Ninety-two percent of patients in Alaska's long term care facilities are supported by the Medicaid program which means that the state (and federal) government has nearly the full burden of all operational costs for the facility. These Medicaid costs increase when additional beds are added, new equipment is purchased or new services (including new types of manpower) are offered. The Division of Public Assistance must effect a provider agreement with any qualified provider who seeks this agreement.

Capital Budget

Alaska has provided substantial financial assistance in the development of health care facilities. The 12th Legislature provided more than $36.6 million by line item appropriation to expand one hospital, replace two others and provide planning assistance for two rural hospitals. The number of requests for state funding has steadily increased.

Revenue Sharing

Alaska has a revenue sharing program (AS 29.90.010) which provides 25 percent plus interest of hospital construction costs to all non-profit hospitals. This program, administered by the Department of Community and Regional Affairs, provides further support for hospital construction projects in addition to any front-end capital funds provided by the state. This additional health facility construction resource underscores the importance of determining the actual need

LAKE OTIS COMMUNITY HOSPITAL

LAKE OTIS CLINIC, INC. P.O. BOX 4-1539 ANCHORAGE, ALASKA 99509
(907) 278-3186

BOX 4-1539 ANCHORAGE, ALASKA 99509
(907) 278-2156

...ms regarding HB 19.

N legislation, I think
...ed.

March 18, 1985

Representative Al Adams
Chairman of Finance Committee
Pouch V
Juneau, Alaska 99811

Re: HB 19
Repeal of Certificate of Need

Dear Representative Adams:

This Bill would permit Providence Hospital to "neuter" my hospital franchise. Neutering can be evil. I object to neutering. Please do not pass this Bill. If passed it not only would mean the end of our Lake Otis Hospital Project in Anchorage, but in addition all small hospitals would have to step aside and leave the field to the big corporations exclusively. This is not in the public interest.

The Certificate of Need law, in effect since 1977, does help to control hospital expansions and therefore "costs" to the patient, or whoever pays the bills including the State. The present law should be modified, however, to permit hospitals to spend up to One Million Dollars without a permit. But the law should require a permit whenever new beds are added.

In effect, in Alaska we have the "franchise" system. And it works well. The record is clear. All 50 states have this system under federal guidelines.

In 1977, Lake Otis was issued a Certificate of Need (the franchise) by the State in compliance with the new law. Shortly thereafter Providence Hospital and others initiated a series of legal maneuvers effectively creating a "legal cloud" on this particular Certificate of Need which blocked access to all financing "until such time as all litigation ceases".

Since the Certificate of Need was issued in 1977, five major lawsuits have been filed against us. To date, we have won three of these lawsuits. A fourth case is now awaiting decision. The fifth and last lawsuit has perhaps another year to go in Superior Court. This is the case filed by Providence Hospital more than three years ago. We won this case in the trial courts on Summary Judgement. Providence took it to the Supreme Court which at first concurred with the trial court, but then on petition from Providence agreed to send the case back to the trial court for review of a single point. We will win this case. It is a great world.

During these past five years, the big hospital corporations have maintained that there was no need for addition beds in the community. Now they claim there is a "crisis". In addition, now the big hospital corporations are asking you to repeal the CON law so that they may expand their hospital and serve the public which so desperately needs their beds now. What they obviously cannot win in court, and they can't, they now seek to obtain by "neutering" our franchise. This is not very nice at all.

We have proceeded on this project in good faith. Our Certified Public Accountants have testified in two separate courts that I have personally invested more than Two Million Dollars in this project. I estimate that an equal amount has been consumed by this project as provided by me and others over the years, exclusive of my time and my personal services. The State has repeatedly testified that our CON (franchise) is valid. The State is even a co-defendant with us in the Providence lawsuit. We just want to proceed with our project.

So, in closing, let me remind you that "neutering" can be a mortal sin. A person with a mortal sin on his soul is not admitted to Heaven. Please don't let Providence and the others commit that sin. Do not repeal Certificate of Need law.

Sincerely,

Your humble and devoted tax payer

Dr. Mike B[illegible]
President
Lake Otis Clinic, Inc.

MB/cm

DIVISION OF PUBLIC ASSISTANCE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
STATE OF ALASKA

Rod Betit, Director
February 28, 1983

PROSPECTIVE VS. RETROSPECTIVE PAYMENT IN RELATION TO MEDICAL ASSISTANCE UNDERTAKINGS

I. General Overview

Hospital and Nursing home rates in Alaska have traditionally been established retrospectively, that is, costs are estimated at the beginning of a fiscal year and an "interim payment" determined. At the end of the fiscal year, the total of interim payments made is compared to the allowable costs of the facility. The difference is either collected from or paid to the facility. This process is referred to as "cost settlement".

Prospective payment, on the other hand, provides for establishment of the payment rate prior to the fiscal year as a result of discussions between each facility and the State, each facility must then operate and provide care at this predetermined rate for the fiscal period.

While the retrospective method assures providers that all of their allowable costs will be reimbursed, a fundamental weakness of these retrospective systems is the lack of incentives to control staffing levels, equipment purchases, wage increases, and service expansion.

In view of reduced federal revenues and a new state spending limit, Alaska needs improved cost containment and predictability from its medical reimbursement system. The system must not only consider price, but also eligible groups and service coverages before the budget year commences. It also must consider the differences in "rural" and "urban" health delivery problems.

II. Problems with Retrospective Cost-Based Reimbursement Systems

- Tendency toward ineffective cost containment -- The key problem with a retrospective system is the lack of incentives to control expenditures so that unnecessary costs are avoided.

- Dependence upon auditing and monitoring procedures -- A retrospective system must have a tight, effective auditing system to monitor costs in order to curb abuses of the system.

- Tendency of the system to become inflexible -- Decisions are often made by accountants based on "generally acceptable accounting principles" rather than on the merits of each individual facility's situation.

- State is uncertain of total program costs until the fiscal period is well over -- Final cost figures may not be known to the State until 6 months after a fiscal year ends.

- Cost Shifting occurs where unallowable costs under Medicaid are borne by other payors (insurance and private payors).

III. Advantages of a Prospective Payment System

- Based on the principle that predetermined rates will result in lower costs. A 1982 study by THE URBAN INSTITUTE concluded that prospective systems lower the rate of increase in hospital spending by several percentage points a year, after an initial start-up period.

- Predictability of costs to the State. Prices are agreed upon by the facilities and the State before the fiscal period starts.

- Predictability of revenues to the facilities. The industry can negotiate wages, purchases and other business decisions with a set service price in mind.

- The technique encourages development of more sophisticated budgeting and cost monitoring capabilities. These are desirable management tools and will permit the State to see how a facilities' budget is built and discuss their assumptions in each of the major cost categories.

IV. Disadvantages of a Prospective Payment System

- Administrative costs are generally greater than those of a retrospective system. However, administrative costs vary greatly according to the design of the system, and as such, this factor is not of significant concern when compared to the total dollars being monitored in the health area.

- Arbitrary cost limiters ("FREEZES", "LIDS") may be introduced into the prospective system to balance costs versus revenues. This eventually places hospitals and nursing homes in a "no win" situation since the rates do not fairly reflect efficiently run facilities' costs.

- If rates are not applied industry wide, cost shifting can still occur if Medicaid rates are set unrealistically low by the State based on arbitrary limiters.

V. Operation of a Prospective Payment System

There are a wide variety of prospective payment systems operated in the acute-care and long-term care sectors around the nation.

A common element of a prospective rate payment setting mechanism is an allowable rate of increase in per diem cost for the following year. This percentage is normally calculated through application of economic indicator such as U.S. Department of Labor wholesale and consumer price

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VI. State

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and reporting

indexes. The percentage is then routinely applied to actual cost from the previous period to arrive at the prospective rate. Determination of allowable rates of increase can be undertaken either on an individual facilities or groups of facilities.

Another element of a prospective payment system is more precisely defined cost categories combined with a uniform method of reporting costs to the State. A common cost breakdown would be labor vs. non-labor with further categorization inside these areas. The following example uses "natural" expense categories in reporting facility costs.

- Labor expenses
  - physician's fees
  - management
  - clerical
  - technical (e.g., LPNs', therapists)
  - registered nurses
  - household services (e.g., dietary, housekeeping workers)
- Non-labor expenses
  - food
  - utilities
  - drugs and supplies
  - maintenance of personnel
  - other

While some level of categorization is necessary to assure accuracy of prediction, the model outlined above may require an excessive level of accounting time and expertise for some of Alaska's smaller facilities. The compromise approach shown below may suffice:

- Salaries and fringe benefits
- Non-labor expenses
  - administrative and general
  - household and maintenance
  - dietary
  - professional care

VI. State Reimbursement Trends

To date, approximately thirty-four states have instituted a prospective system of reimbursement for nursing home services under Medicaid, and sixteen states have instituted a prospective system of reimbursement for hospital services under Medicaid. These prospective systems have taken many forms, each state's structure is a little different. However, they share the same philosophical purposes: "to encourage economy and efficiency, and to establish a uniform system of accounting, budgeting, and reporting in determining a health facility's future reimbursement".

VII. Why Alaska Should [illegible]

1. Total overall [illegible]

In any period [illegible]

According [illegible]

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VII. Why Alaska Should Consider Prospective Payment Now

1. Total, overall spending is growing at 20% each year in Medicaid/GA Medical.

   In any period, total spending is always a function of, 1) the number of recipients, the volume of services used, and the unit price of service. With an automatic cost-of-living increase that expands Alaska's eligible population, coupled with no unit price control or volume limits, Alaska currently has no ability to effectively control growth in medical costs.

   According to a recent study by THE URBAN INSTITUTE, Medicaid payments rose at an annual rate of 15.5 percent from FY73 to FY79 nationally. Alaska had the highest annual rate of increase at 41.8 percent during this same period. Since FY79, costs have increased in excess of 20% annually in Alaska.

   These three factors (recipients, volume, and unit price) need to be considered collectively in any fiscal year. Currently, critical decisions concerning eligible populations, service coverages and unit price are handled independent of each other and do not produce a final cost figure until the fiscal year is past. If total spending is to be contained at a level below 20%, these factors must be considered collectively before each fiscal year starts.

2. Federal funding for Medicaid is reduced in FY83 and later years. The State is facing an estimated $4 to 5 million dollar cutback in federal funding for FY84. Unless additional State funding replaces these lost federal revenues, critical decisions must be made to bring program spending in line with available resources. These decisions must be made before FY84 starts if any real savings are to be achieved.

3. Prospective Systems reduce costs in the long term. The Urban Institute recently concluded that "a consensus is now developing that prospective rate setting is effective in lowering the rate of increase in hospital spending by several percentage points a year, at least in mature rate setting programs after an initial start-up period".

VIII. Why Doesn't the Department of Health and Social Services Simply Adopt Prospective Payment by Regulation?

The Legislature must specifically endorse adoption of a prospective system in Alaska. The Alaska Attorney General has ruled in a 1982 opinion that present Alaska Statutes prevent adoption of a prospective payment system by regulation. The Legislature must change Alaska Statutes to clearly authorize the Department to adopt a prospective system.

IX. What Options Exist to Address the FY84 Shortfall?

1. Do Nothing. This strategy would leave reimbursement in the present retrospective environment and require the Department to pass reductions in federal revenues on to hospitals and nursing homes through reduced rates. Most recent calculations place hospital and nursing home revenue reductions at 8% and 24% respectively for FY84. This strategy would not require any additional funds beyond the FY84 Governor's request for Medical Assistance but would severly impact Alaska facilities.

2. Remain on retrospective system and replace lost federal revenues with State funds, if State law permits. This strategy will require $4 to 5 million in replacement funds and may require a statute change as well. There is some doubt whether the present statutes would permit the Department to pay rates in excess of the federal limits.

3. Same as option #2 but reduce persons eligible and medical services available. Under existing Alaska law, the Department is empowered to eliminate certain medical services and certain eligibility groups if funds were deemed inadequate for FY84. If it were determined that the Department could pay in excess of new federal limits with all State funds, or legislation were passed to permit this, the Department could make reductions in services and eligible groups to partially offset this $4 to 5 million shortfall.

4. Adopt Prospective System and replace lost federal revenues with State funds. This strategy will cost roughly the same as Option #2 but FY84 costs could be predicted with greater certainty. Assuming no changes were made in medical services covered or persons eligible, this option would save the State from 1 to 3% annually compared to Option #2 after the initial start-up period.

5. Adopt Prospective System but reduce persons eligible and medical services available. Herein lies the true value of a prospective system. Once the prospective rules are established and the rates (unit price) for services agreed upon for the fiscal year, eligible groups and medical services are then balanced against unit price to operate within the available appropriation. If no changes were made in persons covered or services offered, the price for this option would be the same as Option #4. If major reduction in eligibles or services were made, the costs for this option would be reduced proportionately.

6. Seek Relief from Congress. This is always an option but not one with as much potential in light of Alaska's present financial image. Nonetheless, there is provision within the new federal changes for special negotiation with the Secretary of Health and Human Services regarding "rural" hospitals. Alaska could pursue this option in conjunction with one of the strategies described in Option 1 through 5 above.

X. Summary

Because of the new state spending limit and concurrent reductions in federal funding, Alaska is facing a $4 to 5 million shortfall in its low income medical assistance programs. If passed on FY84 rates would be reduced 8% and to hospitals and nursing homes, FY84 rates would be reduced 8% and 24% respectively. This could severely cripple if not force closure of several smaller rural facilities in the State.

Alaska must [illegible] eligible populations, medical services covered and unit price against available funds to define an affordable FY84 medical program. While a [illegible] system will not in and of itself eliminate the shortfall, it could provide a [illegible] environment in which critical decisions will be made before the fiscal year starts. If implemented with reasonable cost limiters, minimal cost shifting to other payors would occur.

Alaska State Hospital Association
319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Alaska State Hospital Association

Position Paper

Certificate of Need Repeal

The Certificate of Need program in Alaska (AS.07) should be repealed. It is both inequitable and unnecessary. Its basic presumption is that the Department of Health and Social Services can make better decisions for hospitals and nursing homes than can the facilities themselves.

Basic Issues

1. Equity

- While controlling non-state construction of skilled nursing facilities (SNF's) and intermediate care facilities (ICF's), the program exempts these beds constructed in Pioneers' Homes. Thus any determination of need based on the current program is flawed because forces external to the program can and have - in Anchorage, Juneau, and Ketchikan - altered the factual situation.

- Alaska Native Health Service and the Armed Forces facilities are also exempt from coverage. Their activities have a direct bearing on many other facilities in terms of both service area and referrals.

- Physician office construction and equipment purchase are also exempt.

The inequities are clearly illustrated in the Anchorage area: Providence Hospital, Humana Hospital, Nakoyia Health Care Center, Hope Cottages and the Alaska Treatment Center are included in the CON program while the Alaska Native Health Service Hospital, Elmendorf AFB Hospital, the Anchorage Pioneers's Home and the Diamond Emergency Center are not included. All of these facilities share the same basic service area.

2. Unnecessary

Market place [illegible] of capital expansion for Municipal Health Comple[illegible] the public input [illegible] communities the city [illegible] provide the public [illegible]

Alaska is a [illegible] any appeal for [illegible] health care, which is [illegible]

3. Conformity

[illegible] ([illegible]) [illegible] program of [illegible]

- Conformity is [illegible] Pioneers' Homes.

- There are [illegible] as well as Alaska, [illegible]

- The [illegible] In December of 19[illegible]

- The Reagan [illegible] this program. [illegible] without penalties. [illegible] repeal at best [illegible] change Alaska's [illegible]

4. Other States

- Louisiana [illegible]

- According to [illegible] currently do not [illegible]

- At least [illegible] provisions.

5. Attachments

- Alaska State [illegible] of Certificate of Need [illegible]

- Providence let[illegible] to LCN.

- U.S. Department [illegible] Dennis DeWitt discuss[illegible]

Position Paper
Certificate of Need Repeal
Page Two

2. Unnecessary

Market place economics and competition should be the determinant of capital expansion for health facilities. In Anchorage, the Municipal Health Commission as well as open board meetings provide the public input into a facility's planning process. In smaller communities the city council or borough assembly who own the facility provide the public input opportunity.

Alaska is a developing state with many isolated regions without any appeal for duplication of services. We need to limit access to health care, which is the basic intent of the CON program.

3. Conformity

42 USC 300 m-(d) requires that states conform to the federal program or face a reduction of specified public health service funds.

- Conformity is not achievable without the inclusion of the Pioneers' Homes.

- There are 30 states, including New York and California as well as Alaska, which are not in conformity.

- The penalties have been deferred every year since passage. In December of 1982 they were deferred until October 1, 1983.

- The Reagan Administration is not supportive of continuing this program. Congress is working to create a state optional program without penalties. Thus the likelihood of imposition of penalties is remote at best and the across the board elimination of CON would not change Alaska's current status.

4. Other States

- Louisiana does not have a certificate of need law.

- According to the American Hospital Association, 30 states currently do not conform.

- At least seven states have termination clauses or specific sunset provisions.

5. Attachments

- Alaska State Hospital Association Policy Paper on Repeal of Certificate of Need

- Providence letter to Mayor Knowles explaining opposition to CON.

- U.S. Department of Health and Human Services letter to Dennis DeWitt discussing Alaska's non-conformity.

Position Paper
Certificate of Need
Page Three

(Attachments cont.)

- Alaska Dep[illegible] Don Clocksin discu[illegible] problems, and potent[illegible]

- 42 USC [illegible]

- Alaska [illegible] Representative [illegible] program.

- Alaska Sta[illegible] the repeal of [illegible]

- Alaska Sta[illegible] CON repeal.

- [illegible] Senator Stevens.

Position Paper
Certificate of Need Repeal
Page Three

(Attachments cont.)

- Alaska Department of Administration letter to Representative Don Clocksin discussing Pioneers' Homes exemption, conformity problem, and potential for penalties.

- 42 USC 300m-(4)

- Alaska Department of Health and Social Services letter to Representative Mike [illegible] indicating lack of compliance with federal program.

- Alaska State Medical Association Resolution calling for the repeal of certificate of need.

- Alaska State Hospital Association letter to Stevens on CON repeal.

- Governor Sheffield's response to the Association letter to Senator Stevens.

Region X
MS 833 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

June 22, 1982

Re: IOP 550016
Alaska SHPDA

Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Your letter dated June 11, 1982, requested information about Region X's intentions as a result of the failure of the Alaska Legislature to pass amendments proposed to bring the State Certificate of Need program into compliance with the Federal planning law, as amended. Our course of action is quite clear. We will continue to fulfill our mandated responsibilities guided by options and time frames specified in the law.

Under the existing provisions of Title XV of the Public Health Service Act, as amended, current law requires (in order to be fully designated) that a SHPDA must meet all requirements for full designation, including that of having a complying Certificate of Need program.

If a SHPDA is not eligible for full designation by a certain date (which for Alaska is January 29, 1983) the Secretary must invoke the statutory penalty of withholding most Public Health Service grants and contracts to any entity in the State by 25% the first year, 50%, 75%, and 100% over the next three years. Amendments contained in PL 97-35 extended the date by which a State must have a fully designated SHPDA to avoid imposition of the penalty. However, PL 97-35 also amended Section 1521(b)(2)(B) by specifying that a conditional designation agreement could not extend beyond a State's penalty date.

Fully designated SHPDAs (such as Alaska) which do not have complying CON programs but continue to meet other requirements, will be returned to conditional designation. As noted above, PL 97-35 prohibits the conditional designation of any SHPDA from extending beyond its penalty date. Any SHPDA which remains conditionally designated on its penalty date must be terminated. Therefore, we will send a termination notice to any conditionally designated SHPDA 90-days prior to its penalty date, if it still has not demonstrated that it has a complying CON program.

The enclosed copy of a letter to Commissioner Beirne, from the Regional Health Administrator, further emphasizes the critical nature of having a complying CON program in Alaska.

Also the enclosed copy of a 1981 letter addressed to Mr. Fred [illegible], Esq. concerning Pioneer Homes Certificate of Need review issues, reflects our unchanged position.

I hope the facts in this letter provide the detail of information required to understand the situation. Please call or write, should you need further assistance.

[illegible signature]

[illegible]
Director
[illegible] of Health
[illegible] Development
Region X

Enclosures (2)

Re: [illegible] 550923
Alaska [illegible]

Helen D. Beirne, Ph.D.
Commissioner
Department of Health & Social Services
[illegible]
[illegible], Alaska [illegible]

Dear Dr. Beirne:

[illegible]

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.

FRAN:

I followed up on the request for information on the legislative history of the medicaid rate commission. House Research did not have any ready answers and suggested that we could probably get the info as fast as they could so I have proceeded. I have contacted archives and hopefully will receive transcripts early next week.

I have talked with locals who were around during the time the commission was being formed - this is what they say:

The original intention was for the administration to have control over the commission. However, lobbyists (most notable Dennis Dewitt) rallied the troops and brought pressure from hospital association/care provider groups. The result was a compromise. They agreed on a "neutral" commission which is the current makeup.

As for the CPA, it was the intention that someone knowledgeable about health care financing, who understood costs of hospital care be part of the decision making process.

<u>Comment</u>

This is an interesting situation. You have a commission which seems to have competing roles. On the one hand, the commission pays hospitals on the basis of cost and does not consider health policy. On the other, they are compelled to keep facilities from closing, increasing rates as health care costs increase. Does changing the commission composition negate these roles?

D—

I'd like a CS prepared that it composed of 3 commissioners a health consumer, health provider and a 3rd person maybe accountant. So it strikes balance a little differently.

789-4476
4406

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02–576(2/77)

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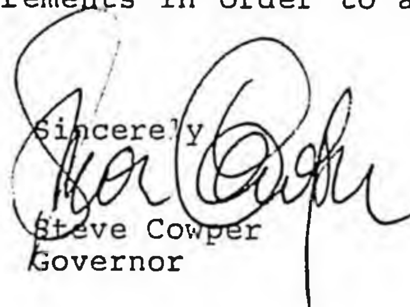
This proposed change would also help assure that the Department of Health and Social Services maintains the Medicaid program within federal requirements in order to allow maximum use of federal money.

Sincerely



Steve Cowper
Governor

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health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Wrangell General Hospital

Chairman-Elect
Jim Gingerich
Fairbanks Memorial Hospital

Immediate Past Chairman
Mike Lockwood
Central Peninsula General Hospital
Soldotna

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Delegate to the American Hospital Association
Sister Barbara Haase
Ketchikan General Hospital

Alternate Delegate to the American Hospital Assoc.
Ed Zeine
Cordova Community Hospital

Delegate to the American Health Care Association
Tom Bolling
Our Lady of Compassion Care Center
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Ed Malewski
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Delegate to the National Congress of Hospital Governing Boards
Jan Trollner
Seward General Hospital

Government Institutions Representative
Frank Sutton
Mt. Edgecumbe Hospital
Sitka

Outpatient Facilities Representative
Avis Hayden
Alaska Treatment Center
Anchorage

Executive Director
Harlan R. Knudson

February 23, 1988

Representative Fran Ulmer
P.O. Box V
Capitol, Room 102
Juneau, Ak 99811

Dear Representative Ulmer:

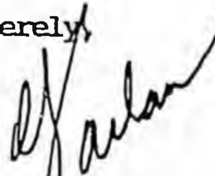
The Health Association of Alaska, representing acute care hospitals and long term health facilities, respectfully asks that you vote "no" on HB 348, revamping the membership of the State Medicaid Rate Commission.

Currently the Commission has the CEO of a licensed health facility; the designee of the Commissioner of Health and Social Services; a licensed physician; a certified public accountant, and a person representing consumers.

Under HB 348, the health facility CEO and the physician would be represented by one person, representing health care providers, and the CPA would be dropped. The Commission would then be comprised of the designees from the Commissioners of Administration; Health and Social Services, and from the Office of Budget and Management. Three (3) of the five (5) members would be state employees.

Under this makeup, the rate process becomes a method to control costs impacting the budget, rather than a vehicle to objectively evaluate and establish a fair rate of payment to health facilities for services rendered to Medicaid and General Relief Medical beneficiaries.

Sincerely,



Harlan R. Knudson
Executive Director

HK/cdr

Bill Saloey and I enjoyed the chance to discuss this with you.

Rod Betit 801-538-6101

1982-83? ORIGINAL INTENTION WAS FOR CONTROL RESIDE IN GOV. OFFICE. HOWEVER, PRESSURE BROUGHT FROM HOSPITAL ASSOCIATIONS, PHYSICIANS - HAMMOND -

COMPROMISE REACHED - HAVE A NEUTRAL BODY - SENSITIVE TO ISSUES - DENNIS DEWIT

why have the commission

CPA - BACKGROUND IN HEALTH CARE FINANCING - HELP UNDERSTAND COSTS CAME HOSPITAL ASSOCIATION

PHYSICIAN - SENSITIVE TO PATIENT / COSTS

ADAMS - ALWAYS CONCERNED THAT WE NEEDED TO SET RATE NOT TO EXCEED BUDGET -

NO OTHER STATE ALLOWS A COMMISSION LIKE THIS TO SET RATES FOR MEDICAID

PROBLEM IS TO STABILIZE THE RATE, BUT AS THE COMMISSION IS COMPOSED, IMPOSSIBLE TO DO. (GENERATOR PROBLEM)

FOCUS OF COMMISSION

- PAYING HOSPITALS ON BASIS OF COST NOT BUDGET
- COMPELLED TO KEEP FROM HAVING TO CLOSE FACILITIES

(competing things)

→ BASICALLY FORCED INTO ENSURING FACILITY REMAINS OPEN -

ROLE OF GOVT IS TO ENSURE ADEQUATE CARE - BUT IS THAT THE ROLE OF THE COMMISSION?

NOT CLEAR THE COMMISSION CAN FUNCTION WITH COMPETING ROLES - NOT CLEAR CHANGING COM WILL DO THE JOB?

NO. 1

STATE OF ALASKA 1988 LEGISLATIVE SESSION
FISCAL NOTE

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						
REVENUE						

FUNDING : (Thousands of Dollars)

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
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 Busch Phone: 465-3355
Division: Medical Assistance Date: 12/8/87

Approved by Commissioner: [signature], Acting Commissioner Date: 12/8/87
Agency:

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

9/15/86

Alaska State Legislature

REPRESENTATIVE
MARK BOYER

HOUSE FINANCE COMMITTEE

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House of Representatives

March 2, 1988

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

RE: HB 348

Dear Madam Chairman:

I write today to support HB 348 and express my concern over the current statutory requirements for rate setting under the medicaid program.

As chairman of the Department of Health & Social Services Budget Subcommittee and as a member of the Governors Interim Health Care Commission, I have gained an appreciation of the costs associated with the State's medicaid budget as well as an interest in curbing the rapidly escalating facility costs component of that budget. While many cost containment measures are highly controversial and often unsuccessful, I am hopeful that by changing the existing board composition to one more responsive to the Legislature and the Administration we will begin to control the escalating costs of care.

HB 348 would provide more executive and legislative oversight over the distribution of health care costs, and in the long-term would provide us with the tools to manage rising health care costs more effectively.

Between FY88 - FY89 the State Medicaid program will grow by 36% from 90.0 million to 121.2 million. The rising costs are a result of increased rates paid to hospitals and nursing homes, greater utilization of existing services and simply more people qualifying for medicaid due to the downturn in the economy.

The provision of health care for Alaskans, especially for poor children, the elderly, the blind and disabled is a fundamental responsibility of government. Thus, we must

expect to pay the rising costs of health care, and can only hope to slow the growth of these costs by sensible, prudent management of costs.

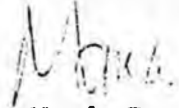
One way of containing the growth of health care costs in the long run is to support and develop less expensive forms of care. For instance, comprehensive prenatal care is a small up front investment when you compare it to the costs incurred for the care of a premature infant. Similarly, in-home services for seniors can postpone or eliminate the need for nursing home care, currently approaching $60,000 per year.

The current medicaid statutes do not allow state policy makers to adequately weigh and choose the health care services which provide maximum quality of life along with the costs issues and question the best use of our financial resources. The five member MRC is charged with setting rates for hospitals and nursing homes which must be paid by the State. If, in any one year, insufficient funds are appropriated by the Legislature to cover the costs of the medicaid program, including those costs set out by the MRC, then services must be cut, not costs. The Administration has no alternative. These services, which are listed in order of priority in the statute, include adult dental services, personal care services to the developmentally disabled, and mental health services.

A current example of how this system works is represented by a pending regulation change at the MRC, (copy attached). If this regulation is adopted by the MRC, an additional $1.9 million will be owed to facilities in FY89. These monies are not included in the FY 89 budget. If they are not appropriated by the Legislature, then services will be cut.

I urge the State Affairs Committee to seriously examine this legislation and give it a favorable recommendation. Unless the rate settling policy decisions are more responsive to the concerns of the legislature and the administration, we will continue to see an unchecked rise in rates for medicaid facilities. A more balanced representation on the commission will be a positive step in the direction of health care cost containment which is a goal I believe we all share.

Sincerely,



Mark Boyer
Representative

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.

COMPARISON OF HOSPITAL AND LONG TERM CARE COSTS

Medicaid Rate Commission
February 3, 1988

HOSPITAL AND LONG TERM CARE COSTS
IN THE STATE OF ALASKA

INTRODUCTION

The ever increasing costs of health care has been an issue not only in the state of Alaska but throughout the country. The health care industry represents the third largest contributor to the gross national product behind agriculture and construction. Health care costs comprise 11% of the gross national product.

With health care expenditures doubling every six years since 1965, it is possible that health care spending could reach $3,000 per capita by 1990.

Hospitals consume the largest proportion of health expenditures with 49% in 1983, physicians services are second at 22% and nursing homes at 9%. Only hospital and nursing home costs have increased as a percentage of total expenditures from 1950 to 1983. Hospitals increased from 35% to 49% and nursing homes from 2% to 9%.

Several factors have been attributed to the increase in health care consumption.

* The over 65 person consumes 3 times the health care that a younger person consumes. With our aging population the consumption of health care increases.

* With the advent of Medicare and Medicaid in the late 60's, large segments of our population became served by public funds where health care services were not available or limited in scope.

* Changes in insurance coverages and insurance more readily available to the general population has reduced price sensitivity from the consuming public.

* Federal payment systems that paid for costs did not encourage providers to reduce costs or seek more efficient or alternate methods of delivering health care.

* Rapidly increasing medical technology including not only higher cost equipment and structures but also treatment modalities to save lives significantly impacted costs.

While these factors are discussed in terms of a national perspective, Alaska faces each of these issues and in many cases more dramatically than on a national level.

STATE OF ALASKA

In recent years, the cost of health care in Alaska has become under increasing scrutiny by both the public and the private sector. Alaska, not unlike other states, does not maintain a sophisticated data base identifying health care costs for the general public or population covered by government programs such as Medicaid and General Relief Medical. There are factors that have been quantified that are important to consider when looking at health care costs in Alaska.

* 30% of the Alaskan population is serviced by Indian Health or Military programs.

* The November consumer price index for Alaska as of November 1987 identified health care costs in Anchorage at 189% above the national average.

* Federal government recognizes a 160% differential in labor costs for Anchorage and 150% for the rest of the state and overall 125% differential on non-labor costs.

* Alaska has a very young population with the over 65 population less than 3% of the population compared to that of the national average of 12% resulting in lower hospital utilization and lower resource consumption per occurrence when compared to the national averages.

* There are still many services not available in Alaska necessitating out of state travel to secure those services such as transplants and specialized therapies.

* Alaska has spent a quarter of a billion dollars in capital expansion throughout the 80's.

The state relatively few population centers with Anchorage being the primary population center. Hospitals and long term care facilities are scattered around the state with relatively little access between facilities except by air. Many of the more remote communities are maintaining hospitals and nursing homes serving a very small population base. The long term care facilities are operated with as few as five patients and hospitals providing less than 500 patient days of care a year. This style of health care delivery, that of providing inpatient services in locations that have very low utilization, has significantly contributed to the high cost of health care in Alaska.

COMPARISON OF ACUTE CARE COSTS

Exhibit 1 contains a comparison of Alaska hospitals to hospitals located in California. The California data represents the Health Systems Agency (HSA) region identified as Golden Empire. This region is located north and east of Sacramento. The data presented represents median values for these facilities. The data reflecting California costs is 1985 data while the data presenting the Alaskan costs is primarily 1986 data. This results in about 5% anticipated inflation not reflected in the California data. All comparison should bear that in mind.

The Alaskan data is the information as contained in a report titled, "A Study of Doctors Influencing Acute and Long Term Care Health Care Costs in Alaska" produced by the Alaska Health Association in January 1988. The California data is produced by the California Health Facilities Commission, State of California Comparative Data for California Health Facilities, Volume 3, (1985).

Utilization of Alaska hospitals is different than California hospitals. The Alaskan rural hospitals specifically Cordova, Petersburg, Seward, Sitka, Valdez, and Wrangell have significantly less utilization than California facilities where median patient days are 5,297. Alaskan median census is 560 days for the 6 smallest facilities. The number of beds for these facilities, as well as the length of stay, is also lower than California facilities.

The expenses identified as patient care include daily hospital services and ancillary services. Daily hospital services would be intensive care, acute care, nursery and other types of room and board services. Ancillary costs include diagnostic as well as therapeutical services including labor and delivery, surgery, lab, x-ray and a host of other services. Daily hospital costs in Alaskan hospitals average approximately 60% above the California costs. The ancillary costs seem to be relatively in keeping with the California costs. It is not possible to make meaningful comparisons for ancillaries since we do not have data on services provided.

The next section identifies overhead costs. The overhead costs have been grouped with capital which includes interest and depreciation; administration which includes management services of administration, fiscal, medical records, inservice and the like and support services which include plant maintenance, dietary, laundry and linen, housekeeping and general upkeep services. These are the areas where the Alaskan costs are markedly above the California area. Capital costs run 5 times that of the median costs in California. Administrative costs are more than double the median costs while support services run approximately 60% above California.

While the costs in Alaskan hospitals are 50% to 300% above the costs in northern California, the amount paid by the general public in the state of Alaska do not necessarily follow.

On the bottom of Exhibit 1 charges per patient day are identified for Alaskan hospitals as well as a percentage of revenue to operating costs. Note that the most expensive facility per day to operate, Valdez, sets its prices at 51.7% of day to day operating costs. The larger facilities located in Anchorage, Juneau, Fairbanks and Ketchikan are able to establish a pricing structure that covers day to day operating costs. This is necessary if a facility is to meet the economic costs of providing services through patient charges. Larger facilities do not have the tax revenue available as smaller facilities. This chart does not reflect the costs of bad debt or charity commonly called uncompensated care or the contractual allowance taken by a variety of payors including Medicare and Medicaid.

Caution should be used when thinking that those facilities where revenue does not cover the operating expenses the consumer is receiving a "bargain". The facilities whose charges do not cover their expenses tend to be small facilities with occupancy rates under 15%. The costs per patient day are on the high end compared to other facilities. What we have are facilities without enough utilization to break even. There are market constraints payors place on acute care hospitals. Hospitals cannot raise their prices to cover whatever costs are incurred. Insurance companies are not going to pay $800 for an acute care bed just because the facility spends that much money.

It should be noted that several of these facilities have public funds supporting them. Some of the facilities have debt service paid including interest and principal payments. This includes Central Peninsula Hospital, South Peninsula Hospital and Sitka Community Hospital. Other facilities including Valdez have direct operating subsidies. All hospitals except Humana Hospital receive revenue sharing from the state. With the high level of tax support in several facilities, the "survival" or "financial viability" of the facility no longer rests with being paid for services rendered. The revenue from other than patient charges influence expenses.

In summary, the following factors need to be considered:

1. It is unrealistic to assume that a hospital that fills only one out of every ten of its beds will ever be self supporting on patient charges.

2. If prices get too high, payors will simply refuse to pay the charges.

3. The two most significant areas where costs were substantially above California include capital and administrative overhead.

4. It appears that tax revenues influence expenditure patterns when an entity survival is not dependent upon the patient revenues for survival.

LONG TERM CARE COMPARISONS

Exhibit 2 compares long term care costs for the facilities in Alaska to the long term care facilities identified as California HSA One or Northern California. The data used in this report for Northern California and Cordova, Ketchikan, Kodiak, Norton Sound, Petersburg, South Peninsula and Wrangell came from the Alaska Hospital Association's, "A Study of The Factors Influencing Acute and Long Term Care Health Care Costs in Alaska" January 1988. The data for Denali, Our Lady of Compassion, St. Ann's, and Wrangell came from the Medicaid Rate Commission's data for 1986. The two separate data sources were used as the Alaska Health Associations' report treated employee benefits differently in free standing facilities than it did in facilities that are co-located with hospitals. This created a material distortion by understating the routine, plant and support costs while overstating administration costs. Heritage Place was not included in this costs study as the data for 1986 did not identify costs by patient care and overhead. The budgeted data from Heritage for 1987 was not used as it is not a reliable indicator of actual expenses but a management plan.

Long term care costs in Alaska range from nearly 90% above the northern California average costs to 500% above the average costs averaging approximately 3-1/2 times that of the northern California long term care services.

A review of the size of the facilities in northern California compared to the facilities in Alaska indicates that size is a significant factor for those facilities where the costs are 3 times or more that of the northern California area. However, when comparing facilities in state, size of the facility does not appear to be that significant of a factor in the variation of costs. The age of the facility and hospital co-located facilities have a significant influence. (See Exhibit 3).

The patient care routine costs in Alaska run approximately 2 to 6 times higher than northern California. With two exceptions, Cordova and Petersburg, the patient care costs in Alaska range from $41.50 per patient day to $66.96 a patient day. The two exceptions are co-located facilities where occupancy rates were 13.5% in Petersburg and 12.2% in Cordova. Both facilities have been rebuilt with state grants. The data for Cordova for the 1986 year do not reflect occupancy in the new facility.

A review of the overhead indicates that Alaska's overhead ranges from 40% to 680% higher than northern California. Capital is one of the major factors contributing to the higher costs. There is one long term care facility in Alaska with lower capital costs than the California comparison. However, the remaining facilities run 100% to 750% higher than the California base. Plant costs and support services very closely parallel the

capital. The administrative costs show an even greater disparities specifically in the facilities that are co-located. These facilities are Cordova, Ketchikan, Kodiak, Norton Sound, Petersburg, South Peninsula and Wrangell. The northern California base represent free standing long term care facilities.

To see if the base of northern California represented an inappropriate comparison to Alaska long term care costs for co-located facilities were compared in Alaska to the rest of the United States. The data was collected from the publication, "Hospital Statistics" by the American Hospital Association, 1983 and 1986 editions. The costs represented 1982 and 1985 expenses. These costs are contained in Exhibit 4. Long term care costs per patient day in co-located facilities actually decreased between 1982 and 1985. This may be a function of changing services or reporting requirements nationally. However, since the data reflecting Alaska costs come from the same publication all data should be consistent. The Alaskan costs were twice as high as the United States average in 1982 and 2-1/2 times higher in 1985.

Total hours paid were also compared. In 1982, Alaska was actually slightly below the national average of total paid hours per patient day. However, by 1985 the staff had increased 41.9% placing it well above the national average. As a reference point, 1982 is the year before the state of Alaska went on prospective rate setting.

Labor costs represents approximately 70% of all long term care costs. It is important that in looking at long term care costs that the labor component be examined. Listed below is data excerpted from the Alaska Health Association's study referenced earlier in this report.

TABLE OF HOURLY WAGE AND STAFFING RATIOS-LONG TERM CARE
FY 1986

	Northern California		Alaska	
	Hours/Day	Average Wage	Hours/Day	Average Wage
Routine Care	2.73	$5.72	3.28	$10.19
Plant	.10	6.23	.10	13.41
Housekeeping	.28	4.72	.38	8.92
Laundry	.15	4.63	.16	9.04
Dietary	.47	5.05	.69	9.38
Social Services	.09	5.74	.09	13.34
Administration	.30	9.18	.82	14.91
TOTAL	4.11		5.52	

Labor costs and hours paid for service between free standing long term care facilities in Alaska and the northern California facilities are compared. Two factors are very apparent from this

comparison. First, Alaska has higher staffing ratio than northern California as evidenced by more hours paid per patient day. Secondly, the average costs per hour of service is twice as high in Alaska. This factor should be considered in two components as hourly wage can reflect higher costs of salaries per type of employee and the mix of staff. The mix of staff is how many RNs to LPNs to Aides.

Medicare has conducted extensive studies on salary differentials across the country. In Alaska the salary differential is nearly 160% in Anchorage and nearly 150% in the rest of the state. Medicare identifies non-urban rural California as an index of 114% above the national average. Since Alaska's hourly wages are nearly double those identified in California data, it is reasonable to assume that the mix of staff in Alaska is also higher. This results in three conditions in Alaska facilities: more staff, higher salaries, and higher level of staff.

The capital costs identified in 1986 comparison do not reflect all of the new building and expansion that has occurred to date. Exhibit 5 is a Commission prepared document identifying the costs upon which the 1988 rates are set and the capital costs built into the 1988 rate. With new facilities, Mary Conrad Center and the Cordova Hospital and long term care facility, capital costs have increased significantly.

The largest differences in costs for long term care relate to the co-located facilities. In these facilities the administrative costs, support costs and capital costs are double and triple that of free standing institutions. This is further evidenced in comparing the percentage as of total costs routine and overhead. By and large California and the free standing institutions run approximately 55% overhead. Cordova is one exception that is also 55% overhead; however, the routine costs are twice that of the average cost in Alaska. Facilities which are attached to hospitals carry a disproportionate burden of the overhead. This has long been recognized by Medicare as well as other states.

When Medicare calculates its "upper limit" or standard of reasonableness, Medicare does not allow all of the costs to co-located facilities to be included in the upper limit. Only 50% of those costs which are higher than the upper limit for free standing long term care are allowed in the upper limit. The upper limit for free standing long term care is capped at 112% of the nationwide median. When the Washington State Commission developed its Accounting and Reporting systems for hospitals, a special allocation method was designed for those facilities that offered both long term care and acute care services. It was recognized that the standard Medicare format for allocating overhead allocated too much overhead to long term care. The costs comparisons used in this report and the basis for establishing long term care rates for Medicaid services does not make an adjustment for the over allocation overhead costs in long

term care. All long term care overhead costs are included in the rate structure.

In summary, the following conclusions can be reached:

1. Capital costs in the state of Alaska are significantly above the northern California comparison base.

2. Administration, port services and routine care services range significantly higher.

3. Alaskan facilities have more staff, higher paid staff, and a higher skill level of staff than the comparative groups.

4. Alaska uses a system that allocates significant overhead costs into the long term care facilities that are co-located with hospitals. This allocation increases the costs by $50 to $200 a day.

5. Small size in facilities impact on costs.

MEDICAID/GRM RATE SETTING

The Medicaid Rate Commission establishes hospital and long term care rates for services rendered to Medicaid and General Relief Medical beneficiaries. The Medicaid rates are established through a public hearing process of the Medicaid Rate Commission. The Medicaid Rate Commission operates within regulations contained in 7 AAC 43.

GENERAL PROVISIONS OF RATE SETTING

The allowable and unallowable costs considered in rate setting are the same for both hospitals and long term care. Costs are generally defined as day to day operating expenses that relate to patient care. The day to day operating costs and the amounts recognized significantly different than the methodology used by Medicare for determining allowable costs. Return on Investment is not recognized for proprietary facilities. Medicare does recognize Return on Investment but is phasing it out in the next year. All interest and depreciation related to patient services is recognized in the state of Alaska. Medicare does not recognize all capital costs in cities where there is more than one hospital.

Medicaid/GRM rate setting system in Alaska does not impose any upper limits or standards that Medicare imposes. This includes full recognition of base year malpractice costs, telephone and other personal service items, hospital base physician charges, laboratory outpatient expenses, and ambulatory surgery costs. The Medicaid Rate Commission also does not impose the upper limit by facility as Medicare does for long term care facilities. A rolling base is used in Alaska that adjusts the historical costs upon which inflation is added. Medicare has a fixed base with periodic readjustments. Rolling base in Alaska does have some limitations in that an increase of no greater than 5% plus inflation is allowed between two base years. Likewise, if a base year costs does not increase, the facility is allowed to keep 50% of the difference up to 5%.

Capital costs including interest depreciation and property insurance are recognized as facility budgeted items.

New facilities are established at average costs with capital based on what the facility budgets for the year at a 40% occupancy rate. The second year of a new facility, the occupancy rate is assumed at 60%. Any new beds or converted beds a facility may have assumes that the occupancy rate on the capital will only be 50% of the existing facility occupancy.

The payment methodology is very sensitive to the costs incurred by each individual facility. The costs differentials experienced in Alaska are fully recognized in this payment system since the actual historic costs is the basis for rate setting.

INCENTIVES/DISINCENTIVES OF PAYMENT SYSTEM

HOSPITALS

The hospital payment rates are established at a percentage of charges not to exceed 100% of charges. Medicaid/GRM purchases between 10% and 15% of a hospital's volume. The influence over a facility's behavior is minimum at this purchasing level. Since day to day operating costs are paid to the extent revenue charges covers day to day operating costs, there are relatively few incentives or disincentives to a facility in taking care for Medicaid/GRM recipients.

LONG TERM CARE

Long term care services in Alaska are almost exclusively provided to the Medicaid population. Between 85% and 90% of all long term care services are paid for by Medicaid. Incentives and disincentives within the system are much stronger than in hospital care.

INCENTIVES

1. To maintain high level of Medicaid patients since they are the "best" payor.

2. There's a trade off between Medicare and Medicaid to take Medicaid patients as it is a "better" payor.

3. Launch large capital projects since all capital costs are paid in the rate structure.

4. In co-located facilities, convert as many beds to long term care since fixed capital costs guaranteed in the payment structure even if the beds are empty.

5. Keep costs slightly under the approved rate to maintain more flexibility and "profit".

DISINCENTIVES

1. Not to find alternative uses for empty beds.

2. Not to take payors who are less than Medicaid patient population.

3. Not to start alternative programs within the facilities that will reduce the overhead in capital costs allocated in long term care.