***To facilitate a united provider voice for best practices, advocacy, partnerships and networking.***

October 27, 2014

Dear Commissioner Streur:

The Alaska Association on Developmental Disabilities (AADD) is the voice of 37 providers of developmental disability services statewide. Our vision is to stand as a full partner with the State of Alaska and be proactive in addressing the needs of individuals who experience intellectual and developmental disabilities. In that role of partnership we deeply respect the goals of the Medicaid Reform Advisory Group to provide stability and predictability of funding, increasing the ease and efficiency of navigating the system for providers and providing whole care for the patient.

We want to thank each member of this group for the time and hard mental work each of you has invested in understanding the complex Medicaid system and for your efforts to select what will best serve the state of Alaska. AADD supports the majority of the recommendations made by the group. We have articulated concerns about some of the recommendations below. Additionally, as a partner in this process we offer five additional options which would provide some cost savings to the Medicaid program.

1. REPEAL OF THE ADULT PUBLIC ASSISTANCE BENEFITS REFINANCED THROUGH MEDICAID in 2004/2005: AADD recommends repealing the APA adjustment implemented in 2004 which added room and board costs to Medicaid reimbursement for any recipients residing in licensed facilities. The original daily increment of $8.65 with inflationary adjustments may reduce the Medicaid budget in excess of $2.5 million if appropriately refinanced through a housing subsidy program or restored through the public assistance program. This would also remove the potential conflict from Medicaid regarding the State’s direction of Medicaid funds for room and board costs, which was the original intent of Adult Public Assistance.
2. CREATE INFRASTRUCTURE FOR PROVIDING COST-EFFECTIVE CARE VIA TECHNOLOGY: A component of Alaska’s high costs includes providing rural services as well as a limited workforce. The technology is available to provide care using telemedicine but currently there is no way for providers to be reimbursed for services provided via telecommunications equipment. For example, Colorado has a system which allows for Medicaid reimbursement for telecare services provided “live”. The recipient and the distant provider interact with one another in real time through an audio-video communications circuit. Potentially, a provider could increase its capacity and increase efficiency by focusing hands-on (more expensive) care to individuals who need that level of care while using telemedicine to provide more as-needed/prompt/monitoring-type support to individuals with a lower level of care.
3. CONSOLIDATE AUDITS AND PROMOTE NATIONAL ACCREDITATION: AADD recommends that audits be consolidated and responsible providers receive recognition. We support the identification and pursuit of any truly fraudulent or abuse billing of Medicaid. One provider can experience as many as seven different Federal and State audits annually, if they provide developmental disability, senior and behavioral health services. The increasing frequency of audits over the past decade has forced providers to increase administrative costs in order to provide adequate and timely responses to audit requests. Responding to multiple audits requires additional levels of infrastructure and resources by providers which detracts from service delivery, especially given current rates. And it increases the cost of doing business. There is currently no recognition of those programs who are billing responsibly and accurately. We propose that consideration be given to programs that have a history of clean audits or who consistently meet accreditation standards set by national accreditation bodies. That consideration could allow programs with an error rate below 5% to bypass the next round of audits, representing cost savings to the State and provider audit systems. Programs not showing improvement in their billing errors would require close monitoring and repeated audits. Providers are also interested in whether the audits are proving successful in the sense of a global reduction of errors in the last five years. If so, that information would both provide support to the work of the Division of Health Care Services as well as the programs offering services.
4. DEVELOP UNIVERSAL TRAINING FOR DIRECT SERVICE WORKERS: AADD recommends universal training for direct service workers to reduce training costs of providers. A significant portion of the cost to providers of recruiting and training direct service staff could be reduced through universal training. Providers appreciate the recent background check regulation allowing fingerprinting to follow the worker. Similar evidence of universal training offered through the Trust Training Cooperative at the Center for Human Development could follow the worker, and there would be a cost savings to providers while assuring a consistency and quality of training.
5. FULLY IMPLEMENT THE COMPLEX BEHAVIOR COLLABORATIVE: AADD recommends re-visiting the report developed by WICHE which clearly outlines the costs and risks in not adequately addressing the needs of Alaskans with cognitive disabilities and complex behavioral needs. Alaska has only implemented one small part of the recommendations. To truly impact the current high costs related to this particular group of individuals, the remaining recommendations need to be operationalized, including developing an acuity rate system which recognizes a spectrum of care needs.

AADD supports many of the recommendations of the Medicaid Reform Advisory Group. We do have significant concerns regarding a few of the recommendations which are documented below.

4. PERSON CENTERED CASE MANAGEMENT

**AADD supports this recommendation and sees a need for a plan designed to define and coordinate efficient and effective case management across the Department, not siloed or duplicated by Divisions, to include: Care Coordination, Case Management and Person Centered Planning.**

Advisory Group recommends the Department identify and draft the necessary regulations to implement a care management program for the over utilization of services by Medicaid patients, and start identifying and working with providers and making necessary regulations to implement a case management system for all Medicaid recipients.

5. COMPREHENSIVE PAYMENT REFORM

**AADD recommends that cost-based rates be developed through a manageable and equitable cost data collection methodology, which may include the addition of service categories which are more suited to the unique service delivery challenges of Alaska. AADD recognizes that payment for “bundled services” could potentially afford cost savings but cautions against the risks of loss of choice for recipients who wish to receive services from a variety of service providers in accordance with a person-centered plan.**

Advisory Group recommends the Department form a comprehensive payment reform working group comprised of stakeholders including medical providers, payers, and patients to review and make recommendations on which payment reform systems could be implemented in Alaska.

8.  CONFLICT FREE CARE COORDINATION

**AADD recommends that the Department view Conflict Free Case Management as compliance with CMS Final Rule rather than a cost savings strategy.**

**AADD further recommends the development of a plan designed to define and coordinate efficient and effective case management across the Department, not siloed or duplicated by the Division, to include: Care Coordination, Case Management and Person Centered Planning.**

Advisory Group recommends the Department move towards conflict free care coordination and table the innovation outlined in #8 until the results can be quantified and evaluated.

10. COST SAVINGS THROUGH CONTRACTED SERVICES

**10a. AADD supports the Advisory Group recommendation.**

Advisory Group recommends the Department not restrict the Alaska pharmacy providers from providing prescriptions, but should explore the option of a contract pharmacy for a limited number of specialty drugs as new specialty prescriptions or bio-meds become available and mandated by law.

**10b.** **AADD supports the recommendation of the MRAG group to use contract nurses, in addition to state staff nurses, to determine eligibility and re-assessment for services, with an understanding that the training and oversight will assure consistency in ratings.**

Advisory Group recommends the Department contract out for Medicaid Home and Community-Based Waiver and Personal Care Assessments.

**10c. AADD supports the Advisory Group recommendation with quality oversight by SDS to assure objective and timely assessments.**

Advisory Group recommends the Department use contract services for all or part of the assessments or re-assessment, and that it is not restricted in the types of personnel to be used for this purpose.

12. REDUCE BENEFITS TO ESSENTIAL BENEFIT PLAN (FOR STATE PLAN BENEFITS ONLY)

**AADD supports the Group’s tabling of this option**.

Advisory Group passes on innovation #12 but instructs the Department to watch the issue of recipient accountability.

13. ELIMINATE LOOPHOLE ALLOWING RESPONSIBLE RELATIVES REFUSING TO FINANCIALLY SUPPORT RELATIVE SO THE RELATIVE CAN OBTAIN MEDICAID

**AADD strongly opposes this option. This option will place needed residential services beyond the financial ability of many families, whether the need is for NICU or behavioral health residential services.**

Advisory Group recommends the Department review the eligibility into family financial responsibility provision by exploring the potential capping of services and reviewing the elimination of the loophole allowing relatives to refuse financial support for Medicaid eligible recipients.

15. UTILIZATION LIMITS FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAP & SPEECH-LANGUAGE THERAPY

**AADD supports the Advisory Group recommendation that the Department adopt utilization limits for PT, OT, and speech therapy through a benefit design.** **It is recommended that the current six month plan of care approval be maintained for early intervention.**

Advisory Group recommends the Department adopt innovation number 15.

18. MEDICAID FEE-FOR-SERVICE INCREASE CO-PAYS, ADD NEW COPAYS, INCREASE ANNUAL CAP

**AADD does not support an increase in co-pays until such a time as there exists an IT system that will allow for its implementation and tracking. AADD does support the recommendation that the Department continue to investigate increases and sustained co-pay strategies.**

Advisory Group recommends the Department continue to investigate increases and sustained co-pay strategies until such a time as there exists an IT system that will allow for its implantation and tracking. Until such a time there is no recommendation to increase co-pays.

19. ALLOW AGED & PERMANENTLY DISABLED WITH FIXED INCOMES TO AUTOMATICALLY RENEWED BASED ON COST OF LIVING INCREASES

**AADD supports the Advisory Group’s recommendation**.

Advisory Group recommends the Department adopt innovation number 19.

20. EXPAND SCOPE OF PRACTICE FOR RNS, LPNS, & HOME HEALTH AIDS

**AADD supports the Advisory Group recommendation to disregard this option, as the Medicaid program does not have the regulatory authority to expand the scope of practice for RNs, LPNs and Home Health Aids**.

Advisory Group recommends the Department disregard innovation number 20

21. LIMIT TOTAL MEDICAID SPENDING TO NO GREATER THAN 4% ANNUAL GROWTH

**AADD supports revisiting this item once cost-based rates have been established.**

Advisory Group recommends the Department establish a plan to manage Medicaid growth to 4% per year or less and implement that plan to the best of its ability.

22. 1915K – CAPTURE ADDITIONAL 6% FEDERAL MATCH. CHANGE 1915 C WAIVER SYSTEM TO 1915K. INCLUDE PCA SERVICES.

**AADD recommends that the Department obtain some assurance of the ongoing stability of the FMAP sought before changing from 1915 C waiver system to a 1915 K and 1915 I waiver plan. Although this would allow for an additional 6% federal match the added complexities of managing two waiver types, coupled with the requirement that states must not have a waitlist may increase overhead costs which renders this benefit ineffective, or unreimbursed if the FMAP is reduced.**

Advisory Group recommends the Department adopt innovation number 22.

23. ACROSS THE BOARD RATE FREEZE FOR ONE YEAR

**AADD does not support an across the board rate freeze**.

**Providers are currently experiencing significant financial pressures. Reimbursement from the Xerox remains problematic. The Conditions of Participation in state regulations, passed in July 2013, impose additional “unfunded mandates” at greater cost to providers. The Affordable Care Act adds additional administrative burden for employers. The CMS Final Rule regulations will have significant impact on almost all providers with the loss of care coordination staff. Home and Community Based rates were frozen from 2005 to 2008 and rates were determined during that freeze. Another freeze will inhibit the ability of the current work on developing fair rates that mirror the cost of services. AADD strongly supports the Advisory Group recommendations that the Department work with providers to reduce the overall administration burden and cost of existing and potential new regulations.**

Advisory Group recommends the Department work with providers to actualize a one year rate freeze. Additionally, the Advisory Group recommends the Department work with providers to reduce the overall administration burden and cost of existing and potential new regulations.

AADD thanks the Medicaid Reform Advisory Committee for this opportunity to share ideas toward the sustainability of Medicaid combined with ease of system navigation for providers and providing whole care for patients and recipients of services.

Sincerely,

Lizette Stiehr

Executive Director, AADD