Guidehouse

Alaska Rate Evaluations

Long Term Services and Supports (LTSS)

Presented to:

Alaska Department of Health (DOH)

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A. Executive Summary

In this report, Guidehouse Inc. ("Guidehouse") presents our evaluation of reimbursement for Medicaid Long-Term Services and Supports (LTSS) reimbursed by the Alaska Department of Health (DOH). The programs included in this service array are 1915(c) waivers, Community First Choice (CFC), Personal Care Services, and Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Care Coordination. In addition to our focus on LTSS, Guidehouse is also evaluating other critical Medicaid services in a phased approach that divides the review into "Phase 1" and "Phase 2." Phase 1 includes LTSS as well as Behavioral Health, Medical Transportation, and Federally Qualified Health Centers (FQHC). Phase 2, following the completion of Phase 1, will include Facility Services, Professional Services, Dental Services, and Other Medicaid Rate Methodologies. The evaluations will provide specific recommendations for improvement in reimbursement in separate reports. It is important to note that this particular report is specifically tailored to Alaska Medicaid's LTSS programs. Guidehouse analysis and findings are centered around the unique needs and challenges associated with delivering LTSS options in Alaska, identifying relevant and actionable solutions for the Department and its LTSS provider partners.

Evaluation Findings and Recommendations

As a fundamental first step in our LTSS evaluation, Guidehouse collected cost information from Alaska providers as well as public industry data to determine whether current payments are adequate to cover the costs of service delivery. Guidehouse conducted a detailed provider cost and wage survey process that invited all Alaska LTSS providers within the scope of the rate review to participate. We further supplemented this survey data with a broader array of Alaska-specific and national industry data and cost standards to serve as an essential frame of reference for understanding the unique cost profile of delivering services within Alaska's LTSS system. Guidehouse employed an "independent rate build-up" methodology to model the various costs expected to be reasonably incurred in delivering each of the services reviewed in the study. These rate build-up models, which analyze rates into individual cost components, served as the basis for the benchmark rates used by Guidehouse as a standard to compare Alaska's current reimbursement to expected provider costs.

Guidehouse's comprehensive findings are summarized below.

- Current Medicaid funding for LTSS is adequate to support service delivery overall. With a few notable exceptions, individual service rates were equitable and largely aligned with service costs benchmarked by Guidehouse.
- Personal care services are home-based services critical to LTSS programs. Current reimbursement appears low and unsustainable to maintain a robust personal care workforce.
- Current LTSS rate methodologies present opportunities for greater clarity and stakeholder engagement, with enhanced transparency strengthening understanding and acceptance while supporting the implementation of more responsive acuity-adjusted rates and advancing the transition toward value-based payment reforms.
- Current LTSS reimbursement and reporting processes are unlikely to comply with the Centers for Medicare & Medicaid Services (CMS) Access Rule requirements if-and-when federal rules come into effect.

- Current LTSS geographic rate differentials are based on a methodology developed nearly 20 years ago, and Alaska will benefit from updating the underlying data to reflect more recent regional cost differences.
- Indirect costs as a proportion of total LTSS costs are substantially greater than indirect cost ratios typically observed in other states, even when accounting for Alaska's overall higher costs.
- Organized Healthcare Delivery System (OHCDS) administrative fees for Environmental Modification (E-Mod) services are low and do not incentivize providers to employ contractors to serve remote and hard-to-reach regions outside Anchorage and Mat-Su where they primarily serve today.

These findings have resulted in recommendations that aim to help align overall service reimbursement, build transparent rate models that allow for more consistent updates and potential enhancements to the Alaska Department of Health's operations to support long term goals. These recommendations are summarized as follows:

- Transition to an independent rate build-up methodology and implement benchmark rates to meet CMS Access Rule requirements and support acuity-adjusted reimbursement.
- Implement a temporary hold harmless policy or risk corridor to ease the shift to new benchmark rates and protect providers from minor payment reductions.
- Update the geographic adjustment framework to reflect current regional cost variations, replacing the outdated index used for LTSS reimbursement.
- Establish a provider cost reporting system to comply with CMS requirements, support reimbursement improvements, and monitor caregiver pay adequacy.
- Introduce tiered rates for select services to better reflect differences in service characteristics and resource needs.
- Align cost assumptions and service expectations for new residential settings with long-term plans for acuity-based reimbursement.
- Revise OHCDS administrative fees and policies for Environmental Modifications and Family Home Habilitation services.
- Plan for changes in non-medical transportation utilization if a brokerage model is adopted for Medicaid transportation coordination.
- Develop an annual rate review process to propose targeted updates based on evolving wage and cost benchmarks across LTSS services.
- Explore ways to expand tribal provider participation in LTSS delivery or coordination to leverage enhanced federal matching funds.

The combination of these recommendations resulted in projected fiscal impact either through the utilization of services or an investment from the state. All 10 recommendations are summarized in **Table 1** below and broken out by individual recommendation, since many of the recommendations can be implemented independently of one another or stair-stepped in a phased implementation based on available resources or other timing considerations. In addition, some of these recommendations require investment from the State in the form of technology costs, additional staff time, or administrative costs, separate from Medicaid claims reimbursement. These various costs are captured in the table below with assumptions built in to capture the estimated top end

and bottom end of the costs. The column "Type of Investment" indicates if the fiscal impact is either through Medicaid service utilization or administrative overheads costs to the State. States may choose to implement all recommendations at the same time or depending on budget limitations and resources they could implement a percentage of the benchmark, specific service category changes or phase in over time.

Table 1. Fiscal Impact by Recommendation

#	Recommendation	Type of Investment	Projected Min: Fed & State	Projected Max: Fed & State	Projected Min: State	Projected Max: State
LT-R1	LTSS Methodology Transition and Rate Recalibration (No Hold Harmless)	Medicaid Service Utilization	$42,758,000	$42,758,000	$19,239,000	$19,239,000
LT-R2	LTSS Hold Harmless	Medicaid Service Utilization	$763,000	$1,921,000	$338,000	$1,190,000
LT-R3	LTSS Geographic Differentials	Medicaid Service Utilization	$74,000	$669,000	$246,000	$366,000
LT-R4	LTSS Cost Reporting - Access Rule, Enhancements, and Web Portal[1]	Administrative State Overhead	$64,000	$1,491,000	$32,000	$745,000
LT-R5	LTSS Rate Tiering	Medicaid Service Utilization	($502,000)	$8,293,000	($239,000)	$3,497,000
LT-R6	LTSS High-Intensity Residential Settings and Acuity-Adjusted Reimbursement Framework	Medicaid Service Utilization	$7,174,000	$7,174,000	$3,413,000	$3,413,000
LT-R7	OHCDS for E-Mods	Medicaid Service Utilization	$8,000	$27,000	$4,000	$13,000
LT-R8	LTSS Administrative Rate Review[2]	Administrative State Overhead	$18,000	$35,000	$9,000	$18,000
LT-R9	Broker for Waiver Transportation	Medicaid Service Utilization	Included in Transportation Rate Evaluation Fiscal Impact	Included in Transportation Rate Evaluation Fiscal Impact	Included in Transportation Rate Evaluation Fiscal Impact	Included in Transportation Rate Evaluation Fiscal Impact
LT-R10	Medicaid LTSS for Tribal Members[3]	Administrative Overhead and/or Medicaid Service Utilization	--	--	--	--
Total[4]	**All**	**All**	**50,356,000**	**$62,367,000**	**$23,132,000**	**$28,571,000**

[1] Analysis assumes a 50 percent FMAP; however, the applicable FMAP may be as high as 90 percent.
[2] Analysis assumes a 50 percent FMAP; however, the applicable FMAP may be as high as 90 percent.
[3] Double dash marks do not indicate a budget neutral fiscal impact but is intended to illustrate that depending on the approach or utilization of services there may be a positive or negative impact.
[4] Due to rounding, the individual category totals do not sum to the aggregate total.

B. Introduction and Background

The Alaska Department of Health (DOH) has engaged Guidehouse Inc. (Guidehouse) to evaluate reimbursement rates for Long-Term Services and Supports (LTSS) programs, including 1915(c) waivers, Community First Choice, Personal Care Services, and TEFRA Care Coordination. This report focuses specifically on LTSS, addressing the unique needs and challenges of these services. While Guidehouse is also assessing other programs such as Behavioral Health (BH), Transportation, and Federally Qualified Health Centers (FQHC), those findings will be presented separately. The evaluation broadly aligns with DOH's priorities and Alaska's healthcare landscape, supporting the development of recommendations that are both actionable and relevant.

Evaluation Findings

As a fundamental first step in our LTSS evaluation, Guidehouse collected cost information from Alaska providers as well as public industry data to determine whether current payments are adequate to cover the costs of service delivery. Guidehouse conducted a detailed provider cost and wage survey process that invited all Alaska LTSS providers within the scope of the rate review to participate. We further supplemented this survey data with a broader array of Alaska-specific and national industry data and cost standards to serve as an essential frame of reference for understanding the unique cost profile of delivering services within Alaska's LTSS system. Guidehouse employed an "independent rate build-up" methodology to model the various costs expected to be reasonably incurred in delivering each of the services reviewed in the study. These rate build-up models, which analyze rates into individual cost components, served as the basis for the benchmark rates used by Guidehouse as a standard to compare Alaska's current reimbursement to expected provider costs.

Based on this benchmarking, Guidehouse's high-level findings note that LTSS reimbursement is adequate overall and that the current rate structure is largely free of substantial rate disparities or misalignments, with a few important exceptions identified in the detail of the report. Despite the sufficiency of the existing LTSS rate structure, Guidehouse highlights several short-term and longer-term trends that are likely to impose new cost pressures and administrative burdens on Alaska Medicaid, especially if anticipated changes in the demographics of the aging and disabled populations, federal home and community-based services (HCBS) policy, and overarching socioeconomic trends come to fruition and begin to exert their effects on the LTSS system. Guidehouse's comprehensive findings are summarized below.

Finding 1 (LT-F1): Current Medicaid funding for LTSS is adequate to support service delivery overall. With a few notable exceptions, individual service rates were equitable and largely aligned with service costs benchmarked by Guidehouse.

Finding 2 (LT-F2): Personal care services are home-based services critical to LTSS programs. Current reimbursement appears low and unsustainable to maintain a robust personal care workforce.

Finding 3 (LT-F3): Current LTSS rate methodologies present opportunities for greater clarity and stakeholder engagement, with enhanced transparency strengthening understanding and acceptance while supporting the implementation of more responsive acuity-adjusted rates and advancing the transition toward value-based payment reforms.

Finding 4 (LT-F4): Current LTSS reimbursement and reporting processes are unlikely to comply with the Centers for Medicare & Medicaid Services (CMS) Access Rule requirements if-and-when federal rules come into effect.

Finding 5 (LT-F5): Current LTSS geographic rate differentials are based on a methodology developed nearly 20 years ago, and Alaska will benefit from updating the underlying data to reflect more recent regional cost differences.

Finding 6 (LT-F6): Indirect costs as a proportion of total LTSS costs are substantially greater than indirect cost ratios typically observed in other states, even when accounting for Alaska's overall higher costs.

Finding 7 (LT-F7): Organized Healthcare Delivery System (OHCDS) administrative fees for Environmental Modification (E-Mod) services are low and do not incentivize providers to employ contractors to serve remote and hard-to-reach regions outside Anchorage and Mat-Su where they primarily serve today.

Evaluation Recommendations

Even if the infrastructure to serve Alaska's aging population is adequate for present needs, the LTSS system will have to continue to grow and adapt as the proportion of older Alaskans and the availability of in-demand workers and caregivers evolve at expected trajectories. Similar adjustments should be considered for the population of individuals with intellectual/developmental disabilities (I/DD), which is also maturing, requiring new types of supports as these individuals age and developing additional medical, behavioral, and adaptive needs. Guidehouse's recommendations are designed to address these needs and to help Alaska strengthen the resilience and adaptability of its LTSS system, supporting ongoing responsiveness to evolving needs within the state as well as emerging federal policy priorities and expectations. These recommendations incorporate stakeholder input gathered throughout the development process and conclude with a prioritized set of options aimed at supporting sensible, efficient investments focused on quality outcomes. Adopting the recommendations below may result in varying rate adjustments and fiscal impacts depending on the service. To support DOH decision-making, we present multiple implementation scenarios with corresponding expenditure projections. Additionally, we also include methodological considerations that underpin the recommended benchmark rates. The full summary of Guidehouse recommendations can be found below.

Recommendation 1 (LT-R1): Alaska Medicaid should transition its LTSS reimbursement methodology to an "independent rate build-up" approach while implementing the benchmark rates derived from this methodology. Transition to a new methodology and cost assumptions will assist the Department in complying with impending CMS Access Rule requirements, supporting more sophisticated acuity-adjusted reimbursement initiatives, and responding more effectively to increasing wage and other cost pressures on LTSS providers.

Recommendation 2 (LT-R2): As a part of the reimbursement methodology transition, Alaska Medicaid should implement a temporary "hold harmless" policy or other risk corridor to manage slight discrepancies between current rates and proposed benchmark rates without unduly penalizing LTSS providers that would otherwise experience small payment decreases.

Recommendation 3 (LT-R3): Alaska Medicaid should consider updating its geographic adjustment framework to account for variation in operating costs among providers serving different areas of the state. Although LTSS reimbursement rates are already adjusted geographically, the index used for differentiating regional costs has remained static for nearly two decades and is due for an overhaul.

Recommendation 4 (LT-R4): Alaska Medicaid should implement an LTSS provider cost reporting system to comply with anticipated CMS Access Rule requirements, support improved acuity-adjusted reimbursement, to measure ongoing adequacy of caregiver pay, and facilitate regular monitoring of and responsiveness to changing provider costs.

Recommendation 5 (LT-R5): Alaska Medicaid should implement tiered rates for select services to reflect variation in service characteristic and population resource needs.

Recommendation 6 (LT-R6): Alaska Medicaid should align cost assumptions and service expectations for its new resource-intensive residential setting options to dovetail with longer-range planning for acuity assessment and reimbursement adjustment based on individual resource need.

Recommendation 7 (LT-R7): Alaska Medicaid should implement changes to OHCDS administrative fees and policies for E-Mod and Family Home Habilitation services.

Recommendation 8 (LT-R8): Alaska Medicaid should plan for potential impacts to non-medical transportation utilization for LTSS waiver participants if the Department adopts a brokerage model for coordinating Medicaid transportation services across the state.

Recommendation 9 (LT-R9): Alaska Medicaid should consider implementing a process for reviewing rates annually and proposing targeted rate updates based on changing wage and cost benchmarks and their differential impacts across the LTSS service array.

Recommendation 10 (LT-R10): Alaska Medicaid should explore additional opportunities to encourage tribal providers to deliver LTSS services directly or establish care coordination agreements with non-tribal LTSS providers to take advantage of enhanced federal matching funds for Medicaid services delivered to Alaska Natives.

Evaluation Fiscal Impact

To better understand the financial implications of benchmark rate adjustments across programs, four basic fiscal impact scenarios were developed to model potential outcomes under varying assumptions. These scenarios are intended to be illustrative to understand potential impacts dependent on state decisions, budget limitations and time of implementation. The goal of this analysis was to estimate the total fiscal impact, including both state and federal shares, and to provide a comparative framework for decision-makers. These scenarios reflect key policy considerations: whether to apply an inflation factor and whether to apply a "hold harmless" methodology. The "hold harmless" option reflects a risk corridor that would allow services resulting in a reduced proposed benchmark rate to maintain current rates temporarily rather than decreasing as suggested by the benchmark rate established within the rate evaluation. The details of these fiscal impact scenarios are fully explained in **Section H: Fiscal Impact Estimates** and are summarized in **Table 2** below. **Table 2** displays the fiscal impact for the four scenarios for the implementation of the proposed benchmark rates for the recommendations attributed to Medicaid service utilization, not including the geographic differential. The dollars and percentage change represent a comparison between SFY 2026 rates and the SFY 2027 proposed benchmark rate dependent on the scenario. The fiscal impact does not represent the administrative overhead costs for the State.

- **Option 1a: LTSS Methodology Transition and Rate Recalibration without Hold Harmless Rates** – This baseline option maintains the current service structure as part of transitioning to the new methodology and allows rate increases and decreases to take effect. This lower-cost scenario reflects updated utilization and cost data, resulting in a projected increase of $42.8M (7.8 percent) overall and $19.2M (7.6 percent) in state share.
- **Option 1b: LTSS Methodology Transition and Rate Recalibration with Hold Harmless Rates** – This option builds on Option 1a by applying a hold harmless provision to prevent rate reductions. This results in a slightly higher fiscal impact of $43.5M (7.9 percent) overall and $19.6M (7.7 percent) in state share.
- **Option 2a: Incorporating Structural Service and Rate Changes without Hold Harmless Rates** – This option builds on Option 1a, involves the implementation of all recommended structural service changes, and allows rate increases and decreases to take in effect. This approach yields a projected increase of $55.8M (10.1 percent) overall and $25.0M (9.9 percent) in state share.
- **Option 2b: Incorporating Structural Service and Rate Changes with Hold Harmless Rates** –

  This option builds on Option 1b, combines structural service changes with a hold harmless provision that maintains current rates for services facing reductions. This scenario reflects the highest fiscal impact at $57.7M (10.5 percent) overall and $26.2M (10.4 percent) in state share. If only partial structural changes are adopted, the impact would likely fall between Options 1a and 2b.

Table 2. Total Fiscal Impact (Four Scenarios) – Difference between SF 2027 Proposed Benchmark Expenditures and SFY 2026 Expenditures

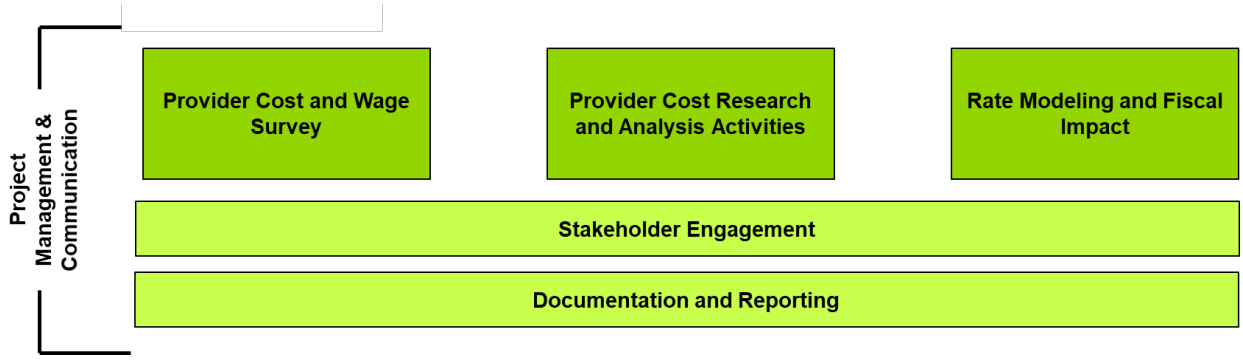
Option	Description	Total Fiscal Impact (State & Federal Share)	Percentage Fiscal Impact (State & Federal Share)	Total Fiscal Impact (State Share)	Percentage Fiscal Impact (State Share)
Option 1a	Not Held harmless with LTSS Rate Methodology Transition	$42,757,000	7.8%	$19,239,000	7.6%
Option 1b	Held Harmless with LTSS Rate Methodology Transition	$43,520,000	7.9%	$19,577,000	7.7%
Option 2a	Not Held Harmless with *all* recommended changes to existing service and rate structures	$55,820,000	10.1%	$25,031,000	9.9%
Option 2b	Held Harmless with *all* recommended changes to existing service and rate structures	$57,741,000	10.5%	$26,221,000	10.4%

Key Study Components

- Provider Cost and Wage Survey: Gathering data from providers for rate review and rebasing efforts.
- Research, Analysis, and Rate Evaluation: Performing research on other state, regional, and national data sources to review, develop rate structures, and inform rate development.
- Rate Modeling and Fiscal Impact: Developing benchmark rate models through research and cost analysis and assessing the fiscal impact of the proposed benchmark rates.
- Stakeholder Engagement: Facilitating engagement with stakeholders including provider representatives, program participants, labor unions, and State staff to solicit feedback throughout the rate evaluation process.

Figure 1 below includes an overview of project initiatives and Guidehouse's approach for each activity as it related to one another.

Figure 1. Overview of Project Initiatives



Focus Areas for Alaska Long-Term Services and Supports

This LTSS rate evaluation focuses on overarching goals that align with the DOH's priorities and the unique characteristics of the state's healthcare environment including:

- Enhancing access to care by supporting sustainable budgets and promoting efficient, high-quality services.
- Addressing the needs of diverse populations, including youth and the elderly with complex care requirements.
- Incorporating Alaska's geographic and regional challenges into service delivery models.
- Recognizing the vital role of Tribal Health Organizations within the Medicaid system.
- Supporting workforce stability through rates that encourage provider recruitment, retention, and resource adequacy.
- Reducing administrative burden for both providers and the state.
- Facilitating ongoing rate maintenance to reflect changing costs and resource needs in Alaska's healthcare market.

The list below highlights the programs and services included in the rate evaluation.

1) 1905(a) Personal Care Services – State Plan
   - Personal Care – Agency Based
   - Personal Care – Consumer Directed

2) 1915(k) Community First Choice Services – State Plan
   - Personal Care – Agency Based
   - Personal Care – Consumer Directed
   - Skill Building – Personal Care
   - Chore
   - Personal Emergency Response

3) 1915(C) HCBS Waivers
   - Alaskans Living Independently
   - Adults with Physical and Developmental Disabilities

- Children with Complex Medical Conditions
- Intellectual and Developmental Disabilities (IDD)
- IDD Individualized Supports Waiver
  (1. Care Coordination; 2. Adult Day and Day Habilitation; 3. Employment – Supported Employment and Pre- Employment; 4. Residential Habilitation-In-Home Supports, Supported Living; 5. Family Home Habilitation (Adult; Child; Acuity Add-on); 6. Group Home Habilitation (Adult; Acuity Add-on); 7. Intervention, Treatment, or Therapy; 8. Meals; 9. Specialized Private Duty Nursing; 10. Nursing Oversight and Care Management; 11. Residential Supported Living (Acuity Add- on); 12. Respite (Agency & Family- Directed); 13. Transportation; 14. Specialized Medical Equipment; 15. Environmental Modifications)

4) LTSS Targeted Case Management – State Plan

- Application (CFC or waiver)
- Initial Support Plan (CFC or waiver)
- Monthly Case Management (CFC only)

5) Intermediate Care Facilities (ICF) for Individuals with ID

- Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (IID) – Residential Care

6) The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Program

- TEFRA Care Coordination

The list below includes new services identified by DOH for rate evaluation and inclusion within the LTSS service array.

- Adult Host Home Care
- Specialized Group Home Habilitation
- Specialized Family Habilitation – Child
- Specialized Family Home Habilitation – Adult
- Organized Healthcare Delivery System (OHCDS) for Family Home Habilitation – Administrative Payment Rate

C. Findings and Recommendations

This section delves into the evaluation's key findings regarding the current reimbursement structure for long-term services and supports and provides recommendations to address issues identified in the findings. Guidehouse's high-level findings note that LTSS reimbursement is adequate overall and that the current rate structure is largely free of substantial rate disparities or misalignments, with a few important exceptions identified in more detail below. Despite the sufficiency of the existing LTSS rate structure, Guidehouse highlights several short-term and longer-term trends that are likely to impose new cost pressures and administrative burdens on Alaska Medicaid, but which the State's present reimbursement methodology is not well-designed to address. Our recommendations are intended to help DOH better "winterize" the LTSS reimbursement framework against these additional stresses and strains on its payment and delivery systems in the years ahead. Just as a homeowner prepares for a change of season by sealing the cracks, disconnecting the hoses, insulating the plumbing, and replacing the filters, DOH will want to be ready for harsher demographic and economic headwinds already beginning to be felt by Medicaid and system providers, their workforce, and the beneficiaries they serve.

C.1. Findings

In Guidehouse's review of Alaska's present reimbursement framework, available evidence suggests the payment system is operating effectively to support service delivery. LTSS systems were especially impacted by the COVID-19 public health emergency (PHE), but the State appears to have successfully navigated the financial and service delivery challenges of the pandemic while taking advantage of additional federal flexibilities and special LTSS funding opportunities through the American Rescue Plan Act (ARPA) to shore up rates and invest in system improvements. While Guidehouse findings identify a few current deficiencies in the system, for the most part they indicate features of the rate structure that are not problems now but may become problems in the near future, once anticipated changes in the demographics of the aging and disabled populations, federal home and community-based services (HCBS) policy, and overarching socioeconomic trends all begin to exert their effects on the LTSS system.

Although Alaska remains demographically one of the youngest states in the nation, its aging population is growing at a notable pace. According to the Alaska Commission on Aging, between 2010 and 2024, the number of residents aged 60 and older increased by 77 percent, while making up a larger proportion of the population, growing from roughly 15 to 22 percent of Alaska residents. Furthermore, projections indicate a fivefold growth in the 85+ population by 2050.[5] So even if the infrastructure to serve Alaska's aging population is adequate for present needs, it will have to continue to grow and adapt as the proportion of older Alaskans and the availability of in-demand workers and caregivers evolve at expected trajectories. Similar adjustments also should be considered for the population of individuals with intellectual/developmental disabilities (I/DD), which is also maturing, requiring new types of supports as these individuals age and develop additional medical, behavioral, and adaptive needs. The COVID-19 PHE proved to be a kind of "stress test" in regard to these larger demographic trends, highlighting vulnerabilities in the caregiving workforce as well as the limitations of institutional care to provide a socially and

[5] State of Alaska Department of Health, Senior Snapshot 2024.

financially sustainable solution to the growing care needs of these vulnerable groups of individuals. Altogether, the experiences of LTSS systems in Alaska and across the country since the onset of the pandemic have underscored the need for more flexible, person-centered care solutions. Federal policymakers have also recognized this mandate to expand high-quality, community-based options and have responded with new policies such as the CMS Access Rule to improve both the quality and cost-effectiveness of expanded HCBS delivery.

With this broader context in mind, Guidehouse identified several prominent features of Alaska's LTSS reimbursement that should be "winterized" to support sustainable service delivery down the road.

C.1.1. Cost Benchmarking Process

As a fundamental first step in our evaluation of LTSS reimbursement, Guidehouse collected cost information from Alaska providers as well as public industry data to determine whether current payments are adequate to cover the costs of service delivery. Guidehouse conducted a detailed provider cost and wage survey process that invited all Alaska LTSS providers delivering services within the scope of the rate review to participate. We further supplemented this survey data with a broader array of Alaska-specific and national industry data and cost standards to serve as an essential frame of reference for understanding the unique cost profile of delivering services within Alaska's LTSS system. These financial data sets furnished Guidehouse with the information required to develop cost "benchmarks" to measure the reasonableness of provider-reported costs and to serve as a standard to evaluate the sufficiency of the current rate structure to supply providers with the resources necessary to deliver quality services.

Guidehouse employed an "independent rate build-up" methodology to model the various costs expected to be reasonably incurred in delivering each of the services reviewed in the study. These rate build-up models, which analyze rates into individual cost components, served as the basis for the benchmark rates used by Guidehouse as a standard to compare Alaska's current reimbursement to expected provider costs. Although the benchmarks were informed by Alaska providers' historical costs, the formulation of ideal benchmarks is designed to function as an independent frame of reference, correcting for the potential influence of historical under- or overfunding in gauging future budgetary needs.

C.1.2. Rate Equity and Overall Reimbursement Adequacy

Finding 1 (LT-F1): Current Medicaid funding for LTSS is adequate to support service delivery overall. With a few notable exceptions, individual service rates were equitable and largely aligned with service costs benchmarked by Guidehouse.

Guidehouse's comparison of current and benchmark rates against the service utilization characteristics of Alaska's LTSS system yielded several relevant findings. First, the benchmarking process indicated that Medicaid LTSS reimbursement has caught up with significant inflationary pressures in the wake of the PHE. Although Guidehouse's benchmark fiscal impact analysis identified the need for additional funding in SFY 2027, the projected need is not significantly higher than what would be expected through inflationary growth. The discrepancy between current expenditure levels and Guidehouse's spend projections (based on our proposed benchmark rates) does not signal overall reimbursement inadequacy, but reflects minor, justifiable differences in the

way the State's current reimbursement methodologies gauge reasonable costs versus Guidehouse's independent rate build-up approach.

C.1.3. Rate Realignment Needs

There are a few notable exceptions to Guidehouse's observation that Alaska's LTSS rates are typically equitable and well-aligned with costs. Guidehouse did not find significant evidence that any individual service rates are overfunded—all discrepancies in which current rates were higher than Guidehouse benchmarks were within the range of two percent—and for services overall, the median difference between current and benchmark rates was 4.3 percent. However, for a small number of service categories, benchmarking revealed the need for significant payment increases to reimburse providers at a rate closer to the reasonable costs they would be expected to incur. Service groupings demonstrating the need for rate increases greater than 10 percent include nursing services; employment services; day habilitation and adult day services; non-medical transportation; family home habilitation; time-limited interventions, treatments, or therapies; and personal care services.

Personal care services are particularly important because they operate as a bedrock home-based service that allows individuals to remain in their homes, averting the need for higher-cost residential services or even more expensive institutionalized long-term care. Because they are vital to the LTSS system, they are also highly utilized. Consequently, even small rate changes can have substantial fiscal impacts. Because of the substantial impacts of increasing rates, personal care reimbursement is likely to become stagnant over time in the absence of service delivery challenges necessitating greater investment in the rates.

Although Guidehouse did not identify signs of significantly depressed utilization due to low service rates, the results of the benchmarking process suggested that current rates, for the most part, are only able to cover caregiver wages, with minimal funds available to sustain competitive benefit offerings or the substantial indirect costs borne by providers to deliver these services. Even if the utilization consequences of low reimbursement are not yet evident, current funding levels are unlikely to sustain the system's present service capacity, much less expand the caregiver workforce to meet anticipated growth in the demand for services.

Finding 2 (LT-F2): Personal care services are home-based services critical to LTSS programs. Current reimbursement appears low and unsustainable to maintain a robust personal care workforce.

Personal care is an illustrative case of the handful of services identified by Guidehouse as "misaligned" and in need of additional funding to keep pace with the cost of care. However, we also noted several minor cases of misalignment, in which otherwise equivalent services receive different reimbursement rates merely because they sit in different programs and so are subject to slightly different rate calculation methodologies and cadences for rate update. For such services, already aligned in principle, Guidehouse did not identify any evidence of service differences that would justify distinct rates. Rather, the source of these slight rate disparities appears to be historical differences in providers' service expenditures and authorized program budgets, contributing to small discrepancies in rates for similar services.

A clear example of this pattern from the LTSS service array is the Respite service delivered under agency-direction versus family-direction. Although the current daily rates for these two services are

the same, the 15-minute rates differ due to historical rate-setting methodologies. Our evaluation, however, found no material differences in rate structures or service units. Guidehouse's benchmarking approach addresses this discrepancy by aligning the rates for agency-directed and family-directed services across both service units.

C.1.4. Methodology Limitations

Guidehouse observed that the current methodology used by Alaska Medicaid to set LTSS rates has been largely effective in establishing sufficient funding to support services. One of the reasons the State has been able to meet rising provider costs is that it maintains a cost reporting program that regularly informs the rate structure with data on actual costs incurred by Alaska's LTSS providers. In many respects, the current cost reporting process (known as the "Cost Survey") managed by the Office of Rate Review (ORR) is both comprehensive and adaptable. It incorporates essential guardrails while minimizing administrative burden on providers by allowing selective participation and offering the flexibility to submit either full or reduced cost reports based on provider characteristics.

The primary goal of this process historically has been to gather cost data to develop allowable cost pools, adjust them to determine total allowable costs, and establish Medicaid reimbursement rates accordingly. Governed by Alaska Administrative Code 7 AAC 145.520–537, the process promotes transparency and compliance with federal CMS requirements. The Division of Senior and Disabilities Services (SDS) also provides training materials and technical support to assist providers, reinforcing the importance of accurate reporting in maintaining equitable access to Medicaid-funded LTSS services.

The cost reporting process is able to operate leanly because it relies heavily on a sampling approach designed to capture the greatest representation of service delivery within the system while requiring the least amount of effort from system providers. Currently, providers are ranked from highest to lowest based on service units, and selections are made until either 80 percent of Medicaid units are represented or five providers are included – whichever threshold is reached first.[6]

Despite the efficiency of ORR's Cost Survey and its ability to adequately measure provider costs and ongoing resource needs, the tradeoff of the reduced administrative burden is that the Cost Survey only captures a relatively "low resolution" understanding of provider costs without additional detail on particular cost drivers affecting the expense of delivering services. Provider costs are for the most part collected in aggregate, so that survey data is unable to determine the proportion of dollars reflecting direct care personnel costs (wages and benefits) versus indirect costs, including program support costs as well as administrative overhead. The Cost Survey does not allow a more granular approach that would track changes in or allow analysis of particular cost drivers such as transportation costs or wage increases.

[6] State of Alaska Department of Health, FAQs – Home and Community Based Waiver and Personal Care Services Rate Methodology and Target Provider List.

Finding 3 (LT-F3): Current LTSS rate methodologies present opportunities for greater clarity and stakeholder engagement, with enhanced transparency strengthening understanding and acceptance while supporting the implementation of more responsive acuity-adjusted rates and advancing the transition toward value-based payment reforms.

While appreciating the effectiveness of the Department's current cost-based LTSS rate methodologies, informed as they are by regularly refreshed provider cost data, Guidehouse also recognizes several important limitations of this approach. Essentially, the current methodology allows Alaska Medicaid to see what it needs to pay to keep rates up to date, but it does not provide sufficient visibility into what Medicaid is actually paying for, in the sense that the Cost Survey does not generate detail on particular types of costs that providers incur or the variation to be found among different provider business models.

First, it fosters uncertainty among both payers and providers as to which costs the LTSS rates are designed to cover. Guidehouse encountered numerous concerns in our stakeholder engagement that providers could not confirm whether rates covered key costs such as transportation expenses or lost revenue due to vacancies. Although it was possible in many cases to delve in depth into the cost reporting process and corresponding rate structure to confirm whether such-and-such costs are encompassed in the rate, it was typically feasible only to confirm *that* these costs are included, but not *what* these included costs actually are. To a certain extent, then, limited rate transparency can reduce provider confidence that all relevant cost categories are reflected in a rate, or that particular cost components, such as direct care wage assumptions, are sufficient to meet ongoing provider needs.

Another challenge with limited visibility into detailed provider costs is that it restricts the State of the levers needed to adjust rates in a more targeted fashion that anticipates likely changes in the labor market (such as a change in the minimum wage law) or administrative costs (a new provider reporting requirement) or incentivizes particular policy initiatives (additional transportation dollars to support community integration, for example). Because the rate setter cannot see clearly into what current rates are covering, the rate setter cannot make precise adjustments designed to impact what payers and providers want to pay for.

Finally, current LTSS rate methodologies do not supply the appropriate resolution of differences in direct care expenses versus indirect costs to be able to comply with increasing federal standards and reporting requirements intended to support improved and ample funding for the caregiver workforce. New federal mandates such as the finalized CMS Access Rule will require States to demonstrate, at least for several key home-based services such as Personal Care, that at least 80 percent of reimbursement is aimed at covering direct care costs, allowing only 20 percent to go toward provider indirect costs beginning in 2028. States will have to confirm not only that rates are designed to support these proportions, but that providers are also compliant in directing at least 80 percent of their expenses to covering direct care costs.

Finding 4 (LT-F4): Current LTSS reimbursement and reporting processes are unlikely to comply with CMS Access Rule requirements if-and-when federal rules comes into effect.

If and when the CMS Access Rule comes into effect, Alaska Medicaid will need to have a rate methodology in place, at least for the limited set of LTSS services subject to the 80/20 rule, that identifies what amounts in the reimbursement rate are aimed at covering direct care costs, and what allowances are included for indirect costs. Additionally, the current ORR Cost Survey process may have to be expanded to confirm whether Alaska providers are compliant with Access Rule requirements.

One of the merits of Alaska's LTSS current rate structure and reimbursement methodology is that it adjusts base rates geographically, providing unique rates to different regions of the state intended to account for the relatively higher and lower costs incurred by agencies operating in diverse economic conditions throughout Alaska. While the recognition of regional variation in provider costs is an achievement of the LTSS program in comparison to other areas of Medicaid that reimburse at a single, statewide rate, Guidehouse has identified a potential need to update the index used to establish these geographic differentials.

Finding 5 (LT-F5): Current LTSS geographic rate differentials are based on a methodology developed nearly 20 years ago and Alaska will benefit from updating the underlying data to reflect more recent regional cost differences.

The geographic adjustment factors used today in the LTSS reimbursement structure rely on the results of a study conducted by the McDowell Group in 2008.[7] The study was commissioned by the Alaska Department of Administration with the intent to promote pay equity among public employees in Alaska by identifying regional differences in cost of living throughout the State. Although the regional differences relative to Anchorage captured in the 2008 study still hold true broadly when compared to economic indicators available today—at least in the sense that operating in many parts of frontier Alaska is still significantly more expensive than operating in Anchorage—evidence suggests that cost of living profiles have evolved for some regions of the state, calling for a need for fresh data and subsequent update to the differentiating geographic factors. One of the previous strengths of the 2008 study, and now more of a weakness, is that its conclusions depend on one-off consumer surveys specific to Alaska and to the study, requiring fresh data collection for update within the narrow regional categories in the report rather than relying on regularly-collected public data that can be adapted to a variety of regional groupings.

C.1.5. Indirect Costs

One of Guidehouse's major findings from the benchmarking process and our analysis of provider cost and wage survey data was that the indirect costs of delivering services are generally high, but also widely variable among participating LTSS providers. Survey results illustrated a number of community providers with lean operations, harnessing efficiencies to drive down administrative overhead and other indirect costs. However, these providers tended to be the exception rather than the rule. Based on our survey data, Guidehouse developed indirect cost benchmarks that averaged administrative costs across the system at roughly 33.4 percent of direct care costs, with

[7] Alaska Department of Administration, Personnel, Alaska Geographic Differential Study, 2008.

indirect program support costs coming in to approximately 29.5 percent of direct care costs. Together, these indirect costs constitute about 40 percent of total service costs, or 40 cents of every dollar spent by Medicaid to deliver services.

In the context of Alaska's LTSS system, indirect costs refer to the operational and organizational expenses that support the delivery of services but are not directly tied to individual client care. These costs are essential to maintaining the infrastructure, workforce, and systems that enable high-quality service delivery. Indirect costs are divided into two primary categories:

- Administrative Costs – These include general management and operational expenses such as:
    - Salaries and wages for administrative and maintenance staff
    - Office supplies, telephone services, liability insurance, and professional memberships
    - Allocated taxes for administrative personnel
    - Rent or mortgage costs for administrative office space

These costs support the leadership, compliance, and administrative functions necessary to operate LTSS programs effectively.

- Program Support Costs – These are costs that facilitate service delivery but are not directly billable to a specific client. They include:
- Program Support Supplies: General supplies, technology, activity costs, and staff training
- Program Support Transportation: Client-related transportation, vehicle maintenance, insurance, and depreciation
- Program Support Building and Equipment: Facility rent or mortgage, utilities, telecommunications, building maintenance, and janitorial services

Finding 6 (LT-F6): Indirect costs as a proportion of total LTSS costs are substantially greater than indirect cost ratios typically observed in other states, even when accounting for Alaska's overall higher costs.

It is true that costs are generally higher in Alaska than in other states, and sometimes substantially higher, but the important point is not that indirect costs in Alaska are just elevated compared to other states—which Guidehouse would expect to be the case—but that they are proportionally greater than in other states, relative to direct care costs, and so also as a percentage of the total cost of services. Goods and services are more expensive in Alaska, but labor costs are, too. Thus, if the labor costs of the direct care workforce are also elevated in Alaska, the general fact of high costs does not necessarily explain why indirect costs are proportionately higher than direct care costs, especially since a large portion of these indirect costs are also labor costs in the form of administrative and support personnel wages and benefits. Guidehouse would expect these indirect personnel costs to be higher in Alaska than in other states, but not relatively higher than the costs of direct care personnel.

The chief difficulty of evaluating indirect costs in Alaska is that the basic conditions of service delivery in the state are so unique that industry data, provider operations, or system experience derived from other states do not always serve as reliable bases for comparison. For example, transportation is an indirect cost incurred in delivering many LTSS services.

However, transportation costs in Alaska, from mileage and the distances covered, to the lack of road networks and greater need for air travel, to the heightened maintenance expense and unbillable delays caused by extreme weather conditions, results in substantially higher indirect costs that are simply not comparable to other states in the lower 48, even frontier states like Montana or Wyoming. For this reason, Guidehouse is unable to pinpoint ultimate causes behind Alaska's higher indirect costs, other than to note that the relative lack of a competitive provider market is evidence that business inefficiency may be a contributing factor.

C.1.6. Organized Healthcare Delivery System Reimbursement Framework

An Organized Healthcare Delivery System (OHCDS) is an arrangement in which a provider that renders a home- or community-based service chooses to offer a different HCBS vendor through a subcontract to facilitate the delivery of vendor goods or services to an individual. This flexibility is offered to allow vendors to participate in Medicaid who would not otherwise deliver services to Medicaid due to the complex administrative barriers of provider enrollment and lack of familiarity with the requirements of medical reimbursement. An OHCDS must provide at least one Medicaid service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. When an OHCDS arrangement is used, the required Medicaid provider agreement is executed between the state and the OHCDS. Since the OHCDS acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS. When an OHCDS arrangement is used to provide waiver services, payment is made directly to the OHCDS, and the OHCDS reimburses its subcontractors.[8]

Alaska seeks to use OHCDS for LTSS waiver services like Environmental Modifications (EMods) and Family Home Habilitation for the following reasons:

- Streamlining contracting by acting as an intermediary between the State and service providers.
- Simplifying billing, payment, and oversight processes.
- Meeting federal Medicaid requirements by verifying that non-traditional services (like home modifications) are delivered by qualified providers.
- Vetting and subcontracting with vendors to maintain service quality and compliance.
- Attracting qualified providers who meet the needs of individuals receiving Family Home Habilitation services.

Especially in Alaska's unique geographic and cultural context, OHCDS may also support specialized and localized service delivery by:

- Managing licensing, training, and oversight for Family Home Habilitation caregivers.
- Enabling culturally appropriate services through potential partnerships with tribal and community-based organizations.
- Offering flexibility in rural and remote areas where direct service provision is challenging.

[8] CMS Waiver Applications, Instructions, Technical Guide, and Review Criteria, 2019.

Finding 7 (LT-F7): OHCDS administrative fees for E-Mods services are low and do not incentivize providers to employ contractors to serve remote and hard-to-reach regions outside Anchorage and Mat-Su where they primarily serve today.

Although OHCDS arrangements streamline the process for recruiting qualified vendors significantly, the process of third-party work delegation and oversight presents its own administrative challenges that can serve as barriers to participation if not overcome. While OHCDS could be an effective service option in Alaska, Guidehouse notes that the option is underutilized, potentially due to a lack of incentives to take on the coordination of service delivery among multiple vendors. Specifically, current administrative fee allowances and requirements may be insufficient to encourage providers to enter into and maintain OHCDS arrangements at a larger scale.

C.2. Recommendations

Section C.2. outlines Guidehouse's recommendations for addressing the reimbursement methodology findings presented in Section C.1. Our recommendations incorporate stakeholder input gathered throughout the development process and conclude with a prioritized set of options aimed at supporting sensible, efficient investments focused on quality outcomes. Adopting the recommendations below may result in varying rate adjustments and fiscal impacts depending on the service. To support DOH decision-making, we present multiple implementation options with corresponding expenditure projections. It is important to note that additional implementation options may exist beyond those presented in this section, based on available funding. For instance, DOH may choose to implement recommendations across all services simultaneously or, depending on budget constraints and available resources, may opt to apply a percentage of the benchmark, target specific service categories, or phase in changes over time.

Specific benchmark recommendations by service are detailed in **Section G** and summarized in **Section I**, while in-depth fiscal impacts are modeled in Guidehouse's analysis in Section H. This section examines the broad intent and implications of Guidehouse's rate evaluation recommendations, explaining the rationale for each recommendation as well as briefly analyzing potential impacts on cost, quality, and access to care within the LTSS system.

Guidehouse recommendations are summarized into the following nine areas for action:

- Methodology Transition and Rate Recalibration
- "Hold Harmless" Provisions and Other Risk Corridors
- Geographic Adjustment
- LTSS Cost Reporting
- Tiered Rates for Select Services
- Resource-Intensive Residential Settings and Acuity-Adjusted Reimbursement
- Organized Healthcare Delivery System (OHCDS) Administrative Fees and Policies
- Brokerage Impacts on Waiver Non-Medical Transportation
- Annual Administrative Rate Review and Update
- Medicaid LTSS for Tribal Members

C.2.1. Methodology Transition and Rate Recalibration

Although Guidehouse considers overall funding for LTSS services to be adequate, we encourage the Department to adopt the "independent rate build-up" approach used to determine rate benchmarks as Alaska's LTSS rate methodology moving forward. An important benefit of this methodology is that it standardizes cost component assumptions and rate methodologies across populations and programs where feasible and appropriate. This standardization promotes consistency, transparency, and fairness in how rates are determined. It allows for easier comparisons and evaluations of different programs and populations, ultimately leading to more informed decision-making.

Recommendation 1 (LT-R1): Alaska Medicaid should transition its LTSS reimbursement methodology to an "independent rate build-up" approach while implementing the benchmark rates derived from this methodology. Transition to a new methodology and cost assumptions will assist the Department in complying with impending CMS Access Rule requirements, supporting more sophisticated acuity-adjusted reimbursement initiatives, and responding more effectively to increasing wage and other cost pressures on LTSS providers.

Based on the rate evaluation, we recommend adopting a rate build-up approach for all services as a replacement for the current approach. This modular methodology will improve transparency by clearly delineating the components that inform the rates, aligning them with service delivery specifications, and enabling targeted review of specific elements such as wages, benefits, and training. In addition to the overall reimbursement trends noted here, it is evident that existing rate structures do not employ cost components consistently across the LTSS program. Cost assumptions about productivity, job types, group sizes, staffing ratios, and administrative overhead should be evaluated to build in consistency where appropriate.

While a similar approach is currently applied to a limited number of services within the LTSS program, expanding it across all services—rather than relying on total service costs and units—will promote greater consistency and alignment with actual cost structures. Furthermore, DOH establishes a stop-loss/stop-gain risk corridor to mitigate financial volatility for DOH and support provider stability during rate transitions. As DOH continues to evolve its rate setting approach, it may incorporate these risk corridors as a standard component of the independent rate build-up approach.

This methodology also supports a more detailed and data-driven rate-setting process by aggregating individual cost components such as direct care costs, overhead, and administrative expenses, tailored to the specific characteristics of each service. Additionally, it will enable DOH to monitor more effectively the cost components included in the rates and the corresponding expenditures that support them.

Rate Component Standardization

DOH should identify equivalent services across programs and within programs to establish standardized rate components to promote rate equity. Cognate services that require the same resources should include the same rate components for equivalent work, regardless of the program in which they are delivered.

To support standardization, DOH should implement uniform wage and benefit assumptions for direct care and supervisory positions across all populations and programs. These rates should incorporate the costs of a standard benchmark benefits package developed to reflect the reasonable cost of benefits. While not all providers may currently offer the full range of benefits, including those reported by a majority of providers in the Alaska DOH Cost and Wage Survey will allow providers the flexibility to offer them in the future.

Wages and benefits are key components in developing service rates, and the benchmark metrics significantly influence final rate determinations. The standardized wages and benefits used in the development of the SFY 2027 proposed benchmark rates are competitive, based on comparisons with industry data and feedback from stakeholders. Due diligence conducted to establish these benchmarks confirms that the recommended wages align with industry standards both within Alaska and nationally across all populations.

As an example of this approach, consider the rate calculation for individual versus group Supported Employment services. Currently, the rate for group services is calculated as a percentage of the individual service rate. As part of the benchmark rate development approach, we standardize key components—such as wages, benefits, and supervision time—across both models. We then differentiate the two based on staffing ratios rather than relying on historical rate relationships. While the relationship between the two rates may still be evaluated and monitored, we recommend implementing and maintaining these distinct rate models to enhance transparency and facilitate future updates, so that it is clear what service characteristics each service is designed to support.

Residential Occupancy and Day Service Attendance Factors

For certain services, such as residential services and day habilitation, an "occupancy rate" or "attendance adjustment factor" is used to further refine the cost assumptions underlying the rate models. Program absences or unoccupied days may occur for various reasons, including non-attendance at a day program due to illness, absences from a residence for family visits, service interruptions caused by weather-related closures, or short-term vacancies before a new resident moves in. To allow providers to recover their annual operating costs, rates typically include either an occupancy factor or a retainer days policy (also known as a "bed hold") to offset revenue lost due to absences.

A retainer days policy addresses this issue by allowing providers to bill for a limited number of days under specific conditions, even when services are not delivered. In contrast, an occupancy adjustment approach permits billing only when services are actually provided but incorporates an adjustment in the rate model to account for anticipated average annual revenue loss due to absences. When absences or vacancies remain reasonably low and reflect efficient operations, a rate that includes an occupancy factor may more accurately align provider revenue with incurred costs. An advantage of incorporating an occupancy adjustment, relative to a retainer day/bed hold policy, is that the cost of the vacancy is federally matched as a part of the service, whereas bed holds are paid entirely out of State funds.

Guidehouse recommends that DOH account for necessary or expected absences and turnover of residents and attendees as an explicit component in residential and day habilitation rate models. Since DOH policies concerning reimbursement for such absences are not governed by retainer or

bed hold provisions, an occupancy adjustment may be applied within the rate structure to reflect these operational realities. Accordingly, Guidehouse has incorporated a residential occupancy adjustment factor of 96 percent (equivalent to 15 days per year) and a day service attendance adjustment factor of 94 percent (equivalent to 22 days per year). While the existing methodology may account for these costs, including this factor as an explicit component in the rate models may enhance transparency by clearly identifying how anticipated absences are addressed in the reimbursement methodology.

Targeted Rate Adjustments

Guidehouse recommends that DOH consider implementing targeted rate adjustments that reflect both rate levels and structural differences across services. While standard inflationary adjustments have been applied for all LTSS in recent years to keep up with evolving economic changes, the rate evaluation reveals that projected rate changes vary significantly by service category.

Not all utilized services are affected equally. Some are expected to experience substantial increases, while others may see minimal or no change. Additionally, several underutilized and unutilized services show wide fluctuations in rate changes, underscoring the need for a more tailored approach.

To address these variations, DOH may prioritize expenditure projections that align with both rate and structural shifts. DOH may also focus on services where current reimbursement rates are least aligned with operational and labor costs.

Example 1: Home-Based Service Rate Ranges
Across home-based services, the difference between SFY 2026 current rates and SFY 2027 benchmark rates ranges from 1.0 percent to 35.1 percent, depending on the service. Chore and Personal Care services fall at the higher end of this range, primarily driven by the wage assumptions used in the benchmark. For instance, compensation alone—estimated at approximately $8.84 per 15-minute unit—appears to strain the current reimbursement rate. In a comparative review of peer states including Hawaii, South Dakota, Montana, Wyoming, and Colorado, Alaska currently is in the middle tier of rates. It aligns more closely with several frontier and Midwestern states. Most of the comparative rates from these states are based on 2023 or early 2024 data and are undergoing revision. With the proposed changes, Alaska's rates are projected to move into the upper quartile nationally, reflecting a more competitive reimbursement structure. Additionally, this rate framework could support DOH in developing a true self-direction or participant-direction rate, should such a model be implemented in the future.

Example 2: Local vs. Non-Local Rates for Time-Limited Intervention, Treatment, or Therapy Services
For time-limited intervention, treatment, or therapy services, the SFY 2027 benchmark rate for non-local services – defined as those requiring travel over 200 miles – is nearly double the SFY 2026 rate. The current methodology, which bases the SFY 2026 rate on twice the local rate, may not adequately reflect the travel requirements necessary for reimbursement. Moreover, the current lack of service utilization may suggest a need to adjust the rate to better align with service expectations and improve access.

By adopting this approach, potential rate modifications may be more responsive to specific cost drivers, service delivery models, and policy objectives.

Fiscal Impact for Recommendation LT-R1

Table 3 below includes the range of costs involved in the LTSS methodology transition and rate recalibration.

Table 3. Recommendation LT-R1 – Methodology Transition and Rate Recalibration Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost – Initial Year (State Only)	Projected Maximum Annual Cost (State Only)
LT-R1: LTSS Methodology Transition and Rate Recalibration	+$42,758,000	+$42,758,000	+$19,239,000	+$19,239,000

C.2.2. "Hold Harmless" Provisions and Other Risk Corridors

In the effort to address transition rate methodologies, some rates may experience a decrease even though other rates and payments as a whole may be increasing. Although methodology transition is ultimately helpful for the system and encourages providers to devote resources where they are most needed, it can also create payment volatility if not carefully considered, injecting new financial risks into the system that can threaten provider stability and potentially interrupt service delivery. In pursuing methodological transition, it will be critical for DOH to establish some level of "risk corridor" to mitigate volatility for providers and facilitate smooth transition to novel rate methodologies and a potentially unfamiliar rate structure and reimbursement environment.

Recommendation 2 (LT-R2): As a part of the reimbursement methodology transition, Alaska Medicaid should implement a temporary "hold harmless" policy or other risk corridor to manage slight discrepancies between current rates and proposed benchmark rates without unduly penalizing LTSS providers that would otherwise experience small payment decreases.

For the sake of analysis, Guidehouse chose a simple rate corridor, a "hold harmless" provision, as a straightforward proof of concept and an illustration of one potential solution to the challenge of rate volatility. This mechanism is especially appropriate for LTSS, as projected rate decreases are minimal and likely to disappear in time on their own without the need for further intervention. In the scenario explored by Guidehouse, rates would be increased to the benchmark, but services otherwise seeing rate decreases would be held harmless, meaning that rates would be frozen at their current level for a certain amount of time to allow providers to adjust to full implementation of benchmark rates. Typical time spans may be a single year, or two years after initial implementation, or in the case of small rate decreases, until inflationary forces eliminate the need for a hold harmless.

For LTSS, four services show decreases from SFY 2026 to SFY 2027 proposed benchmark rates, ranging from -2.5 percent to -1.1 percent. These reductions are primarily due to the standardization of cost assumptions and are not entirely reflective of changes in service delivery or provider performance. Given this context, there may be value in holding these rates harmless. Guidehouse recommends that the DOH consider maintaining the SFY 2026 rates for the services listed in **Table 4** below. Doing so would help DOH support providers by preserving the current rate structure and avoiding potential reductions. The time span for holding these LTSS rates harmless may ideally be one year and/or until annual inflationary impacts eliminate the need for it.

Table 4. Hold Harmless Rate Recommendation - Service List

Procedure Code	Service	Unit	SFY 2025 Rate	SFY 2026 Current Rate (+3.2%)	SFY 2027 Benchmark	Change SFY 2025-27	Change SFY 2026-27
T2024SE	Initial support Plan and Annual Renewal of Support Plan for Waiver or Community First Choice	Annual	$913.71	$942.95	$922.25	0.9%	-2.2%
T2017	Supported Living Habilitation Must be 18 or over	Per 15 Minutes	$14.52	$14.98	$14.81	2.0%	-1.1%
T2017U4	In-Home Supports Habilitation Must be 17 or younger	Per 15 Minutes	$14.52	$14.98	$14.81	2.0%	-1.1%
T1016CG	Nursing Oversight and Care Management (Local)	15 Minutes	$32.04	$33.07	$32.24	0.8%	-2.5%

Fiscal Impact for Recommendation LT-R2

Table 5 below reveals that the minimum and maximum impact to the State for implementing this recommendation ranges from $339k to $1.2M.

Table 5. Recommendation LT-R2 – Hold Harmless Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost – Initial Year (State Only)	Projected Maximum Annual Cost (State Only)
LT-R2: Hold Harmless Rates	+$763,000	+$1,921,000	+$338,000	+$1,190,000

C.2.3. Geographic Adjustment Framework

In the current LTSS program, providers receive regionally variable rates designed to reflect cost disparities across different areas of the state. These differentials are based on the provider's location. However, the existing methodology was developed using a study completed in 2008. Guidehouse recommends updating this methodology to reflect current economic conditions.

Geographic differentials are intended to account for increased costs associated with factors such as cost of living, wages (including retention bonuses), utilities, food, and transportation. The recommended methodology:

- Allows for annual updates using credible, publicly available data sources.
- Promotes consistency between LTSS and Behavioral Health in applying identical differentials across the 18 regions currently used in the LTSS framework.9
- Estimates a fiscal impact of 0.01 percent in increased expenditures at SFY 2027 proposed benchmark rates.

Recommendation 3 (LT-R3): Alaska Medicaid should consider updating its geographic adjustment framework to account for variation in operating costs among providers serving different areas of the state. Although LTSS reimbursement rates are already adjusted geographically, the index used for differentiating regional costs has remained static for nearly two decades and is due for an overhaul.

Guidehouse performed an analysis that leveraged cost and income across Alaska to create geographic differentials for various boroughs and census areas. DOH should consider implementing a geographic differential methodology to account for economic conditions across each region of the state. In contrast to the current geographic adjustment framework employed for LTSS, DOH should consider:

- Transitioning from the outdated, one-time survey data used in its 2008 source study to frequently updated public data sources representing statistically significant population / household / sample size.
- Accounting for both cost and income in regions where there are significant differences between the two parameters to account for relative purchasing power, in contrast to the existing cost-based approach for LTSS.

Geographic rate differentials should be implemented to adjust rates based on regional cost variations. This application would foster equitable access and provider viability across frontier, rural, and urban areas. By recognizing the varying costs of living and operating in different regions, geographic rate adjustments can help maintain provider viability and bolster access to necessary services in all areas of the state.

Leveraging the Economic Policy Institute Dataset

We use the Economic Policy Institute (EPI) dataset, which includes data from 2020 to 2024, as the cornerstone of our analysis. This dataset is a comprehensive collection of publicly available information sourced from reputable organizations, including the U.S. Department of Labor (DOL), U.S. Department of Agriculture (USDA), U.S. Department of Housing and Urban Development (HUD), the Medical Expenditure Panel Survey (MEPS), the federal Bureau of Labor Statistics (BLS), the National Bureau of Economic Research (NBER), and the Henry J. Kaiser Family Foundation (KFF). These sources collectively offer robust insights into various dimensions of economic and social indicators, allowing for a well-rounded perspective.

[9] This recommendation overlaps with Recommendation B3 in Behavioral Health Rate Evaluation Report.

EPI Key Data Sources

- DOL: Provides data on employment, wages, and labor market conditions.
- USDA: Supplies information on agricultural economics, food prices, and nutritional assistance programs.
- HUD: Offers insights into housing affordability, rental markets, and urban development trends.
- MEPS: Delivers detailed data on healthcare expenditures, insurance coverage, and medical services utilization.
- BLS: Shares extensive statistics on inflation, productivity, and other critical labor economics metrics.
- NBER: Contributes research findings on various economic aspects, including business cycles and income distribution.
- KFF: Focuses on health policy analysis, healthcare costs, and public health issues.

Cost Categories

The seven cost categories represent essential areas of household spending:

1. Housing
2. Food
3. Healthcare
4. Transportation
5. Education
6. Childcare
7. Miscellaneous

Each category is weighted based on the specific spending patterns of each borough or census area. This approach allows the dataset to reflect local economic conditions and highlight the cost drivers most relevant to residents in each region.

Additional details on the methodology used to calculate regional costs across these categories in Alaska are provided in **Appendix A.**

Purchasing Power Factor

The purchasing power factor, derived from the Economic Policy Institute (EPI) dataset, is a key element used to reflect regional differences in spending power. This factor is applied only to boroughs or census areas where it exceeds the average, helping to accurately represent lower-income regions without distorting the overall analysis.

We applied greater weight to the cost and purchasing power in regions that are not road-connected—unlike Anchorage, Kenai Peninsula, Mat-Su, and Fairbanks. This targeted approach allows the data set to better reflect the economic realities of these areas.

By incorporating the purchasing power factor in this targeted manner, the analysis highlights the economic challenges faced by lower-spending-power regions and supports the development of more equitable, data-driven policy recommendations.

Through our analysis using EPI's data sources, we developed updated geographic differentials aligned with the 18 LTSS Regions, as shown in **Table 6**. Between 2008 and 2024, geographic differentials in LTSS costs have shifted across Alaska due to evolving economic, demographic, and policy factors. While all regions experienced cost increases – often driven by rising labor expenses, growing service demand, and infrastructure challenges – the extent of those increases relative to Anchorage has decreased over time. Areas that once had significantly higher cost differentials now show narrower gaps, potentially reflecting improvements in service efficiencies and/or access. For example, while the differential for Roadless Interior decreased and rates for road-connected communities such as Glenallen increased, the overall cost increase for Roadless Interior remains higher than that of the road-connected communities. These types of shifts may be attributed to developments in key cost drivers reviewed in the analysis, including healthcare, taxes, transportation, housing, childcare, and food, which may have bridged cost differences in some parts of the State.

Table 6. Proposed Geographic Differentials[10]

Region	Current LTSS Geographic Differential (2008 Study Geographic Differentials)	Proposed Geographic Differential (Economic Policy Institute Data)
Aleutian Region	1.50	1.12
Anchorage Region	1.00	1.00
Arctic Region*	1.48	1.23
Bethel/Dillingham	1.49	1.36
Delta Junction/Tok Region	1.04	1.15
Fairbanks	1.03	1.03
Glennallen Region	1.00	1.03
Juneau	1.09	1.09
Kenai Peninsula	1.01	1.01
Ketchikan/Sitka	1.09	1.09
Kodiak	1.12	1.25
Mat-Su	1.00	1.00
Parks/Elliott/Steese Highways	1.00	1.01
Prince William Sound*	1.08	1.00
Roadless Interior	1.31	1.24
Southeast Mid-Size Communities	1.09	1.09
Southeast Small Communities	1.09	1.09
Southwest Small Communities	1.44	1.35

Implementation Scenarios

Recognizing that maintaining access to LTSS in Alaska's remote regions is a critical priority, Guidehouse recommends retaining the existing geographic adjusters in select regions to support provider sustainability and protect fragile service networks. This recommendation is grounded in both fiscal analysis and strategic access considerations.

[10] The geographic differentials for the two starred regions are maintained at the existing differentials based on the 2008 study.

Based on SFY 2024 Medicaid claims data, six regions—Parks/Elliot/Steese Highways, Delta Junction/Tok, Prince William Sound, Bethel/Dillingham, Arctic, and Roadless Interior—each have three or fewer LTSS providers billing Medicaid. In these areas, preserving provider networks is imperative to help sustain service availability, maintain continuity of care, and prevent loss of provider participation.

To evaluate the impact on LTSS providers, Guidehouse developed a comparative summary of payment changes reflecting the combined effect of benchmark rate updates and geographic differentials. While some geographic differentials are decreasing, increases in benchmark rates offset these reductions in many cases, resulting in net positive impacts for nearly all providers.

However, under the proposed geographic differentials, payment reductions persist for some providers in two regions with low provider capacity, which may pose risks to access and continuity of care. Guidehouse therefore recommends maintaining the current geographic adjusters in these two regions:

1. Prince William Sound
2. Arctic

This targeted approach may help these communities maintain access to LTSS services while balancing fiscal responsibility and supporting provider sustainability. Guidehouse also recommends that DOH monitor the effects of future rate changes and provider growth in these regions to determine when and whether to transition to the proposed EPI-based geographic differential methodology in these two regions as well.

Table 7 below includes the fiscal impact of implementing the proposed geographic differentials with and without maintaining low-capacity regions at the current differentials.

Table 7. Overall Fiscal Impact of Implementing Proposed Geographic Differentials at SFY 2027 Proposed Benchmark Rates

Metric	Minimum Annual Expenditures (Fed + State)	Maximum Annual Expenditures (Fed + State)	Minimum Annual Expenditures (State Only)	Maximum Annual Expenditures (State Only)
Current Geographic Differential (a)	$594,099,000	$609,083,000	$271,976,000	$278,958,000
Proposed Geographic Differentials (b)	$594,180,000	$609,157,000	$272,222,000	$279,205,000
Proposed Geographic Differentials with Maintaining Current Differentials for Specific Low-Capacity Regions (c)	$594,768,000	$609,750,000	$272,341,000	$279,324,000
Scenario 1 Fiscal Impact (Difference between a and b)	$81,000	$74,000	$246,000	$247,000
Scenario 2 Fiscal Impact (Difference between a and c)	$669,000	$667,000	$365,000	$366,000

Fiscal Impact for Recommendation LT-R3

Table 8 below includes the range of costs involved in updating the geographic rate differentials.

Table 8. Recommendation LT-R3 – Geographic Adjustment Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
LT-R3: LTSS Geographic Differentials	+$74,000	+$669,000	+$246,000	+$366,000
Update to Proposed Geographic Differentials	+$74,000	+$81,000	+$246,000	+$247,000
Update to Proposed Geographic Differentials with Maintaining Current Differentials for Specific Low-Capacity Regions	+$667,000	+$669,000	+$365,000	+$366,000

C.2.4. LTSS Cost Reporting System

The CMS 80/20 Rule, finalized in 2024 as part of the Medicaid Access Rule ("Access Rule"), mandates that at least 80 percent of Medicaid payments for home and community-based services (HCBS)—specifically homemaker, home health aide, and personal care services—must be spent on direct care worker compensation.[11] This rule applies to LTSS personal care services, including Personal Care, and Personal Care Skill Building, and it covers a broad range of workers, including RNs, LPNs, home health aides, personal care attendants, and clinical supervisors.

Looking ahead, collecting provider-level cost data for these services may support DOH's implementation and oversight of the Access Rule. Under the rule, DOH will be required to report to CMS on key service delivery metrics, including the percentage of Medicaid payments allocated to direct care worker compensation, the presence and extent of waiting lists, and service delivery timelines for covered services. Although the payment adequacy requirement takes effect in 2030, beginning July 9, 2028, states must submit annual reports indicating the percentage of payments allocated to direct care worker compensation. Starting July 9, 2027, states are required to report on their readiness to comply with the payment adequacy reporting requirement.

Recommendation 4 (LT-R4): Alaska Medicaid should implement an LTSS provider cost reporting system to help the Department of Health comply with anticipated CMS Access Rule requirements, support improved acuity-adjusted reimbursement, measure ongoing adequacy of caregiver pay, and facilitate regular monitoring of and responsiveness to changing provider costs.

Guidehouse recommends maintaining the core elements of the existing process while further tailoring and validating the report content to capture more detailed provider-level cost data, allowing for alignment with the requirements outlined in the rule. DOH may consider maintaining

[11] National Archives, Federal Register, Medicaid Program; Ensuring Access to Medicaid Services.

and/or modifying the “Expenses” and “RevenueStats” sections in the existing cost reporting template to capture the following service-specific information:

- Total Medicaid Payments Received: Includes standard payments for personal care services.
- Direct Care Worker Compensation - Must include distinct cost report lines for:
- Wages and salaries
- Overtime pay
- All forms of paid leave (sick, vacation, holidays)
- Benefits (health, dental, life insurance, retirement)
- Employer payroll taxes
- Excluded Costs (not counted toward the 80 percent):
- Training costs for direct care workers
- Travel costs (e.g., mileage reimbursement, transit subsidies)
- Personal protective equipment (PPE)
- Administrative and Overhead Costs: These costs must be clearly separated and should not exceed 20 percent of Medicaid payments. Moreover, administrative cost reports reported in the reports may serve as a basis for validating generous administrative costs that would serve as a common “source of truth” when assessing provider reimbursement needs and could also facilitate regular administrative rate update to promote ongoing rate adequacy.

DOH may consider developing a dedicated cost reporting template for personal care services. This would build on the existing framework while minimizing the impact of additional data requirements on providers who do not deliver these services.

Incorporating additional data points into cost reports for 80/20 Rule compliance could offer several key benefits:

- Demonstrates Compliance: Cost reporting will help verify that at least 80 percent of Medicaid payments are directed to direct care worker compensation (wages, benefits, payroll taxes), promoting transparency and accountability.
- Supports Oversight: With full compliance required by 2030, accurate cost data may enable DOH to monitor provider adherence and mitigate risks of noncompliance or funding disruptions.
- Enables Exemption Requests: DOH may require that providers seeking hardship or small-entity exemptions from the Access Rule must submit detailed cost reports to justify eligibility.
- Informs Future Rate Reviews: Cost data may be leveraged for future rate reviews to check for alignment between reimbursement levels and provider costs – especially for small or rural providers.
- Guides Workforce Investment: Reporting may reveal compensation gaps and staffing challenges, helping both DOH and providers target investments to stabilize and grow the direct care workforce.

Guidehouse’s recommended rate for personal care services includes an administrative cost allocation of 18 percent, derived from survey data collected from LTSS providers. This structure allocates 82 percent of the total rate to direct care worker compensation—including wages, benefits, and payroll taxes—supporting compliance with the federal 80/20 requirement. This approach reflects actual provider-reported operational costs, aligns with CMS expectations for

transparency and accountability, and provides a defensible basis for rate setting. DOH may consider implementing the recommended rate model while continuing to collect, monitor, and expand provider cost reporting for future review and reporting.

Expanded Cost Reporting

DOH may consider expanding the list of target providers selected for cost reporting to encourage broader participation across provider sizes, geographies, and services delivered, as delineated below.

- Sample Size of Providers and Data: Of the 702 LTSS providers in SFY 2024, a notable number of smaller providers, including those offering Care Coordination and Residential Supported Living, were excluded from the historical cost-based methodology. Cost reporting processes have captured data from approximately 25 LTSS providers. Expanding the provider list may further enhance the stability, representativeness, and overall validity of the findings for future rate development purposes.[12]
- Geographies Covered: Collecting cost data from providers in different regions of Alaska may help identify regional disparities and support targeted healthcare policy and resource allocation in a geographically and economically diverse state.
- Services Included: DOH may consider including Care Coordination service providers going forward, although they are currently excluded from cost reporting. Care Coordinators tend to experience costs that are unique to the nature of the service and their role, and there may be benefit in capturing those costs for regular monitoring, similar to other services currently included in cost reporting.

Guidehouse estimated that a single cost reporting program would require approximately 0.7 FTEs to review, audit, and manage provider cost reports based on information gathered from peer states that manage similar programs. For example, in one peer state that manages programs of similar magnitude and serving similar populations, 4.25 FTEs are required year round to manage six cost reporting programs (DD Services, In-Home Services, Meals, Assisted Living Facilities, Personal Care, Nursing Facilities). The team is comprised of 3 auditor FTEs, 1 supervisor FTE who provides subject matter expertise and oversees the work of the three auditors, and 0.25 SME supervisor FTE who serves as a liaison between the auditors and the State. Given the similarities in the programs, a similar staffing plan may work for DOH. This staffing proposal assumes there is no existing infrastructure for DOH to leverage for implementing and managing the proposed programs. For example, if DOH can leverage existing FTEs that already assists with current cost reporting, the staffing requirements for the enhancements or new cost reports may be adjusted to account for existing staff.

[12] State of Alaska, Office of the Lieutenant Governor, Online Public Notices, Home and Community Based Waiver and Personal Care Target Provider, 2024.

Web-Based Cost Reporting Portal Option

DOH may consider developing a one-stop-shop web portal for providers to submit cost reporting data. A few states have implemented similar solutions for their cost reporting programs, and there are benefits of the web-based method:

- Reduced administrative burden for both DOH and the providers: Providers would be able to populate, save, and submit all information through the web portal instead of an Excel spreadsheet. This may reduce the level of effort required by DOH to quality check and standardize the information received from providers, particularly in preparation for future CMS reporting.
- Increased accuracy and efficiency in data reporting: The web-based tool reduces human processing errors and rework and increases standardization. This method would also enable fast data reporting processes.

DOH may develop a cost reporting web-based application by using Software as a Service (SaaS) tools. A SaaS platform or application is a way to provide services on the internet through a cloud infrastructure. Once the cost reporting data is finalized, DOH may customize cost reporting forms for providers to access on a SaaS-based platform. This would allow users (e.g., providers, state staff) to access the cost reporting application without having any software installed on their computer. Additionally, DOH may put in place appropriate security protocols and implement multi-factor authentication for restricted access.

Guidehouse also recognizes that DOH should consider the initial financial outlay to develop and deploy such a solution. Alternatively, DOH could continue using cost reporting templates on MS Excel which is a common practice in many states.

Fiscal Impact for Recommendation LT-R4

As captured in **Table 9**, unlike other recommendations that represent Medicaid reimbursement costs based on service utilization, these costs include DOH staff time, technology costs and administrative time to stand up the reporting structure. Standing up the cost reporting process includes three separate cost considerations related to initial cost report development, maintenance of the cost reporting process, and the potential for a web-based system. The cost reporting development estimates assume that 0.7 FTEs analysts receiving an annual compensation of $91,000 may be required to manage cost reporting enhancements from Recommendations LT-R4-a and LT-R4-b. DOH should continue to monitor and evaluate the staffing levels required to complete the administrative work as the FTEs provided by Guidehouse are estimates based on experience in other states and may not be reflective of the needs of Alaska in practice. The cost estimates for LT-R4-c is inclusive of Recommendation BH-R4 in the Behavioral Health Rate Study.[13] The estimated cost for implementing overall cost reporting ranges from $62,000 to $1.49M (federal + state), with state-only costs between $32,000 and $745,000, reflecting a wide range of potential fiscal outcomes depending on the implementation approach.

[13] State of Alaska, Department of Health, Behavioral Health Cost Reporting System, 29-30.

Table 9. Recommendation LT-R4 – Cost Reporting Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
LT-R4: LTSS Cost Reporting	+$64,000	$1,490,000	+$32,000	+$745,000
Cost Report Development (Recommendation LT-R4-a and LT-R4-b) – LTSS Only	+$62,000	+$127,000	+$32,000	+$64,000
Web-Based System Development (Recommendation LT-R4-c and Recommendation BH-R4) – LTSS and BH	+$682,000	+$1,363,000	+$341,000	+$682,000

C.2.5. Tiered Rates for Select Services

Tiered rates refer to a payment structure where the reimbursement rate for a service varies based on specific characteristics such as complexity of participant's needs, geographic location, or provider qualification. While existing tiered rates commonly acknowledge the sizes of groups served and distances traveled by road, we have explored tiering of select services based on service location, service activity, provider qualifications, and resource needs, for DOH's consideration. There is also opportunity to further align one or more tiered rates with DOH's new assessment tool.

Recommendation 5 (LT-R5): Alaska Medicaid should implement tiered rates for select services to reflect variation in service characteristic and population resource needs.

We have developed multiple scenarios for each tiered service recommendation highlighted below to offer implementation options. It is important to note that while rate tiering may introduce additional administrative work, it also enhances transparency by offering clearer insight into the types of services being delivered and the corresponding payments made by DOH to providers. DOH may choose to implement one or more of the scenarios depending on evolving service requirements and funding appropriated to the programs. It is important to note that, should these tiers be adopted and implemented, DOH would need to draft and finalize accompanying regulations and conditions of participation.

Stratifying Care Coordination Rates

Ongoing Care Coordination rates are currently the same for the 1915(c) waivers and CFC but are slightly lower for the TEFRA program. This discrepancy is primarily due to the fact that TEFRA rates were not updated during the most recent rate rebasing cycle, nor have they been subject to inflationary or legislative adjustments, while the waiver and CFC rates were adjusted to reflect inflation.

During the rate evaluation process, stakeholders from the LTSS Care Coordination Focus Group and the LTSS Rate Workgroup emphasized the importance of incorporating adjustments for individuals with complex or enhanced needs. Care Coordinators highlighted that "complex needs" can span a range of factors, and it is important to distinguish between two key categories:

- High Acuity Needs: These typically involve individuals with urgent behavioral health conditions or those requiring specialized medical or clinical interventions.
- Time-Intensive Needs: These refer to individuals who may not have urgent medical issues but require significant time and attention due to challenges such as communication barriers, mobility limitations, or cognitive impairments.

To address these differences in resource needs, a structured assessment framework can be used to determine both service eligibility and the intensity of support required. Functional assessment tools, such as interRAI, generate standardized scores that help identify the level of care an individual may need. These scores can inform eligibility thresholds, the type and frequency of services, and the potential risk of institutionalization. As DOH implements the interRAI tool in the coming years, it presents an opportunity to align care coordination rates more closely with assessed levels of need. By tying rates to assessment outcomes, the system can better reflect the varying resource demands associated with supporting individuals with complex or time-intensive needs. Recommendation LT-R6 offers additional guidance for DOH on linking an acuity adjustment framework to reimbursement rates.

As shown in **Table 10**, Guidehouse identified three potential ways to stratify the service to account for potential variation in resource needs and the level of support provided by care coordinators, with the caseload being the key differentiator between the scenarios:

- Scenario 1 proposes a single flat rate for all Care Coordinators that results in 2.8 percent or 3.2 percent fiscal impact depending on the service compared to SFY 2026 expenditures and serves as the baseline for comparison. The fiscal impact associated with this option is presented as part of Recommendation LT-R1.
- Scenario 2 introduces two rates—one for Waiver/CFC and another for TEFRA—with a projected increase of $7.8M in expenditures compared to Scenario 1.
- Scenario 3 adds a third rate for Enhanced/High Acuity clients that is nearly double the Waiver/CFC rate, resulting in a projected $8.3M increase over Scenario 1.

As DOH examines these implementation scenarios, it is also essential to revisit and update provider quality standards and requirements such as service delivery expectations, documentation, training, and other key activities to better align with reimbursement levels.

Table 10. Care Coordination Tiering Scenarios under Rate Structure

Description	Scenario 1	Scenario 2	Scenario 3
Scenario Summary	Establish a flat rate for Care Coordination (Waiver, CFC, TEFRA)	Establish two rates for Care Coordination Waiver/CFC vs. TEFRA	Establish three rates for Care Coordination Waiver/CFC vs. TEFRA vs. Enhanced/High Acuity
Median Caseload – DOH Data	All Care Coordinators = 28	Non-TEFRA CCs = 22 TEFRA CCs = 42	Non-TEFRA CCs = 22 TEFRA CCs = 42 Enhanced 10th PCT = 15

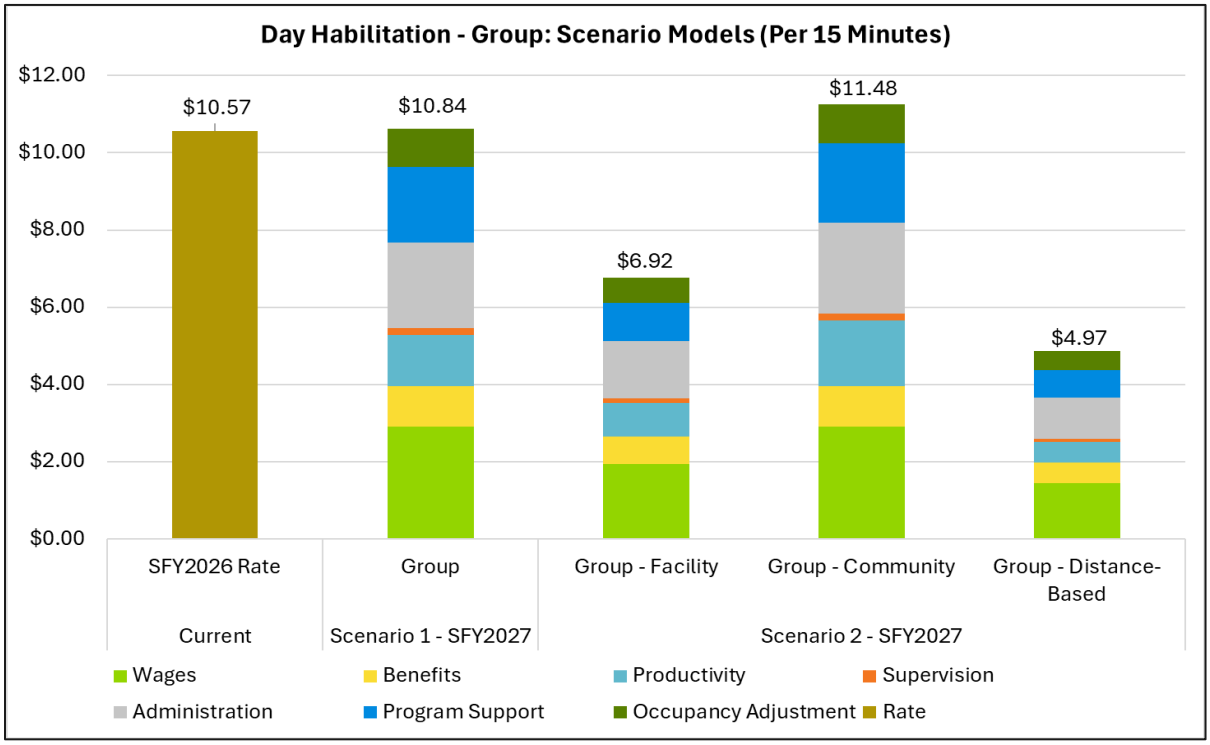
Approximately 75 percent of providers serve only waiver clients, while 22 percent also serve TEFRA clients. Only four providers (3 percent) have a majority TEFRA caseload. As a result, changes to waiver rates are the primary drivers of overall fiscal impact.

Day Habilitation Service Rate Tiering

DOH should consider tiering the Day Habilitation Group service into Community, Facility, and Distance-Based rates. This approach aligns reimbursement with the actual costs of service delivery across different settings currently permitted. Additionally, it aims to promote community integration by offering a higher reimbursement rate for the Community-based tier compared to other tiers, as shown in **Figure 2** below.

- Scenario 1: Applying a flat benchmark rate across all settings results in a uniform 2 percent rate change. The fiscal impact associated with this scenario is included in the impact for Recommendation LT-R1.
- Scenario 2: Introducing tiered rates based on staffing ratios and travel (productivity) assumptions leads to differentiated benchmarks—Facility (1:3), Community (1:2), and Distance-Based (1:4). Projected SFY 2027 fiscal impact estimates assume service utilization is distributed as follows: 75 percent Community, 20 percent Facility, and 5 percent Distance-Based. This results in an approximate $256k reduction in expenditures (State + Federal) compared to Scenario 1.

Figure 2. Day Habilitation Group – Tiering Scenarios



Distinguishing Employment Service Activities

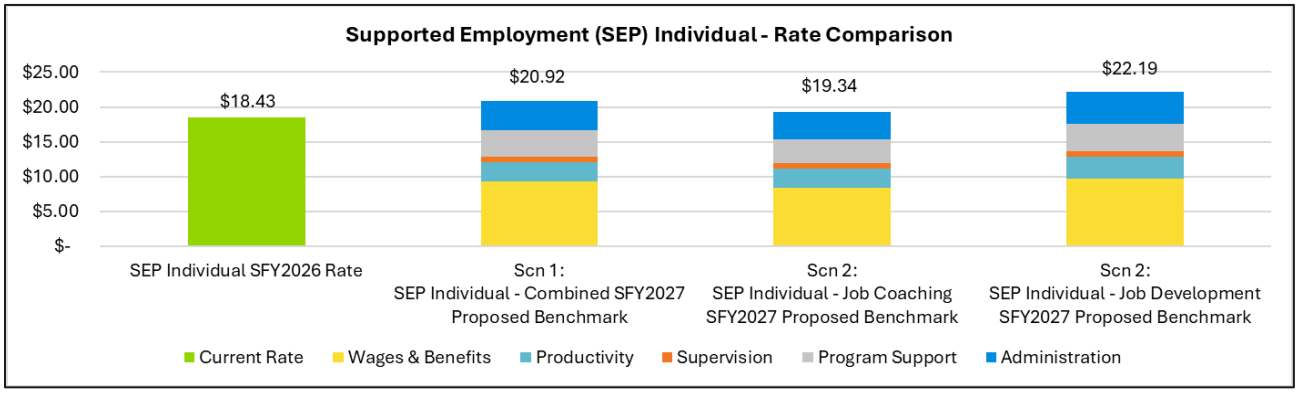
Employment services encompass Supported Employment and Pre-Employment Services. These are currently underutilized compared to other services reviewed. However, for individuals with the most significant disabilities, waiver-funded employment services often become a key option, especially after VR case closure. To better reflect the nature and cost of Pre-Employment and Supported Employment Individual and Group services, Guidehouse recommends that DOH consider a tiered rate structure:

- A lower rate for Job Coaching.
- A slightly higher rate for Job Development, recognizing the increased wage and training requirements associated with this activity.

We evaluated two scenarios for DOH's consideration, in alignment with **Figure 3**:

- Scenario 1: A flat rate bundles both Job Coaching and Job Development into a single service rate. The fiscal impact associated with this scenario is included in the impact for Recommendation LT-R1.
- Scenario 2: Rates are separated into two distinct service activities – Job Coaching and Job Development. The higher wage and training requirements for Job Development contribute to a higher rate compared to Job Coaching. Assuming equal utilization of both tiers, projected SFY 2027 expenditures show a -$246k (State + Federal) difference between the Scenario 2 and Scenario 1.

Figure 3. Supported Employment Individual - Tiering Scenarios Example



Fiscal Impact for Recommendation LT-R5

As shown in **Table 11** below, the financial impact of implementing rate tiering varies significantly, with potential outcomes ranging from cost savings to substantial increases. The minimum estimated annual cost (combined federal and state) is -$502k, while the maximum is $8.3M.

Table 11. Recommendation LT-R5 – Rate Tiering Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
LT-R5: LTSS Rate Tiering	-$502,000	+$8,293,000	-$239,000	+$3,497,000
LT-R5-a: Stratifying Care Coordination Ongoing (2 tiered or 3 tiered structure)	+$8,177,000	+$8,293,000	+$3,425,000	+$3,461,000
LT-R5-b: Day Habilitation Rate Tiering (3 tiered structure)	-$256,000	-$256,000	-$122,000	-$122,000
LT-R5-c: Distinguishing Pre-Employment and Supported Employment Service Activities (2 tiered structure)	-$246,000	-$246,000	-$117,000	-$117,000

C.2.6. Resource-Intensive Residential Settings and Acuity-Adjusted Reimbursement

Residential services are among the most expensive services to deliver within the entire array of HCBS interventions. As a community setting, they are substantially less expensive than comparable institutional services at a nursing facility, an intermediate care facility (ICF) for the intellectually and/or developmentally disabled, or an inpatient hospital stay. In comparison to other HCBS, however, residential services are extremely resource-intensive and so need to be managed appropriately to direct the right resources to the right places at the right time to address the greatest needs. Because the spectrum of resource needs among individuals served within the community can vary widely, from clients requiring only occasional caregiver assistance to those whose care needs verge on requiring institutional capabilities, the potential for major under- and

over-utilization of resources can become a significant concern if the system is unable to distinguish individual resource requirements at a sufficient level of detail.

A common observation among LTSS providers and client advocates heard by Guidehouse has been that residential services, particularly Group Home services, traditionally functioned as a one-size-fits-all solution for a small set of providers serving a wide range of clients. In terms of reimbursement, this one-size-fits-all solution translated into a single daily rate covering average provider costs per client, regardless of individual client needs. As a result, on an individual basis, some clients might receive significantly more funding than their resource needs demanded, and some significantly less.

Although this situation might at first seem inequitable, in a system originally structured around large regional providers, a single rate was relatively unproblematic, as revenue losses incurred from serving high-need, high-cost clients would be offset by the revenue gained from serving clients with relatively minor resource needs. However, as the residential service array and provider base has widened and diversified, this payment logic has proven less tenable, since providers are increasingly able to draw high revenues from lower-need clients, without having to take on higher-need clients whose care is not covered sufficiently under the single rate. The specialization, and perhaps fragmentation, of the provider landscape has fostered the perception of service gaps and a lack of residential settings capable of serving clients with more complex resource needs.

Guidehouse's evaluation comes at a transitional time for the Department and SDS, as Alaska is progressively moving away from the former one-size-fits-all residential approach to more specialized settings designed to address a wider spectrum of care needs. To date, the existing LTSS service array includes a wide range of residential services for all populations including Group Home (including add-ons), Family Home Habilitation (adult and children), Residential Supported Living (multiple home sizes), In-Home Supports, and Supported Living services. Guidehouse also included in our evaluation three novel residential services, not yet implemented, but designed to provide additional service options for clients. These three additional settings include: Specialized Residential Habilitation Group Home, Family Home Habilitation services, and Adult Host Home. SDS is also exploring the potential for an institutional residential option equipped to serve I/DD individuals with higher medical needs than those that can be met in the community. Although SDS does not yet have a concrete plan implementation plan, the Division asked Guidehouse to develop a model of anticipated service costs for a hypothetical Intermediate Care Facility, should the need and a likely provider arise to bring an ICF into operation. If and when these more specialized settings come online, Alaska's LTSS system will serve a wide range of care needs through 17 different residential options of diverse resource intensities. This spectrum is visualized in **Table 12** below, organized by the varying levels of intensity from top to bottom.

Table 12. LTSS Residential Continuum

No	Range of Care Needs
1	Intermediate Care Facility / ICF (POTENTIAL NEW)
2	Specialized Group Home Habilitation (NEW)
3	Specialized Family Home Habilitation – Adult (NEW)
4	Specialized Family Home Habilitation – Child (NEW)
5	Group Home w/1:1 Acuity Add-On
6	Group Home v/ 2:1 Acuity Add-On
7	Residential Supported Living w/ Acuity Add-On
8	Residential Supported Living State Government Owned/Operated
9	Residential Supported Living 5 or Fewer Beds
10	Residential Supported Living 6 – 16 Beds
11	Residential Supported Living 17 or More Beds
12	Group Home
13	Family Home Habilitation - Adult
14	Family Home Habilitation - Child
15	Adult Host Home (New)
16	In-Home Supports
17	Supported Living

Along with Alaska's expansion of LTSS residential settings, SDS is in the middle stages of implementing a new assessment tool, the interRAI, that will foster a more objective, standardized measurement of client care needs. While implementation of the interRAI assessment will be valuable from a clinical perspective, once it is in place throughout the system it can also be harnessed to develop more sophisticated payment methodologies that adjust provider reimbursement based on individual client needs. These objectives will allow DOH to journey further along the "payment maturity" path to value-based care and away from the one-size-fits-all solution, with reimbursement better attuned to individual resource needs, minimizing under- and over-utilization of costly residential options, reducing the potential for provider "cherry-picking" and allowing more effective distribution of resources along the full spectrum of residential care.

Recommendation 6 (LT-R6): Alaska Medicaid should align cost assumptions and service expectations for its new resource-intensive residential setting options to dovetail with longer-range planning for acuity assessment and reimbursement adjustment based on individual resource need.

Over the course of our evaluation, Guidehouse has heard from several stakeholders that Alaska Medicaid lacks a mechanism for adjusting reimbursement by client "acuity." This observation is true in the sense that DOH does not modulate rates within particular settings through the use of rate tiers or other factors designed to take account of individual resource needs. In another sense, though, the evolution of residential options within Alaska's LTSS system has shown an increasing sensitivity to the need to stratify rates based on acuity. Rather than stratifying according to a formal tiered rate methodology within particular service options, Alaska has effectively transitioned to a tiered structure of settings, with specific residential settings designed to meet different intensities of need and care provision. In practice, acuity-adjustment takes place through placement into Alaska's graded residential settings rather than through a differential rate calculation.

Given the status of SDS' interRAI assessment tool implementation, Guidehouse considered the development of specific tiered residential rate recommendations to be premature, as the qualification criteria that would be used to define distinct rate tiers would need to be updated according to more sophisticated and superior standards allowed by application of the interRAI tool. In the interest of not putting the cart before the horse, we have confined our recommendations to developing rate benchmarks for the new resource-intensive residential settings in development, identifying the reimbursement dollars needed for these settings to function as designed. We also note that implementation of these settings coheres with the Department's longer-term acuity-adjustment goals, as they essentially define the standard for high-intensity community residential care, onto which the interRAI assessment can be grafted to establish clinical standards for identifying individual need for these care levels and supporting an understanding of specific resource needs within settings.

In alignment with SDS' program design for its new residential settings, Guidehouse developed recommendations on operational cost and proposed benchmark rates for these services. The section below includes additional information to guide further planning as part of implementation of these new services and settings.

Specialized Residential Habilitation – Group Home and Family Home Habilitation

Guidehouse developed a rate model for Specialized Group Home Habilitation and Family Home Habilitation to support DOH's introduction of these services for individuals with complex or acute needs that exceed the scope of standard habilitation services.[14] These settings are designed to serve as cost-effective alternatives to high-cost institutional environments, such as hospitals and psychiatric facilities.

DOH projects that approximately 20 individuals will use services across both the Specialized Group Home and Family Home Habilitation settings during the initial implementation phase. This projection formed the basis for assessing the fiscal impact of introducing the services.

[14] State of Alaska, Department of Health, Governor Mike Dunleavy Memorandum.

In collaboration with SDS and ORR, and based on discussions regarding the anticipated staffing structures, we employed a rate build-up methodology to construct the model. This approach incorporates the key components outlined in **Table 13** below.

Table 13. Specialized Group Home and Family Home Habilitation Services – SFY 2027 Proposed Benchmark Rate Components

Rate Component	Assumptions and Values
Direct Care Staff Wage	$23.17 / Hour ($159,122 Annual)
Direct Care Hours	18.8 Hours / Day (Includes 2.8 Substitute Hours / Day)
Employee Related Expenses	37.23% of Wages
Specialized Staff	- RN 1 Hour / Week (52 Annual Hours) - Psychologist / Psychiatrist 0.25 Hours / Week (13 Annual Hours) - Behavioral Health Specialist 0.75 Hours / Week (39 Annual Hours)
Program Support and Administrative	37.5% of Wages
Daily Rate	$982.77

We recommend that DOH adopt the proposed benchmark rate as it finalizes the regulatory package for these services.

Adult Host Home Care

DOH is introducing Adult Host Homes as an alternative to traditional residential settings, such as Group Homes and Family Home Habilitation. This model is designed to provide individualized, community-integrated living arrangements for adults who require supportive services. The rate model builds on the Family Home Habilitation structure but includes lower caregiver stipends, reflecting the reduced training and licensing requirements for this service. An Organized Healthcare Delivery System (OHCDS) approach, as proposed for Family Home Habilitation in **Section C.2.7.**, could be an effective way to support and reimburse providers.

To support effective implementation, DOH may consider conducting outreach to gauge provider interest and identify geographic areas with the highest need for Adult Host Home placements. Simultaneously, it is essential to offer comprehensive education and technical assistance to prospective providers regarding applicable licensing and regulatory requirements. Preparing providers to be well-informed and adequately equipped will be critical to maintaining service quality, protecting participant well-being, and achieving the intended outcomes of this model. The introduction of Adult Host Homes is projected to be cost-neutral, as reduced utilization of higher-cost residential services is expected to offset associated expenses.

Section G in this report presents the assumptions included in the Adult Host Home Care rate model.

Intermediate Care Facilities (ICFs)

Guidehouse identified the range of costs for building and operating Intermediate Care Facilities (ICFs), providing a foundational understanding for DOH to move forward with rate implementation.

As a next step, DOH may consider evaluating several key areas to support the implementation of rates that are both effective and responsive to the State's healthcare infrastructure needs. These considerations will help guide strategic decisions around facility planning, funding, and long-term sustainability. Key areas for DOH's consideration include:

- Scale: Determine how many ICFs are needed to meet both current and future demand for services across Alaska.
- Facility Location: Evaluate where facilities should be located based on demand, provider readiness, and proximity to related services such as hospitals or other ICF operations.
- Rate Type: Decide whether to implement a standard rate for all facilities or adopt facility-specific rates. If a standard rate is chosen, consider applying geographic differentials to reflect regional cost variations.
- Cost Reporting: Consider whether to require cost reporting from facilities to support future rate reviews and maintain transparency.

The quantitative impact on DOH depends on the decisions made regarding the areas highlighted above and will vary accordingly. **Section G.3.12** in the report includes the ICF rate model assumptions.

Fiscal Impact for Recommendation LT-R6

Table 14 below includes the estimated fiscal impact for Specialized Residential Habilitation services. The estimates do not include Adult Host Homes and ICF costs.

Table 14. Recommendation LT-R6 – Specialized Residential Settings Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
LT-R6: LTSS High Intensity Residential Settings: Specialized Residential Habilitation (Recommendation LT-R6)	+$7,174,000	+$7,174,000	+$3,413,000	+$3,413,000
Specialized Residential Habilitation – Group Home	+$5,381,000	+$5,381,000	+$2,560,000	+$2,560,000
Specialized Residential Habilitation – Family Home Adult	+$717,000	+$717,000	+$341,000	+$341,000
Specialized Residential Habilitation – Family Home Child	+$1,076,000	+$1,076,000	+$512,000	+$512,000

C.2.7. Organized Healthcare Delivery System (OHCDS) Administration Fees and Policies

For DOH's consideration, Guidehouse recommends administrative fee ranges that may be provided to an OHCDS for Environmental Modification services and Family Home Habilitation services, as noted below.

Recommendation 7 (LT-R7): Alaska Medicaid should implement changes to Organized Healthcare Delivery System (OHCDS) administrative fees and policies for Environmental Modification (E-Mod) and Family Home Habilitation services.

E-Mod Administrative Fees

Environmental Modification services are primarily used in urban regions like Anchorage and Mat-Su based on SFY 2024 claims data. This necessitates revisiting the administrative fee that may incentivize contractors to provide services in other regions of the state as well. DOH may consider maintaining the current maximum reimbursement amount while increasing the administrative fee as a percentage of billed charges. This adjustment should be guided by the range of administrative costs reported in the provider cost and wage survey. The selected percentage should also reflect the responsibilities assumed by an OHCDS in place of a provider agency, as outlined in DOH requirements.

Table 15 below compares Alaska's Environmental Modification reimbursement policy with peer states including Colorado, Minnesota, Maryland, Pennsylvania, New Mexico, South Dakota, and Wyoming. Key findings include:

- **Reimbursement Policy:** Alaska offers a maximum of $40,000 over three years, which is more generous than most peer states. Colorado, Pennsylvania, New Mexico, South Dakota, and Wyoming all have lower caps. Only Maryland exceeds Alaska's limit with a $50,000 lifetime cap, while Minnesota allows up to $40,000 per waiver year for certain waivers.
- **Administrative Fee Policy:** Administrative fee structures vary widely across states, underscoring the importance of reviewing state-specific guidelines when budgeting for these costs. Alaska applies a 2 percent fee or $100, whichever is greater. Key examples from other states include:
  - Colorado uses a 13.56 percent fee based on the lesser of submitted charges or the manufacturer's invoice cost.
  - Other states may apply flat rates of 10 percent or 15 percent of the service cost, with caps such as $375 or $25.

Guidehouse recommends that DOH increase the administrative fee in the range of +4.3 percent to +14.5 percent of the billed amount. This range is informed by a combination of administrative costs reported in provider cost and wage surveys that may apply to an OHCDS including hiring expenses, staff training and development (administrative related), information technology expense (e.g., computers and software), office supplies, postage, and office equipment and furniture (not for direct care), and non-payroll taxes.

Table 15. Peer State Comparison for Environmental Modification OHCDS

State	Service Reimbursement Policy	OHCDC Admin Fee Policy	Admin Fee Percentage based on Billed Amount	Maximum Admin Fee Limits/Ranges based on Maximum Billed Amount Per Year
Alaska (has OHCHS)	$40,000 maximum per participant over 3 years (since July 2024)	2% percent of the billed charges or $100, whichever is greater	+2.00% (current) +4.30% to +14.5% (proposed based on survey; depends on costs covered by an OHCDS)	$267 (current) $573-$1,933
Colorado (has OHCDS)	• $14,000 maximus per 5 years for a few waivers • $10,000 maximum per 5 years for others	13.56% of lesser of the submitted charges or the sum of the manufacturer's invoice cost	+13.56%	$271-$380
Minnesota	• Brain Injury, Community Alternative Care, Community Access for Disability Inclusion, and Developmental Disabilities waivers – Cannot exceed $40,000 per waiver year • Alternative Care and Elderly Waiver – Cannot exceed $21,199 per waiver year	N/A	N/A	N/A
Maryland (has OHCDS)	$50,000 lifetime limit per participant	15% of the total cost of the service provided	+15.00%	Up to $375 (10 year assumed)
Pennsylvania (has OHCDS)	$20,000 per participant over a 10- year consecutive period	$25 or 10% of the cost of the service, whichever is less	+10.00%	Up to $25
Other States	• New Mexico: $6,000 per participant every 5 years • South Dakota: $5,000 per participant per year • Wyoming: $30,000 lifetime limit per participant	N/A	N/A	N/A

Separating Family Home Habilitation Administrative Fees from Caregiver Reimbursement

DOH may consider carving out OHCDS administrative costs for Family Home Habilitation services. According to the provider cost and wage surveys, administrative costs account for an average of 16 percent of total expenses among Family Home Habilitation providers. Based on this, DOH may establish an administrative fee that is 16 percent of the reimbursement rate and flat amount to provide to an OHCDS. This would not be treated as a pass-through deduction from the provider's reimbursement rate.

This approach would help clarify expectations around reimbursement and the allocation of administrative costs. The list below outlines the cost components that contribute to the administrative cost percentage.

- Total Maintenance Employee Salaries and Wages
- Total Administrative Employee Salaries and Wages
- Total Salaries for Contracted Administrative Staff
- Office Equipment and Furniture (not for direct care)
- Interest Expense
- Non-payroll Taxes
- Licensing/ Certification/ Accreditation Fees
- Staff Training and Development (administrative related)
- Insurance (excluding benefits and auto insurance)
- Information Technology Expense (e.g., computers and software)
- Office Supplies
- Postage
- Travel (excluding client transportation and direct care vehicles)
- Cost for Translating Materials

Fiscal Impact for Recommendation LT-R7

Table 16 below presents the estimated minimum and maximum financial impact of implementing an increased administrative fee under Recommendation LT-R7-a, ranging from +4.3 percent to +14.5 percent of the billed amount. These estimates are based on current utilization of Environmental Modification services. In contrast, for implementation of Recommendation LT-R7-b, DOH's associated labor and administrative effort are expected to be absorbed within the broader implementation of OHCDS functions for Family Home Habilitation. As such, no additional labor or administrative costs to the State are anticipated for this recommendation. The cost associated with Family Home Habilitation reimbursement is captured in Recommendation LT-R1.

Table 16. Recommendation LT-R7 – OHCDS Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
LT-R7: OHCDS for E-Mods: Modifying Administrative Fee (Recommendation LT-R7-a only)	+$8,000	+$27,000	+$4,000	+$13,000

C.2.8. Brokerage Impacts on Waiver Non-Medical Transportation

As a part of Guidehouse's wider set of Phase 1 reimbursement evaluations, we have made several recommendations impacting Alaska's medical transportation system, including the implementation of a brokerage system to facilitate client travel needs (see Recommendation MT-R2 in Guidehouse's separate Medical Transportation Evaluation Report for additional details). The installation of a transportation broker is aimed more directly at medical transportation, but it is also likely to substantially affect non-medical transportation provided under Alaska's Medicaid HCBS waiver authorities. If the broker operates as desired, more client transportation options would be available to waiver participants, which would likely increase utilization of transportation services under the waivers. Guidehouse's recommendation here is that SDS coordinate with DOH staff overseeing brokerage planning and potential implementation to estimate potential impacts on the HCBS waivers and the populations they serve.

Recommendation 8 (LT-R8): Alaska Medicaid should plan for potential impacts to non-medical transportation utilization for LTSS waiver participants if the Department adopts a brokerage model for coordinating Medicaid transportation services across the state.

Because specific fiscal impacts to the waivers will depend on how the transportation brokerage is structured and what services and populations brokerage responsibilities will include, Guidehouse has not attempted to model specific fiscal impacts to the waiver system. The potential costs and cost savings of the brokerage itself are discussed in greater depth in Guidehouse's Medical Transportation Report.

C.2.9. Annual Administrative Rate Update

One of the primary virtues of the independent rate build-up methodology is that it allows Medicaid to make targeted rate changes (usually increases) informed by up-to-date cost and service delivery data without having to engage intensive rebasing efforts. Although a thorough rate rebase is recommended every 4-5 years to refresh cost assumptions typically unavailable without a major survey effort, Guidehouse's recommended rate methodology would allow the State to leverage freshly published public staff wage on an annual basis and other data on provider expenses to update information on key cost drivers influencing the rates.

Recommendation 9 (LT-R9): Alaska Medicaid should consider implementing a process for reviewing rates annually and proposing targeted rate updates based on changing wage and cost benchmarks and their differential impacts across the LTSS service array.

DOH may consider implementing a regular administrative rate update process that includes adjustments to wage assumptions or overall rate levels based on applicable inflation indices to account for shifts in the economic environment. If DOH adopts the benchmark rate methodologies recommended by Guidehouse, it would be feasible to review rate assumptions more frequently at an established cadence to determine whether specific cost components such as wages require administrative updates, without necessitating a full rate rebasing. The independent rate build-up approach enables DOH to isolate and evaluate individual rate components (e.g., administrative costs, program support costs, transportation) for targeted review and adjustment.

Currently, DOH uses the S&P Global Market Intelligence Healthcare Cost Review which is paid and proprietary. As an alternative to the index used currently, Guidehouse recommends monitoring inflationary changes using the publicly available Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) data, which provide monthly earnings information for workers in roles comparable to those in DOH-funded programs.[15] Specifically, DOH may consider monitoring CES data across all relevant service areas, including:

- Assisted Living Facilities for Elderly Staff
- Elderly and Persons with Disabilities Staff
- Home Health Care Staff
- Residential Intellectual and Developmental Disability Staff
- Vocational Rehabilitation Services

There are several advantages to using the index derived from BLS CES over alternative measures:

- The BLS updates the average hourly earnings data monthly, offering a timely indicator of cost growth for both current and future rate-setting periods.
- The data is a measure of the national labor market for LTSS providers, making it more responsive to the unique and evolving cost structures in LTSS programs than general healthcare inflation metrics.
- The data is publicly available and can be used by DOH to derive a point-in-time snapshot of growth trends to account for economic shifts, as and when needed.

DOH may also consider reviewing other publicly available sources, as needed, including annual BLS Occupation Employment Wage Statistics (OEWS) data, monthly BLS Employer Costs for Employee Compensation (ECEC) supplemental pay data, and annual Medical Expenditure Panel Survey (MEPS) insurance cost data. These data sources were used as part of the rate evaluation to compare and contrast data reported in provider cost and wage surveys, and they are commonly used by similar programs in other states. DOH may compare key metrics from these resources across occupations, regions, and industries, helping inform policy decisions and economic competitiveness.

[15] U.S. Bureau of Labor Statistics, Current Employee Statistics – CES (National).

Fiscal Impact for Recommendation LT-R9

Table 17 below includes the estimated maximum and minimum SFY 2027 cost to the State for implementing Recommendation LT-R9. These estimates focus on labor costs, as the recommended data sources are publicly available and free of charge.

Table 17. Recommendation LT-R9 – Annual Administrative Rate Update Fiscal Impact

Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
LT-R9: LTSS Administrative Rate Update	+$9,000	+$18,000	+$18,000	+$35,000

C.2.10. Medicaid LTSS for Tribal Members

To support the well-being of Alaska Native communities while strengthening the sustainability of the Medicaid program, DOH may consider exploring opportunities for collaboration with tribal health organizations in the delivery of LTSS. Federal policy allows for a 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid services provided to American Indian and Alaska Native beneficiaries through Indian Health Service (IHS) or tribally operated facilities. This provision offers a pathway to improve access to care while managing state Medicaid expenditures.[16]

Recommendation 10 (LT-R10): Alaska Medicaid should explore additional opportunities to encourage tribal providers to deliver LTSS services directly or establish care coordination agreements with non-tribal LTSS providers to take advantage of enhanced federal matching funds for Medicaid services delivered to Alaska Natives.

Table 18 presents a breakdown of SFY 2024 LTSS Medicaid expenditures in Alaska, highlighting the distribution between IHS and non-IHS members, as well as where services for IHS members were delivered. The table also highlights how much of the IHS-related spending qualified for the enhanced 100 percent federal match. Three key takeaways include:

1. Expenditures for non-IHS members represent a larger share: In SFY 2024, approximately 63 percent of total Medicaid expenditures were associated with individuals who are not IHS members, indicating that the majority of Medicaid spending is directed towards individuals who are not eligible for IHS benefits.
2. Most IHS member services are delivered outside IHS providers: While IHS members accounted for 37 percent of total expenditures, the majority of these services (97 percent) were provided by non-IHS providers. This may suggest opportunities to explore how tribal and non-tribal providers can work together to support service delivery.
3. Limited use of 100 percent FMAP for IHS members: Only 10 percent of expenditures for IHS members qualified for the enhanced 100 percent FMAP, while 90 percent do not. There may be room to consider how more services could align with federal criteria to access this enhanced funding.

[16] Centers for Medicare & Medicaid Services, 100% FMAP for LTSS – Educate Your State.

Table 18. Breakdown of SFY 2024 Expenditures for IHS and Non-IHS Members

Metric	SFY 2024 Expenditure (State + Federal)	Percentage of Total SFY 2024 Expenditures (State + Federal)
a. Total SFY 2024 Expenditures	$513,450,132	100%
b. Non-IHS Member Expenditures	$325,964,222	63%
c. Total IHS Member Expenditures	$187,485,910	37%
c1-i. IHS Member Expenditures at IHS Provider	$6,017,771	3%
c1-ii. IHS Member Expenditures at Non-IHS Provider	$181,468,139	97%
c2-i. IHS Member at 100% FMAP	$18,488,836	10%
c2-ii. IHS Member not at 100% FMAP	$168,997,074	90%

One option is to support tribal health organizations that are interested in expanding their capacity to provide LTSS directly. Another approach is to facilitate care coordination agreements between tribal and non-tribal LTSS providers. These agreements, authorized under CMS guidance, allow non-tribal providers to furnish services to AI/AN Medicaid beneficiaries under the direction of a tribal facility, thereby qualifying the services for 100 percent FMAP.

To assist in this effort, DOH could consider offering technical support to tribal partners who wish to pursue these opportunities. This may include guidance on administrative processes, billing systems, and incorporating LTSS into P.L. 93-638 contracts or compacts.[17-18] DOH might also consider highlighting specific service and reimbursement models (e.g., Adult Host Homes) that reflect the value of tribal participation and the potential cost efficiencies for the State.

D. Stakeholder Engagement

D.1. Stakeholder Engagement Overview

To support the rate evaluation, Guidehouse and DOH worked to identify stakeholders to provide input on the rate study in a variety of ways. Guidehouse and DOH invited individuals and organizations from across the spectrum, including provider representatives, trade associations, and participants, to engage with the study. **Table 19** below includes a summary of stakeholder engagement activities.

[17] University of Alaska, Fairbanks, Tribal Governance.
[18] Bureau of Indian Affairs, Public Law 93-638: Indian Self-Determination and Education Assistance Act, as Amended.

Table 19. Summary of Stakeholder Engagement Activities

Type of Meeting	Description of Meeting	Number of Meetings
Rate Workgroup	Gathered subject matter experts drawn from provider communities with detailed understanding of service provision, operational challenges, and provider costs	6
Care Coordination Focus Group	Convened a group of Care Coordination providers including multi-service providers, Care Coordination-only agencies, and solo Care Coordinators to solicit feedback on survey and rate development	2
Provider Cost and Wage Survey Training	Recorded training sessions and follow-up assistance as needed during the survey response period	2
Alaska Association on Developmental Disabilities (AADD) Survey Q&A Technical Assistance Sessions	Partnered with AADD to provide additional technical assistance on specific survey topic areas as requested by providers including small providers	6
Provider Interviews and Individual Provider Meetings	Conducted in-person interviews with provider and provider associations in 5 regions including Anchorage, Kenai, Mat-Su, Juneau, and Fairbanks, and one-one-one meetings with select service providers	14
Listening Sessions for People with Lived Experience and Family Members	Focus group style meetings with individuals who receive LTSS services and family members/caregivers to understand the challenges participants face within the current system	2
Alaska Native Tribal Health Consortium (ANTHC)	Meeting with ANTHC to provide an overview of the rate evaluation and solicit feedback	1
Alaska Native Health Board (ANHB)	Meeting with ANHB to provide an overview of the rate evaluation and solicit feedback	1
Alaska Commission on Aging (ACoA)	Provided an overview of the rate study and participated in meeting to publicize listening sessions for people with Lived Experience	2
Governor's Council on Disabilities and Special Education (GDDSE)	Provided an overview of the rate study and participated in meeting to publicize listening sessions for People with Lived Experience	2
Service Employees International Union (SEIU) 775 – Caregivers' Union	Focus group style meeting with caregiver members to understand the challenges they face within the current LTSS system	1
Total Meetings	-	**39**

D.2. Rate Workgroup Composition and Role

To support the development of cost-based rates for the State's LTSS services, Guidehouse and DOH worked with service providers and other stakeholders in the rate development process. The rate study considered worker wage levels and benefits, providers' administrative costs, and program support costs, among other factors. This effort was informed by a comprehensive provider cost and wage survey soliciting broad provider participation, analysis of provider-submitted financial and service delivery data, as well as ongoing, extensive stakeholder input throughout the rate evaluation process.

DOH convened a recurring stakeholder forum to support the rate study: a specialized Rate Workgroup to address detailed technical issues and advise the study more broadly across services while representing a wider array of stakeholder interests. Guidehouse invited 17 providers and provider associations representing a diverse mix of services and regions. In all, Guidehouse held 6 Rate Workgroup meetings between September 2024 and July 2025. The list below outlines the composition of this group, their respective roles, and discussion topics.

Composition

- Membership representative of associations and providers directly impacted by rate changes.
- Provider representatives who reflect the full range of services included within the rate study scope.
- Members have a strong understanding of provider finances, reporting capabilities, and service costs

Role

- Provide subject matter expertise on provider cost and wage survey and rate methodology development.
- Review and validate rate model factors and assumptions, including wages, benefits, administration, program support and staffing.
- Provide insight into how current services are delivered.
- Provide recommendations for consideration in the Final Report

Discussion Topics

- Provider Cost and Wage Survey analysis
- Rate build-up approach and rate components
- Benchmark wages and adjustments, including supplemental pay and inflation factor
- Staffing levels and supervision ratios
- Final rate models, current service utilization landscape, and fiscal impact of proposed rates
- Considerations for implementation and future analysis

In addition to the focused stakeholder workgroups, a provider cost and wage survey was deployed to a wider provider community. Guidehouse conducted the first stakeholder meeting to serve as a training session for the wider provider community in filling out the survey. In this meeting, we shared the survey data collection process along with the objective and the methodologies that are used in the rate study.

The provider rate workgroups were as follows:

Rate Workgroup Session #1 (Virtual): The first workgroup session was designed to kick off the rate study process by providing an overview of the scope of the rate study, communication and engagement strategies with providers and the wider community, and anticipated data collection and analysis through the Provider Cost and Wage Survey and other data sources.

Rate Workgroup Session #2 (Virtual): In the second workgroup session, Guidehouse provided a more comprehensive view of the rate study process and the rate buildup approach to help providers understand how Guidehouse intended to utilize the data collected. Five new services that would be addressed during the rate review were introduced: Adult Host Home, Specialized Group Home, Specialized Family Home Habilitation - Adult, Specialized Family Home Habilitation – Child, and the Organized Healthcare Delivery System (OHCDS) for Environmental Modifications and Family Home Habilitation services.

Comparisons of rates for similar services in other states were discussed. Guidehouse provided initial comparisons of key economic indicators, including minimum wage, median household income, and cost of living indices, for Alaska and identified peer states to ground discussions. Since Alaska is unique, and uniquely expensive, these indicators provide a baseline to understand where rates for these services should be expected to lie amongst their peers.

Additionally, Guidehouse previewed the Provider Cost and Wage Survey with the workgroup members and solicited feedback regarding the format of the survey, the availability of the data requested, and timelines for completion. The workgroup was shown and invited to suggest improvements for each page of the survey to maximize the usefulness of the data collected. Adjustments were made to the survey in response to feedback to better align questions to the ways in which providers keep records.

Rate Workgroup Session #3 (In-Person): The third rate workgroup meeting focused primarily on three topics: the Survey currently in circulation, in depth comparisons with peer states, and data related to inflation, supplemental pay, and benefits from publicly available sources.

The General Survey was released on October 11, 2024, and had been in circulation for approximately one month. Guidehouse reviewed participation in the survey training sessions available to providers on October 14th and October 21st as well as the commonly asked questions during those sessions and through email. Additional feedback was requested to include in a Frequently Asked Questions document slated for release shortly after the meeting.

Guidehouse then provided analysis across Alaska and identified peer states of the primary driver of rates for Home and Community Based services: wages. Utilizing data from the Bureau of Labor Statistics, workgroup members were shown how wages for job-types key to LTSS service delivery compared across different regions in Alaska as well as to other states and the national average.

In anticipation of survey data, Guidehouse provided analysis of publicly available data that would later be compared to survey results. Inflation metrics were compared from a variety of sources including the Medicare Economic Index (MEI), Current Employment Statistics (CES), and Consumer Price Index (CPI). The workgroup also reviewed supplemental pay trends over recent years and Guidehouse showed how these components are brought together to develop wages for rate modeling. Initial data and methodology for development of Employee-Related Expenses

("benefits") was reviewed using publicly available data to illustrate how a benefits adjustment would be implemented in rate modeling once survey data was available.

Rate Workgroup Session #4 (Virtual): The fourth rate workgroup meeting focused on the results of survey responses. Overall, Guidehouse received 64 surveys amongst the three types sent to providers. Guidehouse discussed the review and validation process preceding analysis of the survey data and its importance in the absence of auditing. The workgroup reviewed survey participation overall, within each service category, and by region to validate that the data set was sufficiently diverse for credibility. The rate workgroup then reviewed survey data compared to the publicly available data reviewed in the prior meeting including wages by job-type, supplemental pay, wage inflation, and employee related expense data. Guidehouse also used survey data to identify common staffing teams for each service. Workgroup participants provided feedback on these teams of staff and how these services are implemented across different providers, offering key insight into how to balance the requirements and contributions of job types within these teams during rate development. Specifically, participants were able to weigh in on topics such as the time requirements of Job Coaches and Job Developers in the context of Supported Employment services, common staff to client ratios for Adult Day and Day Habilitation, initial analysis of productivity factors, and supervisory span of control.

Rate Workgroup Session #5 (Virtual): The fifth rate workgroup meeting focused on indirect costs, such as administrative and program support expenses, and service specific rate components. Guidehouse showed results of indirect cost analysis, with and without adjustments for outlier data, considered in aggregate and within subcategories where appropriate. Providers were able to validate these analyses as reasonable within their experience. The remainder of the session was spent reviewing rate components specific to individual services. This includes service teams and direct care hours for residential services, stipends for Family Home Habilitation, differences between individual and group service delivery for services where both are available, and costs specific to meals services such as food and delivery costs. Providers offered important insights to these values that were not apparent from survey data alone.

Rate Workgroup Session #6 (Virtual): The final rate workgroup convened to discuss the draft preliminary benchmark rates and methodologies for providers. This session served as a refresher on how Guidehouse builds their rates and provided detailed examples of how each component discussed during the rate study fits into the final draft rate model calculations. Guidehouse also presented fiscal impact scenarios and additional considerations within the session.

The primary purpose of the call was to garner provider feedback on the components and methodology used to calculate the draft rates. After the meeting, Guidehouse reviewed additional feedback shared by Rate Workgroup members to update recommendations related to Personal Care, Group Home, and Specialized Private Duty Nursing services.

Guidehouse emphasized the importance of collaboration and transparency throughout the rate evaluation process. Providers were actively engaged at multiple stages, including the development of benchmark rates and formulation of recommendations.

D.3. Additional Stakeholder Engagement

D.3.1. Provider Survey Technical Assistance Sessions

On top of the focused stakeholder workgroups, Guidehouse deployed a provider cost and wage survey to a wider provider community. Guidehouse developed two recorded trainings for providers to instruct providers on filling out the survey. Additionally, Guidehouse participated in six survey Q&A technical assistance sessions organized by the Alaska Association on Developmental Disabilities (AADD) to assist providers in understanding and completing the Provider Cost and Wage Survey. These sessions each focused on a subset of worksheets within the survey, allowing providers to ask questions and align on how to best respond. These meeting topics are detailed below in **Table 20.**

Table 20. Alaska Association on Developmental Disabilities (AADD) Provider Cost and Wage Survey Technical Assistance

Focus Area	Meeting Date
Total Costs	November 12, 2024
Wages and Benefits	November 21, 2024
Care Coordination	November 22, 2024
Community and Home-Based Services	November 25, 2024
Family Habilitation and Group Home Services	December 3, 2024
Small Providers	December 6, 2024

Additionally, Guidehouse collaborated with DOH and key stakeholders to conduct a series of targeted engagement sessions to develop a comprehensive understanding of the LTSS landscape. These included focused meetings with individuals with lived experience, service providers, and provider industry representatives.

As part of this effort, Guidehouse reviewed a proposal with a provider to establish a new assisted living facility in Nome. This discussion offered valuable insights into the unique costs and logistical considerations associated with building and operating facilities in Alaska.

D.3.2. Care Coordination Focus Group

Guidehouse conducted two focus groups specifically focused on Care Coordination services. Although Care Coordination represents approximately six percent of total claims within the LTSS umbrella, it plays a critical role in the delivery of all related services. While Care Coordination providers were included in the broader workgroup, Guidehouse sought more diverse input than the workgroup alone could offer. To that end, additional invitations were extended to select Care Coordination providers for workgroup meetings addressing related services.

The first focus group, held on October 24, provided an overview of the rate review process, its objectives, the anticipated timeline, and the Care Coordination Provider Cost and Wage Survey. Guidehouse solicited feedback on the survey's format, content, and the feasibility of reporting the requested data. This feedback was used to refine the survey to support comprehensive data collection through methods aligned with current provider data recording practices.

The group also engaged in a detailed discussion on participant acuity and the potential implementation of acuity-tiered rates. Providers described various ways in which participant acuity differs—many of which are difficult to quantify in advance using assessment tools. These include factors such as additional time spent supporting caregivers and participants requiring more frequent non-medical support.

The second Care Coordination focus group convened on February 25, 2025, and centered on survey analysis results, comparisons with peer states, and specific service delivery components. Guidehouse presented peer state wages, economic indices, and rate structures to inform discussions on service delivery and associated challenges. The workgroup reviewed and validated all rate components, including wages, inflation, supplemental pay, employee-related expenses (ERE), and administrative and program costs.

The discussion on acuity-based rates continued, with particular attention to how a tiered system could affect rates for both high-acuity and typical participants. It was noted that allocating more hours to high-acuity participants would reduce the average hours available for typical participants. The group emphasized that both medical and non-medical factors—such as caregiver capability and participant temperament—influence the time required per month.

D.3.3. In-Person Provider and Provider Association Interviews

In collaboration with DOH, Guidehouse recognized the importance of conducting in-person, on-site interviews with providers. Between November 18 and 22, 2024, the Guidehouse team traveled to Alaska to engage directly with stakeholders. The primary objective of this visit was to gain a deeper understanding of provider perspectives, and the unique challenges associated with delivering services across Alaska's diverse geographic regions.

During the visit, the team met with a broad range of providers and associations to learn more about LTSS service delivery throughout the state. Stakeholders included:

- Access Alaska
- Alaska Association for Personal Care Supports
- Alaska Association on Developmental Disabilities
- Alaska Commission on Aging (ACoA)
- Alaska Hospital Association
- Alaska Native Health Board (ANHB)
- All Ways Caring
- Frontier Services
- Governor's Council on Disabilities and Special Education (GCDSE)
- Infinite Solutions
- Mat-Su Children
- Southcentral Foundation
- Southeast Alaska Independent Living
- Strong Solutions
- TIDES

These interviews were highly engaging and provided valuable insights into the rate study approach. They enabled Guidehouse to gather information from providers who may not typically participate in

workgroups or stakeholder meetings. The in-person format facilitated dynamic exchanges and a deeper understanding of the challenges and opportunities faced by LTSS service providers in Alaska. These conversations also supplemented findings from the Provider Cost and Wage Survey, offering a more comprehensive view of service delivery challenges beyond the data submitted in the survey.

Meeting with providers in person proved invaluable for several reasons:

- **Enhanced Communication**: Face-to-face interactions fostered open and candid dialogue, allowing providers to share their experiences, challenges, and perspectives more freely. This direct engagement helped build trust and rapport, which are essential for effective stakeholder collaboration.
- **Nuanced Understanding**: On-site engagement allowed the Guidehouse team to observe firsthand the operational environments and logistical challenges unique to Alaska. This contextual understanding is critical for developing tailored solutions that address specific regional needs.
- **Diverse Perspectives**: The in-person meetings enabled the team to gather insights from a wide range of providers, including those who may not typically participate in formal workgroups. This diversity of viewpoints enriched the overall understanding of the LTSS landscape.
- **Actionable Insights**: The information obtained during these interviews directly informed the rate study approach. Practical experiences and recommendations were incorporated to align the study with real-world conditions and operational challenges.

D.3.4. Listening Sessions for People with Lived Experience and Families

To further elevate the voices of Alaskans receiving LTSS, Guidehouse convened two listening sessions on March 24, 2025—one in the morning and one in the evening—to accommodate participants' schedules. These sessions included individuals who especially use services such as Respite, Day Habilitation, Personal Care, and Transportation. Participants shared their experiences navigating the LTSS system, highlighting both strengths and areas for improvement. **Table 21** below includes attendance information for the sessions.

Table 21. Listening Session for People with Lived Experience Attendance

Type of Attendee	Morning Session	Evening Session
Self-Advocates	2	1
Family Members and Other Supports	19	10
Total Attendees	**21**	**11**

The feedback gathered provided critical input into the rate-setting process, helping tailor recommendations to the specific needs of each service type. For instance, many participants commented on the difficulty of finding contractors to install environmental modifications. This led to OHCDS recommendations designed to increase access to contracting providers by incentivizing existing LTSS providers to engage with traditional contractors who can perform these services.

Additionally, participants noted the high turnover rate of personal care staff along with the difficulty of utilizing all approved hours for Personal Care services due to understaffing. These concerns give additional credence to increases in the rates for these services, allowing providers to offer wages that are sufficiently competitive to retain and attract quality staff. The list below includes the key questions discussed with people lived experience and their family members.

Lived Experience Focus Group Discussion Questions

- Do you feel you have choices in your providers and services? Are there services that Medicaid does not currently cover that you or your family could benefit from?
- Do you or your family members face any challenges with accessing services?
- How has your experience with services changed over time? What are differences in services between children, transition-age youth, and adults?
- What supports might be helpful for people who do not have family, friends, or other natural supports?

D.3.5. Listening Session for Caregiver Union

Guidehouse held a listening session on May 22, 2025, with the Service Employees International Union (SEIU) to gather feedback from Alaskans working on the front lines of Long-Term Services and Supports (LTSS), particularly in personal care and respite services. Guidehouse facilitated the session, explaining its purpose and providing an overview of the LTSS rate study. Participants emphasized the importance of recognizing the dignity of their work and advocated for compensation that reflects the complexity and intimacy of the tasks they perform for clients. The list below includes key questions discussed with the focus groups.

SEIU Focus Group Discussion Questions

- What kind of services do you provide and what challenges do you face as a caregiver in Alaska?
- What do you think would help get more caregivers in rural and remote areas of Alaska?
- How did recent rate increases make a difference to you and other caregivers that you know?
- What would make the care workforce even stronger? What makes the biggest difference in terms of recruitment, retention, and training?

Each listening session lasted approximately one hour, allowing ample time for in-depth discussions and comprehensive feedback from all participants. This collaborative format contributed to shaping the rate study with a broad range of perspectives and expert insights, resulting in more accurate and actionable recommendations. By incorporating specific examples and stakeholder input, the rate-setting methodology was further refined to better address the unique needs of each service type.

E. Data Sources

E.1. Overview of Data Sources

Cost assumptions developed throughout the rate study relied on a wide variety of data sources. Guidehouse drew from DOH claims data, provider data reported through the Provider Cost and Wage Survey, as well as publicly available data that reflect national and regional standards to arrive at cost assumptions. Our approach for this study was to establish assumptions based on provider-reported and State-recommended data when available and appropriate, as well as extensive industry data that reflect wider labor markets for similar populations.

Guidehouse, with support from DOH and the Rate Workgroup, conducted a cost and wage survey to obtain the cost of delivering services from providers including employee salaries and wages, administrative costs, program support costs, provider fringe benefits, and additional service-specific costs. The cost and wage survey provided valuable and detailed information on baseline hourly wages, wage growth rate, administrative costs, program support costs, provider staffing patterns, and provider fringe benefits, as well as staff productivity and transportation for all programs included in the rate study. Guidehouse also analyzed trends in the detailed claims data for services that were in scope for this specific rate study from each of the programs to determine the fiscal impact of implementing the new benchmark rates resulting from the rate rebasing process.

Although most cost assumptions used for rate development were derived from provider-reported survey data, publicly available sources were required for supplemental cost data and for benchmarking purposes to establish a comprehensive rate for some services.

We describe the key features of the provider cost and wage survey as well as the other sources used in the rate development process in the section below.

E.2. Provider Cost and Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey (“Survey”, “Provider Survey”) based on the landscape of services provided in the community to individuals in Alaska with LTSS service needs. During the Rate Workgroup meeting in October 2024, Guidehouse provided an overview of the survey including the objectives, topics, and questions on each worksheet within the survey document and solicited feedback from stakeholders. Guidehouse also gave providers time offline to review and propose feedback and changes to the survey following the initial workgroup meeting. The aim of the survey was to collect provider cost data across multiple services and programs that would serve as the basis for the rate studies. Additionally, Guidehouse aimed to utilize the survey to:

- Capture provider cost data to provide cost foundation for rate studies
- Receive uniform inputs across all providers to develop standardized rate model components
- Measure change in direct care worker wages over time
- Establish baseline cost assumptions for comparing and standardizing services operating in different programs and with different state plan and/or waiver authorities
- Determine cost basis for evaluating rate equity for services

- Gather needed data to understand billable vs. non-billable time and staffing patterns per service
- Investigate differences in costs among frontier/rural/suburban areas
- Solicit general feedback from providers to explore service delivery improvements and efficiencies

The survey was aimed exclusively at collecting information about provider costs incurred in delivering LTSS services under the programs included in the rate study.

E.2.1. Survey Design and Development

Guidehouse designed three surveys with input from DOH staff and the Rate Workgroup, as well as drawing on knowledge gained from conducting similar surveys in other states. The surveys were designed in Microsoft Excel. The General survey included eighteen (18) sections or worksheets on topics outlined in **Table 22** below. Two additional surveys were created for subsets of providers that tend to only provide a specific service such as meals or care coordination. The Meals survey included the same worksheets, but only the Meals worksheet was included in the Program Specific Information section. These two surveys were released on October 11, 2024. The Care Coordination survey contains the same general information worksheets as the other surveys but contains a worksheet for program specific information focused on Care Coordination. This survey was released on October 28, 2024. Both surveys were requested to be completed by December 13, 2024.

Table 22. Provider Cost and Wage Survey Organization and Data Elements

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
Overview	A general overview of what to expect in the survey and the color coding throughout the survey	-
Organization Information	Provider identification, contact information, organizational details, and organizational revenue	Most Recent Full Fiscal Year (Does not have to be audited)
Total Costs	Costs as reported on general ledger	Most Recent Full Fiscal Year (Does not have to be audited)
Wages for Direct Care Staff and Supervisors	Staff Types, Hourly Wages, Supplemental Pay, Bonuses, Wage Increases, and Training Time	Most Recent Full Fiscal Year (Does not have to be audited)
Programs & Services	Services delivered by your organization	Most Recent Full Fiscal Year (Does not have to be audited)
Program Specific Information (12 worksheets)	Information specific to each program including caseloads, productivity, travel time, supervision time, and staffing ratios	Most Recent Full Fiscal Year (Does not have to be audited)
Benefits	Benefits that organizations offer full-time and part-time employees who deliver services – health, vision and dental insurance, retirement, unemployment benefits and workers' compensation, holiday, sick time, and paid time off	July 1, 2024 – September 30, 2024
Additional Provider Feedback	Clarifying comments in addition to the information covered in other worksheets or sections	-

E.2.2. Survey Administration and Support

The General and Meals surveys were released via e-mail on October 11, 2024, to the entire provider community in scope for the rate study. To conduct a successful and accurate survey, Guidehouse facilitated live provider trainings webinar available to all providers on October 14, 2024, and October 21, 2024, following the release of the survey. Additionally, a survey specific to Care Coordination services was released on October 28, 2024, and a live webinar training was offered on November 6, 2024. In the training sessions, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions. The training was recorded and posted to the Alaska website. A link to the recording of the webinar was shared with providers, and DOH distributed a frequently asked questions (FAQ) document developed by Guidehouse to address common questions submitted by providers. Both training sessions were well attended, and an overview of attendance and active participation is shown in **Table 23** below.

Table 23. Provider Cost and Wage Survey Training Session Attendance

Training Participation	October 14th	October 21st	Total
Attended	93	81	174
Questions Received	30	25	55

Guidehouse offered ongoing support and resources in helping providers to complete the survey through a dedicated electronic e-mail inbox which providers could access to receive answers to their specific questions. Additionally, Guidehouse participated in six additional Q&A sessions organized by the AADD, each focused on a different section of the survey or type of provider. Guidehouse offered providers nine weeks to complete the General and Meals surveys and seven weeks to complete the Care Coordination survey and Guidehouse granted an optional extension of up to two weeks if additional time was needed to complete the service-specific tabs.

E.2.3. Provider Cost and Wage Survey Participation

In total, Guidehouse received 64 surveys over the three types released, as noted in **Table 24** below. The General survey, encompassing the majority of services offered under the LTSS umbrella, received fifty responses while the more narrowly tailored Care Coordination and Meals surveys received twelve and two responses respectively.

Table 24. Number of Provider Responses for LTSS Provider Cost and Wage Survey

#	Survey Type	Number of Responses
1	General Survey	50
2	Care Coordination Survey	12
3	Meals Survey	2
All	Total	64

Guidehouse measures "representativeness" by the number of providers, the relative size and scale of providers operations, and total State expenditures represented by surveyed providers. "Large" providers typically have greater capacity than "small" providers to complete cost surveys. Although fewer in number than small providers, large providers tend to receive a substantially higher share of total expenditures. Consequently, their costs are more representative of system costs as a whole. Provider expenditure is a reliable metric to represent the financial impact of the provider on the entire DOH system rather than the raw count of providers alone. According to leading experience management firm, Qualtrics, typical survey response rates fall between 20-30 percent, though response rates depend heavily on survey design, medium, and population size[19]. By expenditure, roughly 42 percent of eligible Medicaid providers completed the survey. Within individual programs, only two, Residential Supported Living and Transportation services, fell below that range. Some programs, such as Time Limited Intervention and Nursing, reported at nearly 100 percent as detailed in **Table 25** below. Specialized Medical Equipment and Environmental Modifications are not included in this analysis.

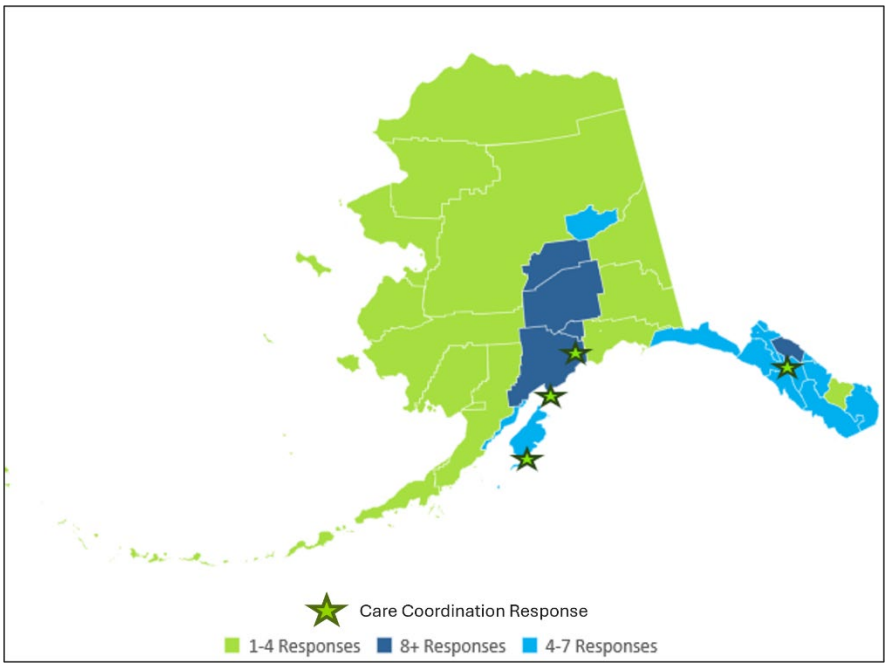
[19] Qualtrics, Survey Distribution Methods, How to Increase Survey Response Rates.

Table 25. Provider Cost and Wage Survey Response Rate by Program Expenditure

Service Category	Total Expenditures	Percentage of Total Expenditures	Expenditures Captured in Survey Submissions	Percentage of Expenditures Captured in Survey Submissions
Care Coordination	$30,112,952	5.9%	$7,391,706	24.5%
Adult Day and Day Habilitation	$69,238,398	13.5%	$42,733,195	61.7%
Employment	$9,659,372	1.9%	$6,764,298	70.0%
Home Based Supports	$62,660,164	12.2%	$40,859,222	65.2%
Intervention, Treatment, Therapy	$876,943	0.2%	$860,978	98.2%
Meals	$4,845,006	0.9%	$2,732,323	56.4%
Nursing	$11,490,882	2.2%	$11,458,119	99.7%
Residential	$318,854,772	62.2%	$99,170,200	31.1%
Transportation	$5,076,657	1.0%	$3,082,892	60.7%
Total	**$512,815,147**	**100.0%**	**$215,052,933**	**41.9%**

Survey participation can also be viewed by region to assess representativeness of the data to the population. Alaska, similar to other frontier states, has large areas of the state with low population density, leading to few providers within those areas. Therefore, when viewing participation on the regional level, it comes as no surprise that the majority of survey responses are from the most population dense areas of the state such as the Anchorage, Juneau, and Mat-Su areas, and we received responses from all regions as shown in **Figure 4** below.

Figure 4. Provider Cost and Wage Survey Participation by Geographic Region



E.2.4. Provider Cost and Wage Survey Review and Validation

After receiving the survey responses, Guidehouse compiled responses and conducted the following quality checks to prepare the data for analysis:

- Completeness: Checked the completion status in all worksheets within individual survey workbooks to determine whether follow-up was required to resolve any issues and missing data. Guidehouse followed up with providers individually within a week of receiving the survey responses if clarification or correction was required.
- Outliers: Reviewed quantitative data points (e.g., wages, productivity, benefits, number of clients and caseloads, staffing patterns) reported across all organizations to identify potential outliers. If any outlier data points were excluded or assumptions were made for rate model inputs, the assumptions were reviewed with DOH and the Rate Workgroup and are documented as such in this report.

It is important to note cost surveys are not subject to auditing, as an established administrative cost reporting process would be. Providers' self-reported data were not audited for accuracy, although outliers were examined and excluded when warranted, and additional quality control checks were conducted to confirm data completeness. The absence of an additional auditing requirement is ultimately a strength rather than a weakness of the cost survey approach, as it allows providers to report their most up-to-date labor costs, a key concern for rate development at a moment of heightened inflation.

Guidehouse utilized the survey data reported by providers to develop several key rate components including baseline hourly wages, productivity factors, and administrative and program support cost factors. **Section G** further outlines how the survey data was utilized for rate setting purposes.

E.3. Claims Data

Guidehouse developed a detailed claims data request to receive the Medicaid claims utilization from DOH. This request included all detailed claims for services that were in scope for this specific rate study. This data was for the full calendar years of 2022 and 2023 as well as January 1, 2024, through June 30, 2024. We requested key fields such as provider detail, payment information, service identifying fields, and units of measure.

E.4. Other Data Sources

Cost assumptions developed throughout the study rely on a wide variety of data sources. The objectives of the rate study aim to establish benchmark rates based on a combination of publicly available resources as well as understanding the necessary cost requirements required to promote access to quality services going forward. As will be detailed in depth in the sections that follow, Guidehouse's provider cost and wage survey furnished the majority of our rate assumptions on employee wages, provider fringe benefit offerings, staff productivity, staff-to-client ratios, and transportation requirements for the array of services.

While cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate in the face of future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the resources required to provide services in the near future or are not comparable to or competitive with the industry as a whole, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the cost assumptions used by Guidehouse frequently draw on national and regional standards, at least for comparison purposes, that reflect wider labor markets as well as median costs typical of broader industries, to benchmark Alaska reported information from the provider cost and wage survey. **Table 26** summarizes some of the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

Table 26. Other Data Sources for Rate Evaluation

Source	Description
Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)[20]	Federal wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage geographic and industry wage comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Provider Price Index (PPI)[21]	Federal index of inflation across multiple industries for Medicaid populations. Updated monthly and includes data series for Residential Developmental Disability Homes, Home Health Care Services, and Nursing Care Facilities. Used for reference to understand annual inflation for provider costs and for recommendations on recurring rate update.
Centers for Medicare and Medicaid Services (CMS) Medicare Economic Index (MEI)	National index of physician practice costs and physician compensation published quarterly by CMS. Used as a potential benchmark for healthcare cost inflation.
Bureau of Labor Statistics, Consumer Price Index (CPI-U)	Federal index of consumer price inflation nationally and in urban Alaska. Updated monthly and includes data series specific to food prices. Used for reference to understand annual inflation for provider costs and for recommendations on recurring rate update.
Bureau of Labor Statistics, Employer Cost for Employee Compensation (ECEC)[22]	The BLS Employer Costs for Employee Compensation (ECEC) data series for the Nursing and Residential Care industry analyzes total compensation by breaking down costs into hourly wage costs as well as expense categories related to mandatory taxes and benefits, insurance, retirement, paid time off, supplemental pay, and other benefits.
Bureau of Labor Statistics, Current Employment Statistics (CES)[23]	Federal index of wage inflation nationally and in Alaska. Updated monthly and includes data series covering Residential Intellectual and Developmental Disability Facilities, Mental Health, and Substance Abuse Facilities, Services for Elderly Persons, Home Health Care Services, Continuing Care Retirement Communities and Assisted Living Facilities, and Child and Youth Services. Used for reference to understand annual inflation for provider costs and for recommendations on recurring rate update.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)[24]	Federal data on health insurance costs, including Illinois-specific data regarding multiple aspects of health insurance (employer offer, employee take-up, premium and deductible levels, etc.) Used for reference in estimating health care costs for benchmark ERE assumptions.
Kelly Blue Book[25]	Average Alaskan purchase prices of vehicles in 2024, such as vans, which may be used to transport clients. Used to determine the average vehicle loan amount used for transportation and residential services.
Bank of America	Typical terms (interest rate and loan period) for new auto loans in Alaska for vehicles similar to those used for client transportation.
United States Department of Agriculture (USDA) Food Plan[26]	Federal budgeting tool used to estimate food costs in various settings. Provides potential cost assumption for food costs per meal.
Feeding America[27]	Typical food costs by state and county/borough. Used for food cost assumptions.

[20] U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics.
[21] U.S. Bureau of Labor Statistics, Producer Price Indexes.
[22] U.S. Bureau of Labor Statistics, Employer Costs for Employee Compensation.
[23] U.S. Bureau of Labor Statistics, Current Employee Statistics – CES (National).
[24] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) Insurance Component (IC).
[25] Kelley Blue Book Website.
[26] Food and Nutrition Service, U.S. Department of Agriculture, USDA Food Plans.
[27] Feeding America Website.

Source	Description
Other State Medicaid Fee Schedules and Reimbursement Methodologies	Data from other states on reimbursement levels for cognate services as well as overall service design. Used for peer state comparison and well as development of best-practice recommendations for improving supported employment service delivery.
Internal Revenue Service [28]	The Internal Revenue Service is the revenue service for the United States federal government, which is responsible for collecting taxes and administering the Internal Revenue Code, the main body of the federal statutory tax law. Used to determine dollar reimbursement per mile.

F. Peer State Comparisons

F.1. Overview

Guidehouse's recommendations for the current evaluation are based on established approaches used in other states, as well as the firm's extensive experience conducting similar evaluations and analyses. To support the development of rate build-up methodologies for comparable LTSS services, Guidehouse compiled data from peer states. These peer state waiver rates were also used to compare and validate final rate pricing across similar services where applicable.

While no two state Medicaid systems are identical due to differences in waiver structures, service definitions, and population needs, comparing similar services across states provides valuable context. Such comparisons help determine whether Alaska's current rates are outliers or if observed differences are attributable to unique service definitions or economic conditions within the state.

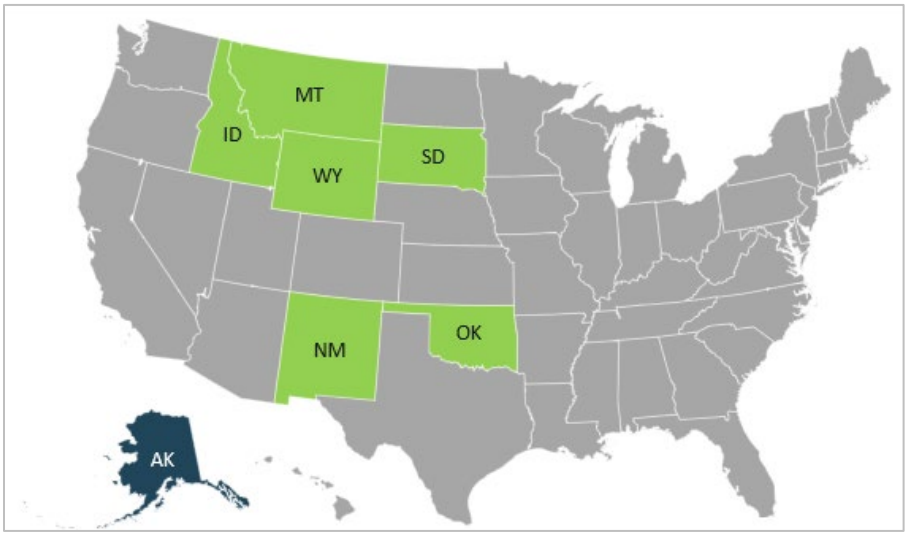
Recognizing Alaska's distinct geographic, demographic, and cultural characteristics, Guidehouse applied a selective approach in identifying peer states and services for comparison. Each service definition was carefully reviewed to confirm its relevance and comparability. For example, in evaluating Care Coordination services, some states differentiate rates based on population groups (e.g., Developmental Disabilities vs. Aging), while others apply rate premiums for additional certifications. These services often lack equivalent Medicare or commercial benchmarks, making Medicaid-based comparisons even more critical.

F.2. Comparison Approach

First, Guidehouse identified peer states that closely resemble Alaska in terms of demographics, geography, Medicaid program design, and the scope of LTSS services offered. As illustrated in **Figure 5**, the initial peer states (highlighted in light green) were selected based on this alignment. While Alaska is distinct from the lower 48 states, the programs and services identified in these peer states provide a meaningful benchmark for comparison.

[28] Internal Revenue Service, Standard Mileage Rates.

Figure 5. Peer States for LTSS Rate Comparison



F.3. Peer State Comparison Analysis

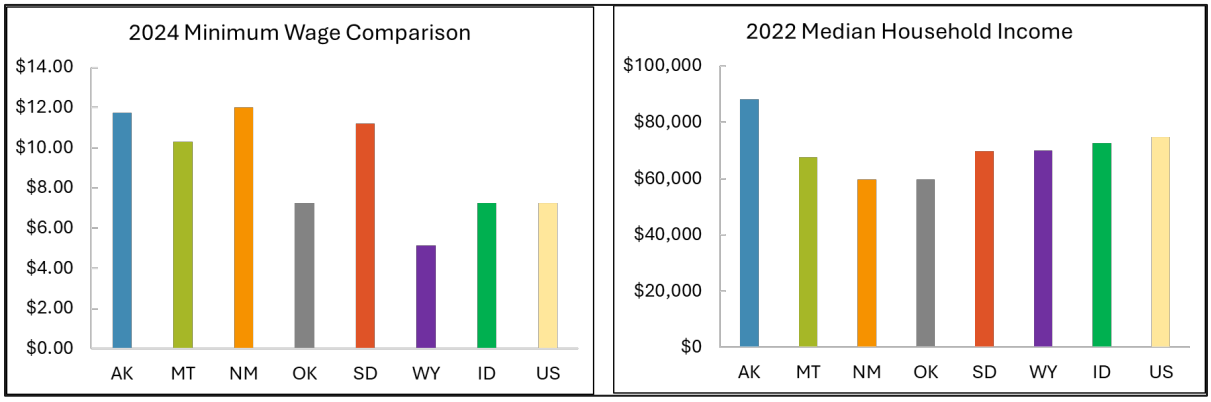
F.3.1. Wage and Cost of Living Comparisons

Alaska presents a higher cost of living compared to many other states. In recognition of this, Guidehouse approached peer state comparisons with the understanding that both the broader Alaskan economy and the specific challenges of service delivery are uniquely complex.

One lens used to compare peer states with Alaska was wage levels. Guidehouse conducted a review of minimum wages across selected peer states. While Alaska's minimum wage may appear similar to that of other frontier states like South Dakota, minimum wage laws do not always reflect actual market conditions. To provide additional context, Guidehouse also examined median household income data published annually by the U.S. Census Bureau. This analysis revealed that Alaskans earn approximately 18 percent more than the national average and 26 percent more than residents of South Dakota, despite only a 5 percent difference in minimum wage between the two states.[29, 30] These comparisons illustrated in **Figure 6** helps contextualize Alaska's wage environment relative to its peers.

[29] ADP, Minimum Wage and Tax Facts.
[30] U.S. Census Bureau, Household Income in States and Metropolitan Areas: 2022.

Figure 6. Minimum Wage and Median Household Income Peer State Comparison

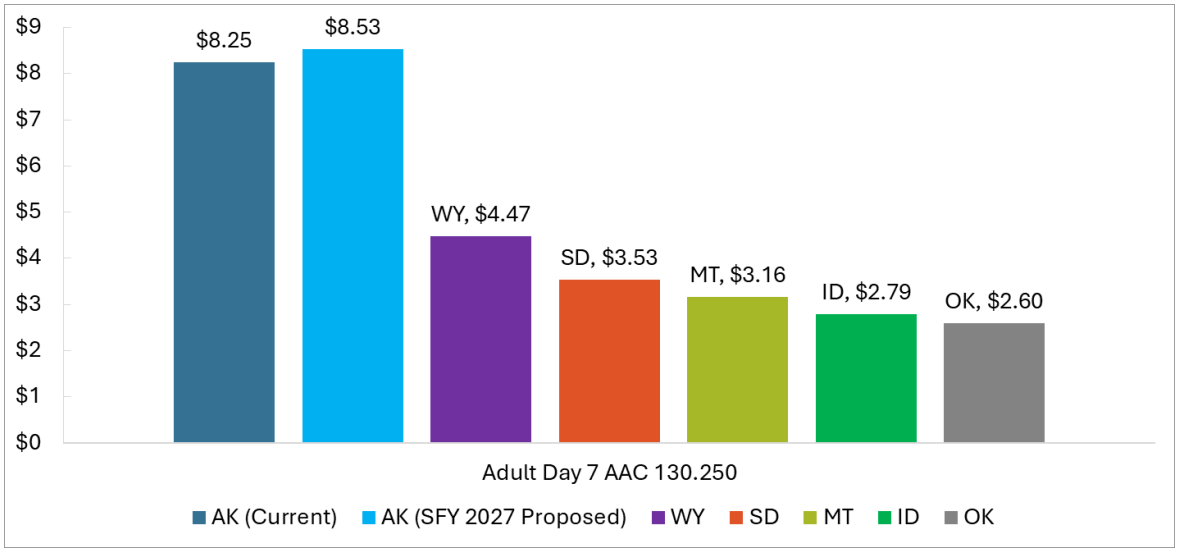


F.3.2. Rate Comparisons

When reviewing the peer states for comparable services, Alaska's rates were varied compared to peer states. Since HCBS services in Medicaid and other state LTSS programs are not always standardized but depend on state-specific criteria and program standards, it was sometimes challenging to find rates that permit an apples-to-apples comparison. Ultimately, Guidehouse focused on procedure codes that follow national standards as well as alignment in service units, for reliable comparison points. **Figures 7-13** below illustrate the Alaska's SFY2026 rates and SFY2027 proposed benchmark rates compared to the peer states and their corresponding rates.

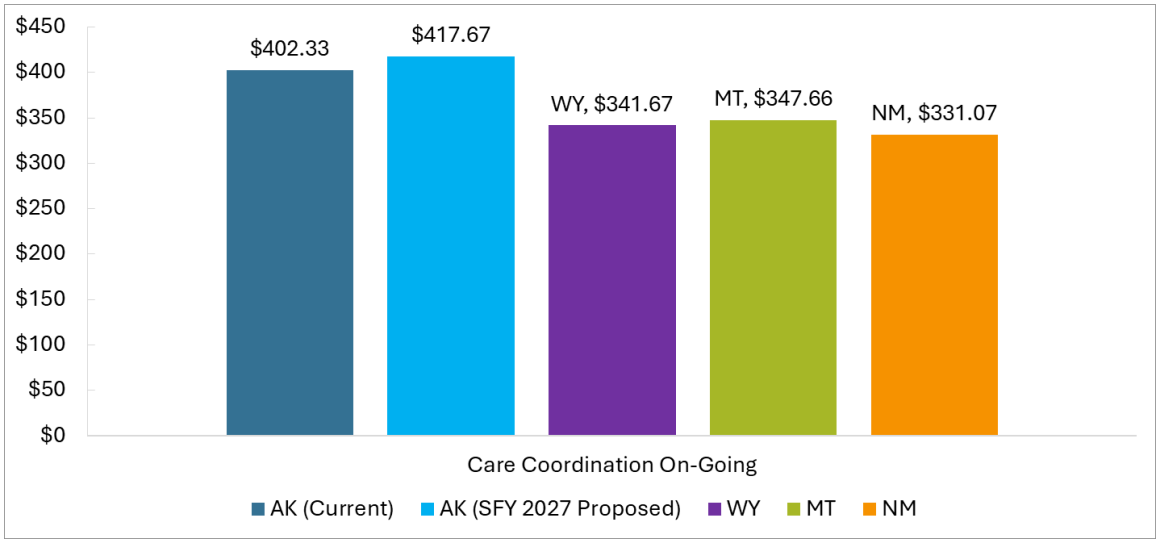
A comparative analysis of Adult Day service rates indicates that Alaska's current rate of $8.25 is higher than those of the other states included in the review—Wyoming, South Dakota, Montana, Idaho, and Oklahoma, as shown in **Figure 7**. The proposed rate for SFY 2027, set at $8.53, reflects a modest increase and maintains Alaska's position above the comparison states. This suggests that Alaska continues to align above regional benchmarks for this service.

Figure 7. Adult Day Rate Comparison (S5100)



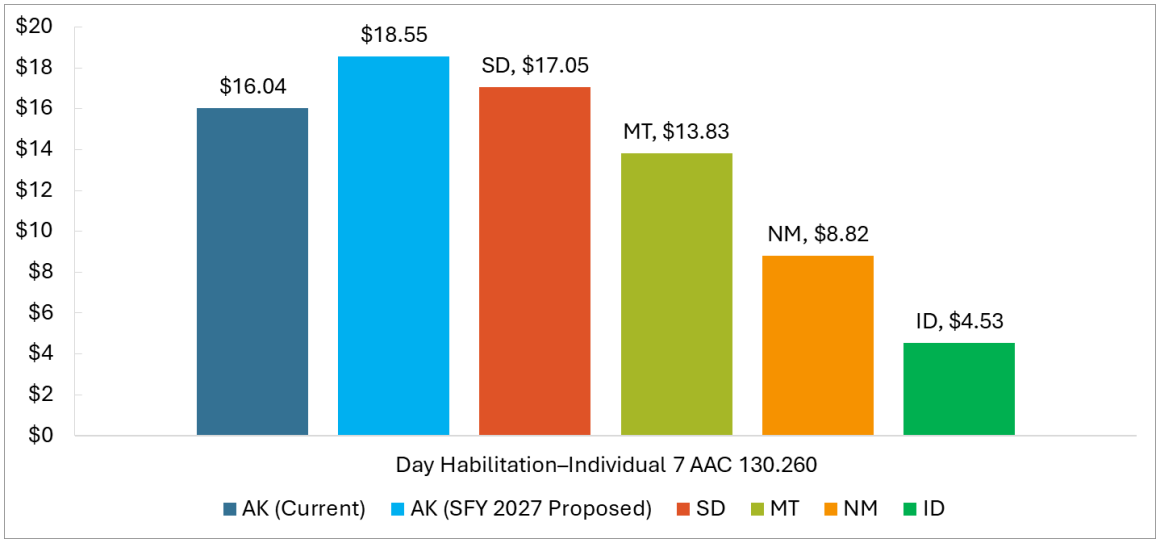
A comparison of care coordination ongoing rates in **Figure 8** below shows that Alaska's current rate of $402.33 is higher than those of Wyoming, Montana, and New Mexico. The proposed rate for SFY 2027, set at $417.67, reflects a modest increase and maintains Alaska's position above the comparison states.

Figure 8. Care Coordination Rate Comparison (T2022)



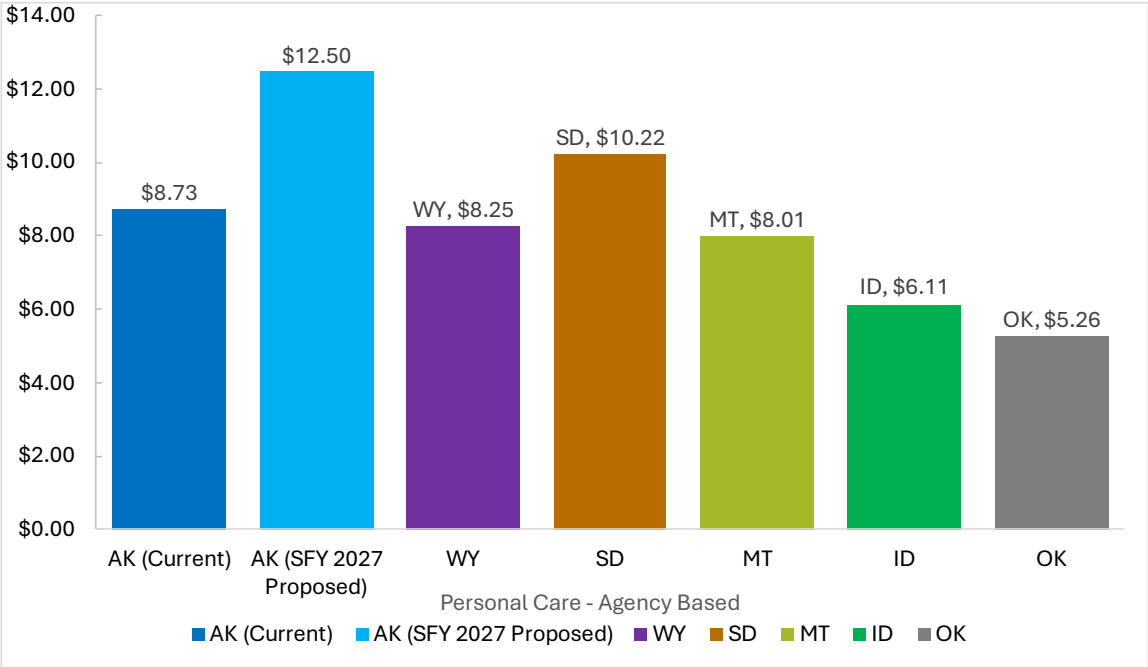
A comparison of Day Habilitation–Individual service rates shows that Alaska's current rate of $16.04 is higher than those in Montana, New Mexico, and Idaho, but slightly below South Dakota's rate of $17.05, as shown in **Figure 9**. The proposed rate for SFY 2027, set at $18.55, would place Alaska above all states included in the comparison. This adjustment reflects a modest upward shift that positions Alaska's rate at the higher end of the peer group.

Figure 9. Day Habilitation – Individual Rate Comparison (T2021)



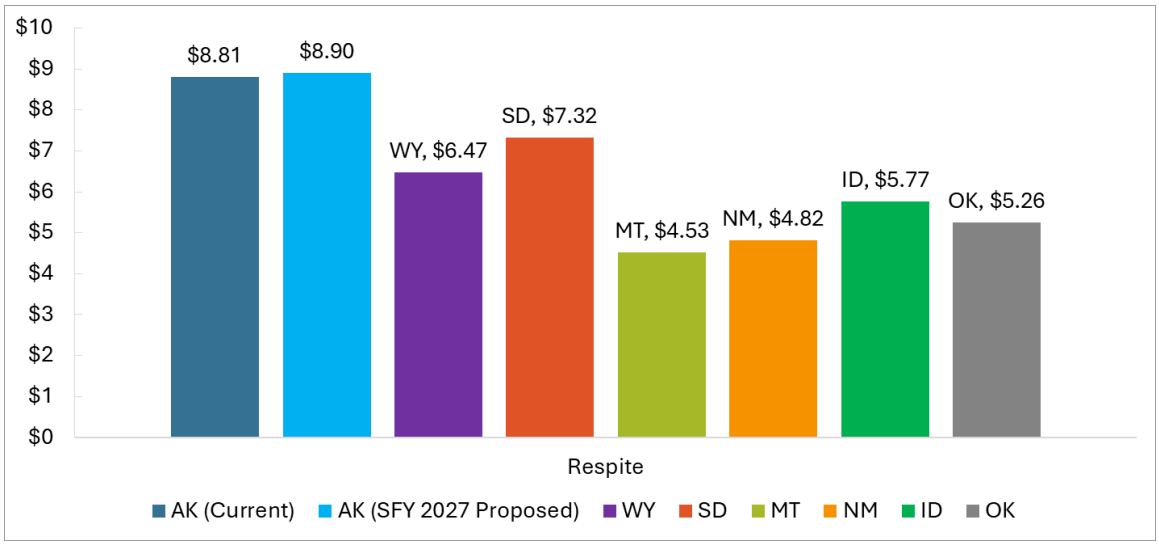
A comparison of personal care agency-based rates shows that Alaska's current rate of $9.01 is higher than those in Wyoming, Montana, Idaho, and Oklahoma, as shown in **Figure 10** below. The proposed rate for SFY 2027, set at $12.50, would place Alaska above all states included in the comparison, including South Dakota, which currently has the highest rate among the peer group at $10.22. This proposed adjustment reflects a measured increase that positions Alaska's rate at the upper end of the range of peer state rates.

Figure 10. Personal Care – Agency-Based Rate Comparison (S5125)



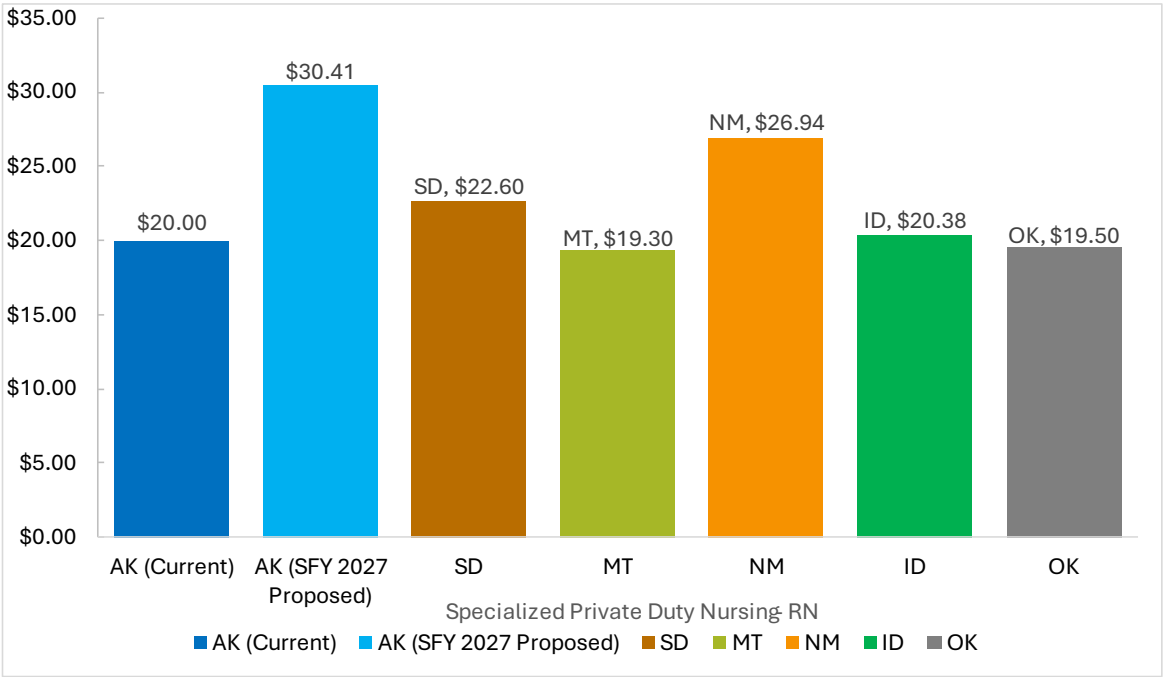
A review of respite care rates indicates that Alaska's current rate of $8.81 is higher than those of the comparison states, which include Wyoming, South Dakota, Montana, New Mexico, Idaho, and Oklahoma, as shown in **Figure 11**. The proposed rate for SFY 2027, set at $8.90, reflects a modest increase and maintains Alaska's position relative to the peer group.

Figure 11. Respite Rate Comparison (S5150)



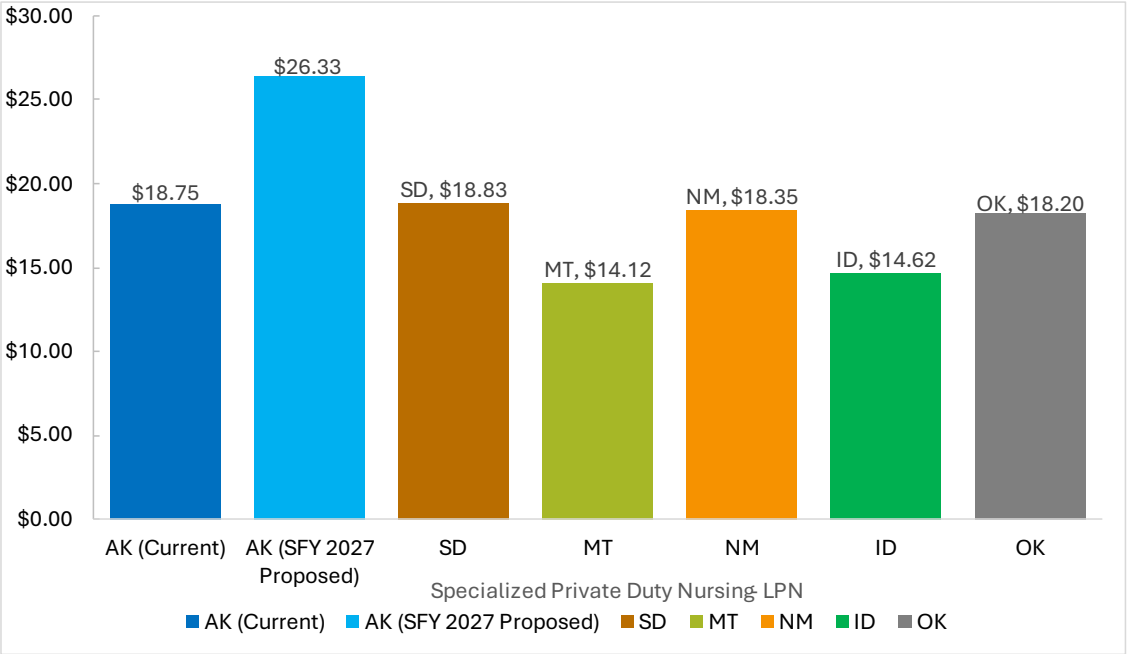
A comparison of Specialized Private Duty Nursing – RN rates in **Figure 12** shows that Alaska's current rate of $20.00 per hour is generally in line with several peer states, including Wyoming, Montana, and Oklahoma. The proposed rate for SFY 2027, set at $30.41 per hour, represents a notable increase and would place Alaska above all states included in the comparison. This change is also reflective of efforts to better align compensation with inflationary changes since the current rate was initially established as well as service expectations and workforce needs.

Figure 12. Specialized Private Duty Nursing (RN) Rate Comparison (T1002 U2)



A comparison of Specialized Private duty Nursing – LPN rates in **Figure 13** shows that Alaska's current rate of $18.75 per hour is generally in line with peer states, slightly below South Dakota ($18.83) and New Mexico ($18.35), and above Montana ($14.12) and Idaho ($14.62). The proposed rate for SFY 2027, set at $26.33 per hour, would place Alaska at the upper end of the peer group. Consistent with trends in the RN services, the proposed benchmarks for Specialized Private Duty Nursing on the whole suggests a targeted effort to strengthen compensation in this service area.

Figure 13. Specialized Private Duty Nursing (LPN) Rate Comparison (T1003 U2)



G. Rate Methodologies and Components

G.1. Overview of Rate Methodologies

Guidehouse employed an independent rate build-up approach to develop payment rates for covered services. The independent rate build-up strategy allows for fully transparent models that consider the numerous cost components that need to be considered when building a rate. The foundation of the independent rate build-up is direct care worker wages and benefits, which comprise the largest percentage of costs for these services while also considering the service design and additional overhead costs that are necessary to be able to provide the service. This approach:

- Uses a variety of data sources to establish rates for services that are: "…consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area." -1902(a)30(A) of the Social Security Act (SSA)
- Relies primarily on credible data sources and reported cost data (i.e., costs are not audited, nor are rates compared to costs after a reporting period and adjusted to reflect those costs).
- Makes additional adjustments to rates to reflect state-specific policy goals – for example, incenting specific kinds of services.

The rate build-up approach, commonly used by states for setting reimbursement rates, is recognized as compliant with CMS regulations and guidelines. This methodology promotes transparency by enabling DOH to clearly delineate the individual components that contribute to the overall rate and to make adjustments as necessary.

For each service included in the rate study, Guidehouse calculated values for each component of the rate model and constructed rates from the bottom up. Many of the proposed service rate benchmarks are based on a consistent set of general assumptions for each rate component, tailored to the specific context and objectives of each service. The rate build-up methodology relies on core wage assumptions for direct care staff, supplemented by estimates for the costs of supporting personnel, activities, and materials required to sustain direct service provision. This section of the report outlines the detailed methodology used to calculate each component of the rate models and identifies the data sources that informed these calculations. The section is divided into the following areas:

- Staff Wages
- Employee-Related Expenditures (ERE)
- Productivity of Direct Care Staff
- Occupancy and Absences
- Attendance Adjustment
- Supervision Patterns
- Staffing Ratios
- Administrative Expenses
- Program Support Expenses

G.2. General Cost Assumptions

The methodology for developing a rate for a unit of service – or a rate model – varies across types of services but generally includes certain key components. A rate model starts with the wage for the primary staff person providing a service and then building upon that wage with fixed or variable cost factors to account for additional program support costs.

Typical components of a rate methodology or rate model include:

- Direct Care Compensation Costs
- Staff Wage Costs
- Employee-Related Expenditures (ERE)
- Supervision Costs
- Billing Adjustments to Direct Care Compensation Costs
- Billable vs Non-Billable Time (Productivity) of Direct Service Staff
- Travel Expense (if applicable)
- Administrative Expenses
- Program Support Expenses

Together, these components sum to a unit rate designed to reimburse a provider organization for all inputs required for quality service delivery. This approach is often called an "independent rate build-up" approach because it involves several distinct rate components whose costs are captured independently through a variety of potential data sources. These costs are essentially "stacked" together into a collective cost per unit that defines the rate needed for cost coverage. **Table 27** illustrates the "building block" structure of Guidehouse's rate development methodology. Although individual rates may incorporate different building blocks, each rate model follows a similar process for identifying the component blocks for inclusion, based on the service requirements and specific adjustments needed to align overall costs with the appropriate billing logic and units of service.

Table 27. Overview of Rate Components*

Direct Care Cost	Calc	Indirect Cost	Calc	Other Rate Model Adjustments	Calc	Result
Cost for Direct Care Services • Wages *(Provider Survey & BLS)* • Benefits *(GH ERE Model & MEPS)* • *Adjusted by billable time, as applicable (Provider Survey, State documentation)* **Supervisory Direct Care Cost** • Wages (Provider Survey & BLS) • Benefits (GH ERE Model & MEPS) Adjusted by supervisor hours	+ (Plus)	**Admin Cost:** Average of ratio derived for each provider based on unique admin and direct care costs for all services **Program Support Wages and Direct Care-Related Costs:** Ratio of program staff salaries and wages and costs related to training, development, technology and activities **Supply Cost:** Ratio of total supply cost to total direct care cost for services across all providers **Transportation Cost:** Ratio of total transportation and vehicle costs to total direct care cost for services across all providers **Percentages are calculated to reflect indirect cost components relative to direct care costs, not as a percentage of the total rate.**	+ (Plus)	Staff Mileage Stipend Values Caseload Occupancy/ Attendance/ No-Show Adjustment Factors Geographic Adjustment Factor	= (Equals)	Service Rate Per Unit of Measurement

**Varies based on service categories*

The different cost components schematized here are discussed in further detail in the following sub-sections of the report.

G.2.1. Staff Wages

Wages for direct care staff represent the largest component of any rate model, as many of the services for which Guidehouse developed rate models rely heavily on the labor of qualified, dedicated personnel who provide LTSS. To accurately assess the wage landscape in Alaska, we utilized data from both surveys by provider organizations and broader industry-wide data sources.

As part of the provider cost and wage surveys, each participating provider reported average hourly or "baseline" wages, along with information on overtime, shift differentials, and other forms of supplemental pay. Providers also shared insights into wage inflation trends and other salary-related factors. The staff categories with the highest number of reported Full-Time Equivalents (FTEs) included Direct Service Professionals (DSPs), Caregivers, Job Coaches, and Care Coordinators, collectively accounting for over 2,500 FTEs. DSPs and similar roles form the

backbone of direct care within the study population, as reflected in the volume of positions reported through the survey. **Table 28** below includes the survey jobs reported in the survey.

Table 28. Provider Cost and Wage Survey – Common Job Types and FTEs

Survey Job Title	Total Number of FTEs	Total Number of Survey Providers
Direct Service Professional	1326.9	64
Caregiver	967.3	50
Job Coach/Employment Specialist	162.6	7
Direct Support Supervisor	149.5	41
Registered Nurse (RN)	90.7	7
Licensed Practical Nurse (LPN)	66.6	2
Care Coordinator	46.0	6
Food Service Staff	36.5	2
Driver (Note: Driver's primary responsibility should be driving.)	14.3	3
Job Development/Employment Specialist	12.7	5
Cook	11.8	2
Food Service Manager	3.0	0
Social Worker	3.0	1
Licensed Clinical Professional Counselor (LCPC)	2.0	1

For all staff types, Guidehouse applied a weighting to the reported wages based on the number of FTEs and then compared the resulting weighted average wages to the mean benchmark wages published by the BLS OEWS specific to Alaska. In collaboration with DOH and the Rate Workgroup, Guidehouse elected to use the survey-weighted average wages in the rate models rather than the BLS benchmarks.

The survey-based wages were deemed to reflect the unique labor market conditions and hiring challenges faced by providers across the state. Moreover, providers expressed that key job types including DSPs do not have direct comparisons in BLS which necessitates closer review of the wages in the survey to identify appropriate comparison points. **Table 29** presents the BLS job classifications used to align with each of the direct care roles reported in the survey, with the BLS wage data adjusted upward by 5.7 percent to account for inflation since the May 2023 reporting period.

Table 29. 2024 Provider Cost and Wage Survey and Bureau of Labor Statistics Alaska Wage Comparison

Survey Job Title	BLS OEWS Job Title	Provider Cost and Wage Survey FTE-Weighted Average Wage – Q3 CY2024	BLS Alaska Average Wage – May 2024 (May 2023 Inflated by 5.7%)
Direct Service Professional	Social and Human Service Assistants (21-1093)	$21.02	$23.79
Caregiver	Home Health and Personal Care Aides (31-1120)	$19.20	$19.59
Job Coach/Employment Specialist	Nursing Assistants (31-1131)	$22.26	$23.93
Direct Support Supervisor	First-Line Supervisors of Personal Service Workers (39-1022)	$32.15	$36.24
Care Coordinator	Healthcare Support Workers, All Other (31-9099)	$29.12	$31.11
Food Service Staff	Food Preparation Workers (35-2021)	$14.16	$18.57
Driver (Note: Driver's primary responsibility should be driving.)	Shuttle Drivers and Chauffeurs (53-3053)	$18.66	$21.27
Job Development / Employment Specialist	Nursing Assistants (31-1131)	$26.21	$23.93
Cook	Cooks, Institution and Cafeteria (35-2012)	$17.76	$24.39
Registered Nurse (RN)	Registered Nurses (29-1141)	$45.58	$55.52
Licensed Practical Nurse (LPN)	Licensed Practical and Licensed Vocational Nurses (29-2061)	$38.88	$37.75
Food Service Manager	First-Line Supervisors of Food Preparation and Serving Workers (35-1012)	$29.24	$24.37
Social Worker	Healthcare Social Workers (21-1022)	$22.29	$35.50
Licensed Clinical Professional Counselor (LCPC)	Substance abuse, behavioral disorder, and mental health counselors (21-1018)	$38.00	$39.37

G.2.1.1. Inflationary Increases in Wages

We also consulted federal data in tandem with survey data to understand how wages and costs have trended over recent years. **Table 30** includes the most recent growth rate from each source, which include:

- **BLS Producer Price Index (PPI).** The BLS publishes a PPI for Medicaid populations, including those for Home Health Care Services and Nursing Care Facilities, which are specific to the populations and services in scope for this study. The most recent PPI data from August 2023 – August 2024 produces an average annual growth rate across indices of 2.7 percent.
- **BLS Current Employment Statistics (CES).** The BLS also publishes CES data which looks at earnings rather than costs. Across relevant employee categories, 2023 to 2024 trends document an annual growth rate in earnings of 3.7 percent.

- **Cost and Wage Survey.** Responding provider organizations recorded the average growth rate of earnings between 2022 and 2023, 2023 and 2024, and 2024 and 2025Q3 for their staff. The average growth rate was roughly 5.6 percent in wages reported in the survey between 2022 and 2025Q3 year over year. This is higher than industry trends, such as the BLS PPI and CES, and may be reflective of additional funding allocated for reimbursement in recent years.

Table 30. Sources of Growth Rates in Relevant Costs and Wages

Source	Time Period	Annual Average Growth Rate
Bureau of Labor Statistics (BLS) Producer Price Index (PPI) – Average Across Multiple Populations • Home Health Care Services – Medicare and Medicaid Patients • Home Health Care – Medicare Patients • Nursing Care Facilities – Medicare and Medicaid Patients • Nursing Care Facilities – Medicare Patients	August 2023-August 2024	2.7%
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) – Average Across Multiple Industries • Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities • Residential Intellectual and Developmental Disability Facilities • Services for the elderly and persons with disabilities • Continuing care retirement communities and assisted living facilities for the elderly • Assisted living facilities for the elderly • Home health care services • Child and youth services	SFY 2024-SFY 2025	3.7%
Alaska LTSS Provider Cost and Wage Survey	2022-Q3 2025	5.6%

To align potential growth in costs during 2024 and to account for economic and labor conditions that may reflect the future cost of service delivery, wage assumptions include the growth rate from the CES average of **3.1 percent**.

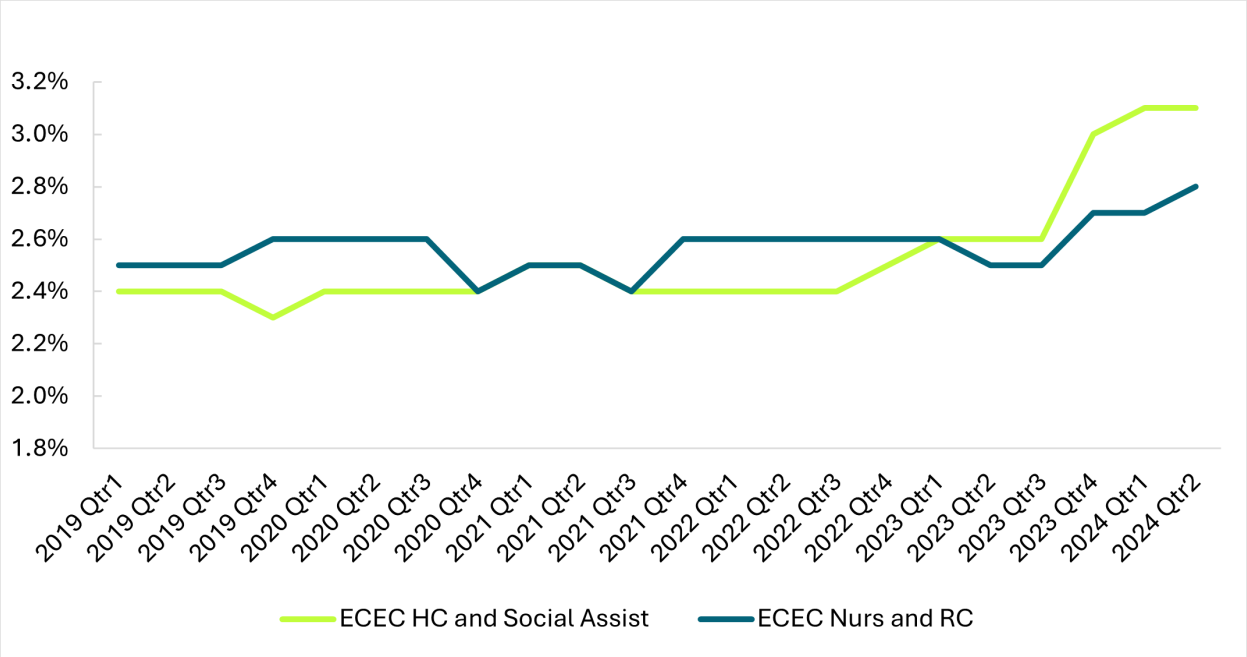
G.2.1.2. Supplemental Pay

Supplemental pay—including costs such as overtime wages, shift differentials, holiday pay, and non-production bonuses in addition to regularly earned wages—was reported in the cost and wage survey. In analyzing the survey results, Guidehouse calculated a supplemental pay percentage of **2.40 percent** by dividing the total supplemental pay reported by the total wages for each provider.

Guidehouse also consulted federal data from two BLS Employer Costs for Employee Compensation (ECEC) quarterly data series: Health Care and Social Assistance and Nursing and Residential Care Facilities. These data sets categorize costs into hourly wages and various expense categories, including mandatory taxes and benefits, insurance, retirement, paid time off, supplemental pay, and other benefits. Based on a five-and-a-half-year average (CY2019–CY2024 Q2), supplemental pay across the selected labor categories averaged **2.55 percent** of the average hourly wage. Guidehouse elected to use the BLS ECEC data because it aligns with provider-

reported data, encompasses all supplemental cost components integral to total compensation, and offers consistent, periodic trends that can be used to project future conditions. Supplemental pay trends from 2019 – 2024 are shown in **Figure 14** below.

Figure 14. 2019 - 2024 Average Supplemental Pay as a Percentage of Wages and Salaries



G.2.1.3. Final Wage Adjustments

The proposed SFY 2027 benchmark wage assumptions used for rate development are computed by inflating the survey FTE-weighted average hourly wages to reflect growth in costs and adding supplemental pay as a function of wage and labor costs, as demonstrated in **Table 31.**

Table 31. Calculation of Wage Adjustment Factors

Result	Calc	No. 1: Baseline Weighted Wage	Calc	No. 2: Supplemental Pay	Calc	No. 3: Annual Cost Inflation
Benchmark Hourly Wage	= (Equals)	Baseline wage developed through Provider Cost and Wage Survey	+ (Plus)	Supplemental pay as a percentage of wages from BLS Employer Costs for Employee Compensation	= (Equals)	Inflation assumptions derived from BLS Current Employment Statistics

For example, using the survey-weighted baseline wage of $21.02 for Direct Support Professionals, Guidehouse applied a 2.55 percent supplemental pay factor, adding $0.54 for a subtotal of $21.56. A subsequent 7.49 percent inflation adjustment added $1.62, resulting in a projected hourly wage of $23.17. **Table 32** includes the benchmark wages recommendations and illustrates the derivation for each job type.

Table 32. SFY 2027 Proposed Benchmark Wage Recommendations

Job Title (Survey)	Survey Reported FTE	CY2024 Q3 FTE Weighted Average Base Wage (Survey)	CY2024 Q3 Weighted Base Wage (Survey) + Supp. Pay	CY2026 Q3 (July 1, 2026) Wage Weighted Base Wage (Survey) + Supplemental Pay + Inflation
Care Coordinator	46.0	$29.12	$29.86	$32.10
Caregiver	967.0	$19.20	$19.69	$21.16
Cook	2.0	$17.76	$18.21	$19.58
Direct Service Professional - Daytime	1,327.0	$21.02	$21.56	$23.17
Direct Support Supervisor	149.0	$32.15	$32.97	$35.44
Driver (Note: Driver's primary responsibility should be driving)	14.0	$18.66	$19.14	$20.57
Food Service Manager	3.0	$29.24	$29.99	$32.23
Food Service Staff	37.0	$14.16	$14.52	$15.61
Job Coach/Employment Specialist	163.0	$22.26	$22.83	$24.54
Job Development/Employment Specialist	13.0	$26.21	$26.88	$28.89
Licensed Clinical Professional Counselor (LCPC)	2.0	$38.00	$38.97	$41.89
Licensed Practical Nurse (LPN)	66.6	$38.88	$39.87	$42.86
Registered Nurse (RN)	90.7	$45.58	$46.75	$50.25
Social Worker	3.0	$22.29	$22.86	$24.57
Transportation Aide	25.0	$14.43	$14.80	$15.91
Respite	250.5	$18.00	$18.46	$19.84
Clinical Supervisor	15.0	$46.67	$47.86	$51.45
Behavioral Specialist/Technician	N/A[31]	$21.07	$21.61	$23.23

G.2.2. Employee-Related Expenses

Total compensation includes wages as well as employment-related expenses (ERE) – for example, DSPs earn not only their wages over the course of the year, but also benefits such as days off, health insurance, and employer retirement contributions. These ERE or fringe benefits include legally required benefits, paid time off, and other benefits such as health insurance. **Table 33** lists the components of ERE and calculates an example ERE percentage for a Direct Service Professional using our wage recommendations.

[31] Derived from the Guidehouse Behavioral Health Provider Cost and Wage Survey

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation. Employers in Alaska pay a federal unemployment tax (FUTA) of 6.00 percent of the first $7,000 in wages and state unemployment tax (SUTA) of a 1.00 percent employer rate and a 0.50 percent rate for employees for a total rate of 1.50 percent for healthcare and social service industry of the first $49,700 in 2024 wages.32 Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.4 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 percent rate of the first $168,600 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act (FICA) contributions. Per the cost and wage survey, employers in Alaska pay an average effective tax of 3.34 percent toward workers' compensation insurance.
- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The average aggregate number of paid days off per year, according to the cost and wage survey, was **28 days** total. As PTO benefits only apply to full-time workers, the daily value of this benefit is multiplied by a part time adjustment factor calculated from survey data of **65.3 percent**, which represents the proportion of the workforce which works full-time for the provider organizations responding to the cost and wage survey.
- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part time adjustment factor, as well as a **take-up rate** specific to each benefit type which represents the proportion of employees who actually utilize the benefit.

Not all providers who responded to the provider cost and wage survey have historically offered a "full" or competitive benefits package. To determine competitive contributions for benefits which are not legally required, Guidehouse analyzed paid time off components in aggregate and data on other benefits only from providers who contribute to their full-time employees' benefits. Analyzing these contributions and take-up rates for providers offering "other benefits" yielded median annual contributions per employee.

We compared benefit information reported in the survey to the publicly available Medical Expenditure Panel Survey (MEPS). MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage. Guidehouse examined MEPS for both private and public sectors and found that the survey data more closely aligned with public sector employers in Alaska. During this comparison we found the average monthly premium reported in the State of Alaska was $1,295 after applying an inflation factor. This came in slightly higher than the average of $1,262 reported in the survey. Guidehouse ultimately decided to use the Survey information over the MEPS data. The provider cost and wage survey data was a better source for health insurance costs than MEPS for LTSS services in Alaska because it is reflective of actual provider costs. However, reported information in the survey was largely in line with costs identified in the MEPS data, corroborating the accuracy of the benefits data submitted by providers and confirming the applicability of the Survey data as an appropriate benchmark for

[32] Alaska Department of Labor and Workforce Development, Alaska Unemployment Insurance Tax Rates For New (Industry) Employers, 2024.

identifying health insurance costs. This assumption is in line with our other assumptions of vision insurance, dental insurance, and other benefits which come from information reported through the cost and wage survey.

Table 33. Health Insurance Cost Comparison

Short Description	MEPS Public Sector 2022	MEPS Private Sector 2023	LTSS Provider Cost and Wage Survey 2024
Average Employer Contribution - Single	$9,016	$7,525	$13,638
Average Employer Contribution - Family	$19,966	$20,248	$30,253
Average Weighted Employer Contribution	$13,986	$11,703	$15,152
Inflation	11.1%	5.4%	-
Average Weighted Employer Contribution	$15,538	$12,335	$15,152
FT Percent - Offers Insurance	82.0%	75.3%	65.3%
Monthly Premium (2024)	**$1,295**	**$1,028**	**$1,262**
Take-Up Rate	71.8%	55.4%	69.6%
Adjusted Annual (Listed FT Rate)	**$9,148**	**$5,146**	**$6,925**

Calculating each ERE component as a percentage of the annual wage assumption for Direct Service Professionals, or $48,194 per year, yielded a competitive fringe benefit package of **37.23 percent** of wages as outlined in **Table 34**.

Table 34. Components of Employee-Related Expenses for a Direct Service Professional

Component	Value / Calculation #1	Value / Calculation #2
Annual Wage	$48,194 ($23.17 x 2080 hours)	$48,194 ($23.17 x 2080 hours)
FUTA	0.60% of up to $7,000	$42 (0.09%)
SUTA	1.50% of up to $49,700	$723 (1.50%)
FICA	7.65% of up to $168,600	$3,687 (7.65%)
Workers' Compensation	3.34%	$1,610 (3.34%)
Legally Required Benefits	**-**	**$6,061 (12.58%)**
Daily Wage	$23.17 x 8 hours	$185.36
Part-Time Adjustment Factor	65.30%	65.30%
Paid Time Off	28 days	28 days
Paid Time Off	**$185.36 x 65.30% x 28 days**	**$3,389 (7.03%)**
Insurance Take-up Rate	48% - 69.6%	48% - 69.6%
Retirement	5.00%	$1,305 (2.71%)
Health Ins.	$1,263/mo.	$6,886 (14.29%)
Dental Ins.	$50.75/mo.	$211 (0.44%)

Component	Value / Calculation #1	Value / Calculation #2
Vision Ins.	$12.58/mo.	$47 (0.10%)
Other Benefits	$6.75/mo.	$44 (0.09%)
Other Benefits	**-**	**$8,494 (17.63%)**
Total ERE per DSP	**Legally Required Benefits + Paid Time Off + Other Benefits**	**$17,945 (37.23% of Annual Wage Assumption)**

As wages rise, costs of contributing to certain benefits, such as healthcare, do not necessarily become more expensive. As wages increase, the proportion of ERE to wages decreases; therefore, we developed individual ERE percentages based on job type.

As an example of how the ERE percentage decreases with a higher wage within **Table 35** we display the ERE values for the following job types:

- Direct Service Professional
- Caregiver
- Care Coordinator
- Registered Nurse (RN)

Similarly, the ERE percentage was calculated for other job types utilizing the proposed benchmark SFY 2027 hourly wages.

Table 35. Examples of Employee-Related Expenses Across Job Types

Metric	Caregiver	Direct Service Professional	Care Coordinator	Registered Nurse (RN)
Hourly Wage	$21.16	$23.17	$32.10	$50.25
Annual Wage	$44,013	$48,194	$66,768	$104,520
Legally Required Benefits	$5,539 (12.59%)	$6,061 (12.58%)	$8,125 (12.17%)	$12,274 (11.74%)
Paid Time Off Benefits	$3,095 (7.03%)	$3,389 (7.03%)	$4,695 (7.03%)	$7,350 (7.03%)
Retirement Plan	$1,192 (2.71%)	$1,305 (2.71%)	$1,808 (2.71%)	$2,831 (2.71%)
Health Insurance	$6,886 (15.65%)	$6,886 (14.29%)	$6,886 (10.31%)	$6,886 (6.59%)
Dental Insurance	$211 (0.48%)	$211 (0.44%)	$211 (0.32%)	$211 (0.20%)
Vision Insurance	$47 (0.11%)	$47 (0.10%)	$47 (0.07%)	$47 (0.05%)
Other Benefits	$44 (0.10%)	$44 (0.09%)	$44 (0.07%)	$44 (0.04%)
Total ERE per Staff	**$17,015(38.66%)**	**$17,945 (37.23%)**	**$21,818 (32.68%)**	**$29,644 (28.36%)**
Hourly Wage with ERE	**$29.34**	**$31.80**	**$42.59**	**$64.50**

G.2.3. Productivity of Direct Care Staff

While direct care staff can only bill for the time during which they are delivering services, they perform other tasks as part of their workday. Productivity factors account for this “non-billable” time, like travel time to a member’s home to deliver services or time spent keeping records or in training, by upwardly adjusting compensation (wages and ERE) to cover the full workday.

Consider a simple example to illustrate this process:

> *A direct care staff person is paid $16 per hour and works an 8-hour day. The cost to the agency for the day is $128 ($16 * 8 hours). However, if half of the staff member's 8-hour day (4 hours) was spent on activities that are non-billable, the agency would only be able to bill for 4 hours of the staff member's time. Therefore, a productivity adjustment would have to be made to allow the agency to recoup the full $128 for the staff cost. The adjusted wage rate per billable hour would need to be $32 in this example. This means the productivity adjustment needs to be 2.0.*

While this is an exaggerated example (a typical productivity adjustment is around 1.2-1.4 for many of the services in scope for this study), it demonstrates the importance of including a productivity factor to fully reimburse for direct support time.

Provider organizations reported the average number of billable hours (out of an assumed 8-hour workday) through the cost and wage survey, which then translated into a productivity factor for staff delivering each service. For example, for Adult Day services, providers reported an average of 6 billable hours per each direct care staff member's 8-hour day, meaning 75 percent of their day is typically spent on client-facing, billable activities. Dividing 8 by 6 (or equivalent, 1 divided by 75 percent or .75) yields a productivity adjustment of 1.33, which is then multiplied by ERE-adjusted wages to get productivity-adjusted compensation. For similar services within the LTSS service array, productivity percentages are standardized to confirm consistency across all programs. This approach allows for a uniform evaluation of service delivery efficiency and effectiveness, facilitating a more accurate comparison and analysis of provider performance. It is important to note that the productivity factor has an inverse relationship with the productivity percentage—meaning that as the percentage of billable time decreases, the productivity factor increases. **Table 36** below includes the productivity assumption by service.

Table 36. Productivity Assumption by Service

Service	Procedure Code	Productivity Percentage	Productivity Adjustment Factor
Day Habilitation - Individual	T2021	75%	1.33
Day Habilitation - Group	T2021HQ	75%	1.33
Day Habilitation - Group - Facility	NEW	75%	1.27
Day Habilitation - Group - Virtual	NEW	79%	1.27
Day Habilitation - Group - Community	NEW	70%	1.43
Adult Day	S5100	75%	1.33
Respite Daily	S5151	87%	1.15
Respite	S5150	83%	1.20
Personal Care	T1019	83%	1.20
Personal Care - Skill Building	S5108	82%	1.22

Service	Procedure Code	Productivity Percentage	Productivity Adjustment Factor
Chore	S5120SE	83%	1.20
Supported Employment - Individual	T2019	75%	1.33
Supported Employment - Group	T2019HQ	69%	1.45
Pre-Employment - Individual	T2019 CG	75%	1.33
Pre-Employment - Group	T2019 TT	69%	1.45
Time limited intervention, treatment or therapy - Local	H2011 CG	64%	1.56
Time limited intervention, treatment or therapy - Non-Local	H2011 TN	16%	6.25
Specialized Private Duty Nursing - LPN	T1003 U2	86%	1.16
Specialized Private Duty Nursing – RN	T1002 U2	86%	1.16
Nursing Oversight and Care Management - Local	T1016 CG	75%	1.33
Nursing Oversight and Care Management – Non-Local	T1016 TN	19%	5.32
Supported Living Habilitation Must be 18 or over	T2017	80%	1.25
In-Home Supports Habilitation Must be 17 or younger	T2017 U4	80%	1.25

G.2.4. Occupancy and Absences

For some services, such as residential programs, an "occupancy rate" is used to further adjust the cost assumptions behind the rate. These adjustments are made for many of the same reasons as staff time is adjusted for "productivity". Namely, if provider costs are divided over all billable units, the rate must account for the fact that not all time which is hypothetically billable when determining the rate can actually be billed by providers. Program absences or unoccupied days occur for a variety of reasons including short hospital stays due to sickness, absences from a residence due to clients visiting their families, or short vacancies in a home before a new resident replaces a former resident. In order to cover a provider's incurred costs across the year, by including an occupancy adjustment, providers are allowed to bill only when the service is actually provided. An occupancy adjustment is added to the rate models to build in the anticipated amount of average annual revenue lost due to bed absences.

G.2.5. Attendance Adjustment

Provider time and revenue lost to missed appointments is a problem to be contended with across health care. Participants may miss scheduled services for a variety of reasons including personal or caregiver illness, transportation challenges, or inclement weather. Providers staff for the time participants are scheduled and when absences occur, it is often not reasonable or possible to make micro-adjustments to staffing. Through the survey, providers indicated that unplanned closures due to weather conditions alone result in approximately 4 percent of appointments being missed. An additional 2 percent of appointments are assumed to be missed due to other factors.

Although it was not possible to quantify lost productivity due to client attendance rates solely through the information reported through the provider cost and wage survey, with further stakeholder and DOH input, Guidehouse determined that a further attendance adjustment was appropriate.

Based on a combination of provider experience, Workgroup feedback and literature review, Guidehouse estimated that a 94 percent attendance rate is a reasonable assumption for the setting and population served in Alaska. We inserted an additional attendance factor into the proposed rate models, augmenting the final rate. This adjustment is distinguished from the billable time adjuster to differentiate between other standard non-billable time elements and productive time lost to missed appointments, thereby allowing the State to implement alternative attendance targets and assumptions down the road as needed. For rate benchmarking purposes, Guidehouse applied the 94 percent adjustment factor for applicable services to the overall rate as an attendance adjustment.

G.2.6. Supervision Patterns

While direct care staff deliver services, other staff are often present to supervise, usually multiple staff at one time. Wages for supervisors are often higher, but proportionate, to the wages of the direct care staff they supervise and are therefore included in independent rate models as a separate component or add-on to the primary staff wage. The supervision cost component captures the cost of supervising direct care staff. It should be noted that supervision costs are distinct from administrative costs related to higher-level management of personnel. Supervision is time spent in direct oversight of and assistance with care provision and is frequently conducted by staff who are themselves providing direct care as a part of their role.

The cost and wage survey includes questions regarding the number of direct care staff supervised by one supervisor and the total number of hours a supervisor spends, on average, directly supervising staff; for most service groups, the average number of staff supervised by one supervisor ranged from eight to ten. For example, for Day Habilitation services the supervisor span of control was 12 staff to one supervisor, on average. Developing this add-on accounts for the costs of employing supervisors to help support appropriate delivery of services.

G.2.7. Staffing Ratios

Just as one supervisor may oversee the work of multiple direct care staff simultaneously, one direct care staff may deliver a service to multiple clients simultaneously. As services are reimbursed per-client, this means the costs associated with direct service can be split across multiple units of service in cases when the ratio of staff to clients (“staffing ratio”) is more than one-to-one.

Staffing needs of each service typically vary and require examination to assign the appropriate staff wage rate assumptions. The cost and wage survey asks for the average staffing ratios of each service, and analysis of survey results across provider organizations as well as careful readings of service definitions informed assumptions of staffing ratios. And while many services genuinely call for individualized or 1:1 (meaning one staff member to one client) staffing ratios, some allow for appropriate delivery of services to small groups, ranging from two to five clients per staff member, on average. To promote consistency across the LTSS service array, staffing ratios for comparable services will be standardized. This approach supports a uniform assessment of service delivery efficiency and effectiveness, enabling more accurate comparisons and analyses of provider

performance. By incorporating consistent staffing assumptions, the rate-setting methodology is better aligned with the broader goals of quality and access in LTSS services.

G.2.8. Administrative Expenses

Administrative expenses reflect costs associated with operating a provider organization, such as costs for administrative employees' salaries and wages along with non-payroll administration expenses, such as licenses, property taxes, liability and other insurance. Rate models typically add a component for administrative expenses so as to spread costs across the reimbursements for all services an organization may deliver; our recommended rates reflect this methodology by establishing a percentage add-on for each service rate.

To determine an administrative add-on, Guidehouse calculated the ratio of administrative costs to direct care wages and benefits by summing administrative costs reported in the cost and wage survey, then dividing by total direct care wages and benefits inflated according to new wage and fringe assumptions for direct care workers and other direct care workers for the time period captured in the survey. Administrative costs include several categories:

- **Payroll Administrative Expenses:** Employees and contracted employees who perform administrative activities or maintenance activities earn salaries and benefits, which count toward payroll expenses in the calculation of total administrative costs.
- **Non-Payroll Administrative Expenses:** Costs including office equipment and overhead comprise non-payroll administrative expenses, net of bad debt and costs related to advertising or marketing.
- **Facility and Utilities for Administrative Use:** Rent, mortgage, and depreciation for administrative space factors into total administrative costs, as do utilities and telecommunication expenses relating to administrative use.

Direct care costs include the salaries, wages, taxes, and benefits for direct care employees. After dividing administrative costs by direct care costs for each provider, Guidehouse calculated an average ratio of 33.4 percent. Our recommended rate models incorporate the ratio of 33.4 percent, which adds a dollar amount to a unit rate by multiplying the rate components of productivity-adjusted direct care staff and supervisor compensation by the average administrative percentage.

G.2.9. Program Support Expenses

Program support expenses reflect costs associated with delivering services, which are not related to either direct care or administration but still have an impact on the quality of care. These costs are specific to the program but are not billable, and may include:

- **Program Support Wages and Direct Care-Related Costs:** Employees and contracted employees who perform program support activities earn salaries and benefits, which count toward direct care-related expenses in the calculation of total program support costs. These may also include costs for staff training and development, activities costs, and expenses for devices and technology, all of which are related to the quality of care but not specifically billable.
- **Supplies:** This includes the costs of program supplies used by client in, for example, day programs.

- **Client Transportation:** When client transportation is "bundled" into a service, this means the service definition includes transportation of the client to and from the location of service delivery. These costs may include costs relating to actually transporting the client (e.g., mileage); vehicle licensing, acquisition, registration, leasing, and insurance; vehicle maintenance and repair; and vehicle depreciation.
- **Building and Equipment:** When services are delivered at a facility, certain costs for the direct care facility may be included such as utilities and telecommunications, building maintenance and repairs, facility janitorial, landscaping, other costs outside of rent, and non-administrative equipment costs and depreciation.

Similar to the calculation for administrative costs, the program support percentage is calculated based on cost data reported in the provider cost and wage survey. Program support costs reported by providers were calculated in relation to direct care costs reported in the provider cost and wage survey. The largest components of this add-on are building and equipment which comprise 12.6 percent of the direct care costs, and client transportation costs at 6.8 percent of direct care costs. Wages and Benefits accounted for 5.7 percent and supplies accounted for an additional 4.3 percent. The combination of these 4 program support numbers, Guidehouse arrived at an overall program support add-on of 29.5 percent, however this depends on the service – a service which does not include client transportation would not include the transportation component just as a service which is delivered in the member's home may not include the building and equipment portion of program support.

G.3. Service-Specific Cost Assumptions

Guidehouse organized all services across all LTSS programs into a common set of service categories to review and evaluate the diverse array of services. These service categories were developed to group similar services together in the provider cost and wage survey to support efficient and standardized reporting that would support the rate development process, as well as to identify similar service designs and rate model structures for closely related services. However, the rate development process also considered the distinct specifications and nuances of complex services that demonstrated differences from other services within a service category. The list below captures the 10 service categories included in the rate study.

1) Care Coordination
   - Care Coordination On-Going (Waiver, CFC, TEFRA)
   - TEFRA – Assessment and Reassessment

2) Day
   - Day Habilitation – Individual and Group
   - Adult Day Care

3) Employment
   - Supported Employment – Individual and Group
   - Pre-Employment – Individual and Group

4) Home-Based
   - Respite

- Personal Care
- Personal Care Skill Building
- Chore

5) Meals
- Home Delivered meals
- Congregate Meals

6) Nursing
- Nursing Oversight and Care Management (Local and Non-Local)
- Specialized Private Duty Nursing - RN and LPN

7) Residential
- Family Home – Adult and Children (including Family Home Habilitation OHCDS)
- Specialized Family Home Habilitation
- Group Home (including Add-On)
- Specialized Group Home
- In-Home Supports
- Residential Supported Living (including Add-On)
- Supported Living
- Adult Host Home

8) Therapy
- Time Intervention, Treatment, and Therapy (Local and Non-Local)

9) Transportation
- Transportation – Local and Non-Local
- Transportation – Paratransit
- Transportation – Attendant Care

10) Others
- Environmental Modifications (including E-Mods OHCDS)
- Specialized Medical Equipment
    a. Intermediate Care Facilities (ICFs) – Operational Costs

G.3.1. Adult Day and Day Habilitation Services

The Adult Day and Day Habilitation category is for Habilitation services performed in the community or in a facility. The following services are included in this category:

- Day Habilitation – Individual
- Day Habilitation – Group
- Adult Day – Per 15 minutes
- Adult Day – Half Day

Rate Components: These services include wages for a caregiver, productivity adjustment, supervision time, increased staffing ratio for the group setting, administration add-on, and program support costs that include all components. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey where appropriate. **Table 37** below includes day service assumptions.

Table 37. Adult Day and Day Habilitation Rate Components and Rates

Service Code	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T2021	Day Habilitation – Individual	15 Minutes	1	75%	29.40%	33.40%	$16.04	$18.55
T2021HQ	Day Habilitation – Group	15 Minutes	2	75%	29.40%	33.40%	$10.57	$10.84
S5100	Adult Day	15 Minutes	3	75%	29.40%	33.40%	$8.25	$8.53
S5101	Adult Day	Half Day	3	79%	29.40%	33.40%	$118.35	$136.48

G.3.2. Personal Care and Chore Services

The Personal Care and Chore services category covers services that are performed in the home to support an individual living in the community. These services most often have the primary service provider as a Caregiver. This category includes the following services:

- Personal Care
- Personal Care – Skill Building
- Chore

Job Types and Service Team: Guidehouse referenced the provider cost and wage survey as well as the provider manuals and input from DOH to identify the expected staff type for each service. The Agency-Based Personal Care service includes supervision by a Registered Nurse, distinguishing it from the Consumer-Directed Personal Care service.

Rate Components: These services include wages for a Caregiver, productivity adjustment, supervision time, nursing oversight time, administration add-on, and program support costs that include supplies. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate. The productivity adjustment for Personal Care – Skill Building is modified to account for training time specific to the service. **Table 39** below includes the rate assumptions for Personal Care and Chore services.

Administrative Costs: The administrative overhead for these services is set at 22.2 percent of wages, based on provider cost and wage survey data from personal care providers. This allocation supports a division between direct care compensation and administrative costs that aligns with CMS-2442-F, the "Access Rule," which requires that 80 percent of Medicaid payments for these programs be directed toward compensation for direct care workers.

Table 38. Personal Care and Chore Rate Components and Rates

Service	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T1019	Personal Care – Agency Based	15 Minutes	1	83%	4.3%	22.2%	$9.01	$12.50
T1019U3	Personal Care – Consumer Directed	15 Minutes	1	83%	4.3%	22.2%	$9.01	$11.92
S5125	Personal Care – Agency Based	15 Minutes	1	83%	4.3%	22.2%	$9.01	$12.50
S5125SE	Personal Care – Consumer Directed	15 Minutes	1	83%	4.3%	22.2%	$9.01	$11.92
S5108	Personal Care – Skill Building	15 Minutes	1	82%	4.3%	22.2%	$11.66	$12.05
S5120SE	Chore	15 Minutes	1	83%	4.3%	22.2%	$9.43	$11.92

G.3.3. Respite Services

The Respite services category covers services that are performed in the home to support the caregiver of an individual living in the community. These services most often have the primary service provider as a Caregiver. This category includes the following services:

- Respite
- Respite – Family Directed
- Respite Daily
- Respite Daily – Family Directed

Job Types and Service Team: Guidehouse referenced the provider cost and wage survey, as well the provider manuals and input from the Department to identify the expected staff type for each service.

Rate Components: These services include wages for a Respite Caregiver, productivity adjustment, supervision time, administration add-on, and program support costs that include supplies. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate. **Table 39** includes rate components and rates for Respite services.

Administrative Costs: Consistent with Personal Care services, the administrative overhead for these services has been set at 22.2 percent of wages.

Table 39. Respite Rate Components and Rates

Service	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
S5150	Respite	15 Minutes	1	83%	4.30%	22.20%	$8.81	$8.90
S5150U2	Respite – Family Directed	15 Minutes	1	83%	4.30%	22.20%	$8.13	$8.90
S5151	Respite	Daily	1	87%	4.30%	22.20%	$455.71	$460.22
S5151U2	Respite – Family Directed	Daily	1	87%	4.30%	22.20%	$455.71	$460.22

G.3.4. Employment Services

The Employment services category covers services that are designed to assist participants seeking gainful employment in the community. These services most often have the primary service providers as Job Coaches and Job Developers. Employment Services includes the following:

- Supported Employment - Individual
- Supported Employment - Group
- Pre-Employment – Individual
- Pre-Employment - Group

Job Types and Service Team: Guidehouse referenced the provider cost and wage survey, as well the provider manuals and input from the Department to identify the expected staff type for each service.

Rate Components: These services include wages for a Job Coach, productivity adjustment, supervision time, Job Developer support time, administration add-on, and program support costs that include supplies, building, and equipment. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate. **Table 40** below includes Employment Service rate components and rates.

Table 40. Employment Service Rate Components and Rates

Service	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T2019	Supported Employment – Individual	15 Minutes	1	75%	29.40%	33.40%	$18.43	$20.92
T2019HQ	Supported Employment – Group	15 Minutes	2	69%	29.40%	33.40%	$11.95	$12.04
T2019CG	Pre-Employment – Individual	15 Minutes	1	75%	29.40%	33.40%	$18.43	$20.92
T2019TT	Pre-Employment - Group	15 Minutes	2	69%	29.40%	33.40%	$11.95	$12.04

G.3.5. Time Limited Intervention, Treatment, or Therapy Services

The Time Limited Intervention, Treatment, or Therapy services category covers services that support crisis intervention. These services most often have the primary service provider as a Licensed Clinical Professional Counselor. This category includes the following services:

- Time Limited Intervention, Treatment, or Therapy – Local
- Time Limited Intervention, Treatment, or Therapy – Non-Local

Rate Components: These services include wages for a Licensed Clinical Professional Counselor, productivity adjustment, supervision time, administration add-on, and program support costs that include Support staff wages and supplies. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate.

Productivity: Non-Local services require that providers travel a minimum of 200 miles to perform the service. Productivity is adjusted for Non-Local services to account for the significant travel time required.

Table 41 below includes rate components and rates for time limited intervention, treatment, or therapy services.

Table 41. Time Limited Intervention, Treatment, or Therapy Rate Components and Rates

Service	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
H2011CG	Time Limited Intervention, Treatment, or Therapy - Local	15 Minutes	1	64%	10.00%	33.40%	$33.07	$33.56
H2011TN	Time Limited Intervention, Treatment, or Therapy – Non-Local	15 Minutes	1	16%	10.00%	33.40%	$66.14	$191.91

G.3.6. Specialized Private Duty Nursing Services

The Specialized Private Duty Nursing services category covers services that support nursing in a participant's home. These services most often have the primary service provider as a Registered Nurse (RN) or Licensed Practical Nurse (LPN). This category includes the following services:

- Specialized Private Duty Nursing – RN
- Specialized Private Duty Nursing – LPN

Rate Components: These services include wages for a Nurse (RN or LPN as appropriate), productivity adjustment, supervision time, administration add-on, and program support costs that include Support staff wages, client transportation, and supplies. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate.

Table 42 below includes Specialized Private Duty Nursing rate components and rates.

Table 42. Specialized Private Duty Nursing Rate Components and Rates

Service	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T1002U2	Specialized Private Duty Nursing - RN	15 Minutes	1	86%	23.70%	33.40%	$20.00	$30.41
T1003U2	Specialized Private Duty Nursing - LPN	15 Minutes	1	86%	23.70%	33.40%	$18.75	$26.33

G.3.7. Nursing Oversight and Care Management Services

The Nursing Oversight and Care Management services category covers services that support care in a participant's home that requires nursing oversight or input. These services most often have the primary service provider as a Registered Nurse (RN). This category includes the following services:

- Nursing Oversight and Care Management – Local
- Nursing Oversight and Care Management – Non-Local

Rate Components: These services include wages for a Nurse (RN or LPN as appropriate), productivity adjustment, supervision time, administration add-on, and program support costs that include Support staff wages and supplies. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate.

Productivity: Non-Local services require that providers travel a minimum of 200 miles to perform the service. Productivity is adjusted for Non-Local services to account for the significant travel time required.

Table 43 below includes Nursing Oversight and Care Management rate components and rates.

Table 43. Nursing Oversight and Care Management Rate Components and Rates

Service	Service Description	Unit	Group Size	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T1016CG	Nursing Oversight and Care Management - Local	15 Minutes	1	75%	16.90%	33.40%	$33.07	$32.24
T1016TN	Nursing Oversight and Care Management – Non-Local	15 Minutes	1	19%	16.90%	33.40%	$131.44	$198.94

G.3.8. Congregate and Home Delivered Meals Methodologies

The Meals services category covers services that provide meals to participants in a congregate setting (at a facility) or deliver meals to the home of the participant. These services utilize the talents of Cooks as well as Other Food Prep and Delivery staff. This category includes the following services:

- Meals - Congregate
- Meals – Home Delivered

Rate Components: These services include wages for Cooks and Other Food Prep and Delivery staff, supervision time, administration add-on, food costs, kitchen and dining room square footage as appropriate, and mileage for delivered meals. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in provider cost and wage survey as appropriate.

Food Costs: A primary driver for any meal program is the cost of food. To determine the average price for a meal in Alaska, Guidehouse used a combination of publicly available data sources. The United States Department of Agriculture (USDA) publishes costs for four food plans monthly: Thrifty, Low, Moderate, and Liberal. These plans are also stratified by age. The May 2024 Low-Cost Plan indicates that the national average for meals for the male population aged 51-70 is $283.90 per month. However, since costs are generally higher in Alaska, Guidehouse also sought out additional data that would be more targeted to the state. Feeding America is a non-profit network of food banks across the United States. Since 2011, they have published an annual *Map the Meal Gap* study that offers a view into the cost of food at the county/borough level. Based on their 2022 findings, an average meal in Alaska was $4.70. Inflated to CY2024 using the CPI-U index for Food in Urban Alaska, the cost of the same meal would be $4.91. On a monthly basis, assuming three meals a day, this comes to a total of $448.04.

Table 44 below includes rate components and rates for Meals services.

Table 44. Congregate and Home Delivered Meals Rate Components and Rates

Service	Service Description	Unit	Food Cost (per meal)	Staff Cost (per meal)	Capital Cost (per meal)	Delivery Cost (per meal)	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T2025	Meals - Congregate	Per Meal	$4.91	$25.17	$1.51	$0	$31.26	$31.59
S5170	Meals – Home Delivered	Per Meal	$4.91	$25.17	$0.76	$2.71	$32.17	$33.55

G.3.9. Care Coordination Service Methodologies

The Care Coordination service category covers services that involve organizing and managing a participant's care across multiple providers. These services utilize a Care Coordinator as the primary service provider. This category includes the following services:

- Care Coordination – Ongoing
- Community First Choice – Application for Waiver
- Community First Choice – Initial Support Plan / Annual Renewal of Support Plan
- TEFRA – Assessment
- TEFRA – Reassessment
- TEFRA – Screening
- TEFRA – Plan of Care

Caseload Assumptions – Care Coordination rates in Alaska differ from typical fee-for-service structures by operating on a monthly basis rather than a narrowly defined time period. Care Coordinators and Case Managers perform essential tasks—such as communicating with providers, completing applications, and interacting with caregivers—that support participant outcomes but do not involve direct interaction and are not traditionally billable. To account for this, a caseload assumption is used to estimate the time spent monthly with a typical client.

Guidehouse analyzed survey responses and DOH caseload data to assess current and projected caseload expectations. The survey indicated higher caseloads than the DOH caseload data; however, Guidehouse relied on the DOH caseload data due to its greater reliability and granularity. Measures of center were calculated using both the average and median, with the median selected to mitigate the influence of outliers.

Based on provider feedback, Guidehouse analyzed TEFRA Care Coordinator caseloads separately from those serving waiver participants. The analysis showed that TEFRA coordinators maintain significantly higher caseloads, indicating a lower workload intensity for TEFRA clients. Guidehouse used this caseload to inform the development of the TEFRA low-acuity tiered rate. This analysis also led to a reduced caseload assumption for waiver-only coordinators, which guided the development of the moderate-acuity tiered rate for waiver and CFC participants.

To account for higher acuity needs for the Enhanced Care Coordination rate, Guidehouse used the 10th percentile caseload. Although Alaska has not yet implemented acuity stratification tools such as the interRAI framework, the 10th percentile offers a reasonable proxy for estimating time requirements for higher-acuity care in alignment with the provider cost and wage survey data. **Table 46** summarizes the caseload analysis based on survey and DOH caseload data. Additional information about the proposed tiering framework is highlighted in Section C.2.5.

Table 45. Care Coordination Caseload Analysis

Metric	Caseload	Rate Model Impacted
DOH Average	31	N/A
DOH Median	28	Care Coordination Standard
DOH Median – TEFRA	42	Care Coordination – TEFRA
DOH Median – Non-TEFRA	22	Care Coordination – Waiver / CFC / Non-TEFRA
DOH 10th Percentile	15	Care Coordination – Enhanced
Provider Cost and Wage Survey Average	39	N/A
Provider Cost and Wage Survey Median	36	N/A

Rate Components: These services include wages for a Care Coordinator / Case Manager, program support costs that include Wages and Benefits for all services and transportation costs for monthly services, and an administrative overhead adjustment. **Table 46** below displays the Proposed SFY 2027 Benchmark rates and primary components for Care Coordination services.

Table 46. Care Coordination Service Rate Components and Rates

Service	Service Description	Unit	Program Support	Administrative Overhead	Caseload / Hours for Task	Proposed SFY 2027 Benchmark Rate
T2022	Care Coordination – Ongoing	Monthly	16.8%	33.40%	Caseload – 28	$417.67
T2022 CG	Care Coordination – Ongoing	Monthly	16.8%	33.40%	Caseload – 28	$417.67
T2022 TS	Case Management – Community First Choice	Monthly	16.8%	33.40%	Caseload – 28	$417.67
T1023 SE	Application for Waiver – Community First Choice	One Annual	10%	33.40%	Hours – 3	$221.34
T2024 SE	Initial Support Plan / Annual Renewal of Support Plan – Community First Choice	One Annual	10%	33.40%	Hours – 12.5	$922.25
T2024	Assessment – TEFRA	One Annual	10%	33.40%	Hours – 3.75	$276.68
T2024 U4	Reassessment – TEFRA	One Annual	10%	33.40%	Hours – 1.75	$129.12
T1023 CG	Screening – TEFRA	One Annual	10%	33.40%	Hours – 1.25	$92.23
T2024 CG	Plan of Care - TEFRA	Monthly	16.8%	33.40%	Caseload – 28	$417.67

G.3.10. Residential Habilitation Service Methodologies

Residential Habilitation Services are designed to help individuals with disabilities acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to live as independently as possible in community-based settings. This category includes the following services[33]:

- Group-Home Habilitation – Provided in a licensed group home with shared living arrangements and staff support.
- Family Home Habilitation – Provided in a licensed assisted living or foster home by a non-family caregiver. Includes 24-hour care, supervision, and support with daily living activities.
- In-Home Support Habilitation – Must be 18 or over – Services delivered in the individual's own home or a primary caregiver's home, tailored to their specific needs.
- Supported-Living Habilitation – Must be 17 or younger – Delivered in a semi-independent or supported apartment setting, offering individualized support to promote independence.

[33] https://health.alaska.gov/media/3pxnuklz/residentialhabilitationservicescop.pdf

G.3.10.1. Group Home Habilitation Services

Group Home Habilitation services include the following rates:

- Group Home: Group Home Habilitation Must be 18 or over – Per Day
- Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 1 Direct Care Staff – Per 8 Hours
- Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 2 Direct Care Staff – Per 8 Hours
- Specialized Group Home – Adult – Per Day

The rate model includes the following key components:

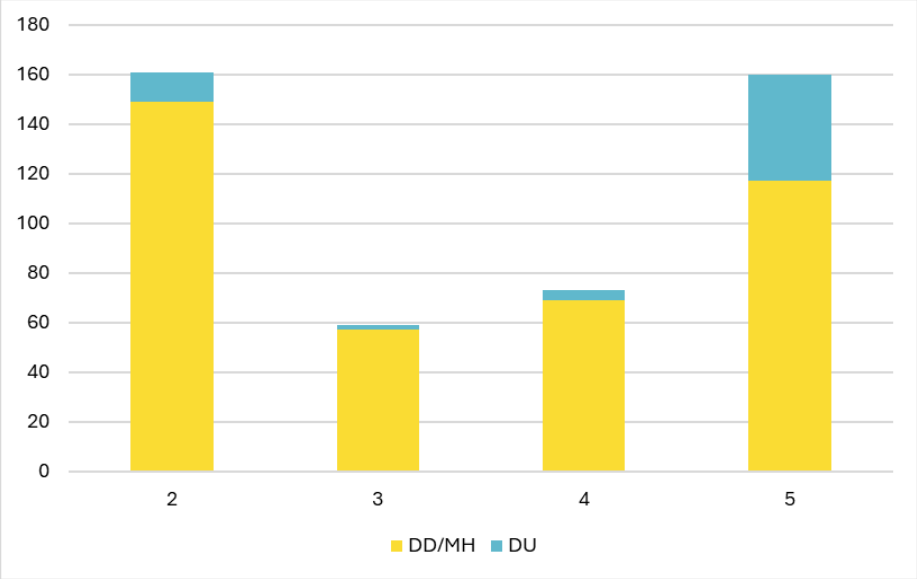
- Staffing Pattern: The weekly staffing pattern for a Group Home per person assumes that participants spend eight hours per weekday engaged in activities outside the home.
- Supervision: Supervisors are assumed to oversee sixteen staff members on average across multiple homes.
- Acuity Add-On: Acuity add-ons available to participants that require additional staffing at a 1:1 or 2:1 staff to participant ratio. The acuity add-on rates include additional DSP staffing time to accommodate these additional staff.
- Transportation: Staff transportation costs (air and ground) and client transportation costs for typical travel needs are included based on provider feedback in the Survey.
- Primary and Substitute Staffing Hours Calculations: A key rate component of the Group Home models is the calculation of the primary and substitute hours required to staff the Group Home setting. Total hours required for daytime, nighttime and day program/school hours all need to be considered to account for adequate staffing for the number of residents. The annual DSP primary hours represent the total number of staffed service delivery hours.
- Weekly Funded Hours: The calculation of total annual staffing hours per participant begins with the weekly funded hours assumption. Hours are divided into three categories based on typical activity levels of participants: Prime Time, Non-Prime Time, and Night. Prime Time hours are typically 9 a.m. – 5 p.m. and represent the time that participants are most active. This is also the time of day that participants typically attend day programs and require less staff support. This assumption is set at eight hours for weekend days, and four hours for weekdays when participants are more commonly engaged in activities outside the home. Night hours represent time participants are typically sleeping and are staffed at eight hours throughout the week. Non-Prime Time hours refer to the waking hours not covered by prime time. These are periods where participants are less active and are staffed at eight hours on weekends and four hours throughout the week. These assumptions are detailed in **Table 47** below.

Table 47. Group Home Weekly Funded Hours

Time Type	Prime Time	Non-Prime Time	Night
Sun	8	8	8
Mon	4	4	8
Tue	4	4	8
Wed	4	4	8
Thu	4	4	8
Fri	4	4	8
Sat	8	8	8
Weekly Total	**41**	**41**	**56**
Annual Total	**1,877**	**1,877**	**2,920**

- Home Size: Guidehouse used licensed facility data to analyze the capacity of a typical group home. Data from the Alaska Department of Health, Division of Health Care Services divides homes into three categories: SS, DD/MH, and DU. The SS category contains "Adults age 18 and older who have physical disability, are elderly or suffer from dementia but who are not diagnosed as chronically mental ill." This category of homes does not fall under the LTSS umbrella and was not used for the analysis. The MH/DD category contains "Adults, age 18 years or older; who have a mental or developmental disability." And the DU category contains "Adults age 18 and older who have physical disability, are elderly or suffer from dementia and/or have a mental or developmental disability." These categories contain group homes and RSL facilities. Guidehouse limited the analysis to homes of size 5 or less to limit skewing impacts of RSL facilities. This analysis showed that roughly one third of group homes support two residents, one third support five, and one third support 3 or 4 residents. For a service with such relatively small differentiation in home sizes, Guidehouse and DOH determined that tiered rates would add more complication than benefit and decided to maintain a standardized rate across home sizes. The variation of home sizes is shown in **Figure 15** below.

Figure 15. Average Number of Licensed Beds in Group Home Facilities



- Minimum Staff Hours: The minimum staffing for a given home size can be calculated by dividing the total staffing hours in the weekly staffing pattern by the number of residents in the home. These calculations are shown by time period in **Table 48** below.

Table 48. Group Home Minimum Staff Hours

Acuity	Home Size	Prime Time	Non-Prime Time	Night	Funded Hours
Standard	2	939	939	1,460	3,337
Standard	3	626	626	973	2,225
Standard	4	469	469	730	1,669
Standard	5	375	375	584	1,335
Standard	2 – 5 (Average)	602	602	937	2,141
Acuity-Add on (1 client: 1 staff)	1	2,920	0	0	2,920
Acuity-Add on (1 client: 2 staff)	1	2,920	0	0	2,920

- Staffing Ratios: Staffing ratios for Group Homes are shown below by acuity and time period. Acuity staffing ratios in **Table 49** are specific to home sizes. The standard staffing ratio is blended from staffing ratios used in home sizes 2 – 5.

Table 49. Group Home Staffing Ratios

Acuity	Home Size	Prime Time	Non-Prime Time	Night
Standard	2	1.00	1.00	1.00
Standard	3	1.50	1.20	1.00
Standard	4	2.00	1.33	1.00
Standard	5	2.50	1.43	1.00
Acuity-Add on (1 client: 1 staff)	1	1.00	1.00	1.00
Acuity-Add on (1 client: 2 staff)	1	2.00	2.00	2.00

- Actual Staffing Hours: These staffing ratios are then applied to the minimum staffing hours from the table above. This results in annual staffing hours per resident, adjusted for home size and all staffing ratios. These hours are shown in **Table 50** below.

Table 50. Group Home Staffing Hours

Acuity	Home Size	Prime Time	Non-Prime Time	Night	Funded Hours
Standard	2	939	939	1460	3337
Standard	3	939	751	973	2663
Standard	4	939	626	730	2294
Standard	5	939	536	584	2059
Standard	2 – 5 (Average)	939	713	937	2588
Acuity-Add on (1 client: 1 staff)	1	1,737	0	0	1,737
Acuity-Add on (1 client: 2 staff)	1	3,474	0	0	3,474

- Substitute Hours: Substitute hours represent the hours needed to cover non-productive hours due to staff training, paid time off, and resident absences from day programs. The training hour assumptions assume a staff turnover rate of 41 percent and required annual training hours per staff as 39 hours. This is derived from survey averages of 52 annual hours for new staff and 26 annual hours for existing staff. The PTO related substitution assumes 28 days of paid time off, consistent with the 28-day average paid time off reported by providers in the Survey. Additionally, substitute hours are calculated for time that participants may spend away from the home engaged in day programs or other activities. This accounts for the 6 hours per weekday in the prime time and non-prime time categories that are not included in the weekly funded hours. Substitute hours are then calculated, assuming an average of 21 weekdays per month. **Table 51** includes Group Home substitute hours.

Table 51. Group Home Substitute Hours

Acuity	Home Size (FTE)	Substitute Hours - Training	Substitute Hours – Paid Time Off	Substitute Hours – Other Programs	Total Substitute Hours
Standard	2 (1.60)	26	359	202	587
Standard	3	21	287	161	469
Standard	4	18	247	139	404
Standard	5	16	222	124	362
Standard	2 – 5 (Average)	20	279	156	455
Acuity-Add on (1 client:1 staff)	0.84 (1,737 / 2080)	13	187	106	306
Acuity-Add on (1 client:2 staff)	1.67 (3,474 / 2,080)	27	374	210	611

These hourly calculations feed into each of the Group Home models based on setting and variation in resource need intensity defined by that setting. **Table 52** below includes Group Home Habilitation SFY 2027 proposed benchmark rates.

Table 52. Group Home Habilitation Service Rate Components and Rates

Service	Service Description	Unit	DSP Hours per Resident (Primary & Substitute)	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T2016	Group Home Habilitation	Daily	3,044	11.10%	33.40%	$468.17	$470.26
T2016 CG	Group Home or Family Home Habilitation Acuity Add-on 1 to 1	Per 8 Hours	2,043	0%	33.40%	$164.55	$237.43
T2016 TG	Group Home or Family Home Habilitation Acuity Add-on 2 to 1	Per 8 Hours	4,086	0%	33.40%	$329.10	$474.86
NEW	Specialized Group Home / Specialized Family Home Habilitation (Adult & Child)	Daily	6,868	4.10%	33.40%	N/A	$997.47

G.3.10.2. Family Home Habilitation Residential Services

Family Home Habilitation services include the following rates:

- Family Home Habilitation Must be 18 or over – Adult – Per Day
- Family Home Habilitation Must be under 17 or younger – Child – Per Day
- Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 1 Direct Care Staff – Per 8 Hours (see **Section G.3.10.1**)
- Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 2 Direct Care Staff – Per 8 Hours (see **Section G.3.10.1**)
- Specialized Family Home – Adult – Per Day (see **Section G.3.10.1**)

The rate model includes the following key components:

- Caregiver Stipend: The primary caregiver receives a monthly stipend to cover costs of care for the participant. Included stipends are based on provider feedback in the Survey.
- Supervision: Supervision costs are included based on provider feedback in the Survey.
- Transportation: Costs of client transportation are included based on feedback from the Survey and the current IRS mileage rate.

Table 53 below includes Family Home Habilitation rate components and rates.

Table 53. Family Home Habilitation Service Rate Components and Rates

Service	Service Description	Unit	Monthly Stipend (Based on Provider Cost and Wage Survey)	Daily Stipend	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
S5140	Family Home Habilitation – Adult	Daily	$3,307	$109	4.10%	33.40%	$195.06	$277.79
S5145	Family Home Habilitation – Child	Daily	$3,836	$126	4.10%	33.40%	$211.09	$303.24

G.3.10.3. Supported Living and In-Home Supports Services

Supported Living and In-Home Supports services include the following rates:

- Supported Living Habilitation – Must be 18 or over – Per 15 Minutes
- In-Home Supports – Must be 17 or younger – Per 15 Minutes

The rate model includes the following key components:

- Productivity: A productivity adjustment of 1.25 (80 percent) s included to account for non-billable time required to deliver services.
- Program Support: A program support adjustment of 10 percent is included to account for the wages and benefits of support staff and the costs of supplies required to deliver services.

Table 54 below includes Supported Living and In-Home Supports rate components and rates.

Table 54. Supported Living and In-Home Supports Service Rate Components and Rates

Service	Service Description	Unit	Productivity	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T2017	Supported Living Habilitation	Per 15 Minutes	80%	10.0%	33.40%	$14.98	$14.81
T2017 U4	In-Home Supports	Per 15 Minutes	80%	10.0%	33.40%	$14.98	$14.81

G.3.10.4. Residential Supported Living Services

Residential Supported Living (RSL) services include the following rates:

- Residential Supported Living: State Government Owned/Operated
- Residential Supported Living: 5 or Fewer Beds Non-State Government Owned/Operated
- Residential Supported Living: 6 – 16 Beds Non-State Government Owned/Operated
- Residential Supported Living: 17 or More Beds Non-State Government Owned/Operated
- Residential Supported Living: Acuity Add-On Non-State Government Owned/Operated

The rate model includes the following key components:

- Staffing Pattern: The weekly staffing pattern for a Residential Supported Living facility per person assumes that participants spend six hours per weekday engaged in activities outside the home.
- Supervision: Supervisors are assumed to oversee sixteen staff members on average, potentially across multiple homes.
- Transportation: Staff transportation costs (air and ground) and client transportation costs for typical travel needs are included based on provider feedback in the Survey.
- Staffing Hours Calculations: A key rate component of the RSL models is the calculation of the primary and substitute hours required to staff the RSL setting. Total hours required for daytime, nighttime and day program/school hours all need to be considered to account for adequate staffing for the number of residents. The annual DSP primary hours represent the total number of staffed service delivery hours.
- Weekly Funded Hours: The calculation of total annual staffing hours per participant begins with the weekly funded hours assumption. Hours are divided into three categories based on typical activity levels of participants: Prime Time, Non-Prime Time, and Night. Prime Time hours are typically 9 a.m. – 5 p.m. and represent the time that participants are most active. This assumption is set at 8 hours throughout the week. Night hours represent time participants are typically sleeping and are staffed at 8 hours throughout the week. Non-Prime Time hours refer to the waking hours not covered by prime time. These are staffed at 8 hours throughout the week. These assumptions are detailed in **Table 55** below.

Table 55. Residential Supported Living Weekly Funded Hours

Time Type	Prime Time	Non-Prime Time	Night
Sun	8	8	8
Mon	8	8	8
Tue	8	8	8
Wed	8	8	8
Thu	8	8	8
Fri	8	8	8
Sat	8	8	8
Weekly Total	**56**	**56**	**56**
Annual Total	**2,920**	**2,920**	**2,920**

- Minimum Staff Hours: The minimum staffing for a given home size can be calculated by dividing the total staffing hours in the weekly staffing pattern by the number of residents in the home. These calculations are shown by time period in **Table 56** below.

Table 56. Residential Supported Living Minimum Staff Hours

Acuity	Home Size	Prime Time	Non-Prime Time	Night	Funded Hours
Standard / Acuity Add-On	5	584	584	584	1,752
Standard	10	292	292	292	876
Standard	17	172	172	172	516

- Staffing Ratios: Staffing ratios for RSL are shown in **Table 57** below by acuity and time period. Staffing ratios in the table are given compared to home size (e.g. prime time staffing for standard acuity home size 10 has a staffing ratio of 1.33 to 10)

Table 57. Residential Supported Living Staffing Ratios

Acuity	Home Size	Prime Time	Non-Prime Time	Night
Standard / Acuity Add-On	5	1.00	1.00	1.00
Standard	10	1.33	1.33	1.00
Standard	17	1.70	1.70	1.70

- Actual Staffing Hours: These staffing ratios are then applied to the minimum staffing hours from the table above. This results in annual staffing hours per resident, adjusted for home size and all staffing ratios. These hours are shown in **Table 58** below.

Table 58. Residential Supported Living Staffing Hours

Acuity	Home Size	Prime Time	Non-Prime Time	Night	Funded Hours
Standard / Acuity Add-On	5	584	584	584	1,752
Standard	10	389	389	389	1,167
Standard	17	292	292	292	876
Standard	**Average**	**421**	**421**	**421**	**1,265**

- Substitute Hours: Substitute hours represent the hours needed to cover non-productive hours due to staff training, paid time off, and resident absences from day programs. The training hour assumptions assume a staff turnover rate of 41 percent and required annual training hours per staff as 39 hours. This is derived from survey averages of 52 annual hours for new staff and 26 annual hours for existing staff. The PTO related substitution assumes 28 days of paid time off, consistent with the 28-day average paid time off reported by providers in the provider cost and wage survey. **Table 59** below includes the substitute hours by home size.

Table 59. Residential Supported Living Substitute Hours

Acuity	Home Size	FTE	Substitute Hours - Training	Substitute Hours – Paid Time Off	Outside Program	Total Substitute Hours
Standard / Acuity Add-On	5	0.84 (1,752 / 2,080)	14	189	105	308
Standard	10	0.84 (1,167 / 2080)	7	94	105	206
Standard	17	0.25 (876 / 2,080)	4	55	95	154
Standard	Average	0.61 (1,265 / 2080)	8	113	102	223

Table 60 below includes the Residential Supported Living SFY 2027 proposed benchmark rates.

Table 60. Residential Supported Living Service Rate Components and Rates

Service	Service Description	Unit	Home Size	DSP Hours per Resident (Primary & Substitute)	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
T2031	RSL – 17 or more beds	Daily	17+	1,374	4.10%	33.40%	$223.38	$235.76
T2031 US	RSL – 6 to 16 beds	Daily	6 – 16	1,488	4.10%	33.40%	$222.96	$235.76
T2031 UR	RSL – 5 or fewer beds	Daily	5	2,060	4.10%	33.40%	$222.96	$235.76
T2031 CG	RSL – State Government Owned/Operated	Daily	Variable	1,488	4.10%	33.40%	$223.38	$235.76
T2031	RSL – Acuity Add-On	Daily	N/A	2,060	4.10%	33.40%	$493.66	$506.85

G.3.10.5. Adult Host Home

DOH is introducing Adult Host Homes as an alternative to traditional residential settings, such as Group Homes and Family Home Habilitation. This model is designed to provide individualized, community-integrated living arrangements for adults who require supportive services. The rate model builds on the Family Home Habilitation structure but includes lower caregiver stipends, reflecting the reduced training and licensing requirements for this service.

The rate model includes the following key components:

- Caregiver Stipend: The primary caregiver receives a monthly stipend to cover costs of care for the participant. Included stipends are based on provider feedback in the Survey.
- Supervision: Supervision costs are included based on provider feedback in the Survey.
- Transportation: Costs of client transportation are included based on feedback from the Survey and the current IRS mileage rate.

Table 61 below includes the Adult Host Home SFY 2027 proposed benchmark rate.

Table 61. Adult Host Home Service Rate Components and Rates

Service	Service Description	Unit	Daily Stipend	Program Support	Admin.	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate
NEW	Adult Host Home	Daily	$98	4.10%	33.40%	N/A	$256.92

G.3.11. Transportation Service Methodologies

The Transportation services category covers services that provide transportation for LTSS service recipients that do not utilize residential services under the LTSS waivers. These services most often have the primary service provider as a Driver. This category includes the following services:

- Transportation – Local
- Transportation Attendant
- Transportation – Non-Local
- Paratransit

Rate Components: These services include wages for a Driver, productivity adjustment, supervision time, administration add-on, vehicle costs, and mileage expenses. To keep the rates consistent, the models include components that are calculated as an average across all service costs reported in the provider cost and wage survey, as appropriate.

Vehicle Cost

Vehicle ownership is a prerequisite to offering Transportation services. In the case of Paratransit, the vehicle needs additional modifications to accommodate participant needs. The cost of an appropriate vehicle and additional modifications have been considered in the final rate recommendation.

Mileage

The costs of operating and maintaining a vehicle are key to providing transportation services. These vehicle costs are represented in the model utilizing the IRS mileage rate. The rate is published annually and is informed by a study of fixed and variable vehicle costs including fuel, maintenance, repairs, tire, depreciation, insurance, and registration expenses.

Table 62 below includes SFY 2027 proposed benchmark rate for Transportation services.

Table 62. Transportation Service Rate Components and Rates

Service	Service Description	Unit	SFY 2026 Rate	SFY 2027 Benchmark Rate
T2003	Transportation – Local	Per Trip	$22.98	$25.99
T2001SE	Transportation Attendant	Per Trip	$22.98	$25.99
T2003TN	Transportation – Non-Local	Per Trip	$45.95	$63.00
T2003CG	Paratransit	Per Trip	$45.95	$49.60

G.3.12. Intermediate Care Facility (ICF) Service Methodologies

The Intermediate Care Facility (ICF) model is designed to provide care to those participants for whom community-based care is not a feasible option due to the acuity of the behavioral and medical conditions they experience. Alaska opened its first ICF, Old Valdez, in 1961 with a fifty-bed capacity. Other facilities opened (and closed) in the following years and, in 1996, there were around 40 individuals living in ICF care with more on the waiting list. Introduction of the HCBS waiver program gave the only remaining private facility in Alaska, Hope Cottages, the opportunity to voluntarily close its program and transition the 40 people in their care to community-based care[34].

As a result, Alaskans who require the level of care provided by an ICF must currently seek that care outside the state. To explore options for expanding in-state access to this level of care, the DOH engaged Guidehouse to assess the costs and identify an appropriate benchmark rate for establishing an ICF facility within Alaska.

Direct Care Costs

Direct care costs are primarily incurred through the wages and other employment related expenses of direct care staff. Guidehouse researched staffing at ICF locations in other states to understand the typical staffing requirements of these facilities. Then, using the wages and benefits information gleaned from the LTSS and Behavioral Health Provider Cost and wage surveys deployed in the fall of 2024 along with BLS wage data, Guidehouse modeled costs for a six-bed facility. Wage, ERE, FTE, and direct care cost assumptions and calculations are detailed in **Table 63** below.

Table 63. Intermediate Care Facility Direct Care Costs

Direct Care Staff Type	Hourly Staff Type Wage Inflated to (Midpoint CY 2026)	Hourly Staff Type Wage with ERE	FTE	Total Annual Cost
Registered Nurses	$50.25	$64.50	0.25	$33,540
Licensed Practical Nurses	$42.86	$55.58	1.25	$144,508
CNAs and Orderlies	$25.61	$34.75	8	$903,533
Residential Manager	$35.44	$46.62	1	$96,973
Physical Therapists	$60.29	$76.62	1	$159,379
Rehab/Therapy/Aides	$23.40	$32.08	3	$200,169
Service Coordinator	$24.57	$33.50	0.15	$10,451

Indirect Costs

Indirect costs are those costs which are not tied to the direct daily care of a participant but are required to appropriately deliver the service. In the context of ICF care, this includes costs such as housekeeping, laundry, grounds and building maintenance, food, supplies, and administrative expenses. Due to the high cost of food and other consumables in Alaska, Guidehouse has set this percentage slightly higher at **25 percent**.

[34] Alaska Association on Developmental Disabilities, The ICF/IID and Alaska: A Study Report Projects.

Capital Costs

Capital costs refer to the expenses of the facility itself (mortgage/depreciation) as well as costs associated with large equipment such as vehicles and lifts. Capital costs can be highly variable based on geography as well as the number of years a facility has been in operation. While a facility that has been a going concern for decades may have largely or entirely paid for their building may have a capital expense as low as 2 percent, a new facility will have more significant capital investment requirements. Additionally, building in Alaska faces challenges that are less common in other areas of the country. For these reasons, Capital expenses are assumed to account for **12 percent** of total costs.

Occupancy Adjustment

In Intermediate Care Facilities (ICFs), an occupancy factor of 94% is used in rate models to account for reimbursement of providers despite unavoidable absences. Residents may be away temporarily—for example, visiting family or during short vacancies between admissions—which means providers cannot bill for those days. However, the facility still incurs fixed costs such as staffing, utilities, and overhead. By incorporating an occupancy adjustment into the rate, DOH can help align provider revenue with actual annual costs. This approach supports financial stability for providers while promoting efficient operations, as it reflects a realistic balance between billable days and the true cost of maintaining care capacity.

Benchmark Rate

The proposed benchmark rate below provides comprehensive staffing for an ICF serving a variety of clients. The rate can be implemented "as-is" or has the flexibility to be adjusted to different staffing mix as needed to accommodate a specific provider focus or DOH priorities. The difference in rates between ICFs and Specialized Residential Habilitation captured in **Section G.3.10** is primarily driven by economies of scale. ICFs with six-bed configurations tend to have higher per-unit costs due to fixed overhead expenses being distributed across fewer residents, resulting in a lower rate of $943.22. In comparison, specialized residential habilitation settings, which may operate with eight or more beds, reflect a slightly higher reference rate of $997.47. These rate differences highlight the potential operational factors that influenced cost structures and rate development. The Cost Centers and Benchmark Rate are shown in **Table 64** below.

Table 64. Intermediate Care Facility Proposed Benchmark Rate

Cost Center	Annual Costs
Direct Care Costs	$1,223,282
Indirect Costs	$485,429
Capital Costs	$233,006
Total Annual	$1,941,717
Facility Size	1 : 6
Total Cost per Patient per Day	$886.63
Occupancy Adjustment	0.94
Proposed SFY 2027 Benchmark Rate (Per Day)	**$943.22**

Recommendation LT-R6 includes key decisions for DOH to consider in implementing ICFs.

H. Fiscal Impact Estimates

The fiscal impact analysis is an essential process used to assess how benchmark rate recommendations may affect overall spending. This approach incorporates several key components and methodologies to support accurate projections and informed decision-making.

H.1. Utilizing Fiscal Year 2024 Claims Data

A key component of the fiscal analysis is the use of claims utilization data from fiscal year 2024. By leveraging this data, we can project future costs under the new benchmark rates with a high degree of accuracy. This historical claims data offers valuable insights into patterns of service use and expenditure, enabling us to forecast future financial impacts in a structured and evidence-based manner.

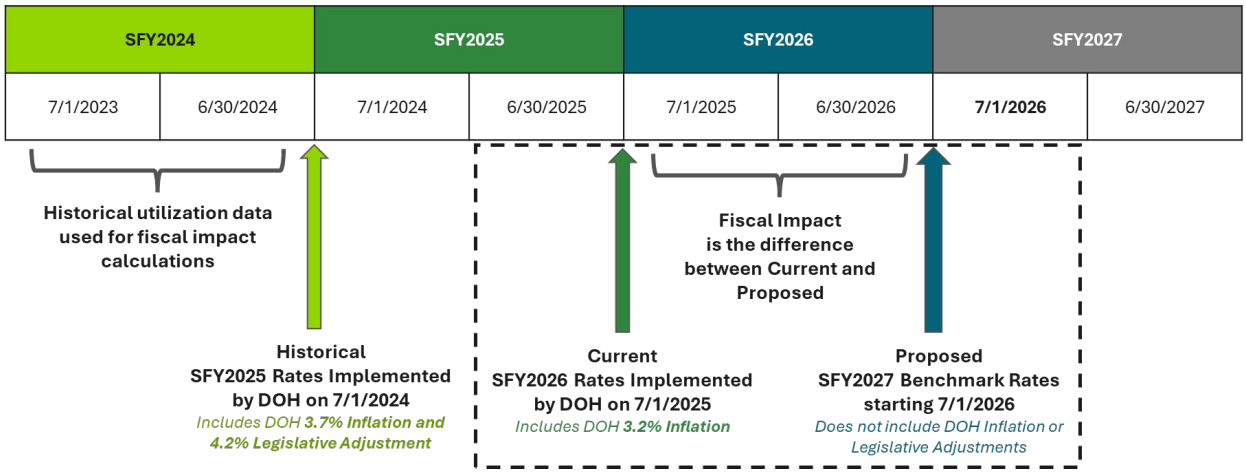
While claims data is a critical resource, it may occasionally contain incomplete or inconsistent reporting elements—such as missing IHS indicators or program designations—which can introduce complexity into the fiscal impact analysis. To maintain the integrity of our calculations, approximately $242,000 in claims were set aside due to insufficient data. These excluded claims represent about 0.05 percent of the total, accounting for 0.28 percent of the removed claims in the most affected service category.

H.2. Comparative Analysis with Existing Rates

To support the robustness of our benchmark rate recommendations, we conduct a comparative analysis with the most recently published SFY 2026 published rates. Through this process, we can identify discrepancies, validate our projections, and align our recommendations with current market standards. To display impacts in a way that allows direct comparison of rates, all impacts are shown using the current geographic differentials paid to providers. Such comparative analysis helps in maintaining the integrity and reliability of our fiscal evaluations.

Figure 16 below includes key components and time period for fiscal impact estimation. The fiscal impact presented in this section is for one year as captured in this figure.

Figure 16. Time Period for Benchmark Fiscal Impact and Rates



H.3. Incorporating Federal Medical Assistance Percentages (FMAP)

Our analysis incorporates the Federal Medical Assistance Percentages (FMAP) for various programs, including the Medicaid 1915(c) waiver, Community First Choice, Personal Care Services, and TEFRA, as shown in **Table 65** below. These variables play an important role in shaping the fiscal landscape. We have also accounted for IHS members within our projections to reflect their distinct circumstances. This approach supports a fiscal impact analysis that is inclusive and considers all relevant factors.

Table 65. Federal Medical Assistance Percentage (FMAP) by Program Category

IHS Provider	IHS Member	FMAP Program Category	FMAP
Y	Y	1915(c) Waiver	100.00%
Y	N	1915(c) Waiver	52.42%
N	Y	1915(c) Waiver	52.42%
N	N	1915(c) Waiver	52.42%
Y	Y	Community First Choice	100.00%
Y	N	Community First Choice	58.42%
N	Y	Community First Choice	58.42%
N	N	Community First Choice	58.42%
Y	Y	Personal Care Services	100.00%
Y	N	Personal Care Services	52.42%
N	Y	Personal Care Services	52.42%
N	N	Personal Care Services	52.42%
Y	Y	TEFRA	100.00%
Y	N	TEFRA	52.42%
N	Y	TEFRA	52.42%
N	N	TEFRA	52.42%

H.3.1 Fiscal Impact Data Considerations

To perform the analysis and calculations based on SFY 2024 base data, certain assumptions were made to address data exceptions, as outlined below:

- Removed Claims: Some waiver service claims could not be linked to a specific program and were therefore excluded from the analysis. These claims account for approximately $245,000, representing about 0.05% of total claims.
- FMAP Assignment: Some claims were paid at 100 percent FMAP even though the billing provider, recipient, or both were not identified as IHS. Most of these claims involved IHS recipients served by non-IHS providers. Guidehouse assigned these claims to 100 percent FMAP rather than applying the standard methodology, to better reflect the anticipated payer.
- Specialized Services FMAP: Impacts for Specialized Group Home and Specialized Family Home Habilitation services were calculated using the 1915(c) waiver FMAP of 52.42 percent.
- Adult Host Home: The fiscal impact associated with this service is assumed to be cost neutral, as it may offset utilization of existing services that are already accounted for in the fiscal analysis.

H.4. LTSS Fiscal Impact Options

Guidehouse conducted a fiscal impact analysis as part of the rate evaluation to understand how proposed changes will affect state and federal LTSS program expenditures. It supports transparent and data-driven decision-making and aligns potential rate adjustments with broader policy goals related to improving access and quality of care. Modeling multiple options may allow DOH to prepare for varied outcomes that are responsive to changing economic conditions, program composition, service arrays, and other program changes. It is important to note that additional implementation options may exist beyond those presented in this section, based on available funding. DOH may choose to implement recommendations across all services simultaneously or, depending on budget constraints and available resources, may opt to apply a percentage of the benchmark, target specific service categories, or phase in changes over time. **Table 66** below shows a summary of the four options.

1. **Option 1a: LTSS Methodology Transition and Rate Recalibration Without Hold Harmless Rates**[35]
   This baseline option maintains the current service structure as part of transitioning to the new methodology and allows rate increases and decreases to take effect. This lower-cost scenario reflects updated utilization and cost data, resulting in a projected increase of $42.8M (7.8 percent) overall and $19.2M (7.6 percent) in state share. The essence of this option lies in its stringent approach to fiscal management. By allowing rate decreases, it emphasizes the redistribution of current funds without seeking additional budget allocations. This option allows for spending to be aligned closely with existing cost structures and utilization patterns, minimizing the potential for budgetary excess. It provides a clear picture of how conservative fiscal policies can affect state and overall expenditures, with funding increases carefully managed and justified through existing financial parameters.
2. **Option 1b: LTSS Methodology Transition and Rate Recalibration with Hold Harmless Rates**[36]
   This option builds on Option 1a by applying a hold harmless provision to prevent rate reductions. This results in a slightly higher fiscal impact of $43.5M (7.9 percent) overall and $19.6M (7.7 percent) in state share. The "hold harmless" approach prioritizes the stability of providers by ensuring that those facing potential rate decreases remain unaffected. This scenario is designed to minimize disruption and maintain consistent funding levels across the board. However, this stability comes at a cost, as the lack of downward adjustments means that increases in funding are not counterbalanced, leading to a rise in the fiscal impact. This scenario underscores the trade-offs between stability and cost containment, demonstrating the financial implications of maintaining rate floors without accounting for broader economic factors or cost reductions.

[35] Option 1a captures the Medicaid Service Reimbursement fiscal impact for recommendations LT-R1.
[36] Option 1b captures the Medicaid Service Reimbursement fiscal impact for recommendation LT-R1 and LT-R2.

3. **Option 2a: Incorporating Structural Service and Rate Changes without Hold Harmless Rates**[37]
   This option builds on Option 1a – it involves the implementation of all recommended structural service and rate changes, and allows rate increases and decreases to take in effect. This approach yields a projected increase of $55.8M (10.1 percent) overall and $25.0M (9.9 percent) in state share.

   Specifically, this option explores the addition of new services and the introduction of new or expanded tiers for existing services, thereby modifying current service and rate structures. The goal is to capture the broader range of services identified by DOH as part of this study, in order to meet both provider and client needs. At the same time, it aims to align spending with existing cost structures and utilization patterns, minimizing the potential for budgetary excess, similar to Option 1a. This option does not capture the change in geographic differentials that is provided in Section C.2.3 and Appendix B to allow for direct comparisons across years and options.

4. **Option 2b: Incorporating Structural Service and Rate Changes with Hold Harmless Rates**[38]
   This option build on Option 1b – it combines structural changes in services and rates with a hold harmless provision that maintains current rates for services facing reductions. This option reflects the highest fiscal impact at $57.7M (10.5 percent) overall and $26.2M (10.4 percent) in state share. If only partial structural changes are adopted, the impact would likely fall between Options 1a and 2b.

   Specifically, this option explores the addition of new services and the introduction of new or expanded tiers for existing services, thereby modifying current service and rate structures, similar to Option 2a. The hold harmless approach outlined in Option 1b is further applied in this option. This option does not capture the change in geographic differentials that is provided in Section C.2.3 and Appendix B to allow for direct comparisons across years and options.

[37] Option 2a captures the Medicaid Service Reimbursement fiscal impact for recommendations LT-R1, LT-R5, LT-R6, and LT-R7.
[38] Option 2b captures the Medicaid Service Reimbursement fiscal impact for recommendations LT-R1, LT-R2, LT-R5, LT-R6, and LT-R7.

Table 66. SFY 2026-SFY 2027 Fiscal Impact Options

Option	Assessment	Fiscal Impact Percentage
Option 1a	Not Held Harmless with LTSS Rate Methodology Transition and Rate Recalibration	7.8%
Option 1b	Held Harmless with LTSS Rate Methodology Transition and Rate Recalibration	7.9%
Option 1c	Not Held Harmless with all recommended changes to existing service and rate structures	10.1%
Option 1d	Held Harmless with all recommended changes to existing service and rate structures	10.5%

H.5. LTSS Fiscal Impact Analysis

Table 67 below captures the overall fiscal impact across the four options. Together, these options highlight the trade-offs between cost containment and tiering service structures, with each step toward reform and provider protection requiring greater financial investment.

Table 67. Overall Fiscal Impact Options – State and Federal Share

Option	Description	Total SFY 2027 Expenditures (State & Federal Share)	Total Fiscal Impact and Percentage Fiscal Impact (State & Federal Share)	Total SFY 2027 Expenditures (State Share)	Total Fiscal Impact and Percentage Fiscal Impact (State Share)
Option 1a	Not Held Harmless with LTSS Rate Methodology Transition and Rate Recalibration	$594,100,000	$42,758,000 [7.8%]	$271,976,000	$19,239,000 [7.6%]
Option 1b	Held Harmless with LTSS Rate Methodology Transition and Rate Recalibration	$594,863,000	$43,521,000 [7.9%]	$272,314,000	$19,577,000 [7.7%]
Option 2a	Not Held Harmless with *all* recommended changes to existing service and rate structures	$607,163,000	$55,821,000 [10.1%]	$277,768,000	$25,031,000 [9.9%]
Option 2b	Held Harmless with *all* recommended changes to existing service and rate structures	$609,084,000	$57,742,000 [10.5%]	$278,958,000	$26,221,000 [10.4%]

H.5.1. Fiscal Impact by Program

The fiscal impact of Alaska's LTSS programs varies widely depending on the option. Programs like ALI and IDD show the greatest sensitivity to structural changes and rate protections, with expenditures peaking under the most comprehensive reform option – Option 2b. In contrast, Community First Choice and Personal Care Services remain fiscally stable across all options, suggesting that their current rate structures are already well-aligned with service delivery. Smaller programs such as TEFRA and ISW show relatively minor or inconsistent changes, reflecting their limited scale or variability in utilization. **Tables 68-72** below highlight how different programs respond differently to rate adjustments, both overall and by option.

Table 68. Fiscal Impact by Program – All Options

Program	Option 1a Total Impact (Federal & State Share)	Option 1a Total Impact (State Only)	Option 1b Total Impact (Federal & State Share)	Option 1b Total Impact (State Only)	Option 2a Total Impact (Federal & State Share)	Option 2a Total Impact (State Only)	Option 2b Total Impact (Federal & State Share)	Option 2b Total Impact (State Only)
ALI	$10,890,000	$4,691,000	$10,943,000	$4,707,000	$14,380,000	$6,026,000	$14,432,000	$6,042,000
APDD	$4,018,000	$1,911,000	$4,071,000	$1,936,000	$4,523,000	$2,145,000	$4,615,000	$2,209,000
CCMC	$824,000	$388,000	$892,000	$418,000	$1,241,000	$576,000	$1,258,000	$611,000
IDD	$10,717,000	$5,090,000	$11,287,000	$5,351,000	$18,480,000	$8,722,000	$20,228,000	$9,790,000
ISW	$489,000	$233,000	$507,000	$240,000	$1,508,000	$699,000	$1,519,000	$706,000
Community First Choice	$7,893,000	$3,170,000	$7,894,000	$3,170,000	$7,892,000	$3,170,000	$7,893,000	$3,170,000
Personal Care Services	$7,893,000	$3,740,000	$7,893,000	$3,740,000	$7,893,000	$3,740,000	$7,893,000	$3,740,000
TEFRA	$33,000	$15,000	$33,000	$15,000	-$98,000	-$47,000	-$98,000	-$47,000
Total	**$42,758,000**	**$19,239,000**	**$43,521,000**	**$19,577,000**	**$55,821,000**	**$25,031,000**	**$57,742,000**	**$26,221,000**

Table 69 below includes the fiscal impact by program for Option 1a.

Table 69. Fiscal Impact by Program – Option 1a (State and Federal)

Program	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2026 Calculated to SFY 2027 Calculated	Percentage Change SFY 2026 Calculated to SFY 2027 Calculated
ALI	2,473,964	$144,025,011	$157,715,000	$168,605,000	$10,890,000	6.9%
APDD	1,052,579	$25,952,756	$27,344,000	$31,362,000	$4,018,000	14.7%
CCMC	706,797	$12,915,326	$13,558,000	$14,382,000	$824,000	6.1%

Program	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2026 Calculated to SFY 2027 Calculated	Percentage Change SFY 2026 Calculated to SFY 2027 Calculated
IDD	7,814,311	$277,840,366	$295,011,000	$305,728,000	$10,717,000	3.6%
ISW	420,919	$7,528,705	$8,203,000	$8,692,000	$489,000	6.0%
Community First Choice	2,688,369	$22,245,882	$24,581,000	$32,474,000	$7,893,000	32.1%
Personal Care Services	2,680,102	$22,202,884	$24,431,000	$32,324,000	$7,892,000	32.3%
TEFRA	1,920	$496,984	$500,000	$533,000	$33,000	6.6%
Total	**17,838,961**	**$513,207,912**	**$551,342,000**	**$594,100,000**	**$42,758,000**	**7.8%**

Table 70 below includes the fiscal impact by program for Option 1b.

Table 70. Fiscal Impact by Program – Option 1b (State and Federal)

Program	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2026 Calculated to SFY 2027 Calculated	Percentage Change SFY 2026 Calculated to SFY 2027 Calculated
ALI	2,473,964	$144,025,011	$157,715,000	$168,658,000	$10,943,000	6.9%
APDD	1,052,579	$25,952,756	$27,344,000	$31,415,000	$4,071,000	14.9%
CCMC	706,797	$12,915,326	$13,558,000	$14,450,000	$892,000	6.6%
IDD	7,814,311	$277,840,366	$295,011,000	$306,298,000	$11,287,000	3.8%
ISW	420,919	$7,528,705	$8,203,000	$8,710,000	$507,000	6.2%
Community First Choice	2,688,369	$22,245,882	$24,581,000	$32,475,000	$7,894,000	32.1%
Personal Care Services	2,680,102	$22,202,884	$24,431,000	$32,324,000	$7,893,000	32.3%
TEFRA	1,920	$496,984	$500,000	$533,000	$33,000	6.6%
Total	**17,838,961**	**$513,207,912**	**$551,342,000**	**$594,863,000**	**$43,521,000**	**7.9%**

Table 71 below includes the fiscal impact by program for Option 2a.

Table 71. Fiscal Impact by Program – Option 2a (State and Federal)

Program	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2026 Calculated to SFY 2027 Calculated	Percentage Change SFY 2026 Calculated to SFY 2027 Calculated
ALI	2,473,964	$144,025,011	$157,715,000	$172,095,000	$14,380,000	9.1%
APDD	1,052,579	$25,952,756	$27,344,000	$31,867,000	$4,523,000	16.5%
CCMC	706,797	$12,915,326	$13,558,000	$14,799,000	$1,241,000	9.2%
IDD	7,814,311	$277,840,366	$295,011,000	$313,491,000	$18,480,000	6.3%
ISW	420,919	$7,528,705	$8,203,000	$9,711,000	$1,508,000	18.4%
Community First Choice	2,688,369	$22,245,882	$24,581,000	$32,473,000	$7,892,000	32.1%
Personal Care Services	2,680,102	$22,202,884	$24,431,000	$32,324,000	$7,893,000	32.3%
TEFRA	1,920	$496,984	$500,000	$402,000	-$98,000	-19.6%
Total	**17,838,961**	**$513,207,912**	**$551,342,000**	**$607,163,000**	**$55,821,000**	**10.1%**

Table 72 below includes the fiscal impact by program for Option 2b.

Table 72. Fiscal Impact by Program – Option 2b (State and Federal)

Program	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2026 Calculated to SFY 2027 Calculated	Percentage Change SFY 2026 Calculated to SFY 2027 Calculated
ALI	2,473,964	$144,025,011	$157,715,000	$172,147,000	$14,432,000	9.2%
APDD	1,052,579	$25,952,756	$27,344,000	$31,959,000	$4,615,000	16.9%
CCMC	706,797	$12,915,326	$13,558,000	$14,816,000	$1,258,000	9.3%
IDD	7,814,311	$277,840,366	$295,011,000	$315,239,000	$20,228,000	6.9%
ISW	420,919	$7,528,705	$8,203,000	$9,722,000	$1,519,000	18.5%
Community First Choice	2,688,369	$22,245,882	$24,581,000	$32,474,000	$7,893,000	32.1%
Personal Care Services	2,680,102	$22,202,884	$24,431,000	$32,324,000	$7,893,000	32.3%
TEFRA	1,920	$496,984	$500,000	$402,000	-$98,000	-19.6%
Total	**17,838,961**	**$513,207,912**	**$551,342,000**	**$609,084,000**	**$57,742,000**	**10.5%**

H.5.2. Fiscal Impact by Service Category

Similar services were grouped to assess the impact of rate changes across categories. The most affected service categories—both proportionally and in total expenditures—are Adult Day and Day Habilitation and Home-Based Supports. These categories saw rate increases applied to high-utilization services, which significantly influenced overall spending. In contrast, the Nursing category experienced a substantial 51.6% rate increase for non-local nursing oversight and care management; however, due to low utilization, the overall budget impact remains minimal. Residential services represent the third-largest category by total dollars. Although the proportional increase in expenditures is relatively modest, Residential accounts for 62.1 percent of current total spending, making even small percentage changes financially significant. Collectively, these three categories (Adult Day and Day Habilitation, Home-Based Supports, and Residential) comprise 88 percent of current LTSS expenditures.

Care Coordination shows a notably larger fiscal impact under Options 2a and 2b. Projected expenditures increase from approximately $0.9–$1.0M in Options 1a and 1b to $9.0–$9.1M in Options 2a and 2b. This shift is driven by the introduction of tiered rates for waiver and TEFRA populations. Waiver participants represent roughly 98.6 percent of all Care Coordination claims, and aligning rates more closely with the time and effort required to deliver services results in a significant reallocation of funds toward higher-utilization services.

Tables 73-77 below highlight the fiscal impact by individual service categories, both overall and by option.

Table 73. Fiscal Impact Options by Service Category – All Options

Service Category	Option 1a Total Impact (Federal & State Share)	Option 1a Total Impact (State Only)	Option 1b Total Impact (Federal & State Share)	Option 1b Total Impact (State Only)	Option 2a Total Impact (Federal & State Share)	Option 2a Total Impact (State Only)	Option 2b Total Impact (Federal & State Share)	Option 2b Total Impact (State Only)
Care Coordination	$901,000	$397,000	$1,019,000	$433,000	$9,078,000	$3,858,000	$9,194,000	$3,894,000
Adult Day and Day Habilitation	$10,403,000	$4,497,000	$10,403,000	$4,497,000	$10,147,000	$4,375,000	$10,147,000	$4,375,000
Employment	$1,028,000	$489,000	$1,028,000	$489,000	$782,000	$372,000	$782,000	$372,000
Home Based Supports	$16,005,000	$7,009,000	$16,005,000	$7,009,000	$16,005,000	$7,009,000	$16,005,000	$7,009,000
Intervention, Treatment, Therapy	$14,000	$7,000	$14,000	$7,000	$14,000	$7,000	$14,000	$7,000
Meals	$143,000	$68,000	$143,000	$68,000	$143,000	$68,000	$143,000	$68,000
Nursing	$5,016,000	$2,387,000	$5,025,000	$2,391,000	$5,016,000	$2,387,000	$5,016,000	$2,391,000
Residential	$8,561,000	$4,058,000	$9,197,000	$4,356,000	$13,930,000	$6,619,000	$15,735,000	$7,769,000

Service Category	Option 1a Total Impact (Federal & State Share)	Option 1a Total Impact (State Only)	Option 1b Total Impact (Federal & State Share)	Option 1b Total Impact (State Only)	Option 2a Total Impact (Federal & State Share)	Option 2a Total Impact (State Only)	Option 2b Total Impact (Federal & State Share)	Option 2b Total Impact (State Only)
Transportation	$679,000	$323,000	$679,000	$323,000	$679,000	$323,000	$679,000	$323,000
Specialized Medical Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Environmental Modifications	$8,000	$4,000	$8,000	$4,000	$27,000	$13,000	$27,000	$13,000
Total	**$42,758,000**	**$19,239,000**	**$43,521,000**	**$19,577,000**	**$55,821,000**	**$25,031,000**	**$57,742,000**	**$26,221,000**

Table 74 below includes the fiscal impact by service category for Option 1a.

Table 74. Fiscal Impact by Service Category – Option 1a (State and Federal)

Service Category	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2027 Calculated VS SFY 2026 Calculated	Percent Difference SFY 2027 Calculated vs SFY 2026 Calculated
Care Coordination	71,695	$30,112,952	$31,865,000	$32,766,000	$901,000	2.8%
Adult Day and Day Habilitation	4,365,488	$69,238,398	$74,587,000	$84,990,000	$10,403,000	13.9%
Employment	617,584	$9,659,372	$10,176,000	$11,204,000	$1,028,000	10.1%
Home Based Supports	4,272,609	$62,660,164	$68,706,000	$84,711,000	$16,005,000	23.3%
Intervention, Treatment, Therapy	28,494	$876,943	$943,000	$957,000	$14,000	1.5%
Meals	165,893	$4,845,006	$5,282,000	$5,425,000	$143,000	2.7%
Nursing	589,189	$11,490,882	$11,526,000	$16,542,000	$5,016,000	43.5%
Residential	4,498,334	$318,854,772	$342,338,000	$350,899,000	$8,561,000	2.5%
Transportation	218,705	$5,076,657	$5,527,000	$6,206,000	$679,000	12.3%
Specialized Medical Equipment	2,315	$206,425	$206,000	$206,000	$0	0.0%
Environmental Modifications	36	$186,340	$186,000	$194,000	$8,000	4.3%
Total	**14,830,342**	**$513,207,912**	**$551,342,000**	**$594,100,000**	**$42,758,000**	**7.8%**

Table 75 below includes the fiscal impact by program for Option 1b.

Table 75. Fiscal Impact by Service Category – Option 1b (State and Federal)

Service Category	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2027 Calculated VS SFY 2026 Calculated	Percent Difference SFY 2027 Calculated vs SFY 2026 Calculated
Care Coordination	71,695	$30,112,952	$31,865,000	$32,884,000	$1,019,000	3.2%
Adult Day and Day Habilitation	4,365,488	$69,238,398	$74,587,000	$84,990,000	$10,403,000	13.9%
Employment	617,584	$9,659,372	$10,176,000	$11,204,000	$1,028,000	10.1%
Home Based Supports	4,272,609	$62,660,164	$68,706,000	$84,711,000	$16,005,000	23.3%
Intervention, Treatment, Therapy	28,494	$876,943	$943,000	$957,000	$14,000	1.5%
Meals	165,893	$4,845,006	$5,282,000	$5,425,000	$143,000	2.7%
Nursing	589,189	$11,490,882	$11,526,000	$16,551,000	$5,025,000	43.6%
Residential	4,498,334	$318,854,772	$342,338,000	$351,535,000	$9,197,000	2.7%
Transportation	218,705	$5,076,657	$5,527,000	$6,206,000	$679,000	12.3%
Specialized Medical Equipment	2,315	$206,425	$206,000	$206,000	$0	0.0%
Environmental Modifications	36	$186,340	$186,000	$194,000	$8,000	4.3%
Total	**14,830,342**	**$513,207,912**	**$551,342,000**	**$594,863,000**	**$43,521,000**	**7.9%**

Table 76 below includes the fiscal impact by program for Option 2a.

Table 76. Fiscal Impact by Service Category – Option 2a (State and Federal)

Service Category	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2027 Calculated VS SFY 2026 Calculated	Percent Difference SFY 2027 Calculated vs SFY 2026 Calculated
Care Coordination	71,695	$30,112,952	$31,865,000	$40,943,000	$9,078,000	28.5%
Adult Day and Day Habilitation	4,365,488	$69,238,398	$74,587,000	$84,734,000	$10,147,000	13.6%
Employment	617,584	$9,659,372	$10,176,000	$10,958,000	$782,000	7.7%
Home Based Supports	4,272,609	$62,660,164	$68,706,000	$84,711,000	$16,005,000	23.3%
Intervention, Treatment, Therapy	28,494	$876,943	$943,000	$957,000	$14,000	1.5%
Meals	165,893	$4,845,006	$5,282,000	$5,425,000	$143,000	2.7%
Nursing	589,189	$11,490,882	$11,526,000	$16,542,000	$5,016,000	43.5%
Residential	4,498,334	$318,854,772	$342,338,000	$356,268,000	$13,930,000	4.1%
Transportation	218,705	$5,076,657	$5,527,000	$6,206,000	$679,000	12.3%
Specialized Medical Equipment	2,315	$206,425	$206,000	$206,000	$0	0.0%
Environmental Modifications	36	$186,340	$186,000	$213,000	$27,000	14.5%
Total	**14,830,342**	**$513,207,912**	**$551,342,000**	**$607,163,000**	**$55,821,000**	**10.1%**

Table 77 below includes the fiscal impact by program for Option 2b.

Table 77. Fiscal Impact by Service Category – Option 2b (State and Federal)

Service Category	SFY 2024 Units of Service	SFY 2024 Paid	SFY 2026 Calculated Expenditures	SFY 2027 Calculated Expenditures	Difference SFY 2027 Calculated VS SFY 2026 Calculated	Percent Difference SFY 2027 Calculated vs SFY 2026 Calculated
Care Coordination	71,695	$30,112,952	$31,865,000	$41,059,000	$9,194,000	28.9%
Adult Day and Day Habilitation	4,365,488	$69,238,398	$74,587,000	$84,734,000	$10,147,000	13.6%
Employment	617,584	$9,659,372	$10,176,000	$10,958,000	$782,000	7.7%
Home Based Supports	4,272,609	$62,660,164	$68,706,000	$84,711,000	$16,005,000	23.3%
Intervention, Treatment, Therapy	28,494	$876,943	$943,000	$957,000	$14,000	1.5%
Meals	165,893	$4,845,006	$5,282,000	$5,425,000	$143,000	2.7%
Nursing	589,189	$11,490,882	$11,526,000	$16,542,000	$5,016,000	43.5%
Residential	4,498,334	$318,854,772	$342,338,000	$358,073,000	$15,735,000	4.6%
Transportation	218,705	$5,076,657	$5,527,000	$6,206,000	$679,000	12.3%
Specialized Medical Equipment	2,315	$206,425	$206,000	$206,000	$0	0.0%
Environmental Modifications	36	$186,340	$186,000	$213,000	$27,000	14.5%
Total	**14,830,342**	**$513,207,912**	**$551,342,000**	**$609,084,000**	**$57,742,000**	**10.5%**

I. Benchmark Rates

Based on the above assumptions, Guidehouse developed rates for each service in the scope of the study. A summary of the benchmark rates developed is shown in **Table 78** below.

Table 78. SFY 2027 Proposed Benchmark Rates[39]

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Care Coordination On-Going	Per Month	T2022	ALI	1915(c) Waiver	$402.33	$417.67	3.8%
Care Coordination On-Going	Per Month	T2022	APDD	1915(c) Waiver	$402.33	$417.67	3.8%
Care Coordination On-Going	Per Month	T2022	CCMC	1915(c) Waiver	$402.33	$417.67	3.8%
Care Coordination On-Going	Per Month	T2022	IDD	1915(c) Waiver	$402.33	$417.67	3.8%
Care Coordination On-Going	Per Month	T2022CG	IDD-ISW	1915(c) Waiver	$402.33	$417.67	3.8%
Case Management (Community First Choice Only)	Per Month	T2022 TS	Community First Choice	State Plan	$402.33	$417.67	3.8%
Application for Waiver or Community First Choice	One Initial one additional as approved	T1023 SE	Waiver or Community First Choice	State Plan or 1915(c) Waiver	$220.01	$221.34	0.6%
Initial support Plan and Annual Renewal of Support Plan for Waiver or Community First Choice	One Annual	T2024 SE	Waiver or Community First Choice	State Plan or 1915(c) Waiver	$942.95	$922.25	-2.2%
Care Coordination Plan of Care[33]	Per Month	T2024 CG	TEFRA	1915(c) Waiver	$384.81	$417.67	8.5%
Assessment[33]	Annual	T2024	TEFRA	1915(c) Waiver	$268.46	$276.68	3.1%
Reassessment[33]	Annual	T2024U4	TEFRA	1915(c) Waiver	$127.10	$129.12	1.6%
Screening[33]	One Initial one additional as approved	T1023CG	TEFRA	1915(c) Waiver	$90.33	$92.23	2.1%

[39] The TEFRA and Specialized Private Duty Nursing rates for SFY 2026 do not reflect the 3.2% inflationary adjustment applied by DOH, which is applicable only to all other services.

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Care Coordination – Enhanced (High Acuity)	Per Month	NEW	Waiver or Community First Choice	1915(c) Waiver	N/A	$779.66	N/A
Care Coordination Waiver or Community First Choice ONLY	Per Month	NEW	Waiver or Community First Choice	1915(c) Waiver	N/A	$531.59	N/A
Care Coordination TEFRA ONLY (Low Acuity)	Per Month	NEW	TEFRA	1915(c) Waiver	N/A	$278.45	N/A
RSL State Government Owned/Operated	Per Day	T2031 CG	ALI	1915(c) Waiver	$223.38	$235.76	5.5%
RSL State Government Owned/Operated	Per Day	T2031 CG	APDD	1915(c) Waiver	$223.38	$235.76	5.5%
RSL-5 or fewer beds per EIN1 Non-State Gov't Owned & Operated	Per Day	T2031 UR	ALI	1915(c) Waiver	$222.96	$235.76	5.7%
RSL-5 or fewer beds per EIN1 Non-State Gov't Owned & Operated	Per Day	T2031 UR	APDD	1915(c) Waiver	$222.96	$235.76	5.7%
RSL-6-16 beds per EIN1 Non-State Gov't Owned & Operated	Per Day	T2031 US	ALI	1915(c) Waiver	$222.96	$235.76	5.7%
RSL-6-16 beds per EIN1 Non-State Gov't Owned & Operated	Per Day	T2031 US	APDD	1915(c) Waiver	$222.96	$235.76	5.7%
RSL-17 or more beds per EIN1 Non-State Gov't Owned & Operated	Per Day	T2031	ALI	1915(c) Waiver	$223.38	$235.76	5.5%
RSL-17 or more beds per EIN1 Non-State Gov't Owned & Operated	Per Day	T2031	APDD	1915(c) Waiver	$223.38	$235.76	5.5%
RSL-Acuity Add-on Non-State Gov't Owned & Operated	Per Day	T2031TG	ALI	1915(c) Waiver	$493.66	$506.85	2.7%
RSL-Acuity Add-on Non-State Gov't Owned & Operated	Per Day	T2031TG	APDD	1915(c) Waiver	$493.66	$506.85	2.7%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Time limited intervention, treatment or therapy	Per 15 Minutes – Local	H2011 CG	APDD	1915(c) Waiver	$33.07	$33.56	1.5%
Time limited intervention, treatment or therapy	Per 15 Minutes – Local	H2011 CG	CCMC	1915(c) Waiver	$33.07	$33.56	1.5%
Time limited intervention, treatment or therapy	Per 15 Minutes – Local	H2011 CG	IDD	1915(c) Waiver	$33.07	$33.56	1.5%
Time limited intervention, treatment or therapy	Per 15 Minutes – Local	H2011 CG	IDD-ISW	1915(c) Waiver	$33.07	$33.56	1.5%
Time limited intervention, treatment, or therapy	Per 15 Minutes Non-Local	H2011 TN	APDD	1915(c) Waiver	$66.14	$191.91	190.2%
Time limited intervention, treatment, or therapy	Per 15 Minutes Non-Local	H2011 TN	CCMC	1915(c) Waiver	$66.14	$191.91	190.2%
Time limited intervention, treatment, or therapy	Per 15 Minutes Non-Local	H2011 TN	IDD	1915(c) Waiver	$66.14	$191.91	190.2%
Time limited intervention, treatment, or therapy	Per 15 Minutes Non-Local	H2011 TN	IDD-ISW	1915(c) Waiver	$66.14	$191.91	190.2%
Family Home Habilitation- Adult Must be 18 or over	Per Day	S5140	APDD	1915(c) Waiver	$195.06	$277.79	42.4%
Family Home Habilitation- Adult Must be 18 or over	Per Day	S5140	CCMC	1915(c) Waiver	$195.06	$277.79	42.4%
Family Home Habilitation- Adult Must be 18 or over	Per Day	S5140	IDD	1915(c) Waiver	$195.06	$277.79	42.4%
Specialized Family Home Habilitation- Adult Must be 18 or over	Per Day	NEW	APDD, CCMC, IDD	1915(c) Waiver	N/A	$997.47	N/A

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Family Home Habilitation-Child Must be 17 or younger	Per Day	S5145	CCMC	1915(c) Waiver	$211.09	$303.24	43.7%
Family Home Habilitation-Child Must be 17 or younger	Per Day	S5145	IDD	1915(c) Waiver	$211.09	$303.24	43.7%
Specialized Family Home Habilitation-Child Must be 17 or younger	Per Day	NEW	APDD, CCMC, IDD	1915(c) Waiver	N/A	$997.47	N/A
Group Home Habilitation Must be 18 or over	Per Day	T2016	APDD	1915(c) Waiver	$468.17	$470.26	0.5%
Group Home Habilitation Must be 18 or over	Per Day	T2016	CCMC	1915(c) Waiver	$468.17	$470.26	0.5%
Group Home Habilitation Must be 18 or over	Per Day	T2016	IDD	1915(c) Waiver	$468.17	$470.26	0.5%
Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 1 Direct Care Staff	Per 8 Hours	T2016 CG	APDD	1915(c) Waiver	$164.55	$237.43	44.3%
Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 1 Direct Care Staff	Per 8 Hours	T2016 CG	CCMC	1915(c) Waiver	$164.55	$237.43	44.3%
Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 1 Direct Care Staff	Per 8 Hours	T2016 CG	IDD	1915(c) Waiver	$164.55	$237.43	44.3%
Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 2 Direct Care Staff	Per 8 Hours	T2025 TG	APDD	1915(c) Waiver	$329.10	$474.86	44.3%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 2 Direct Care Staff	Per 8 Hours	T2025 TG	CCMC	1915(c) Waiver	$329.10	$474.86	44.3%
Group Home or Family Home Habilitation Acuity Add-on – 1 Recip. to 2 Direct Care Staff	Per 8 Hours	T2025 TG	IDD	1915(c) Waiver	$329.10	$474.86	44.3%
Specialized Group Home Habilitation Must be 18 or over	Per Day	NEW	APDD, CCMC, IDD	1915(c) Waiver	N/A	$997.47	N/A
Supported Living Habilitation Must be 18 or over	Per 15 Minutes	T2017	APDD	1915(c) Waiver	$14.98	$14.81	-1.1%
Supported Living Habilitation Must be 18 or over	Per 15 Minutes	T2017	CCMC	1915(c) Waiver	$14.98	$14.81	-1.1%
Supported Living Habilitation Must be 18 or over	Per 15 Minutes	T2017	IDD	1915(c) Waiver	$14.98	$14.81	-1.1%
Supported Living Habilitation Must be 18 or over	Per 15 Minutes	T2017	IDD-ISW	1915(c) Waiver	$14.98	$14.81	-1.1%
In-Home Supports Habilitation Must be 17 or younger	Per 15 Minutes	T2017 U4	CCMC	1915(c) Waiver	$14.98	$14.81	-1.1%
In-Home Supports Habilitation Must be 17 or younger	Per 15 Minutes	T2017 U4	IDD	1915(c) Waiver	$14.98	$14.81	-1.1%
In-Home Supports Habilitation Must be 17 or younger	Per 15 Minutes	T2017 U4	IDD-ISW	1915(c) Waiver	$14.98	$14.81	-1.1%
Respite	Per 15 Minutes	S5150	ALI	1915(c) Waiver	$8.81	$8.90	1.0%
Respite	Per 15 Minutes	S5150	APDD	1915(c) Waiver	$8.81	$8.90	1.0%
Respite	Per 15 Minutes	S5150	CCMC	1915(c) Waiver	$8.81	$8.90	1.0%
Respite	Per 15 Minutes	S5150	IDD	1915(c) Waiver	$8.81	$8.90	1.0%
Respite	Per 15 Minutes	S5150	IDD-ISW	1915(c) Waiver	$8.81	$8.90	1.0%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Respite Family-Directed	Per 15 Minutes	S5150 U2	CCMC	1915(c) Waiver	$8.13	$8.90	9.5%
Respite Family-Directed	Per 15 Minutes	S5150 U2	IDD	1915(c) Waiver	$8.13	$8.90	9.5%
Respite Family-Directed	Per 15 Minutes	S5150 U2	IDD-ISW	1915(c) Waiver	$8.13	$8.90	9.5%
Respite	Per Day	S5151	ALI	1915(c) Waiver	$455.71	$460.22	1.0%
Respite	Per Day	S5151	APDD	1915(c) Waiver	$455.71	$460.22	1.0%
Respite	Per Day	S5151	CCMC	1915(c) Waiver	$455.71	$460.22	1.0%
Respite	Per Day	S5151	IDD	1915(c) Waiver	$455.71	$460.22	1.0%
Respite	Per Day	S5151	IDD-ISW	1915(c) Waiver	$455.71	$460.22	1.0%
Respite Family-Directed	Per Day	S5151 U2	CCMC	1915(c) Waiver	$455.71	$460.22	1.0%
Respite Family-Directed	Per Day	S5151 U2	IDD	1915(c) Waiver	$455.71	$460.22	1.0%
Respite Family-Directed	Per Day	S5151 U2	IDD-ISW	1915(c) Waiver	$455.71	$460.22	1.0%
Nursing Oversight and Care Management	Per 15 Minutes - Local	T1016 CG	CCMC	1915(c) Waiver	$33.07	$32.24	-2.3%
Nursing Oversight and Care Management	Per 15 Minutes - Local	T1016 CG	IDD	1915(c) Waiver	$33.07	$32.24	-2.3%
Nursing Oversight and Care Management	Per 15 Minutes - Non-Local	T1016 TN	ALI	1915(c) Waiver	$131.44	$198.94	51.6%
Nursing Oversight and Care Management	Per 15 Minutes - Non-Local	T1016 TN	APDD	1915(c) Waiver	$131.44	$198.94	51.6%
Nursing Oversight and Care Management	Per 15 Minutes - Non-Local	T1016 TN	CCMC	1915(c) Waiver	$131.44	$198.94	51.6%
Nursing Oversight and Care Management	Per 15 Minutes - Non-Local	T1016 TN	IDD	1915(c) Waiver	$131.44	$198.94	51.6%
Specialized Private Duty Nursing Must be 21 or over[33]	Per 15 Minutes Registered Nurse	T1002 U2	ALI	1915(c) Waiver	$20.00	$30.41	51.8%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Specialized Private Duty Nursing Must be 21 or over[33]	Per 15 Minutes Registered Nurse	T1002 U2	APDD	1915(c) Waiver	$20.00	$30.41	51.8%
Specialized Private Duty Nursing Must be 21 or over[33]	Per 15 Minutes Registered Nurse	T1002 U2	IDD	1915(c) Waiver	$20.00	$30.41	51.8%
Specialized Private Duty Nursing Must be 21 or over[33]	Per 15 Minutes LPN/LVN	T1003 U2	ALI	1915(c) Waiver	$18.75	$26.33	26.0%
Specialized Private Duty Nursing Must be 21 or over[33]	Per 15 Minutes LPN/LVN	T1003 U2	APDD	1915(c) Waiver	$18.75	$26.33	26.0%
Specialized Private Duty Nursing Must be 21 or over[33]	Per 15 Minutes LPN/LVN	T1003 U2	IDD	1915(c) Waiver	$18.75	$26.33	26.0%
Day Habilitation–Individual	Per 15 Minutes	T2021	APDD	1915(c) Waiver	$16.04	$18.55	15.6%
Day Habilitation–Individual	Per 15 Minutes	T2021	CCMC	1915(c) Waiver	$16.04	$18.55	15.6%
Day Habilitation–Individual	Per 15 Minutes	T2021	IDD	1915(c) Waiver	$16.04	$18.55	15.6%
Day Habilitation–Individual	Per 15 Minutes	T2021	IDD-ISW	1915(c) Waiver	$16.04	$18.55	15.6%
Day Habilitation–Group	Per 15 Minutes	T2021 HQ	APDD	1915(c) Waiver	$10.57	$10.84	2.6%
Day Habilitation–Group	Per 15 Minutes	T2021 HQ	CCMC	1915(c) Waiver	$10.57	$10.84	2.6%
Day Habilitation–Group	Per 15 Minutes	T2021 HQ	IDD	1915(c) Waiver	$10.57	$10.84	2.6%
Day Habilitation–Group	Per 15 Minutes	T2021 HQ	IDD-ISW	1915(c) Waiver	$10.57	$10.84	2.6%
Day Habilitation–Group Community	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$11.48	N/A
Day Habilitation–Group Facility	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$6.92	N/A
Day Habilitation–Group Distance-Based	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$4.97	N/A
Supported Employment-Individual	Per 15 Minutes	T2019	APDD	1915(c) Waiver	$18.43	$20.92	13.5%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Supported Employment-Individual	Per 15 Minutes	T2019	CCMC	1915(c) Waiver	$18.43	$20.92	13.5%
Supported Employment-Individual	Per 15 Minutes	T2019	IDD	1915(c) Waiver	$18.43	$20.92	13.5%
Supported Employment-Individual	Per 15 Minutes	T2019	IDD-ISW	1915(c) Waiver	$18.43	$20.92	13.5%
Supported Employment-Individual Job Coaching	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$19.34	N/A
Supported Employment-Individual Job Development	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$22.19	N/A
Supported Employment-Group	Per 15 Minutes	T2019 HQ	APDD	1915(c) Waiver	$11.95	$12.04	0.8%
Supported Employment-Group	Per 15 Minutes	T2019 HQ	CCMC	1915(c) Waiver	$11.95	$12.04	0.8%
Supported Employment-Group	Per 15 Minutes	T2019 HQ	IDD	1915(c) Waiver	$11.95	$12.04	0.8%
Supported Employment-Group	Per 15 Minutes	T2019 HQ	IDD-ISW	1915(c) Waiver	$11.95	$12.04	0.8%
Supported Employment-Group Job Coaching	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$10.46	N/A
Supported Employment-Group Job Development	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$12.01	N/A
Pre-Employment–Individual	Per 15 Minutes	T2019 CG	APDD	1915(c) Waiver	$18.43	$20.92	13.5%
Pre-Employment–Individual	Per 15 Minutes	T2019 CG	CCMC	1915(c) Waiver	$18.43	$20.92	13.5%
Pre-Employment–Individual	Per 15 Minutes	T2019 CG	IDD	1915(c) Waiver	$18.43	$20.92	13.5%
Pre-Employment–Individual	Per 15 Minutes	T2019 CG	IDD-ISW	1915(c) Waiver	$18.43	$20.92	13.5%
Pre-Employment–Individual Job Coach	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$19.34	N/A
Pre-Employment–Individual Job Developer	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$22.19	N/A
Pre-Employment–Group	Per 15 Minutes	T2019 TT	APDD	1915(c) Waiver	$11.95	$12.04	0.8%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Pre-Employment–Group	Per 15 Minutes	T2019 TT	CCMC	1915(c) Waiver	$11.95	$12.04	0.8%
Pre-Employment–Group	Per 15 Minutes	T2019 TT	IDD	1915(c) Waiver	$11.95	$12.04	0.8%
Pre-Employment–Group	Per 15 Minutes	T2019 TT	IDD-ISW	1915(c) Waiver	$11.95	$12.04	0.8%
Pre-Employment–Group Job Coaching	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$10.46	N/A
Pre-Employment–Group Job development	Per 15 Minutes	NEW	APDD, CCMC, IDD, ISW	1915(c) Waiver	N/A	$12.01	N/A
Adult Day	Per Half Day	S5101	ALI	1915(c) Waiver	$118.35	$136.48	15.3%
Adult Day	Per Half Day	S5101	APDD	1915(c) Waiver	$118.35	$136.48	15.3%
Adult Day	Per 15 Minutes	S5100	ALI	1915(c) Waiver	$8.25	$8.53	3.4%
Adult Day	Per 15 Minutes	S5100	APDD	1915(c) Waiver	$8.25	$8.53	3.4%
Meals–Home Delivered	Per Meal	S5170	ALI	1915(c) Waiver	$32.17	$33.55	4.3%
Meals–Home Delivered	Per Meal	S5170	APDD	1915(c) Waiver	$32.17	$33.55	4.3%
Meals–Home Delivered	Per Meal	S5170	CCMC	1915(c) Waiver	$32.17	$33.55	4.3%
Meals–Home Delivered	Per Meal	S5170	IDD	1915(c) Waiver	$32.17	$33.55	4.3%
Meals-Congregate	Per Meal	T2025	ALI	1915(c) Waiver	$31.26	$31.59	1.1%
Meals-Congregate	Per Meal	T2025	APDD	1915(c) Waiver	$31.26	$31.59	1.1%
Meals-Congregate	Per Meal	T2025	CCMC	1915(c) Waiver	$31.26	$31.59	1.1%
Meals-Congregate	Per Meal	T2025	IDD	1915(c) Waiver	$31.26	$31.59	1.1%
Transportation	Per Trip up to 20 miles-Recipient	T2003	ALI	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip up to 20 miles-Recipient	T2003	APDD	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip up to 20 miles-Recipient	T2003	CCMC	1915(c) Waiver	$22.98	$25.99	13.1%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Transportation	Per Trip up to 20 miles-Recipient	T2003	IDD	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip up to 20 miles-Recipient	T2003	IDD-ISW	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip greater than 20 miles Recipient	T2003 TN	ALI	1915(c) Waiver	$45.95	$63.00	37.1%
Transportation	Per Trip greater than 20 miles Recipient	T2003 TN	APDD	1915(c) Waiver	$45.95	$63.00	37.1%
Transportation	Per Trip greater than 20 miles Recipient	T2003 TN	CCMC	1915(c) Waiver	$45.95	$63.00	37.1%
Transportation	Per Trip greater than 20 miles Recipient	T2003 TN	IDD	1915(c) Waiver	$45.95	$63.00	37.1%
Transportation	Per Trip greater than 20 miles Recipient	T2003 TN	IDD-ISW	1915(c) Waiver	$45.95	$63.00	37.1%
Transportation	Per Trip Attendant or Escort	T2001 SE	ALI	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip Attendant or Escort	T2001 SE	APDD	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip Attendant or Escort	T2001 SE	CCMC	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip Attendant or Escort	T2001 SE	IDD	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation	Per Trip Attendant or Escort	T2001 SE	IDD-ISW	1915(c) Waiver	$22.98	$25.99	13.1%
Transportation Paratransit Provider	Per Trip Recipient	T2003 CG	ALI	1915(c) Waiver	$45.95	$49.60	7.9%
Transportation Paratransit Provider	Per Trip Recipient	T2003 CG	APDD	1915(c) Waiver	$45.95	$49.60	7.9%
Transportation Paratransit Provider	Per Trip Recipient	T2003 CG	CCMC	1915(c) Waiver	$45.95	$49.60	7.9%

Service	Service Unit	Procedure Code	Program	Authority	SFY 2026 Rate	SFY 2027 Proposed Benchmark Rate	Difference between SFY 2026 Rate and SFY 2027 Proposed Benchmark Rate
Transportation Paratransit Provider	Per Trip Recipient	T2003 CG	IDD	1915(c) Waiver	$45.95	$49.60	7.9%
Transportation Paratransit Provider	Per Trip Recipient	T2003 CG	IDD-ISW	1915(c) Waiver	$45.95	$49.60	7.9%
Personal Care – Agency Based	Per 15 Minute	T1019	Personal Care Services	State Plan	$9.01	$12.50	35.2%
Personal Care – Consumer Directed	Per 15 Minute	T1019 U3	Personal Care Services	State Plan	$9.01	$11.92	35.2%
Personal Care-Agency Based	Per 15 Minute	S5125	Community First Choice	State Plan	$9.01	$12.50	35.2%
Personal Care – Consumer Directed	Per 15 Minute	S5125 SE	Community First Choice	State Plan	$9.01	$11.92	35.2%
Skill Building – Personal Care 1	Per 15 Minute	S5108	Community First Choice	State Plan	$11.66	$12.05	3.3%
Chore	Per 15 Minute	S5120 SE	Community First Choice	State Plan	$9.43	$11.92	26.4%

J. Appendix

Appendix A: Economic Policy Institute – Geographic Differentials

Understanding the Cost-of-Living Categories

The EPI dataset synthesizes data into seven primary cost-of-living categories, which together offer a detailed picture of the economic realities faced by individuals and families in different regions. These categories are discussed below along with the sources they are derived from for the EPI dataset:

Housing

Data for rental costs are sourced from the U.S. Department of Housing and Urban Development's (HUD) fiscal year 2024 fair market rents (FMRs). These FMR estimates are used to determine costs for federal housing assistance programs. HUD calculates FMRs for each area using five-year data from the American Community Survey (ACS) and definitions of metropolitan areas provided by the Office of Management and Budget. Nonmetropolitan counties have their own FMRs, while counties within the same metro area share the same FMRs.

Fair market rent estimates are set at the 40th percentile of rental costs, meaning 40 percent of standard-quality rental units are rented below this price. These figures are adjusted for county-level variation using ACS median gross rent data. A metro-level population-weighted average rent is created and adjusted to reflect the ratio of ACS metro rent to ACS county-within-metro rent.

HUD provides rental rates for studio apartments and one-bedroom through four-bedroom apartments. The Economic Policy Institute (EPI) family budgets assume:

- A one-adult household occupies a studio.
- A two-adult household occupies a one-bedroom apartment.
- Families with one or two children occupy a two-bedroom unit.
- Families with three or four children occupy a three-bedroom unit.

Rental costs include shelter and all tenant-paid utilities, excluding telephone, cable or satellite, and Internet services.

Transportation Costs

Transportation expenses include the costs of commuting, vehicle ownership, public transit, and fuel. These expenses vary based on geographical differences in transportation infrastructure and the availability of public transportation.

EPI uses data from the Center for Neighborhood Technology (CNT) and its Housing and Transportation Affordability Index (2023). Transportation costs in the H+T index comprise three major components: auto ownership, auto use, and transit use. CNT estimated these components using data from the Consumer Expenditure Survey, the 2019 National Transit Database, CNT's AllTransit database, and the Illinois Department of Natural Resources.

For the data provided to the Economic Policy Institute (EPI), CNT modified these costs to account for different family sizes in the Family Budget Calculator and assumptions about trip purposes. Adults in all family types are assumed to be working and are considered commuters. CNT adjusted

the miles traveled component of their equation to include only work and nonsocial trips for the first adult in a household and only work trips for the second adult (in two-adult households). According to national data from the 2022 National Highway Transportation Survey, this equates to 75 percent of average total vehicle miles traveled for the first adult and 42 percent for the second adult, if applicable.

The 2025 update inflates the transportation data to 2024 dollars using the regional transportation Consumer Price Index (BLS 2025c).

Food Costs

Food costs encompass groceries, dining out, and nutritional programs, and can vary significantly depending on regional agricultural production, distribution complexities, and local economic conditions.

The USDA's Center for Nutrition Policy and Promotion provides data on food costs through its report, "Official USDA Food Plans: Cost of Food at Home at Four Levels" (USDA 2024). This report outlines four national standards for nutritious diets: the "Thrifty Plan," "Low-Cost Plan," "Moderate-Cost Plan," and "Liberal Food Plan." Our analysis utilizes the USDA Low-Cost Plan, which assumes most food is purchased at grocery stores and prepared at home. The data used is from June 2024, reflecting the average weekly cost (Carlson, Lino, and Fungwe 2007).

County-level food costs are adjusted using a multiplier based on 2023 data from Feeding America's "Map the Meal Gap" project. This report provides average meal cost estimates for a meal consumed by a 19-to-50-year-old male under the USDA's Thrifty Food Plan, using data from over 65,000 stores. County-level multipliers are generated by dividing these meal costs by the national average and then applying these multipliers to USDA estimates to reflect local food price variations more accurately.

Childcare Costs

Childcare expenses include daycare, preschool, and after-school programs, and are influenced by local regulations, labor market conditions, and demand-supply dynamics. The 2025 Family Budget Calculator estimates childcare costs using data from the National Database of Childcare Prices (NDCP), supplemented with information from Child Care Aware of America's Child Care Data Center and their annual "price of care" reports.

Healthcare Costs

Healthcare expenditures include medical services, insurance premiums, and out-of-pocket expenses. Cost differences arise from variations in healthcare access, insurance markets, and regional health issues.

Health care expenses comprise ACA health insurance exchange premiums and out-of-pocket expenditures. The Family Budget Calculator assumes insurance from ACA health exchanges.

Premiums are sourced from the KFF 2024 Health Insurance Marketplace Calculator, reflecting the lowest-cost bronze plan, adjusted for family size, user age, and tobacco surcharge. Calculations assume adults are 40-year-old nonsmokers.

Out-of-pocket costs are calculated using three-year averages from the geocoded MEPS data for 2019-2021, adjusted to 2021 dollars, provided by the Agency for Healthcare Research and Quality. Costs are differentiated by region and insurance coverage, considering both adults and children separately.

Taxes

Tax rates, including income, property, and sales taxes, differ by state and locality, impacting disposable income and service rate adjustments. The National Bureau of Economic Research's TAXSIM (Version 35) is a microsimulation model for calculating U.S. federal and state income tax rates. It uses 32 input variables such as state, marital status, wage income, rent paid, childcare expenses, and capital gains. The model outputs federal tax liability, state tax liability, and FICA tax liability. Local taxes and sales taxes are not included in the calculations.

Other Necessities

This category includes essential expenses such as clothing, personal care items, and household goods. These costs can significantly impact the overall cost of living. “Other necessities” are defined using Bureau of Labor Statistics (BLS) Consumer Expenditure Survey (CEX) data and include apparel, personal care, household supplies, reading materials, and school supplies, excluding entertainment and other miscellaneous items. The calculation uses data from families in the 20th- to 40th-percentile range of the income distribution and found that "other necessities" account for 33.6 percent of food and housing costs in 2023 data.

Purchasing Power

In addition to the seven primary categories, we consider an eighth factor: median income and total expenditure across these categories. By analyzing both income levels and spending patterns, we develop a purchasing power factor.

To construct these eight factors, we used average values across all family sizes from the EPI dataset, which ranges from single-adult households to households with two adults and four children. Using the EPI dataset and its detailed expenditure categories allows for informed adjustments to service rates based on geographic differentials. This approach promotes consistency and transparency in rate-setting and reflects cost-of-living differences appropriately. These insights provide a basis for recommending adjustments to service rates.

Weighted Approach

Using the EPI Dataset, we can create a sophisticated weighting system to accurately reflect the spending habits of each borough or census area. This system is designed to generate weights across all seven cost buckets, providing a detailed depiction of economic conditions and incorporating a weight for purchasing power in applicable areas.

Appendix B: Fiscal Impact by Geography

Tables 79-83 below present the impacts by Alaska's designated LTSS fiscal regions. This section reflects impacts based solely on existing geographic differentials and does not incorporate the recommendations outlined in Section C.2.3.

For SFY 2024, no LTSS claims were identified for any services in the Glennallen, Aleutian, and Southwest Small Community regions; therefore, these regions do not contribute to the total impact. The Roadless Interior region does contribute to the total impact, but not to the state share, as all claims for SFY 2024 are associated with both Indian Health Service (IHS) members and IHS providers. Services provided to IHS members by IHS providers are fully covered by federal funding.

Claims that could not be linked to a specific region are grouped under the "No Region Designated" category. For these claims, the Anchorage geographic differential of 1.00 was applied to calculate fiscal impact. This category accounts for approximately 0.7 percent of the total impact.

Table 79. Fiscal Impact Options by Geography – All Options

Fiscal Region	Option 1a Total Impact (Federal & State Share)	Option 1a Total Impact (State Only)	Option 1b Total Impact (Federal & State Share)	Option 1b Total Impact (State Only)	Option 2a Total Impact (Federal & State Share)	Option 2a Total Impact (State Only)	Option 2b Total Impact (Federal & State Share)	Option 2b Total Impact (State Only)
31 - Anchorage	$26,960,000	$12,083,000	$27,225,000	$12,199,000	$33,930,000	$15,001,000	$35,078,000	$15,635,000
32 - Fairbanks	$2,144,000	$900,000	$2,227,000	$938,000	$3,043,000	$1,313,000	$3,186,000	$1,416,000
33 - Parks/Elliott/ Steese Highways	$24,000	$11,000	$24,000	$11,000	$31,000	$15,000	$43,000	$21,000
Glennallen Region	$0	$0	$0	$0	$0	$0	$0	$0
35 - Delta Junction/Tok	$180,000	$84,000	$180,000	$84,000	$188,000	$88,000	$188,000	$88,000
36 - Roadless Interior	$35,000	$0	$35,000	$0	$42,000	$0	$42,000	$0
37 - Mat-Su	$5,901,000	$2,751,000	$6,044,000	$2,817,000	$7,613,000	$3,584,000	$7,961,000	$3,809,000
38 - Kenai Peninsula	$3,575,000	$1,647,000	$3,657,000	$1,684,000	$5,123,000	$2,393,000	$5,254,000	$2,484,000
39 - Prince William Sound	$113,000	$54,000	$125,000	$59,000	$139,000	$67,000	$141,000	$73,000
40 - Kodiak	$325,000	$151,000	$330,000	$153,000	$377,000	$178,000	$406,000	$193,000
41 - Arctic	$61,000	$1,000	$64,000	$1,000	$108,000	$4,000	$128,000	$6,000

Fiscal Region	Option 1a Total Impact (Federal & State Share)	Option 1a Total Impact (State Only)	Option 1b Total Impact (Federal & State Share)	Option 1b Total Impact (State Only)	Option 2a Total Impact (Federal & State Share)	Option 2a Total Impact (State Only)	Option 2b Total Impact (Federal & State Share)	Option 2b Total Impact (State Only)
42 - Bethel/Dillingham	$98,000	$36,000	$104,000	$36,000	$133,000	$38,000	$134,000	$38,000
Aleutian Region	$0	$0	$0	$0	$0	$0	$0	$0
44 - Southwest Small Communities	$0	$0	$0	$0	$0	$0	$0	$0
45 - Southeast Communities	$3,023,000	$1,370,000	$3,173,000	$1,439,000	$4,201,000	$1,931,000	$4,258,000	$2,022,000
Out of State	$7,000	$3,000	$7,000	$3,000	$4,000	$2,000	$8,000	$4,000
No Region Designated	$313,000	$146,000	$326,000	$152,000	$890,000	$418,000	$916,000	$432,000
Total	**$42,758,000**	**$19,239,000**	**$43,521,000**	**$19,577,000**	**$55,821,000**	**$25,031,000**	**$57,742,000**	**$26,221,000**

Table 80. Fiscal Impact by Geography – Option 1a (State and Federal)

Fiscal Region	SFY 2026 Calculated Expenditures	SFY 2027 Option 1a Expected Expenditures	Difference SFY 2027 Expected Expenditures Option 1a vs SFY 2026 Calculated	Percent Difference SFY 2027 Expected Expenditures Option 1a vs SFY 2026 Calculated
31 - Anchorage	$317,882,000	$344,842,000	$26,960,000	8.5%
32 - Fairbanks	$38,619,000	$40,763,000	$2,144,000	5.6%
33 - Parks/Elliott/Steese Highways	$1,355,000	$1,379,000	$24,000	1.8%
Glennallen Region	$0	$0	$0	0.0%
35 - Delta Junction/Tok	$556,000	$736,000	$180,000	32.4%
36 - Roadless Interior	$600,000	$635,000	$35,000	5.8%
37 - Mat-Su	$86,465,000	$92,366,000	$5,901,000	6.8%
38 - Kenai Peninsula	$44,237,000	$47,812,000	$3,575,000	8.1%
39 - Prince William Sound	$1,988,000	$2,101,000	$113,000	5.7%
40 - Kodiak	$5,958,000	$6,283,000	$325,000	5.5%
41 - Arctic	$2,501,000	$2,562,000	$61,000	2.4%

Fiscal Region	SFY 2026 Calculated Expenditures	SFY 2027 Option 1a Expected Expenditures	Difference SFY 2027 Expected Expenditures Option 1a vs SFY 2026 Calculated	Percent Difference SFY 2027 Expected Expenditures Option 1a vs SFY 2026 Calculated
42 - Bethel/Dillingham	$1,086,000	$1,184,000	$98,000	9.0%
Aleutian Region	$0	$0	$0	0.0%
44 - Southwest Small Communities	$0	$0	$0	0.0%
45 - Southeast Communities	$40,533,000	$43,556,000	$3,023,000	7.5%
Out of State	$471,000	$478,000	$7,000	1.5%
No Region Designated	$9,090,000	$9,403,000	$313,000	3.4%
Total	**$551,342,000**	**$594,099,000**	**$42,758,000**	**7.8%**

Table 81. Fiscal Impact by Geography – Option 1b (State and Federal)

Fiscal Region	SFY 2026 Calculated Expenditures	SFY 2027 Option 1b Expected Expenditures	Difference SFY 2027 Expected Expenditures Option 1b vs SFY 2026 Calculated	Percent Difference SFY 2027 Expected Expenditures Option 1b vs SFY 2026 Calculated
31 - Anchorage	$317,882,000	$345,107,000	$27,225,000	8.6%
32 - Fairbanks	$38,619,000	$40,846,000	$2,227,000	5.8%
33 - Parks/Elliott/Steese Highways	$1,355,000	$1,379,000	$24,000	1.8%
Glennallen Region	$0	$0	$0	0.0%
35 - Delta Junction/Tok	$556,000	$736,000	$180,000	32.4%
36 - Roadless Interior	$600,000	$635,000	$35,000	5.8%
37 - Mat-Su	$86,465,000	$92,509,000	$6,044,000	7.0%
38 - Kenai Peninsula	$44,237,000	$47,894,000	$3,657,000	8.3%
39 - Prince William Sound	$1,988,000	$2,113,000	$125,000	6.3%
40 - Kodiak	$5,958,000	$6,288,000	$330,000	5.5%
41 - Arctic	$2,501,000	$2,565,000	$64,000	2.6%
42 - Bethel/Dillingham	$1,086,000	$1,190,000	$104,000	9.6%
Aleutian Region	$0	$0	$0	0.0%
44 - Southwest Small Communities	$0	$0	$0	0.0%
45 - Southeast Communities	$40,533,000	$43,706,000	$3,173,000	7.8%
Out of State	$471,000	$478,000	$7,000	1.5%
No Region Designated	$9,090,000	$9,416,000	$326,000	3.6%
Total	**$551,342,000**	**$594,863,000**	**$43,520,000**	**7.9%**

Table 82. Fiscal Impact by Geography – Option 2a (State and Federal)

Fiscal Region	SFY 2026 Calculated Expenditures	SFY 2027 Option 2a Expected Expenditures	Difference SFY 2027 Expected Expenditures Option 2a vs SFY 2026 Calculated	Percent Difference SFY 2027 Expected Expenditures Option 2a vs SFY 2026 Calculated
31 - Anchorage	$317,882,000	$351,812,000	$33,930,000	10.7%
32 - Fairbanks	$38,619,000	$41,662,000	$3,043,000	7.9%
33 - Parks/Elliott/Steese Highways	$1,355,000	$1,386,000	$31,000	2.3%
Glennallen Region	$0	$0	$0	0.0%
35 - Delta Junction/Tok	$556,000	$744,000	$188,000	33.8%
36 - Roadless Interior	$600,000	$642,000	$42,000	7.0%
37 - Mat-Su	$86,465,000	$94,078,000	$7,613,000	8.8%
38 - Kenai Peninsula	$44,237,000	$49,360,000	$5,123,000	11.6%
39 - Prince William Sound	$1,988,000	$2,127,000	$139,000	7.0%
40 - Kodiak	$5,958,000	$6,335,000	$377,000	6.3%
41 - Arctic	$2,501,000	$2,609,000	$108,000	4.3%
42 - Bethel/Dillingham	$1,086,000	$1,219,000	$133,000	12.2%
Aleutian Region	$0	$0	$0	0.0%
44 - Southwest Small Communities	$0	$0	$0	0.0%
45 - Southeast Communities	$40,533,000	$44,734,000	$4,201,000	10.4%
Out of State	$471,000	$475,000	$4,000	0.8%
No Region Designated	$9,090,000	$9,980,000	$890,000	9.8%
Total	**$551,342,000**	**$607,162,000**	**$55,821,000**	**10.1%**

Table 83. Fiscal Impact by Geography – Option 2b (State and Federal)

Fiscal Region	SFY 2026 Calculated Expenditures	SFY 2027 Option 2b Expected Expenditures	Difference SFY 2027 Expected Expenditures Option 2b vs SFY 2026 Calculated	Percent Difference SFY 2027 Expected Expenditures Option 2b vs SFY 2026 Calculated
31 - Anchorage	$317,882,000	$352,960,000	$35,078,000	11.0%
32 - Fairbanks	$38,619,000	$41,805,000	$3,186,000	8.2%
33 - Parks/Elliott/Steese Highways	$1,355,000	$1,398,000	$43,000	3.2%
Glennallen Region	$0	$0	$0	0.0%
35 - Delta Junction/Tok	$556,000	$744,000	$188,000	33.8%
36 - Roadless Interior	$600,000	$642,000	$42,000	7.0%
37 - Mat-Su	$86,465,000	$94,426,000	$7,961,000	9.2%
38 - Kenai Peninsula	$44,237,000	$49,491,000	$5,254,000	11.9%
39 - Prince William Sound	$1,988,000	$2,129,000	$141,000	7.1%

Fiscal Region	SFY 2026 Calculated Expenditures	SFY 2027 Option 2b Expected Expenditures	Difference SFY 2027 Expected Expenditures Option 2b vs SFY 2026 Calculated	Percent Difference SFY 2027 Expected Expenditures Option 2b vs SFY 2026 Calculated
40 - Kodiak	$5,958,000	$6,364,000	$406,000	6.8%
41 - Arctic	$2,501,000	$2,629,000	$128,000	5.1%
42 - Bethel/Dillingham	$1,086,000	$1,220,000	$134,000	12.3%
Aleutian Region	$0	$0	$0	0.0%
44 - Southwest Small Communities	$0	$0	$0	0.0%
45 - Southeast Communities	$40,533,000	$44,791,000	$4,258,000	10.5%
Out of State	$471,000	$479,000	$8,000	1.7%
No Region Designated	$9,090,000	$10,006,000	$916,000	10.1%
Total	**$551,342,000**	**$609,083,000**	**$57,742,000**	**10.5%**