FAQs- Home and Community Based Waiver and Personal Care Services Rate Methodology and Target Provider List

GENERAL FAQs

1. Does this notice apply to me?

Response: Every year on August 1 the Department will list the top service providers (Target Provider List) who are required to report that year's annual reports. The list will include the fiscal years that are to be reported, the due date of the report and if the report is a Full or Reduced report year. Please note, providers who solely bill for *transportation services, care coordination services, and residential supported living services* cannot be selected as a target provider.

2. How did the Department determine which providers are target providers?

Response: For each service category except for *transportation services, care coordination services, and residential supported living services*, total Medicaid units of service for dates of service of the prior state fiscal year, were identified and organized by provider Tax ID. (For example: the August 1, 2020, Target Provider List used SFY2019 claims.) 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 ranked the providers until either 80% of the Medicaid service units were represented or 5 providers were identified, whichever occurred 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.

3. Will a Target Provider List be published every year?

Response: Yes, a new Target Provider List will be published every year and will be made available on the website https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx under List of Target Providers or upon request at orrcostreport@alaska.gov after August 1st.

4. If my organization is not selected as a target provider this reporting cycle, could I be picked to be a target provider in future years? How will I know if I am picked?

Response: Each August 1, a new Target Provider List is selected using the criteria listed in the Personal Care & HCB Waiver Rate Setting Methodology. It is possible that a provider would not be selected to submit annual reports in one reporting cycle, but due to the ranking produced using the provider's Medicaid claims the next year, be selected to submit annual reports in the next reporting cycle. Each August 1st, the Department will notice the Target Provider List in the following methods:

1. Publicly notice on the Alaska Online Public Notice System
2. Submit an SDS e-Alert.
3. Post the list on the Department's website currently located at: http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx.

5. What is a Full annual report and how is a Reduced annual report different?

Response: A Full annual report, as specified in 7 AAC 145.531(c), consists of:

1. A completed cost survey, including a signed cover sheet
2. Audited financial statements (AFS)
3. Post audit working trial balance that ties to the AFS
4. A reconciliation of the post-audit working trial balance to the expense worksheet of the cost survey

This information will be utilized by the Office of Rate Review in accordance with the Personal Care & HCB Waiver Rate Setting Methodology to help inform future Personal Care and Home and Community Based Waiver rates.

A Reduced annual report has the same components as a Full annual report listed above, except that 1) only the certification letter and the statistics worksheet of the cost survey are required, 2) a reconciliation of the post audit working trial balance to the expense worksheet of the cost survey will not be required, and 3) providers that have less than $750,000 in Medicaid revenue related to personal care services or home and community based waiver services may submit reviewed financial statements instead of audited financial statements. This applies **ONLY** when a Reduced report is required.

6. When are the annual reports due for the target providers and for which years are they required to report?

Response: Providers listed on the August 1 Target Provider List are required to submit their annual report within 8 months of the provider's fiscal year end. The annual report must cover the fiscal year that ends in the year as noted on the list.

Report	Due On
Fiscal Year Ending June 30 (SFY)	February 28
Fiscal Year Ending August 31 (FYE)	April 30
Fiscal Year Ending September 30 (FFY)	May 31
Fiscal Year Ending December 31 (CY)	August 31

For example, the following reports would be due to the Department for providers listed on the August 1, 2024, Target Provider List.

Report	Due On
Fiscal Year Ending June 30, 2024 (SFY24)	February 28, 2025
Fiscal Year Ending August 31, 2024 (FY24)	April 30, 2025
Fiscal Year Ending September 30, 2024 (FFY24)	May 31, 2025
Fiscal Year Ending December 31, 2024 (CY24)	August 31, 2025

7. Where do I find the Cost Survey?

Response: The current cost survey can be found at the following link: https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx under "Documents needed to complete the Annual Report" section or a copy can be requested through email at orrcostreport@alaska.gov.

8. Where do I submit my annual report information?

Response: Annual report information can be submitted via electronic mail to: orrcostreport@alaska.gov.

While providers may submit PDF or excel versions of the cost survey and post audit working trial balance, the Department requests excel versions be submitted. Certifying signatures of the CEO on the cover sheet of the cost survey must be sent via PDF.

9. What happens if I am identified as a target provider and I do not report?

Response: Per 7 AAC 145.531(h), if a target provider fails to submit a complete annual report as outlined in the regulations, the Department may reduce Medicaid payments for services listed in 7 AAC 145.531(a) by five 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.

10. Are there instructions or assistance in how to fill out the cost survey?

Response: Yes, instructions for filling out the cost survey can be found at the following link: https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx under "Documents needed to complete the Annual Report" section or requested at orrcostreport@alaska.gov.

In addition, providers can submit questions related to the cost survey to orrcostreport@alaska.gov and staff at the Office of Rate Review will work through questions with providers. If a provider requires additional support, one on one assistance can be requested to ensure a complete and accurate report can be obtained from the provider.

11. 7 AAC 145.531(b) (2)(B) and 7 AAC 145.531(d) mentions a situation in which providers with less than $750,000 in Medicaid payment for personal care and waiver services in the applicable state fiscal year can submit a reviewed financial statement instead of an audited financial statement. In addition, the August 1 target list notes if a provider received less than $750,000 in Medicaid payments for personal care and waiver services for the applicable state fiscal year. Does that mean I can submit a reviewed financial statement instead of an audited financial statement for this reporting cycle?

Response: A provider can submit a reviewed financial statement in place of an audited financial statement **only** when the Department calls for a **Reduced** annual report **AND** the provider **Received** less than $750,000 in Medicaid payment for personal care and waiver services for the applicable state fiscal year. The Target Provider List will identify providers who may submit a reviewed financial statement by noting Yes or No on the Target Provider List in the "Less than $750,000 in Medicaid payments to PC & HCBW" column.