FAQs – Home and Community Based Waiver and Personal Care Services Rate Methodology

OVERVIEW

1. Does the new regulation change rates?
Response: No. This regulation changes the way in which future rates are calculated. The *earliest* new rates could be set using this methodology is January 1, 2018, with sometime after July 1, 2018 being more likely*.

* All rates are subject to legislative appropriation, and in the current budget climate, we cannot guarantee any rate increases due to the efforts to rebasing rates based upon costs. However, the rate rebasing process is critical so we can establish the correct rates for these important services going forward.

2. Why is the Department changing its rate methodology?
Response: The current rate methodology for Home and Community Based Waiver (HCBW) and Personal Care Attendant (PCA) providers requires all providers to submit a financial report annually. This is a large administrative and financial burden for smaller providers. The proposed Target Rate Methodology requires a smaller number of providers to report. There will be approximately 30-40 providers who will be required to submit and will account for a majority of the services paid for under the 1915(c) waiver. This will relieve a majority of providers from having to submit annual reports.

3. What is the new target rate methodology?
Response: Please review the Personal Care & HCB Waiver Medicaid Rate Setting Methodology document adopted by reference in the proposed regulations for a detailed account of the methodology.

As a high level overview, the methodology changes the number of providers who are required to submit annual reports. Under current regulations, all providers must report. Under the proposed regulations, the Department utilizes claims data to identify the providers that provide the most units of service for each service. Providers identified under this process are then requested to submit their annual report to inform rate setting. All other providers will not need to report.

The methodology also lists the detail steps that will occur with the target providers’ cost reports after they are submitted to the Department in setting future rates. This process is a highly complex step by step process that takes into account geographic factors, inflation, room and board, units of
service, an access factor and stop loss principles. The process cannot be easily summarized separate from that document.

4. Are all HCBW and PCA service rates set using the Target Methodology?
Response: No. The target methodology does not include Residential Supported Living services and Care Coordination services. The regulations list separate methodologies for these services.

5. I am a care coordinator or assisted living provider. Since we are not in the target methodology, do we still need to submit annual reports when the new regulations become effective?
Response: No. Standalone residential supported living (T2031, T2031 US, T2031 UR) and care coordination agencies will not be required to submit annual reports and cannot be target providers.

If an agency offers other HCBW/PCA services in addition to residential supported living (T2031, T2031 US, T2031 UR) and care coordination, and they are identified as a target provider due to their utilization of the other HCBW/PCA services, they may be required to submit annual reports.

6. When will the new regulations become effective?
Response: The proposed regulation completed public comment on December 9th, 2016. As the regulations still have to go through internal review, Department of Law Review, and to the Lt. Governor, it will be several more months until the regulations are effective.

CARE COORDINATION

7. What is the methodology for Care Coordination services?
Response: Until July 1, 2018, the rates for care coordination services will remain at the same rates. If inflation is granted in SFY18, an inflation factor will be applied to rates in FY19.

Some providers have entered into a two year pilot project to provide an “enhanced care coordination service. This service has additional requirements, so has a higher payment rate to compensate for additional quality measurement oversight, training, and supervision by the participating care coordination agencies.

Since enhanced care coordination is done through individual provider agreements, it is not mentioned in the proposed regulations.

8. What will happen with rates for Care Coordination services after July 1, 2018?
Response: As discussed in #7, if inflation is approved in FY18, it will be applied to FY19 rates. If the two year enhanced care coordination pilot project proves valuable, the enhanced care coordination rate will be put into regulation.
RESIDENTIAL SUPPORTED LIVING

9. What about Residential Supported Living services? How will rates for those services be set in the future?

_Response:_ Residential Supported Living services will be set using a percentage of the average Anchorage Nursing Home rates. The percentage will be determined by looking at the Medicare Cost Reports for the Anchorage Nursing Homes and identifying expenses that are allowable in assisted living. Certain costs are incurred by a nursing facility that is not allowed to be reimbursed by Medicaid in an assisted living facility. These expenses include but are not limited to Room & Board, Physical Therapy, Occupational Therapy, etc. For the full details on the proposed rate methodology, please review Personal Care & HCB Waiver Medicaid Rate Setting Methodology document adopted by reference in the proposed regulations.

10. I thought we were supposed to have acuity tiered rates for Residential Supported Living services?

_Response:_ The Department worked with the provider community on establishing an acuity based reimbursement system for Residential Supported Living. That effort was hold while the Division of Senior and Disabilities Services prepares to transitions to using a new assessment tool to assess the functional needs of recipients for all home and community based services.

Therefore, the proposed regulations do not include tiers but include methodology for a single rate based off a percentage of the average Anchorage Nursing Home rate.

11. So when are the rates using this methodology going to be effective for Residential Supported Living services?

_Response:_ Like the Target Rate System, the earliest new rates could be set using this methodology is January 1, 2018, with sometime during SFY19 being more likely.

TARGET RATE METHODOLOGY

12. How will the Department determine which providers are target providers will be required to report annually?

_Response:_ For each service category except for Transportation - paratransit services (T2003 CG), care coordination services and residential supported living services, total Medicaid units of service will be identified and organized by provider Tax ID over the most recent state fiscal year for which timely filing has passed. Starting with providers who provided the highest number of Medicaid service units and working down to providers who provided the lowest number of Medicaid service units, the Office of Rate Review will rank the providers (highest unit providers to lowest unit providers) until either 90% of the Medicaid service units are represented or 5 providers are identified, whichever occurs first. Each service category is defined as the procedure codes and modifiers that are reported together in a cost center on the expense worksheet of the cost survey. For example, Day Habilitation-Individual and Day Habilitation-Group are reported together in a cost center on the expense worksheet and will be analyzed together to determine the highest providers of day habilitation services. For services that are reported together in which the units of service are
different, such as Adult Day Care – 15 minutes and Adult Day Care – Half Day, the half day units will be recalculated into 15 minute units using 3.5 hours as the standard half-day time.

13. How will I know if my organization is a Target provider?
*Response:* Once the Office of Rate Review identifies the target providers for each service category, it will generate a target list consisting of the identified providers and their corresponding fiscal years. If a provider is a target provider for multiple services, the target provider will be listed once on the list. On August 1st of each year, ORR will publish the most recent target list on its website, and notify providers through the SDS E-Alert system. As stated above, the target list is based on Medicaid service units provided during dates of service in the most recent state fiscal year for which timely filing has passed. For example, the target list published on or after August 1, 2017 will be based on dates of service between July 1, 2015 and June 30, 2016.

14. Will I only have to report expenses for the services that I am in the top 5?
*Response:* No, Target providers will be required to report all expenses so that the expenses on the provider’s Audited Financial Statements tie to the total expenses reported on the cost report expense worksheet. This means Target providers that provide care coordination and/or residential supporting living services in addition to other HCBW services will need to report on all services provided.

15. Are annual reports still due 9 months after the provider’s fiscal year?
*Response:* No, taking in effect public comment, the proposed regulations require providers to submit annual reports 7-8 months after the provider’s fiscal year. This proposed change is a result of collaboration with provider organizations to allow the Department to use more recent historical cost information to avoid “stale data”. The decision between 7-8 months will be made as part of internal review of public comments.

16. Are annual reports the same as the ones we have previously submitted?
*Response:* No, the proposed regulations include a new requirement: a reconciliation of the post-audit working trial balance to the expense worksheet of the cost survey. This will allow the Department to help providers ensure that costs have been captured in the correct cost center. In addition, collaboration with provider organizations has resulted in changes in the Cost Survey adopted by reference. These changes are minor and include new expense subcategories within each cost center and a home office cost report sheet.

17. Do I have to fill out the home office cost report sheet?
*Response:* If you organization has a separate entity that provides management services, a home office cost report must be submitted. However, the Department will allow providers to submit their own home office cost report rather than fill out the Alaska Cost Survey home office cost report sheet if pre-approved by the Department.

**CURRENT REPORTS**

18. Are reports for FY16 due from all providers?
Response: Until the new proposed regulations become effective, 7 AAC 145.531 is still in effect requiring all providers to submit an annual report. The Department has waived the requirement to submit an FY16 annual report for all providers via a letter sent over the SDS E-Alert system and placed on the Office of Rate Review website at http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx.

VOLUNTARY FY16 SUBMISSION FROM TARGET PROVIDERS

19. I thought we were going to have the target providers submit FY16 reports under this new methodology?

In working with the provider community, the Department and stakeholders have been attempting to use FY16 reports to inform rates on or after January 1, 2018. Due to changes during the regulatory process, the proposed regulations were not effective on or before August 1, 2016. Therefore, the Department cannot require potential target providers to submit cost information.

The Department will attempt to ask target providers to voluntarily submit their FY16 reports to be used to inform rates on or after January 1, 2018.

20. Who are the providers that are requested to submit their FY16 annual reports voluntarily?

Response: The list of providers who are requested to report are:

**State Fiscal Year Providers**
1. Access Alaska Incorporated
2. Assets Inc
3. Center for Psychosocial Development, Inc
4. Community Connections
5. Day Break (Anchorage Community Mental Health Services)
6. Fairbanks Resource Agency
7. FOCUS
8. Frontier Community Services
9. Hope Community Resources
10. Kenai Senior Services
11. Mat-Su Senior Services
12. Mat-Su Services for Children and Adults, Inc.
13. REACH, Inc.
14. The Arc of Anchorage
15. Wasilla Area Seniors Inc

**Federal Fiscal Year & 8/31 FYE Providers**
16. The Salvation Army
17. Easter Seals Alaska

**Calendar Fiscal Year Providers**
18. AAA Alaska Cab Inc
19. Consumer Direct Care
20. Genacta In Home Care
21. Good Samaritan Care Services Corporation
22. Greenwood Lodge Adult Day Care Services
23. Hearts and Hands Adult Day
24. Hearts and Hands of Care Inc
25. Nataliya's Care Services, LLC
26. Quickride LLC
27. Redi Rides of Alaska
28. ResCare HomeCare

**Unknown Fiscal Year End Providers**
29. Health Court Foods, Inc.

21. **When are the providers listed above requested to report?**

*Response:*
Providers are requested to submit their FY16 annual reports. SFY16 (July 1, 2015 – June 30, 2016) providers are requested to submit information on May 31st, 2017. FFY16 (October 1, 2015 – September 30, 2016) and August 31st (September 1, 2015 – August 31, 2016) fiscal year end providers are requested to submit information on May 31st, 2017. CY16 providers are requested to submit information on July 31st, 2017.

The Department will submit summary level claims information to each provider for their billed and paid FY16 claims to help fill out the Revenue and Statistics page.

22. **What information is being requested from the voluntary target providers?**

*Response:*
The information requested from voluntary target providers includes:
1. A completed cost survey, including a signed cover letter
2. Audited financial statements
3. Post audit working trial balance that ties to the audited financial statements
4. A reconciliation of the post audit working trial balance to the Expense Worksheet of the cost survey

23. **What happens if the Department does not get enough response from the requested providers voluntarily?**

*Response:*
If the Department cannot get enough interest from requested providers to submit FY16 reports voluntarily, the rate rebasing effort (pending the proposed regulations becoming effective) would have to wait until August 1, 2017 to publish the target providers and use FY17 reports submitted in CY18 to calculate rebased rates that would be effective on or after January 1, 2019.