Home and Community Based Waiver and Personnel Care Attendant Payment Rate and Cost Survey Information

Frequently Asked Questions July 13, 2012

Question 1. When do I need to complete and send in the first financial data and cost survey?

Answer 1. The first Cost Report (financial data and cost survey) will relate to the first provider fiscal year that begins on or after January 1, 2011. Based on the three most common fiscal years the first report will be:

- January 1, 2011 through December 31, 2011; Cost Report due 9 months after year end or October 1, 2012,
- July 1, 2011 through June 30, 2012; Cost Report due 9 months after year end or April 1, 2013, and
- October 1, 2011 through September 30, 2012; Cost Report due 9 months after year end or July 1, 2013.

Question 2. Will there be an Excel version of the Cost Report made available for provider use?

Answer 2. Yes. The Department plans to make an Excel version of the Cost Survey available on the SDS website shortly before April 30, 2012.

Question 3. Will technical assistance be provided when it is time to complete the Cost Survey?

Answer 3. Office of Rate Review staff is available to assist in the understanding of the department's requirements implemented in the new payment system.

Question 4. Where do we send the Cost Survey's and the Annual Report when complete?

Answer 4. Once complete please mail the Cost Report (with Cost Survey) to Office of Rate Review; 3601 C Street, Suite 978; Anchorage, Alaska 99503-5936 or they may be emailed to a dedicated email address ORRCostReport@alaska.gov . The email address will be established later and providers will be notified through the E-Alert system.

Question 5. **P**er 7 AAC 145.520(j) the cost of room and board will be removed at $40.00 per day. How will this be applied or determined?

Answer 5. In the future after providers submit cost surveys in accordance with 7 AAC 145.535 the costs associated with room and board must be removed as non-reimbursable. The cost per day is defined as $40 per regulation. Each available bed day will be multiplied by $40 to arrive at a non-reimbursable room and board cost to be removed. Available bed days are the average number of licensed beds multiplied by the days of the year (365 or 366).

Question 6. 7 AAC 145.535(e) requires that a provider report in a manner consistent with GAAP unless otherwise specified in the cost survey instructions. Non GAAP accounting/reporting is not accurate. Thus the Chief Executive Officer would not ethically be able to sign that the cost survey is a true, correct, and complete statement. How can the CEO be expected to sign this document if it is not an accurate reflection of the costs based on GAAP?

Answer 6. A provider subject to Generally Accepted Accounting Principles (GAAP) must maintain their books and records in accordance with GAAP. Compliance with cost reporting requirements that may vary from the providers financial reporting under GAAP does not make the Cost Survey inaccurate. For example the Departments regulations require depreciable asset lives no shorter than IRS allowable lives. However GAAP will allow accelerated depreciation. The CFO can sign the Certification by Chief Executive Officer page representing the accuracy of the Cost Survey and its requirements that excludes accelerated depreciation.

The CFO is not attesting to the Cost Survey's accuracy in accordance with only GAAP. The CEO's certification asserts that the Cost Survey has been completed in accordance with the requirements in the Medicaid regulations. Therefore compliance with the regulatory requirements (GAAP and non-GAAP) is appropriate and accurate.

Example: differences between what may be reported under financial reporting under GAAP and what is reported for IRS purposes are not unusual. It does not mean that the IRS Tax Return is inaccurate. The responsible individual can sign the tax return without concerns of inaccuracy just because the IRS and Financial GAAP records are different.

Costs reported in accordance with GAAP on the Audited Financial Statements can be appropriately classified on the Cost Survey as non-reimbursable if the cost is not allowable for the Medicaid Waiver program. In that way costs can be reported in accordance with the Medicaid regulations and match the expense amount reported under GAAP in the financial statements.

Question 7. Will compilations or other reviews that are less than a full Audited Financial Statement (AFS) be acceptable?

Answer 7. No. Providers earning more than $200,000 must provide an AFS. Providers earning less than $200,000 may choose to not provide a complete AFS, however a rate reduction effective 1-1-2014 will be applied in accordance with 7 AAC 145.520(l).

Question 8. Does the Cost Survey part of the Cost Report need to be audited by the CPA firm?

Answer 8. No. Only the provider's financial statements are required to be audited.

Question 9. If the only service a provider offers is TEFRA care coordination services do I need to comply with the cost reporting requirements for Waiver and PCA providers?

Answer 9. No. The reporting requirements apply only to providers offering Home and Community Based Waiver Services and Personnel Care Services.

Question 10. If a care coordination agency that is receiving less than $200,000 in Medicaid payments provides both TEFRA and Waiver care coordination services and chooses to not provide the Cost Report information per 7 AAC 145.531(e) will the rate reduction apply to both TEFRA and Waiver client services?

Answer 10. Yes. The TEFRA rate is dependent on the providers Home and Community Based Waiver service rate. The provider's are indistinguishable. If a provider chooses to non-report the rate reduction will apply to the Waiver provider, and therefore the TEFRA provider, effective January 1, 2014.

Question 11. Must a provider report if they are a new provider and have less than 12 months of business activity to report?

Answer 11. No. New providers with less than 12 months of business activity do not need to submit an Annual Report under 7 AAC 145.531(e). The Cost Survey is part of the Annual Report (if requested) and new providers with less than 12 months of business activity will not be required to submit for the partial year. Once a provider has a complete fiscal year the requirements related to the annual report submittal are effective.

Question 12. The replies to questions 7 and 10 state that a rate reduction will not be effective until 1-1-2014. Does that mean that the rate reduction will not apply to claims for dates of service prior to 1-1-2014?

Answer 12. No. The Department intends to follow the regulations. The regulations require the penalty to be "effective 30 days after the due date". However the department does not have access to or knowledge of all provider year-end dates. Administratively the department will only be <u>certain</u> that a provider has not complied with the requirements until after December 31, 2013. Efforts to obtain provider year-end dates are currently being considered and the rate reductions for non-compliant providers may be imposed more timely.

Question 13. If I am a provider receiving less than $200,000 and want to exercise the option to not submit an Audited Financial Statement and receive only a 10% rate reduction, what documents must be submitted?

Answer 13. Providers receiving less than $200,000 in Medicaid revenue may choose to not submit an AFS and receive a 10% rate reduction. Documents that must be submitted in the Annual Report in order to not receive the additional 10% rate reduction will be:

- Working Trial Balance (7 AAC 145.520(*l*)(1)(C))
- Cover Sheet from the Cost Survey (7 AAC 145.531(e)(1))
- Statistics Worksheet from the Cost Survey (7 AAC 145.531(e)(4))
- Cost Survey if the department has requested one (7 AAC 145.531(e)(5))