

Public Notice- Public Comments/Questions & Responses- Rate Changes, Medicaid- Facilities, Hospitals, Professional Services, & Waivers (JU2017200200); 06/05/2017.

1. Question re: amendment to 7 ACC 130.260(c) Why is DHSS proposing this (drastic and deleterious) reduction to 8 hours/week day habilitation when there is no longer a budget restriction from the legislature? I will appreciate a response on the Alaska Online Public Notice System and the DHSS website.

Response: To live within DHSS's proposed budget for next year, which does not include an increase in funding to offset program growth, it is necessary to reduce projected spending by \$30 million in General Funds. One area of growth for the Medicaid program has been habilitation services under Home and Community-Based Waivers. In FY16, the Division had established an external stakeholder workgroup to address reductions in the state's budget which would impact home and community based services. That workgroup recommended a soft cap of 8-12 hours for all recipients receiving day habilitation services regardless of age, living situation, or type of waiver. Thus, the Department put forward the recommendation to cap day habilitation hours as one element to help the Department to live within its proposed FY18 budget.

2. If at least adequate money will be in the budget the obvious question is "why would DHSS restrict services that have been so beneficial to so many?" I don't have an answer and would very much like to hear your reasoning.

Response: See above answer. There is not adequate funding to keep paying for everything the Department has been paying for in past years. Federal guidance says that when limits on a waiver service are imposed, the limits must not pose obstacles to the service achieving its stated purpose. Given the array of services available to participants in the IDD, APDD, and CCMC waiver, the Department believes that the reduction in hours would not pose an obstacle to achieving day habilitation's overall purpose of fostering the acquisition of skills, appropriate behavior, greater independence and personal choice.

3. The proposed legislation exempts "specialty psych hospital" from modification of the payment rate. Will you confirm if the State of Alaska classifies Bartlett's Inpatient Psychiatric Unit as a "specialty psych hospital"?

Response: The proposed language to the regulations states : "...facilities licensed as specialized psych hospitals through the state division of health care services, Health Facilities Licensing Certification List, updated April 2017, will be exempt from this provision and will be reimbursed at 100 percent of the rate calculated in (1) - (9) of this subsection. " A review of the referenced certification list indicates Bartlett is licensed as a General Acute Care Hospital. Currently the only facilities licensed as specialty psych hospitals are Alaska Psychiatric Institute and North Star Hospital.

4. Am I understanding this correctly, that the proposed revised conversion factor will only be the difference of, "not applying the inflation rate for fiscal year 2018", or will the true revised conversion factor be calculated in a different manner?

Response: The proposed state fiscal year (SFY) 18 conversion factor is calculated using the current Alaska Medicaid SFY 2017 conversion factor of \$45.2560 as a starting point. The SFY17 conversion factor is not inflated, and then is adjusted down to \$40.573. This represents a 10.3% decrease to the SFY17 conversion factor.

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5. Are all hospital that have a license to operate or support psych patients, psych clinics, wards, department etc. exempt, or does this only exempt hospitals that are specifically licensed to solely provide psych services?

Response: Only the hospitals that are specifically licensed as of April 2017 as a psych specialized hospital are exempt from the proposed rate reduction.

6. Is there only a freeze on 2018 Medicaid reimbursement, a 5% reduction in Medicaid reimbursement, or both a 2018 freeze and a 5% reduction?

Response: The proposed regulations have several components that impact rates. The proposed regulations call for 1) a freeze on 2018 Medicaid rebasing for facilities that have their rates set using prospective payment methodologies (inpatient hospital, outpatient hospital, nursing homes, and federally qualified health centers), 2) a freeze on inflation for SFY18 for services that receive customary inflation during non-rebase years, and 3) a reduction of 5% for inpatient hospital, outpatient hospital, and ambulatory surgery center payment rates and a 10.3% reduction in professional fee schedule payment rates.

7. Realistically, what is going to happen to the individuals served if these hours go away? Will their families be responsible for those hours or will those individuals be forced into facilities (at Medicaid's expense)?

Response: There is not adequate money to keep paying for everything the Department has been paying for in past years. The Department believes that the reduction in day habilitation hours would not pose an obstacle to achieving the purpose of fostering the acquisition of skills, appropriate behavior, greater independence and personal choice. Waiver participants will still have access to other waiver and/or community services that can foster independence, such as

- *Waiver supported employment*
- *Waiver respite*
- *Other state/federal initiatives (e.g. employment services through the Division of vocational rehabilitation (DVR))*
- *Waiver residential services*
- *Natural supports, and/or*

Community volunteer supports.

8. How are payments for these Medicaid services consistent with efficiency, economy, and quality of care if some of the corresponding payment methodologies are modified to cut rates and the other payment methodologies in a way that maintains current rates? Again, if all of these services are subject to the same rate setting methodology, why are some (namely hospitals and ambulatory surgery centers) treated differently than the others?

Response: Not all Medicaid payment rates are set using the same methodology. For example, historically, behavioral health services have not received inflationary increases while other provider types' fee schedules have been adjusted by inflation when inflationary increases have been given. The Department has to consider various factors regarding Medicaid reimbursement rates when facing a budget shortfall. Some of these considerations include what the payer mix is for the provider type (is the

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service primarily funded by Medicaid) and if a reduction in access to care for a particular provider type would result in more costly services being delivered to the recipient in a different setting.

9. If physicians and hospitals must bear the additional cost at all, wouldn't it make more sense to share that cost equally, 7% Physicians, 7% hospitals? What is the argument for not doing that?

Response: The Department has to consider various decisions regarding changes to Medicaid reimbursement rates when facing a budget shortfall such as which provider types would be affected and to what magnitude. The consideration to reduce professional reimbursement at a larger percentage than hospitals included analyzing Alaska Medicaid rates in comparison to Alaska Medicare rates. For professional services, Alaska Medicaid currently reimburses 26.1% above Alaska Medicare rates. For hospital services, they are subject to a federal reporting requirement called the Upper Payment Limit that requires the State to prove that the reimbursement level is below the maximum threshold set by the Centers for Medicare and Medicaid Services.

10. I sent a letter regarding the limiting of day habilitation hours and the negative impact that will result on my daughter. Now, I am interested to find out what the plans are for replacing those hours that will be taken away?

Response: Waiver participants facing reductions in day habilitation hours will still have access to other waiver and/or community services that can foster independence, such as

- *Waiver supported employment*
- *Waiver respite*
- *Other state/federal initiatives (e.g. employment services through the Division of vocational rehabilitation (DVR))*
- *Waiver residential services*
- *Natural supports, and/or*
- *Community volunteer supports.*

11. Within HSS a review was conducted and it was determined that the average number of hours used each week was only 8. If this is true, how was the review conducted?

Response: The average number of day habilitation hours used was determined using Medicaid claims payment data.

12. Where did the budget go that was approved for individuals that did not utilize their approved hours? How is this being used? Where did that money go? Shouldn't it have been used for the individual it was approved for? Or at least contributed to the renewal plan of care budget?

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Response: In FY16, an external stakeholder workgroup was tasked with recommending reductions in the state's budget which would impact home and community based services. That workgroup put forth a soft cap of 8-12 hours for all recipients receiving day habilitation services regardless of age, living situation, or type of waiver. The stakeholders knew that, often, individuals have more hours authorized in their plans of care than are provided. The Department normally requests supplemental funding from the Legislature to cover unanticipated increases in its budget. For FY18, however, the Department was instructed that it must limit its need for increased funding, despite upward trends in service utilization and the number of individuals served.

13. In regard to 7AAC 130.270, Proposed change,

"(4) more than three months of services under (b)(1), **(b)(3), or** (b)(4)...unless the home and community- based waiver services provider demonstrates that the recipient

(a) Needs additional preparation time

(b)Is preparing for new job placement

Why are there no exceptions for the individuals require additional allotted time to develop skills or locate suitable employment that are described in (b)(3) or (b)(4)? How can this be person centered or individualized when each person's needs are different especially in skill development. Typically, it is in the areas of (b)(3) and (b)(4) where more time is needed for an individual to succeed or progress to make this service effective.

Response: To live within DHSS's proposed budget for next year, which does not include an increase in funding to offset program growth, it is necessary to reduce projected spending by \$30 million in General Funds. The Department acknowledges the importance of developing skills and locating suitable employment as part of the supported employment waiver service; the inclusion of time limits formalizes current practice.

14. Can the HSS actually impose these changes without approval by the legislature?

Response: Under Alaska Statutes AS 47.07, the Alaska Department of Health and Social Services (DHSS) has the ability to establish rates and make other changes to reimbursement policy without legislative approval. All changes must comply with state and federal Medicaid law. Federal oversight is provided by our federal counterparts, the Centers for Medicare and Medicaid Services (CMS), through a process called a State Plan Amendment (SPA). At the state level, the Alaska Department of Law reviews the regulations for compliance with state statutes. State regulations can be subject to legislative review if the Joint Administrative Regulation Review Committee chooses to take up a regulation package for review, but this is a relatively rare occurrence.

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15. We want to determine if the rate cut applies to small facilities that have a "small facilities agreement" (7 AAC 150.190). We believe the DHSS intends for the rate cut to apply to these facilities but there is ambiguity in the regulations, so we would request clarity.

Response: It is the State's intention to include facilities that have a "small facilities agreement" (7 AAC 150.190) in the proposed rate change.

Regulation 7 AAC 150.190 provides guidance on criteria that is used to determine if a facility qualifies for a small facility agreement, requirements and terms of a small facility rate agreement, and year-end reporting requirements for facilities electing to enter into a small facility agreement. Rate calculations for facilities under a small facility rate agreement are calculated under 7 AAC 150.160(b) for inpatient per-day rates and 7 AAC 150.160(c) for outpatient percent of charges reimbursement rate.

The variable difference in 7 AAC 150.190 rate setting is the inflationary adjustment factors applied to small facility agreement rates. Under the 7 AAC 150.160 rate setting methodology, adjustment factors identified in 7 AAC 150.150 are applied as applicable to the rate. Under 7 AAC 150.190, the first year payment rate that begins after the base year payment year rate will be increased by updating the noncapital portion of the payment rate annually at three percent per year and by updating the capital portion of the payment rate annually at the rate of 1.1 percent per year. As these rates are calculated under 7 AAC 150.160(b) and 7 AAC 150.160(c), the proposed language of 7 AAC 150.160(b)(10) and 7 AAC 150.160(c)(7) establishing the payment rate for state fiscal year 2018 at 95 percent of the calculated rate still applies to facilities with small rate agreements.

16. Could you please explain and provide detail to the following wording in the proposed changes to 7 AAC 130.260(c): **“the provider has documented to the department’s satisfaction, in a format approved by the department”**. What is the criteria for reaching “department’s satisfaction”? If the criteria has been developed, please provide a copy of the criteria? Has the department developed the approved format? If so, please provide a copy of the format

Response: The form/format and criteria that will be used to document the need for additional hours are not yet available for review because the department has not finalized them. The department expects that any requests for additional day habilitation hours beyond the regulatory limit would contain a person-centered explanation of individual's specific needs and circumstances and why the additional hours are required to prevent institutionalization and to protect the individual's health and safety.