ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

February 29, 2024

Director Lori Wing-Heier
Alaska Division of Insurance
Department of Commerce, Community,
and Economic Development
Juneau AK, 99811
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Dear Director Wing-Heier,

For 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and a growing number of healthcare partners across the continuum of care. AHHA members play an invaluable role, both as community providers and essential employers, in cities, towns, and villages across Alaska.

The Department of Commerce, Community, and Economic Development is requesting input on health care reimbursement and the future of healthcare payment in the insured market as well as other payers. The department welcomes written comments on in-network contract requirements and payment methodologies, out-of-network payment calculations, ways to pay for value-based care, direct primary care arrangements, new payment models the State should consider, as well as how government payers impact the insured market.

Given our geography, Alaska's healthcare system experiences unique challenges that are directly relevant to reimbursement for services and rethinking the future of healthcare payment. AHHA has identified four areas of impact on the cost of healthcare that are relevant for the future of healthcare payment and reform: (1) opportunities for innovation, (2) challenges with long-term care, (3) rural healthcare delivery, and (4) behavioral health.

Context for the Alaska Market

Alaska has 26 hospitals, which are categorized as follows: 13 critical access hospitals, 5 sole community hospitals, 3 general acute care hospitals, and 5 specialty hospitals (which include 2 military hospitals). A significant portion of Alaska's hospitals and healthcare is run by a robust tribal health system: 8 of Alaska's 26 hospitals are tribal facilities.

Alaska's hospitals consist of approximately 1,500 acute care beds, which include about 160 intensive care unit beds. Given Alaska's geography, around 21% of these acute care beds are not accessible from the road system. Nationally, the average for acute care is 2.4 acute care beds per 1,000 people. In Alaska, setting aside military hospitals, psychiatric hospitals, and specialty hospitals, we have about 2.0 acute care beds per 1,000 Alaskans.

Alaska has 20 nursing homes statewide, with all but 5 nursing homes being co-located with either a critical access hospital or sole community hospital. Based on this count, Alaska has the fewest nursing homes in the country with the next closest being Vermont and Wyoming, which both have close to double Alaska's capacity. Alaska has the fewest average beds per facility

with 40 beds—the next lowest state is South Dakota with 62 beds. Finally, Alaska has the fewest long-term care beds in the country per 1,000 persons who are 65 and older, and no specialty long-term care facilities, such as Alzheimer's memory care or geriatric psychiatric and chemical dependency facilities.

Alaska ranks next to last in the country for inpatient psychiatric bed capacity. If Alaska's only psychiatric hospital runs at full capacity, Alaska has 14 beds per 100,000 residents compared to the national average of 21 beds per 100,000. Moreover, acute psychiatric services for adolescents are virtually non-existent save for the single adolescent psychiatric hospital in Anchorage, and less than five residential treatment centers statewide.

The lack of a robust system of care for behavioral health, social services, complex care needs, and post-acute placement has a profoundly negative effect on patient care. Hundreds of patients spend weeks in Alaska hospitals and nursing homes each year waiting for placement to a lower level of care, despite being medically cleared to leave. It is not uncommon for Alaska hospitals to have multiple patients "in house" for 100+ extra days because there are no lower-level placement options. This has a direct impact on healthcare costs throughout our whole healthcare system.

Insufficient pathways to care funnel patients into the most expensive and restrictive settings. Alaska's acute care hospitals are improving care within their facilities by investing in staff training, physical design, process improvements, and developing stronger relationships with community providers. However, internal improvements cannot compensate for broad deficiencies in the system of care.

Opportunities for Innovation

As the Division of Insurance evaluates the future of healthcare payment, Alaska's hospitals and nursing homes also recognize the need for real system change in Alaska. It is a given that facilities statewide are stressed from capacity and access issues, so change is critical, and we believe Alaska's healthcare providers are in the best position to lead that change from their local communities.

First, Alaska's healthcare system and geography are well-suited for testing and innovation. We have a closed environment that is less impacted by interstate travel than other states. Alaska's population is small, and there are distinct population centers in different healthcare markets. Also, Alaska has diverse provider types for experimentation, ranging from large, system-based acute care hospitals, to mid-sized, public, sole community hospitals, critical access hospitals co-located with nursing homes, and tribal entities.

Considering the need for system change and the fertile environment for innovation, AHHA recommends the State partner with providers to redesign the future of healthcare payment using 1115 demonstration projects and pilot projects through the Center for Medicare & Medicaid Innovation. The time for innovation is now, and hospitals and nursing homes want recognition and assistance at the federal level for implementing these innovation projects in Alaska.

The best example is the proposed coordinated care demonstration project on Alaska's Kenai Peninsula. More specifically, Moda Health, Central Peninsula Hospital (CPH) and South Peninsula Hospital are ready to partner with the State of Alaska to establish a high-performing system of care on the Kenai Peninsula through a Medicaid Coordinated Care Demonstration project. The proposed Medicaid coordinated care demonstration project will establish a model grounded in community-based, multidisciplinary care teams built around relationships with primary care providers. Initially connecting patients to primary care providers, the project will move to establish certified primary care medical homes that integrate and coordinate culturally sensitive care for Medicaid beneficiaries.

The proposed model will transform the local Medicaid delivery system from one that rewards volume to one that supports value and is designed to deliver better healthcare for Alaskans. This demonstration project can achieve improved outcomes while enhancing the experience for both patients and providers and reducing the overall Medicaid per capita growth rate, saving money over time for the State of Alaska.

The proposed project is modeled off the success of Oregon's Coordinated Care Organization model, where Moda was one of the founding members and is the current administrator of the Eastern Oregon Coordinated Care Organization (EOCCO) that operates in 12 rural and frontier counties serving nearly 80,000 Medicaid members. Over time the model as described above has resulted in an investment of savings by EOCCO of nearly $300 million back into Eastern Oregon through enhanced provider payments, which are the result of value-based payment models and improvements in quality measures/outcomes. Additionally, EOCCO has invested over $20 Million of the savings into grass root community initiatives to increase access to healthy foods, workforce training programs and many other initiatives as identified by the local communities that are positively impacting members social determinates of health.

The Kenai project does exactly what the Division of Insurance is contemplating for healthcare reimbursement and the future of healthcare payment in the insured market as well as other payers—uses local healthcare providers and systems to implement value-based payment models at the community level in a way that fundamentally changes how healthcare is financed in Alaska. Approving the Kenai project and maximizing opportunities for other provider-led 1115 demonstration projects and pilot projects is the single best chance we have to truly change healthcare delivery and costs in Alaska.

Challenges with Long-Term Care

As stated earlier in these comments, Alaska has 20 nursing homes statewide, with all but 5 nursing homes being co-located with either a critical access hospital or sole community hospital. Based on this count, Alaska has the fewest nursing homes in the country, the fewest average beds per facility, and the fewest long-term care beds per 1,000 persons who are 65 and older. We also have no specialty long-term care facilities, such as Alzheimer's memory care or geriatric psychiatric and chemical dependency facilities.

Based on these statistics, it is no surprise that our long-term care providers are extraordinarily vulnerable and susceptible to operational disruptions from workforce shortages, capacity strain, resident throughput problems to lower levels of care, and reimbursement delays. Long-term

care facilities are crucial to moving medically-cleared patients out of hospitals and stepping them down to lower levels of care, and given the vulnerability described above, the future of healthcare reimbursement must consider a fully-supported long-term care delivery system. This means addressing current system deficiencies that are literally crushing our providers and stifling access to care throughout the full continuum.

For example, Alaska Medicaid's administration of third-party liability (TPL) documentation requirements for claim processing stresses numerous nursing homes in our state. While the TPL requirement is federal, Alaska Medicaid's administration of it is causing millions of dollars in delayed payments to providers. The time-consuming process for attempting to resolve these massive outstanding balances is crushing on billing staff and drives up accounts receivable to levels never experienced before.

As the Division of Insurance evaluates the future of healthcare payment in Alaska, it should incorporate a deep dive into system enhancements that could automate the TPL verification process in Alaska Medicaid since long-term care coverage does not exist for most third-party payers.

Additionally, we need to take a hard look at reimbursement for lower-level facility services like assisted living. The healthcare system relies on the ability to move patients to the appropriate level of care and we are experiencing barriers throughout the post-acute environment, including assisted living. AHHA has long supported increasing assisted living rates because adequate reimbursement to these critical providers should improve the ability of hospitals and nursing homes to place medically cleared patients and residents to a more appropriate level of care that is far more cost-effective for overall healthcare spending.

Rural Healthcare Delivery

As stated earlier, Alaska has 13 critical access hospitals (CAH) including eight tribally operated CAHs. Eleven of the CAHs have a co-located nursing home. There are also five hospitals with rural or sole community hospital designations. These facilities are the center of healthcare for the rural communities / regions they serve. As the Division of Insurance considers the future of healthcare reimbursement, it is critical to recognize, preserve, and strengthen Alaska's rural hospitals to ensure that people living in rural communities have access to essential services.

Rural hospitals often have more obstacles to overcome than their urban counterparts. These include lower patient volumes and a lack of a balanced payer source. Commercial pay is typically the highest payer for hospitals, however, CAHs tend to have a lower percentage of private insurance payers. The rural payer mix generates insufficient revenue to cover high fixed operating expenses, so many rural hospitals lack the operating margins needed to access capital funding to replace or update facilities and purchase necessary health information technology or upgrades. Additionally, despite their small size, rural hospitals must also sustain a highly-trained workforce.

Rural hospitals are uniquely positioned to provide patient-centered care. Many want to try new and innovative ways of providing their communities with efficient and convenient access to high-quality healthcare across the care continuum. More specifically, there is a desire to invest

in preventive care, care coordination, and population health management initiatives. However, the existing reimbursement structures make it impossible for meaningful investment without negatively impacting financial sustainability. It is crucial that healthcare payments be specifically tailored to the needs of rural hospitals to address the unique challenges they face, including workforce shortages, geographic isolation, and financial instability.

Currently, reimbursement is focused on inpatient care and not aligned with prevention, chronic care, or population health needs. Moreover, due to low inpatient volumes, payments for services are not adequate to cover all the fixed costs of operating a rural hospital. The problem is not just the amount of payment, but the method of payment. To help keep rural hospitals open, there needs to be a fundamental shift in the way these organizations are paid. A more patient-focused payment system that is specifically designed to support both the fixed and variable costs of delivery of services is necessary.

Any effort to decrease healthcare costs must pay specific attention to rural facilities to ensure they are reimbursed and financed fairly by federal, state, and local resources, private payors, and patients such that the health of the population can be improved. The following table provides information on the small and rural hospitals in Alaska.

Critical Access Hospitals in Alaska						
Community	Hospital Name	Acute Beds	Long-Term Care Beds	Swing Beds	Tribally Operated	% Medicaid & Medicare Days
Cordova	Cordova Community Medical Center	13	10	13	No	82%
Dillingham	Kanakanak Hospital	16	0	4	Yes	57%
Homer	South Peninsula Hospital	22	28	22	No	73%
Ketchikan	PeaceHealth Ketchikan Medical Center	25	29	0	No	70%
Kodiak	Providence Kodiak Island Medical Ctr	25	22	25	No	61%
Kotzebue	Maniilaq Health Center	17	18	0	Yes	58%
Nome	Norton Sound Regional Hospital	19	15	0	Yes	73%
Petersburg	Petersburg Medical Center	12	15	5	No	55%
Seward	Providence Seward Medical Center	6	40	6	No	82%
Sitka	SEARHC/Mt Edgecumbe Hospital	25	12	20	Yes	51%
Utqiaġvik	Samuel Simmonds Memorial Hospital	14	0	0	Yes	75%
Valdez	Providence Valdez Medical Center	11	10	10	No	75%
Wrangell	SEARHC Wrangell Medical Center	8	14	8	Yes	71%

Rural/Sole Community Hospitals in Alaska						
Community	Hospital Name	Acute Beds	Long-Term Care Beds	Swing Beds	Tribally Operated	% Medicaid & Medicare Days
Juneau	Bartlett Regional Hospital	73	60	0	No	70%
Soldotna	Central Peninsula Hospital/Heritage Pl	49	60	39	No	61%
Bethel	Yukon-Kuskokwim Delta Reg Hospital	50	18	0	Yes	75%
Fairbanks	Fairbanks Memorial Hospital/Denali Ctr	152	90	0	No	62%
Palmer	Mat Su Regional Medical Center	74	0	4	No	61%

Behavioral Health

Over the past five years, two collaborative projects led by the Alaska Hospital & Healthcare Association (AHHA) have engaged a wide range of stakeholders in examining behavioral health services in Alaska and developing strategies to address the huge gaps and delays in availability and integration of services. The work identified the need for increased access to basic resources, respite care, and specialized residential settings or group homes, and an investment in a range of strategies to prevent, intervene early, and divert youth from the Emergency Department and highest-level behavioral health settings.

Access to behavioral healthcare in Alaska is challenging, and the disconnect between what treatments are covered between physical and mental healthcare significantly adds to the lack of transparency and difficulty for Alaskans looking to access needed care. The federal Mental Health Parity and Addiction Equity Act of 2008 provided a definitive legal standard that coverage for mental health and substance use disorder treatment cannot be more restrictive than coverage for other medical treatment.

However, policy challenges continue to prevent the full realization of parity. These challenges include issues such as non-compliance of insurance plans, a lack of transparency and accountability for utilization management policies and procedures, and misalignment between law enforcement and behavioral healthcare. Recent state regulatory enforcement and compliance efforts have focused on correcting insurance practices around utilization review, provider network design, formulary design, and coverage and reimbursement. These compliance examinations have resulted in substantial fines in some cases as well as other resolutions, with specific examples detailed in the following table.

State	Agency	Action
Connecticut	Insurance Department (2020/2021)	Issued $575,000 in fines against four health plan subsidiaries as well as $500,000 in payments to fund education programs.
Delaware	Office of the Insurance Commissioner (2020)	Announced completion of the first round of mental health parity examinations involving major health insurers resulting in $597,000 in parity violations. The violations included improper pre-authorization requirements for substance use disorders, unfair formulary tiers, inappropriate medication restrictions, and improper utilization management/claims processes.
Illinois	Department of Insurance (2020)	Announced fines totaling over $2 million against five major insurance companies for violating the 2008 federal parity law.
Maine	Bureau of Insurance	Requires plans under its jurisdiction to complete a checklist of coverages they must provide or must offer to provide and indicate where these sections can be found in the plans.
Massachusetts	Office of the Attorney General (2020)	Reached settlements with five health insurance companies and two companies that manage behavioral health coverage for insurers that resulted in more than $900,000 in fines.
New Hampshire	Insurance Department (2020)	Market conduct exams started in 2017 found problems with the offering of and reimbursement for mental health and substance use disorder treatments at two of the state's insurers. The department found the health plans were reimbursing providers for mental health services at lower rates

		than they do for other medical treatments but stopped short of accusing them of violating the Federal Parity Law.
New York	Departments of Financial Services and Health (2020)	Promulgated regulations authorized in the state budget (and Senate Bill 4356 above) requiring health insurers to develop and implement mental health and substance use disorder parity compliance programs by Dec. 29, 2020, and annually attest that such programs are in place. The regulations require insurers to designate an experienced individual, such as the parity compliance officer, to be responsible for assessing, monitoring, and managing parity compliance and to have written policies and procedures describing how their compliance is assessed, monitored, and managed. The regulations also identify specific practices defined to be improper under law.
Oregon	Department of Consumer and Business Services (2017)	Issued over $550,000 in fines against four health plans for parity violations related to categorical denial of mental health treatments including Applied Behavior Analysis (ABA) therapy.
Rhode Island	Office of the Health Insurance Commissioner	Completed a market conduct examination of Blue Cross/Blue Shield of Rhode Island in 2018 that resulted in the company agreeing to pay $5 million to expand mental health services. The money, in lieu of a traditional fine, was directed into a fund at the RI Foundation, which is used for prevention of mental health problems and intervention.

Efforts to align policies and practices for coverage of behavioral healthcare by insurance companies operating in the State of Alaska with the nationally defined legal standards has the potential to improve access to care for Alaskans and begin to eliminate inequities perpetuated within the system of care.

Conclusion

Thank you for the opportunity to provide input on health care reimbursement and the future of healthcare payment in the insured market as well as other payers. Healthcare is complex, and we hope you find our comments around the four areas of impact relevant for the future of healthcare payment and reform. We stand ready to partner with you on these and other efforts as you continue working to address Alaska's healthcare challenges.

Sincerely,

Jared C. Kosin, JD, MBA
President & CEO