DEPARTMENT OF HEALTH & SOCIAL SERVICES

PROPOSED CHANGES TO REGULATIONS

7 AAC 140. Medicaid Coverage; Facility and Facility-Based Services.
Sec 700. End-stage renal disease facility enrollment requirements.

7 AAC 145. Medicaid Payment Rates.
Sec 607. End-stage renal disease facility payment rate.

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PUBLIC REVIEW DRAFT
June 13, 2018

COMMENT PERIOD ENDS: August 2, 2018

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paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.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 140. Medicaid Coverage; Facility and Facility-Based Services.
Sec 700. End-stage renal disease facility enrollment requirements.

7 AAC 140.700. End-stage renal disease facility enrollment requirements.

7 AAC 140.700 is amended by adding a new subsection to read:

(c) On or before the last day of the sixth month after the close of its fiscal year, an end-stage renal disease facility shall submit an annual report to the department. The annual year-end report must be submitted as required even if the clinic did not provide medical services to Medicaid recipients during that fiscal year. The annual year-end report shall include the following items:

(1) the most recent uniform Medicare cost report submitted by the facility to the facility's Medicare fiscal intermediary;

(2) any supporting schedules submitted with the facility's Medicare cost report or otherwise submitted in support of the Medicare cost report that were transmitted to the Medicare fiscal intermediary;

(3) audited financial statements that include financial information specific to the reporting facility for the time period that matches the submitted Medicare cost report. The submission must also include any audit adjustments made by the financial statement auditors;

(4) reconciliation of the audited financial statements to Worksheet A of the submitted Medicare cost report;

(5) the facility's post-audit working trial balance;

(6) reconciliation of the post-audit working trial balance to Worksheet A of the Medicare Cost Report; and

(7) appropriate Medicaid Form E-1 reporting forms, adopted by reference in 7 AAC 160.900.

7 AAC 140.700 is amended by adding a new subsection to read:

(d) If an end-stage renal disease facility receives an extension for timely filing a Medicare cost report from the facility's Medicare fiscal intermediary, the facility must forward to the department a copy of the Medicare fiscal intermediary's letter that grants the extension within 30 days of the date on the letter. After receipt of the letter, the department will grant a corresponding extension for the facility's year-end report.

7 AAC 140.700 is amended by adding a new subsection to read:

(e) The department will withhold two percent (2%) of the treatment payment due to any facility that fails to submit complete information as required in (c) of this section.

7 AAC 140.700 is amended by adding a new subsection to read:

(f) Each annual year-end report will be date stamped upon receipt by the department. The department will acknowledge the date of receipt in a written notice either by mail using the United States Postal Service, or by e-mailing the facility. Within 20 days after receipt of an annual year-end report, the department will review the report to determine whether all required items have been submitted and are complete. The department will

(1) send a written notice to the facility either by mail using the United States Postal Service, or by e-mail during the department's 20-day review period if the department determines that the annual year-end report is incomplete;

(2) clearly identify in the written notice, the deficiencies and the time by which the corrected or modified annual year-end report must be received by the department. The department will give the facility at least seven days following receipt of the notice to submit the corrected or modified annual year-end report to the department. If the department does not provide written notice during the 20-day period, the department will treat the year-end report as complete.

7 AAC 140.700 is amended by adding a new subsection to read:

(g) The department may conduct audits, perform special analysis, and review the records of an end-stage renal disease facility to verify compliance with Medicare and Medicaid regulations. A facility shall provide to the department financial and all other information regarding Medicaid claims for services provided by the facility to eligible recipients and shall provide access to all facility locations and records as requested by the department.

(Eff. 4/1/2012, Register 201; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.070

AS 47.07.030

Title 7 Health and Social Services.
Chapter 145. Medicaid Payment Rates.
Sec 607. End-stage renal disease facility payment rate.

7 AAC 145.607. End-stage renal disease facility payment rate.

7 AAC 145.607(a) is amended to read:

(a) The department will pay a facility that meets the requirements of 7 AAC 140.700 - 7 AAC 140.720 a composite, per-treatment payment rate [OF $1,000] for hemodialysis and **a separate composite per treatment payment rate** [$500] for peritoneal dialysis. **The facility may bill a maximum of one treatment per day, and a maximum of three hemodialysis treatments per week. The facility shall be required to medically justify billing more than the allowed maximum .The composite per treatment payment rates for hemodialysis and peritoneal dialysis will be adjusted annually each July 1.**

7 AAC 145.607(b) is amended to read:

(c) [(b)] The rates established for end-stage renal disease facilities are all-inclusive, except that the department will pay separately for erythrocyte-stimulating agents and parenteral iron replacement products in accordance with 7 AAC 145.410(g).

7 AAC 145.607 is amended by adding a new subsection to read:

(b) The composite, per treatment payment rates for hemodialysis and for peritoneal dialysis will be calculated as statewide weighted averages. The department will use the following to develop the statewide weighted averages:

(1) Alaska Medicaid claim information from the Medicaid Management Information System that identifies the number of hemodialysis and separately the number of

peritoneal dialysis treatments delivered to Alaska Medicaid recipients during the most recent calendar year for which timely filing has passed; and

(2) the Average Cost Per Treatment included on Medicare Cost Reports filed with the Medicare fiscal intermediary by end-stage renal disease clinics in accordance with 7 AAC 140.700(c) for the calendar year that aligns with the information gathered under 7 AAC 145.607(b)(1).

(A) The cost for the hemodialysis cost per treatment will be taken from the *Average Cost of Treatments* values entered on the *Computation of Average Cost Per Treatment Basic Composite Cost* worksheet for maintenance hemodialysis portion of the *Medicare Cost Reports* received from end-stage renal disease facilities in accordance with 7 AAC 140.700(c).

(B) The cost for the peritoneal cost per treatment will be taken from the *Average Cost of Treatments* values entered on the *Computation of Average Cost Per Treatment Basic Composite Cost* worksheet for *Home Program Continuous Ambulatory Peritoneal Dialysis (CAPD)* and for *Home Program Continuous Cycling Peritoneal Dialysis (CCDP)* portion of the *Medicare Cost Reports* received from end-stage renal disease facilities in accordance with 7 AAC 140.700(c). If the average cost of treatments from the *Computation of Average Costs Per Treatment Basic Composite Cost* are reported as weekly costs on the *Medicare Cost Report*, the department will divide hemodialysis values by three treatments per week and peritoneal dialysis values by seven treatments per week to calculate the average cost per daily treatment.

(Eff. 4/1/2012, Register 201; am 1/1/2013, Register 204; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.070

AS 47.07.030