DEPARTMENT OF HEALTH AND SOCIAL SERVICES

PROPOSED CHANGES TO REGULATIONS

7 AAC 145.500-.537.
MEDICAID PAYMENT RATES;
PERSONAL CARE SERVICES & HOME & COMMUNITY-BASED WAIVER SERVICES PAYMENT RATES.

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PUBLIC REVIEW DRAFT
September 7, 2016

COMMENT PERIOD ENDS: November 2, 2016

Please see the public notice for details about how to comment on these proposed changes.

Notes to reader:

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4**.** When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

Title 7 Health and Social Services.

Chapter 145
Medicaid Payment Rates

Article 6
Payment Rates; Personal Care and Home Health Care

7 AAC 145.500 is repealed and readopted to read:

7 AAC 145.500. Personal care services payment rates

(a) For providing personal care services under 7 AAC 125.010 - 7 AAC 125.199, the department will pay a unit of service at the lesser of the

(1) amount charged by the provider in accordance with 7 AAC 145.020; or

(2) rates established in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900.

(Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 8/18/2015, Register 215; am___/___/2016, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

Article 7
Payment Rates; Home and Community-Based Waiver Services

7 AAC 145.520 is repealed and readopted to read:

7 AAC 145.520. Home and community-based waiver services payment rates

(a) The department will pay a home and community-based waiver services provider in accordance with the rates and methodologies set out in this section.

(b) For care coordination services provided under 7 AAC 130.240, the department will pay a unit of service at the lesser of the

(1) amount charged by the provider in accordance with 7 AAC 145.020; or

(2) rates established in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900.

(c) For specialized medical equipment and supplies provided under 7 AAC 130.305, the department will pay at the lesser of the

(1) amount charged by the provider in accordance with 7 AAC 145.020; or

(2) the maximum allowable amount specified for that item in the *Specialized Medical Equipment Fee Schedule*, adopted by reference in 7 AAC 160.900.

(d) For specialized private duty nursing services provided under 7 AAC 130.285, the department will pay a unit of service at the lesser of the

(1) amount charged by the provider in accordance with 7 AAC 145.020; or

(2) the rate described in 7 AAC 145.250.

(e) For environmental modification services provided under 7 AAC 130.300, the department will pay at 100 percent of billed charges to a home and community-based waiver

services provider that oversees the purchase and installation of an environmental modification for a recipient. In addition, the department will pay the provider an administrative fee of two percent of the billed charges or $100, whichever is greater, if the provider is

(1) certified under 7 AAC 130.220(a) (1)(K); and

(2) an organized health care delivery system under 42 C.F.R. Part 447.

(f) For chore services provided under 7 AAC 130.245, adult day services provided under 7 AAC 130.250, residential supported-living services provided under 7 AAC 130.255, day habilitation services provided under 7 AAC 130.260, residential habilitation services provided under 7 AAC 130.265, supported-employment services provided under 7 AAC 130.270, intensive active treatment services provided under 7 AAC 130.275, respite care services provided under 7 AAC 130.280, transportation services provided under 7 AAC 130.290(a), or meals services provided under 7 AAC 130.295, the department will pay a unit of service at the lesser of

(1) the amount charged by the provider in accordance with 7 AAC 145.020; or

(2) rates established in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900.

(g) For residential supported-living services provided by state-owned and operated providers under 7 AAC 130.255, the department will pay a unit of service at the lesser of

(1) the amount charged by the provider in accordance with 7 AAC 145.020; or

(2) rates established for residential supported-living services in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900.

(h) For the types of service listed in (f) of this section, other than intensive active

treatment services provided under 7 AAC 130.275,

(1) if the provider's average per-unit allowed amount for the type of service, for claims with dates of service after June 30, 2009 and before October 1, 2009, and processed before February 3, 2010, is higher than the rate established under (f) of this section, the recipient care rate before the earlier of the effective date of newly rebased rates using the methodology established in the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology* or July 1, 2018, is the average per-unit allowed amount for the period after June 30, 2009 and before October 1, 2009.

(i) A qualified recipient receiving residential supported-living services under 7 AAC 130.255 that are assigned procedure code T2031 in the Healthcare Common Procedure Coding System (HCPCS), adopted by reference in 7 AAC 160.900, or group-home habilitation services under 7 AAC 130.265 that are assigned procedure code T2016 in the *Healthcare Common Procedure Coding System*, is eligible for, in addition to the qualified recipient's daily rate provided for under (f) and (h) of this section, an acuity add-on rate at the daily rate established in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900. For purposes of this subsection, a qualified recipient is a recipient for whom the department has given prior authorization under 7 AAC 130.267 for additional services.

(j) If a recipient has been determined eligible for Medicaid coverage under 7 AAC 100.002(d) (8), the recipient's income, exclusive of the personal needs allowance and other deductions described in 7 AAC 100.550 - 7 AAC 100.579 is a prior resource for home and community-based waiver services. Once the department has determined the recipient's monthly liability under 7 AAC 100.550 - 7 AAC 100.579, the recipient shall pay that liability toward the

cost of care for home and community-based waiver services. If a recipient is receiving residential supported living services under 7 AAC 130.255, the recipient shall pay the liability first to the recipient's residential supported-living services provider, and second to other home and community-based waiver services providers if any monthly liability remains.

(Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 4/1/2012, Register 201; am 7/1/2013, Register 206; am 1/1/2014, Register 208; am 7/1/2015, Register 214; am 8/18/2015, Register 215; am ____/____/2016, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 145 is amended by adding a new section to read:

7 AAC 145.____. Re-establishing and adjusting payment rates in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*

(a) On or after July 1, 2017 , rates of payment in the department's *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900, shall be reestablished at least every four years using the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*, adopted by reference in 7 AAC 160.900.

(1) Rates for personal care services provided under 7 AAC 125.010 - 7 AAC 125.199, chore services provided under 7 AAC 130.245, adult day services provided under 7 AAC 130.250, day habilitation services provided under 7 AAC 130.260, residential habilitation services provided under 7 AAC 130.265, supported-employment services provided under 7 AAC 130.270, intensive active treatment services provided under 7 AAC 130.275, respite care services provided under 7 AAC 130.280, transportation services

provided under 7 AAC 130.290(a), and meals services provided under 7 AAC 130.295, shall be reestablished using annual reports in 7 AAC 145.531 as described in the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*.

(2) Rates for care coordination services provided under 7 AAC 130.240 shall be reestablished using sources that include the Alaska Bureau of Labor Statistics and the Internal Revenue Service as described in the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*.

(3) Rates for residential supported-living services provided under 7 AAC 130.255 shall be reestablished using long term care facility Medicare Cost Reports as described in the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*.

(b) Each July 1 that rates of payment in the *Chart of Personal Care and HCB Waiver Service Medicaid Rates* are not reestablished under (a), the department shall adjust the rates of payment in the *Chart of Personal Care and HCB Waiver Service Medicaid Rates* for inflation using the CMS Home Health Agency Market Basket in the most recent quarterly publication of Global Insight's *Healthcare Cost Review* available 60 days before July 1, as directed in the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*.

(c) Each July 1, rates of payment in the *Chart of Personal Care and HCB Waiver Service Medicaid Rates* that are reestablished under (a) or adjusted under (b) shall be further adjusted to reflect regional differences in the cost of doing business based on the designated planning regions described in Table I-I of the *Alaska Geographic Differential Study 2008*, dated April 30, 2009 and adopted by reference in 7 AAC 160.900, with a factor of 1.00 being the lowest factor applied and with the four southeast regional factors being

averaged to a single weighted applicable factor of 1.09. (Eff. ____/____/2016, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 145.531 is repealed and readopted to read:

7 AAC 145.531. Personal care services or home and community-based waiver services accounting and reporting

(a) For personal care services provided under 7 AAC 125.010 - 7 AAC 125.199, chore services provided under 7 AAC 130.245, adult day services provided under 7 AAC 130.250, day habilitation services provided under 7 AAC 130.260, residential habilitation services provided under 7 AAC 130.265, supported-employment services provided under 7 AAC 130.270, intensive active treatment services provided under 7 AAC 130.275, respite care services provided under 7 AAC 130.280, transportation services provided under 7 AAC 130.290(a), or meals services provided under 7 AAC 130.295, target providers, as defined in (b) and described in department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*, shall complete and submit an annual report to the department in accordance with this section.

(b) Each August 1, the department shall publish a list of providers on its website and through the State's Online Public Notice System. This list of providers shall be known as the target providers.

(1)The department shall establish the list of target providers each August 1 following the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology* using Medicaid units of service and a time period consisting of the state fiscal year that precedes the state fiscal year that ends in in the calendar year in which the list is

published.

(2) The target providers shall complete and submit an annual report to the department no later than seven months after the end of the target provider's fiscal year that ends in the calendar year in which the list is published.

(3) A state-owned and operated provider cannot be a target provider.

(c) An annual report consists of

(1) a cover sheet or letter signed by the chief executive officer indicating that the submitted information is complete and accurate to the best of the officer's knowledge;

(2) audited financial statements completed in accordance with generally accepted auditing standards (GAAS) or generally accepted government auditing standards (GAGAS);

(3) a post-audit working trial balance that ties to the audited financial statements;

(4) a completed statistics worksheet from the department's *Cost Survey*, adopted by reference in 7 AAC 160.900; the target provider shall complete the worksheet in accordance with the *Cost Survey 2016 Instructions*, adopted by reference in 7 AAC 160.900, and shall submit a completed worksheet regardless of whether the department requests a complete cost survey; and

(5) a complete cost survey if the department has requested one, including a reconciliation of the post-audit working trial balance to the expense worksheet of the cost survey.

(d) A target provider shall maintain a system of accounts, records, and books to document and track financial and statistical information related to personal care services provided under 7 AAC 125.010 - 7 AAC 125.199 or home and community-based waiver services provided under 7 AAC 130. A target provider is responsible for ensuring that financial and statistical information is adequate to report annual costs and usage by each

home and community-based waiver service provided.

(e) A target provider shall base all financial and statistical information on an accrual method of accounting and comply with generally accepted accounting principles. For the target provider to base financial and statistical information on an accrual method of accounting,

(1) revenues must be reported in the period earned, regardless of when the payment was received; and

(2) costs must be reported in the period in which they were incurred.

(f) A target provider's accounting system must be adequate to separate allowable costs from non-allowable costs and capable of producing detailed reporting of allowable costs by home and community-based waiver service. Non-allowable costs and costs not related to the provision of recipient services must be separately tracked and reported.

(g) If a target provider fails to submit a complete annual report timely, the department may reduce Medicaid payments for services listed in (a) by 20 percent, starting as early as the day following the date the complete annual report is due, with the payment reduction remaining in effect until the complete annual report is received.

(Eff. 3/1/2011, Register 197; am 11/3/2012, Register 204; am 1/1/2014, Register 208; am____/____/2016, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 145.533 is amended to read:

7 AAC 145.533. Personal care services or home and community-based waiver services allowable costs

(a) For purposes of **the annual report in** 7 AAC 145. 531**,** [- 7 AAC 145.537,] costs are allowable costs if they are reasonable, necessary, and related to the service provided. For purposes of this section,

(1) a cost is reasonable if the amount expended does not exceed what a prudent buyer who seeks to minimize costs would pay for an item or service; and

(2) a cost, direct or indirect, is necessary if it is appropriate in developing and maintaining the required standard of operation for providing recipient care in accordance with state law.

(b) **For purposes of the annual report in 7 AAC 145.531, allowable** [ALLOWABLE] costs include, subject to (a) of this section,

(1) wages, salaries, and associated costs; those costs must be commensurate with compensation paid for equivalent staff positions or similar duties on a state-specific industry level; the **target** provider shall support each cost with a timesheet, or other contemporaneous documentation, that supports time worked and the category of service if applicable; in this paragraph, "associated costs" include

(A) payroll taxes;

(B) insurance for

(i) the owner-employee;

(ii) an employee who is a related party; and

(iii) other employees and staff;

(C) payments for contract labor services; and

(D) other labor costs that can be tied directly to recipient care;

(2) travel costs for recipients and **target** providers including transportation, per diem, and meal allowances that are an allowable element of a covered service;

(3) the costs of items or services purchased for recipients that are necessary to carry out the recipients' approved plans of care;

(4) board of directors' expenses, including travel and training costs directly associated with board functions on behalf of the **target** provider, but excluding lobbying activities;

(5) bonuses to owners or other related parties, except that to be allowable, bonuses

(A) may not represent any form of profit sharing or distribution of profits;

(B) may not be determined on the level of profit earned by the **target** provider;

(C) must be clearly defined in a written agreement or employment policy;

(D) may not be made only to related parties;

(E) must be based upon the same criteria for all members of the same employee classification type; in determining the employee classification type, part-time employees may be considered a different classification type than full-time employees;

(F) must be made available to all employees of the same classification type; however, if the employee classification type predominantly consists of related parties, the bonuses are nonallowable costs; and

(G) may not be made available only to employees who are officers, stockholders, or the highest paid individuals of the organization, and may not otherwise discriminate in favor of certain employees;

(6) general service costs, including the costs of

(A) personal services and associated benefits, training, and travel of the owner, the **target** provider's executive director, and the **target** provider's secretarial, clerical, accounting, and other administrative staff;

(B) office equipment, including leased equipment, supplies, postage, related professional subscriptions, and associated procurement costs;

(C) rent, a lease, interest on capital loans, utilities, equipment, security systems, and routine maintenance; and

(D) professional dues for professional staff;

(7) contractual costs for consulting, legal, and financial accounting and auditing services directly related to the provision of care;

(8) insurance expenses, including professional liability, automobile, and facility coverage, and bonding;

(9) advertising costs limited to

(A) announcing the opening of or change of name of a facility;

(B) recruitment of personnel;

(C) advertising for the procurement or sale of items;

(D) obtaining bids for construction or renovation;

(E) advertising for a bond issue;

(F) informational listing of a **target** provider in a telephone directory;

(G) listing a facility's hours of operation; and

(H) advertising specifically required as part of a **target** provider's accreditation process; and

(10) depreciation expense on assets used in the provision of covered service care to the extent the useful lives are no shorter than the useful life allowed under 26 U.S.C. (Internal Revenue Code) by the United States Department of the Treasury, Internal Revenue Service for federal income tax purposes; equipment expense is allowable only in accordance with generally accepted accounting principles.

(c) **For purposes of the annual report in 7 AAC 145.531, non-allowable** [NON-ALLOWABLE] costs include

(1) items or services purchased for recipients that are not necessary to carry out approved plans of care;

(2) lobbying expenses;

(3) fund raising expenses;

(4) contingency funds;

(5) fines, penalties, and bad debts;

(6) contributions or donations;

(7) entertainment expenses, including meals, banquets, gratuities, and decorations;

(8) organization dues that are based on a percentage of grant award amounts;

(9) other costs not allowed under requirements or special conditions related to other state grant awards to the **target** provider;

(10) public relations and community education expenses related to advertisements, brochures, newsletters, marketing, surveys, and staff and community development activities; and

(11) costs incurred by a **target** provider related to a court or administrative proceeding initiated by a **target** provider, except that costs incurred on an issue in a court or

administrative proceeding originally initiated by a **target** provider are allowable costs if the provider is the prevailing party on the issue under a final order, and the rules governing the proceedings do not make provision for the award of fees and costs to a prevailing party.

(d) The department will evaluate the costs reported by target providers to determine the relationship to recipient care and to determine whether individual cost survey reports are reasonable and accurate for use in rate-setting determinations.

(e) Accurate cost reporting is the responsibility of the target provider. The target provider is responsible for including in the cost survey report all costs incurred, based on an accrual method of accounting, and in accordance with allowable and non-allowable cost provisions in this section and other applicable provisions of 7 AAC 105 - 7 AAC 160. The cost survey is limited to actual allowable costs and other financial and statistical information. The target provider may not impute or report a cost on the cost survey if

(1) the cost was not actually incurred; or

(2) documentation does not exist for the cost, even if the cost was actually incurred during the reporting period.

(f) A target provider shall maintain adequate documentation to support the compensation of owners and other related parties. If a target provider fails to provide adequate documentation upon request to substantiate the cost to the related party, and if that cost exceeds $5,000, the reported cost is non-allowable. The minimum documentation for each owner or related party cost in excess of $5,000 is

(1) identification of the related party's total cost;

(2) the basis of allocation of direct and indirect costs to the target provider;

(3) other business entities served by the related party;

(4) a detailed written description of actual duties, functions, and responsibilities;

(5) documentation substantiating that the services performed were not duplicative of services performed by other employees;

(6) daily timesheets or other documentation verifying the hours and days worked;

(7) the total amount of compensation paid for these duties, with a breakdown detailing regular salary, overtime, bonuses, benefits, and other payments;

(8) documentation of regular, periodic payments or accruals of the compensation; and

(9) if applicable, a detailed allocation worksheet indicating how the total compensation was allocated across all business components that received benefit of the effort.

(g) Allowable expenses in related-party transactions are reported on the cost survey at the cost to the related party. However, those costs may not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased or leased elsewhere in an arm's length transaction.

(h) Total expenses on the cost survey must match the audited financial statements.

(i) The department may determine a cost survey report to be unacceptable and return it to the target provider for

(1) use of an incorrect cost-reporting period;

(2) failure to provide required financial and statistical data or providing inaccurate financial and statistical data;

(3) failure to maintain all work papers and any other records that support the information submitted on the cost survey relating to all allocations, cost centers, cost or statistical line items, and schedules; or

(4) failure to complete the cost survey report in accordance with 7 AAC 145, other applicable provisions of 7 AAC 105 - 7 AAC 160, and the *Cost Survey 2016 Instructions*, adopted by reference in 7 AAC 160.900.

(j) A target provider shall maintain records to support cost survey information related to all expenses, allocations, statistical data, surveys, and schedules. Upon review of the cost survey report and the supporting documents listed in the *Cost Survey 2016 Instructions*, the department may make a written request for clarification, additional information, or additional documents. No later than 21 days after the department issues the request, the target provider shall provide the requested clarification, additional information, or additional documents.

(k) Documentation for all costs reported on the cost survey must be available for review and maintained for a minimum of seven years.

(*l*) If documentation is inadequate to support a reported cost, the department will disallow the cost.

(Eff. 3/1/2011, Register 197; am ____/____/2016, Register____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045

AS 47.07.030

7 AAC 145.535 is repealed:

7 AAC 145.535. Personal care services or home and community-based waiver services cost survey. Repealed. (Eff. 3/1/2011, Register 197; am 11/3/2012, Register 204; am____/____/2016, Register____)

7 AAC 145.537 is amended to read:

7 AAC 145.537. Related parties for purposes of personal care services or home and community-based waiver services

For purposes of **7 AAC 533,** [7 AAC 145.531 - 7 AAC 145.537,] a related party is

(1) a person with an immediate family relationship with an owner, director, or officer of the contracted **target** provider; for purposes of this paragraph, the following individuals have an immediate family relationship with an owner, director, or officer of the **target** contracted provider:

(A) a spouse;

(B) a natural parent, child, or sibling;

(C) an adopted parent, child, or sibling;

(D) a stepparent, stepchild, or stepsibling;

(E) a father-in-law, mother-in-law, brother-in-law, son-in-law, sister-in-law, or daughter-in-law;

(F) a grandparent or grandchild;

(G) an uncle or aunt by blood or marriage;

(H) a first cousin by blood or marriage;

(I) a nephew or niece by blood or marriage;

(2) a member of the **target** provider's board of directors or board of trustees;

(3) a person or organization that is affiliated or associated with the **target** provider in a manner that permits either entity to exercise over the other, directly or indirectly, a degree of ownership, legal control, or practical influence beyond that which occurs in an arm's length transaction.

(Eff. 3/1/2011, Register 197; am ____/____/2016, Register____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045

AS 47.07.030

7 AAC 145 is amended by adding a new section to read:

7 AAC 145._____. Exceptional changes to payment rates for home and community-based waiver services and personal care services

(a) If application of the methodology in the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology*, adopted by reference in 7 AAC 160.900, results in a rate in the *Chart of Personal Care and HCB Waiver Services Medicaid Rates*, adopted by reference in 7 AAC 160.900, that does not allow reasonable access to quality care provided by an efficiently and economically managed provider, the department may increase the rate or rates if:

(1) The department finds by clear and convincing evidence that the rate established using the department's *Personal Care & HCB Waiver Medicaid Rate Setting Methodology* does not allow for reasonable access to quality care provided by an efficiently and economically managed provider; and,

(2) Increasing the rate or rates is in the public interest.

(b) In determining whether increasing the rate or rates is in the public interest, the department must consider at least:

(1) the necessity of the rate increase to allow reasonable access to quality care provided by an efficiently and economically managed provider;

(2) the assessment of continued need for the services in the community;

(3) whether providers have taken effective steps to adopt effective strategies to alleviate or avoid the future need for exceptional changes to payment rates;

(4) whether Medicaid recipients will lose access to Medicaid services available to the general public in the same geographic area if exceptional changes to payment rates are not made;

(5) the availability of other resources to providers; and

(6) other factors relevant to assess reasonable access to quality care provided by an efficiently and economically managed provider.

(Eff. ____/____/2016, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040 AS 47.07.045