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State/Territory Name: Alaska

State Plan Amendment (SPA) #: 19-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group/ Division of Reimbursement Review

February 24, 2020

Adam Crum, Commissioner
Department of Health and Social Services
3601 C Street, Suite 902
Anchorage, AK 99503-7167

RE: TN 19-0005

Dear Mr. Crum:

We have reviewed the proposed amendment to Attachments 4.19-A and D of your Medicaid State plan submitted under transmittal number (TN) 19-0005. The proposed amendment reduces inpatient hospital, inpatient psychiatric and nursing facility rates, and freezes inflation adjustments for inpatient hospital and nursing facility services for SFY 2020.

Based upon the information provided by the State, we have approved the amendment for incorporation into the official Alaska State Plan with an effective date of July 1, 2019. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please call DRR Analyst, Thomas Couch at (208) 861-9838 or by email at Thomas.Couch@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 19-0005

2. STATE: AK

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201,
42 CFR 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 (3,230,737) ~~$ (4,087,945)~~ (P&I)
b. FFY 2020 (9,692,212) ~~$ (12,263,834)~~ (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages 3, 5, 6, 7, 27a
Attachment 4.19-D pages 3, 6, and 7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 3, 5, 6, 7, 27a
Attachment 4.19-D pages 3, 6, and 7

10. SUBJECT OF AMENDMENT:
Cost Containment via rate reduction and inflation freeze - FACILITIES

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Albert E. Wall

14. TITLE: Deputy Commissioner, Alaska DHSS

15. DATE SUBMITTED: September 27, 2019

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/27/19

18. DATE APPROVED: February 24, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:
12/9/19: State authorized P&I change to block 7.

FORM HCFA-179 (07-92)

* Management fees or home office costs that are not reasonably attributable to the management of the facility. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.

Allowable patient-related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state, and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments, and discounts taken by payers. Base year costs and rate calculations may be adjusted for regulatory changes in allowable costs that become effective after the last adjustment for inflation.

If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

1. the terms of issuance describing the nature and extent of the activities authorized by the certificate; and
2. the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

II. Inflation Adjustments

Allowable base year costs are adjusted for inflation. Inflation adjustments may be reduced if a facility fails to timely file their year-end reports with the Department. The department will utilize the most recent quarterly publication of Global Insight's "Health Care Cost Review" available 60 days before the beginning of a facility's fiscal year. For the inflation adjustment relating to allowable non-capital costs, the department will utilize the Global Insight Hospital Market Basket. Allowable capital and allowable home office capital will be adjusted using the Global Insight Health Care Costs, Building Cost Index, CMS New 1997-based PPS Hospital Capital IPI.

For state fiscal year 2020, inflationary adjustments to the non-capital and capital payment rate for facilities not being rebased with a new four-year rate cycle beginning in state fiscal year 2020, will not be applied. Facilities licensed as Critical Access Hospitals will be exempt from this provision.

allowable base year capital costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific capital routine cost per-day.

3. The percentage of base year capital costs in each ancillary cost center is applied to the Medicaid ancillary costs for the cost center calculated by first dividing allowable ancillary costs by total inpatient days and applying the resulting per-day costs to paid Medicaid inpatient days. The sum of the Medicaid allowable capital costs for all ancillary cost centers is divided by the sum of the allowable paid Medicaid inpatient days for all ancillary cost centers resulting in the facility's base year Medicaid-specific capital ancillary cost per day.

4. The sum of the Medicaid allowable capital costs for all ancillary cost centers determined in #3 (above) is removed from the total base year Medicaid specific ancillary costs determined by dividing total base year ancillary costs by total inpatient days and applying the resulting amount to the total paid Medicaid inpatient days. The resulting base year allowable ancillary cost is then divided by paid Medicaid inpatient days to arrive at the facility's base year Medicaid specific non-capital ancillary cost per-day.

Each base year component rate is then adjusted for inflation in accordance with Section III and summed to arrive at the facility's prospective payment rate.

The capital components of the prospective payment rate will be adjusted for Certificate of Need assets placed into service if their total value is at least $5 million. This adjustment will reflect appropriate capital costs for the prospective year based on the certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

For purposes of determining prospective payment rates, nursery days constitute inpatient days and swing-bed days do not constitute inpatient days. Costs and charges associated with swing-bed services, determined by applying the swing-bed rate in the base year to the number of swing-bed days, are removed prior to calculating the prospective payment rate. For the routine cost centers, the Medicaid inpatient days are the covered days from payment history reports generated by the Division of Health Care Services (commonly known as the MR-0-14). For the ancillary cost centers, Medicaid inpatient days will be those days reported in either the facility reported Medicaid audited days or covered days from the payment history reports.

Prospective payment rates for facilities that are calculated and paid on a per-day basis as discussed in this section will be no greater than the per-day rates proposed in the certificate of need application and other information provided as a basis for approval of the certificate of need for the first year during which the following are available for use and for two years immediately following the first year:

1. opening of a new or modified health care facility;
2. alteration of bed capacity; or
3. the implementation date of a change in offered categories of health service or bed capacity.

If a facility is granted a certificate of need for additional beds, the additional capital payment add-on to the per-day rate will include the base year's inpatient days plus additional days associated with the additional beds. The additional days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Except for critical access hospitals, costs are the lower of costs or charges in the aggregate to the general public. For state fiscal year 2018, the payment rate will be 95% of the payment rate in state fiscal year 2017.

For state fiscal year 2020, the payment rate will be 95% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

B. Optional Prospective Payment Rate Methodology and Criteria for Small Facilities

A facility that had 4,000 or fewer total inpatient hospital days as an acute care, specialty or psychiatric hospital, or as a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year during calendar year 2001 may elect to be reimbursed for inpatient hospital services under provisions of this Subsection. If a facility that meets this criterion does not elect to participate during its first fiscal year after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

If a facility that elected to be reimbursed under the prior Optional Payment Rate Methodology for Small Hospitals for its payment years beginning in calendar year 1998 until the last day of its fiscal year ending during the period of July 1, 2001 through June 30, 2002, does not elect to participate after its agreement expires or does not terminate the agreement for its first fiscal year beginning after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa. Its prospective payment rate will be determined pursuant to Subsection IVa until a rebasing has been executed.

A facility electing to be reimbursed under this subsection must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have lapsed.

The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this subsection. A re-basing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IV.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection rather than Subsection IVa, its prospective payment rate will be based on its 1999 established rate or the rate calculated under Subsection IVa at the election of the facility. If the facility elects its 1999 payment rate, its initial year prospective payment rate during calendar year 2001 will be determined as follows:

The prospective payment rate will be expressed as a per-day rate, composed of separate capital and non-capital components.

1. The capital component is calculated by dividing the facility's Medicaid capital per adjusted admission reflected in its 1999 payment rate by the average Medicaid length of stay and adjusted for inflation by 1.1 percent per year for each fiscal year after the first year of election and ends at the expiration of its agreement.
2. The non-capital component is calculated by dividing the facility's allowable Medicaid costs per adjusted admission by the facility's average Medicaid length of stay, and subtracting the capital component from the quotient. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election and ends at the expiration of the agreement.

For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For state fiscal year 2020, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

For state fiscal year 2020, the payment rate will be 95% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection under the provisions of Subsection IVa, its prospective payment rate for the first year beginning in calendar year 2001 and each year thereafter until the facility's agreement expires will be determined pursuant to Subsection IVa except that the non-capital and capital components of the payment rate will be adjusted annually for inflation, except when the state implements cost containment, after the first year by 3 percent and 1.1 percent respectively. For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For state fiscal year 2020, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

For state fiscal year 2020, the payment rate will be 95% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

Inpatient Psychiatric Services for Individuals Under 21

Payment to an accredited residential psychiatric facility for the treatment of individuals under 21 years of age is at daily rates established by the department. The department will pay for therapeutically appropriate, medically necessary diagnostic and treatment services, including the following services: individual psychotherapy; group psychotherapy; family psychotherapy; group skill-development; individual skill-development; family skill-development; pharmacologic management and medication administration; crisis intervention; and intake assessment. In SFY20, the payment rates will be 95% of the SFY19 rates.

The daily reimbursement rates are published and available at:
http://manuals.medicaidalaska.com/inpatient_psych_rptc/inpatient_psych_rptc.htm.

The rates were last updated to be effective for services on or after 7/1/19.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state, and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments, and discounts taken by payers. Base year costs and rate calculations may be adjusted for regulatory changes in allowable costs that become effective after the last adjustment for inflation.

If a certificate of need is required on assets purchased after the base year, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

1. the terms of issuance describing the nature and extent of the activities authorized by the certificate; and
2. the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

III Inflation Adjustments:

Allowable base year costs are adjusted for inflation. Inflation adjustments may be reduced if a facility fails to timely file their year-end reports with the Department. The department will utilize the most recent quarterly publication of Global Insight's "Health Care Cost Review" available 60 days before the beginning of a facility's fiscal year. For the inflation adjustment relating to allowable non-capital costs, the department will utilize the CMS Nursing Home without Capital Market Basket. Allowable capital and allowable home office capital will be adjusted using the Skilled Nursing Facility Total Market Basket Capital Cost Component.

For state fiscal year 2020, inflationary adjustments to the non-capital and capital payment rates for facilities not being rebased with a new four-year rate cycle beginning in state fiscal year 2020 will not be applied. Facilities licensed as a Tribal Skilled Nursing Facility will be exempt from this provision.

IV Determination of Prospective Payment Rates:

The prospective payment rate for long-term care services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program.

days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Costs are considered the lower of costs or charges in the aggregate to the general public.

For state fiscal year 2020, the payment rate will be 97% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as a Tribal Skilled Nursing Facility will be exempt from this provision.

A. Optional Prospective Payment Rate Methodology

A facility that had 4,000 or fewer total inpatient hospital days as a combined hospital-nursing facility or 15,000 or fewer Medicaid nursing days as a non- combined nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year may elect to be reimbursed for inpatient acute care services under provisions of this Subsection at the time of rebasing. All facilities qualifying for the Optional Payment Rate Methodology for Small Hospitals may elect to participate in the program described in this Subsection.

If a facility meets these criteria and does not elect to participate during its first fiscal year after rebasing, the facility may not reverse its decision and elect to participate under this Subsection until after a subsequent rebasing occurs under the provisions of Subsection IVa. Facilities currently participating in the program may not elect the option under this Subsection until after their current agreement expires. If a facility still qualifies to participate after their agreement expires, they may elect to do so under this Subsection.

A facility electing reimbursement by this optional methodology must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have elapsed. The department will also consider if the agreement conflicts with the public concern that needy persons in the state receive uniform and high quality medical care; distribution of adequate medical services; and if appropriate appropriations are available to fund rates established under this Subsection. The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this Subsection. A rebasing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IVa.

The prospective payment rate will be determined as follows:

1. The prospective payment rate is expressed as a per-day rate, composed of separate capital and non-capital components.

2. For the first year of the agreement, the capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at 1.1 percent per year for each fiscal year after the first year of election until the agreement expires.
3. For the first year of the agreement, the non-capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election until the agreement expires.

For state fiscal years 2016, 2017, 2018, and 2020 the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For state fiscal year 2020, the payment rate will be 97%of the facility's rate that would have been effective July 1, 2019. Facilities licensed as a Tribal Skilled Nursing Facility will be exempt from this provision.

Increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement will be allowed, based on the provisions in Subsection IVa, if the following conditions are met:

1. The assets placed into service have a value of at least $5,000,000;
2. The facility obtains one or more Certificates of Need for the assets placed into service; and
3. The facility provides a detailed budget that reflects the allowance for the new assets before the prospective payment rate is increased.

In most cases, a facility must use the "exceptional relief" process for appealing department decisions pursuant to Subsection XII. The administrative appeals process outlined in Subsection VIII will be used only when an appeal relates to one of the following subjects:

1. The facility's eligibility to elect rate setting under this Subsection;
2. The violation of a term of the rate agreement between the facility and the department;
3. The denial of an increase in the capital component of the prospective payment rate for new assets related to an approved Certificate of Need.

A small facility acute care hospital may elect a new four-year rate agreement as described in this Subsection of the facility becomes a combined acute care hospital-nursing facility. The facility may choose this option within 30 days after the combination of the two facilities. The nursing facility payment rate is calculated as follows: