ESTABLISHMENT
OF A RATE-SETTING METHODOLOGY
FOR HOME AND COMMUNITY-BASED SERVICES
IN ALASKA

Preliminary Research and Initial Report

Prepared for the
Alaska Department of Health and Social Services
Division of Senior and Disabilities Services

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I. Executive Summary

A. Background

The Medicaid home and community based (HCB) services waiver program is the major public financing mechanism for providing long term care services in community settings. Authorized under section 1915(c) of the Social Security Act, states have used HCB services waiver programs to serve a wide variety of populations, who are at risk for institutionalization including seniors, people with physical disabilities, HIV/AIDS, mental retardation and developmental disabilities (MRDD), and traumatic brain injury (TBI), and children who are medically fragile and/or technology-dependent. The proportion of spending for Medicaid beneficiaries receiving HCB services has increased steadily over the past ten years.

The Alaska Medicaid program currently operates four waiver programs: Older Alaskans (OA), Adults with Physical Disabilities (APD), Mental Retardation and Developmentally Disabled (MRDD) and Children with Complex Medical Conditions (CCMC). These categories are collectively referenced as HCB waiver programs and provide eligible recipients with alternatives to institutional placement. Additional home care services are offered through the Medicaid State Plan Personal Care Assistant Program to frail elderly recipients and functionally disabled and handicapped recipients of all ages. These programs are administered by the Division of Senior and Disabilities Services (DSDS) operating within the Department of Health and Social Services (DHSS).

Alaska, like many states, is struggling with issues surrounding the provision of long term care services. These include a growing population of aged and disabled persons and escalating costs of health care. There are concerns that the current rate methodology for HCB services needs to be reviewed and enhanced. The current methodologies are in many ways a legacy of the state grant funding mechanisms that once accounted for nearly all financing for HCB services. Furthermore, reimbursement for HCB services has operated under a rate freeze in recent years which effectively has set rates using aggregated historical claims expenditure data to continue average per-unit levels of reimbursement at each HCB provider. Where appropriate, the state wishes to develop a more uniform approach to the reimbursement of similar services.

B. Project overview

DHSS has engaged the firm of Myers and Stauffer to provide assistance with the process of developing and implementing a new reimbursement methodology for HCB services. Myers and Stauffer is performing the project in three main phases:

1) Preliminary Research. This phase of the project includes review of current DHSS reimbursement methodologies, an evaluation of recent long term care and Alaska Medicaid studies looking for common recommendations and an evaluation of the HCB programs and rate methodologies in six comparable states.

2) Presentation of Potential Reimbursement Methodologies. This second phase of the project requires the presentation of at least three potential reimbursement methodologies for HCB services. The methodologies to be proposed will be based on the preliminary research, findings, interaction with DHSS staff and feedback from the provider community and other stakeholders.

3) Development of a Transition Plan. The final phase of the project will include the creation of a plan for implementation of a new HCB reimbursement methodology. In addition to drawing on Myers and Stauffer's experience with Medicaid reimbursement policies, this phase of the project will involve significant interaction with DHSS staff, the provider community and other stakeholders.

This report represents the presentation of the methodology and findings of the preliminary research associated with the first phase of the project.

C. Summary of report methodology and findings

1. Development of a DHSS rate matrix

One of the components of the project requires an overview of the various methodologies that are used by the Department of Health and Social Services (DHSS) to reimburse providers for Medicaid and other related health care services. To present this comparison, Myers and Stauffer has prepared a comprehensive matrix of the reimbursement methodologies utilized by DHSS. The matrix was created by reviewing relevant portions of the Alaska Statutes (AS), the Alaska Administrative Code (AAC) and Medicaid provider billing manuals. Myers and Stauffer also participated in discussions with staff from the Office of Rate Review, Division of Health Care Services, Division of Senior and Disabilities Services, Division of Behavioral Health and Office of Children's Services. These discussions served to refine the rate matrix and gather "hands-on" information regarding the manner in which rate-setting policies are actually implemented.

The resulting matrix of reimbursement methodologies, included in the appendices to this report, provides a significant level of detail regarding the varied ways that DHSS sets rates for health care services. Several categories of rate derivation were observed, including methodologies that were based on provider cost data, Medicare systems, billed charges or historical expenditure data. Myers and Stauffer also observed rates that were set directly via the regulatory process and rates that were based on other fee schedules and methodologies highly specific to the type of service being reimbursed. The high level review of the reimbursement methodologies sharpens the focus of the potential methodologies that are available for consideration for any health care service, including potential methodologies for HCB services. The creation of the rate matrix has also fostered a better understanding of the inter-relationship of recipients, services and providers and how potential reimbursement methodologies for HCB services may intersect and overlap with other provider reimbursement methodologies.

2. Evaluation of recent Alaska long term care reports

Several studies related to long term care issues have been conducted in Alaska. This project calls for a comparison of three recent significant studies. These include the "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025" published on February 15, 2006 by the Lewin Group and ECONorthwest; "Alaska's Long Term Care and Cost Study Final Report" published in September 2005 by Public Consulting Group, Inc.; and "Medicaid Program Review Final Report" published in January 2007 by the Pacific Health Policy Group. Myers and Stauffer was asked to review these reports and provide discussion regarding the common themes addressed in all three reports and how these reports impact future discussion regarding the reimbursement methodology for HCB services.

The material contained in all three reports is extensive and informative. In comparing the three reports, we found numerous commonalities in findings and recommendations, all of which are generally complementary. The Lewin Group and ECONorthwest report has a generally different focus than the other two; namely, it was intended to study Medicaid program spending overall in order to forecast projected spending in each Medicaid program eligibility and service category over time. In contrast, recommendations contained in the Pacific Health Policy Group report are especially useful in terms of the numerous opportunities identified to revise HCB waiver service definitions and program requirements to reduce the use of 100% state funds by securing additional federal match. Recommendations contained in the Public Consulting Group, Inc. report target a number of refinements to cost reporting requirements for HCB providers.

Myers and Stauffer has identified and developed three common issue categories from the reports:

1) Issues and recommendations relating to state matching funds for personal care and HCB waivers.

2) Issues and recommendations relating to spending/reimbursement.

3) Issues and recommendations relating to tribal health providers.

Further discussion of these themes is included in the report. The major issues and recommendations from these reports will be carefully considered and incorporated whenever possible as Myers and Stauffer makes specific reimbursement recommendations for Alaska's HCB waiver program.

3. Evaluation of six comparable states

Myers and Stauffer was requested to compare the current Alaska Medicaid HCB program with the programs and reimbursement methodologies of Medicaid programs in six comparable states. In selecting states to include for comparison purposes, we considered the rural and urban mix, population density and geographical challenges, and the size of the Native American populations. The states selected for comparison were Montana, New Mexico, North Dakota, South Dakota, Wyoming and Idaho. For each of the comparison states, Myers and Stauffer obtained information regarding the waiver programs operated in each state. Preliminary information was gathered from the website of the Centers for Medicare and Medicaid Services (CMS) and other applicable state

websites. Myers and Stauffer also contacted individuals within the waiver programs of the comparison states and solicited additional information via an e-mail survey.

From the data we developed a matrix of the various states and their waivers. This information is intended to assist DHSS in the development of the proposed reimbursement methodologies.

The result of the data indicates that Alaska is in a very similar position to many of the comparison states, dealing with a rate system that is linked to the past and complicated by various issues. At the same time the State is attempting to develop standardized, equitable reimbursement methodologies in a rapidly changing environment. As development of the rate methodologies progresses, it may be useful to delve more deeply into the information from the comparison states and raise more specific questions.

4. Conclusions

The preliminary research performed by Myers and Stauffer serves as a starting point for the process of recommending changes to the current reimbursement methodology for HCB services under the Alaska Medicaid program. The next two phases of the project will require ongoing collaboration between DHSS, DSDS, the provider community, other stakeholders and Myers and Stauffer. Concepts learned from the analysis of all DHSS reimbursement methodologies and the reimbursement methodologies in other states will play a significant role in the ongoing project activities. Recommendations from the three reports on the Medicaid program and long term care will also provide focus for the development of alternate methodologies. With this preliminary research as a foundation, Myers and Stauffer will continue the process to develop an alternate reimbursement methodology for HCB services that is fair, consistent, reasonable, understandable, defensible and in the best interest of the clients, the program, the providers and other stakeholders.

II. Introduction

A. Description of the project and current deliverable

The Division of Senior and Disabilities Services (DSDS) is concerned that the current rate methodology for HCB services needs to be reviewed and enhanced. The current methodologies are in many ways a legacy of the state grant funding mechanisms that once accounted for nearly all financing for HCB services. Furthermore, reimbursement for HCB services has operated under a rate freeze in recent years which effectively has aggregated historical claims expenditure data to set rates that continue the average per-unit levels of reimbursement for each HCB services provider.

Prior to the rate freeze, agency-based services were reimbursed according to methods that were somewhat based on principles of cost reimbursement. However, due to lack of consistency and provider accountability, the reimbursement calculation methods led to a reliance on self-declared provider costs with many instances of methodological exceptions being allowed.

The reimbursement rates for supported living services at assisted living homes (currently relying on base rates with facility tiers and regional adjustments, but previously based on provider-specific cost data) and personal care services (currently a single state-wide hourly rate) evolved along slightly different lines. However, the related nature of these services and the overlap in the provision of these services by common providers warrants their inclusion in a review of the reimbursement methodology. Where appropriate, DSDS wishes to develop a more uniform approach to reimbursement of similar services.

To assist in obtaining the knowledge base and to form a foundation for future project activity and the resulting final deliverable, DHSS has asked Myers and Stauffer to provide an initial report that explores three issues related to the HCB reimbursement methodology. Myers and Stauffer has been requested to a) develop a matrix of Medicaid provider reimbursements under DHSS including agency responsibility, pertinent legislation and regulations and rate structure; b) evaluate recent long-term care and Medicaid studies looking for common recommendations; and c) evaluate the HCB programs and rate methodologies in six comparable states.

1. Provider reimbursements matrix

To gain an understanding of the current reimbursement methodologies used within DHSS, Myers and Stauffer was requested to review the statutory and regulatory basis for the current reimbursement methodologies. This was requested to include a review of public and internal documents and policies used as a basis for reimbursement. This includes provider billing manuals and department memoranda. The review was expected to lead to a summary of various reimbursement methodologies currently used, the dates the methodologies were last revised, and the dates on which rates were last calculated.

This information should then be organized into a rate matrix, which hopefully will aid in understanding the similarities and differences between the proposed methodologies and the rate setting methodologies currently in place. Also, since there is significant overlap of HCB recipients, providers and services, the interaction of a modified HCB reimbursement with the entire DHSS rate system should be more apparent.

2. Evaluation of recent long-term care and Medicaid studies

In the past two years, three significant studies relating to the long-term care environment in Alaska have been published. These reports have addressed the current long term care infrastructure; the Alaska Medicaid program, both in general and specifically regarding long term care and HCB services; the changing demographic situation and recommendations for future enhancement to the long term care system and the Alaska Medicaid program.

DHSS has requested a thorough review of these studies and a presentation to compare and contrast the common observations and recommendations made in the reports.

3. Evaluation of the HCB programs and rate methodologies

DHSS has requested a six-state review to provide information on the variation in services and rates across waiver programs and states. HCB services waivers are a diverse set of programs designed to serve specific target populations. Although these waivers operate under the same federal statutory authority, the programs may be administered by states in significantly different ways. Each state uses different subdivisions of state government for waiver administration. For example, a state unit on aging may administer a waiver for seniors while a developmental disabilities unit may operate a waiver for people with mental retardation.

Waiver services are delivered through complex networks that include state and local public agencies, large and small private providers, case managers, individual personal assistants and attendants, clinicians and families, neighbors and other community members. Although systems may not be interchangeable between states, concepts that have been developed in other states may assist Alaska in addressing issues and concerns with the long-term care system.

The first deliverable serves as a starting point for the process of recommending changes to the current reimbursement methodology for HCB services under the Alaska Medicaid program. Future project steps will include the recommendation of methodologies for HCB reimbursement and the development of a transition plan to implement the new methodology.

B. Brief description - Medicaid home and community based (HCB) services waiver program

1. Relevant legislation

Medicaid was first enacted in 1965 as a companion program to Medicare. It is the major public payer for long term care services and initially paid for services provided mainly in institutions such as nursing facilities.

In 1981 Congress authorized the waiver of certain Federal requirements which enabled states to provide services in the individual's home or other community setting. The waiver programs are called 1915(c) waivers after the section of the Social Security Act that authorized them.

Under 1915 (c) waiver authority, states can provide services not usually covered by the Medicaid program, as long as these services are required to prevent a person from being institutionalized. Services covered under waiver programs include case management, homemaker, health aide, personal care, adult day health, habilitation, and respite care.

Over the years, various other pieces of legislation have helped reduce Medicaid's institutional bias. A chart of key legislation impacting waivers is included in Appendix B-1. Medicaid now pays for a comprehensive range of home and community services, which provides alternatives to institutional care.

According to the CMS website, every state, except Arizona and Vermont has at least one 1915(c) waiver program serving individuals with mental retardation or developmental disabilities (MRDD) and one serving seniors and or non-elderly people with physical disabilities. Arizona and Vermont also provide similar home and community based services through statewide 1115 demonstration waivers. States have also begun serving adults and children with HIV and AIDS, children with special health care needs, people with traumatic brain injury (TBI) and people with chronic mental illness.

The growth of the HCB services waiver program has been steady throughout its history, with more pronounced recent growth due to legal pressures and the federal emphasis on expanding HCB services options. Chart 2.1, developed from the Center for Medicaid and State Operations, Division of Financial Management CMS 64 data, illustrates the growth in the HCB services program since 1997.

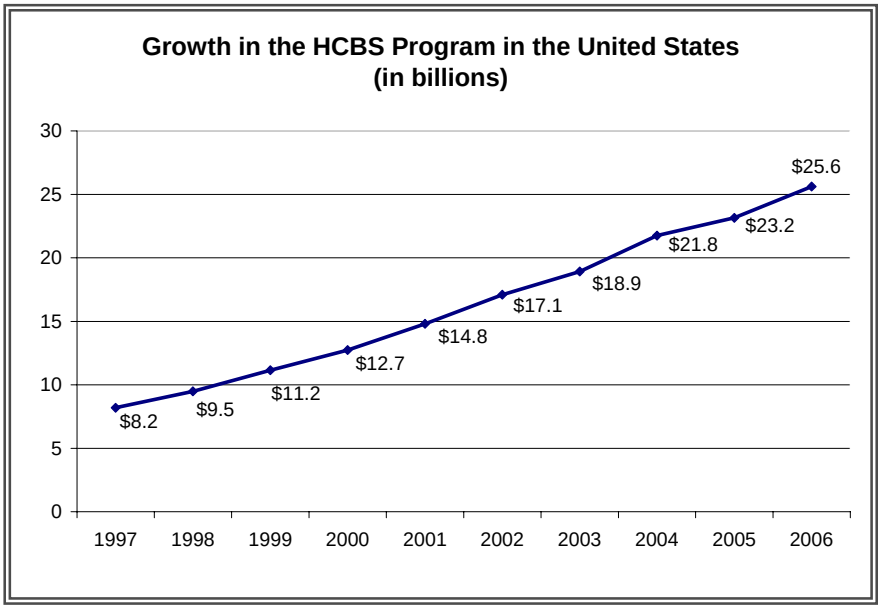

Chart 2.1

2. Current issues

a. Rebalancing Long Term Care

The New Freedom Initiative (NFI), introduced by the Bush administration in early 2001, is a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses.

This initiative supports states' efforts to meet the goals of the *Olmstead v L.C.,* a Supreme Court decision[1], which requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

States vary greatly in the proportion of Medicaid long term care funds expended on HCB services. According to the American Association of Retired Persons (AARP) publication "Across the States Profiles of Long Term Care and Independent Living", Oregon and New Mexico spent over two-thirds of their long term care dollars on HCB services while Mississippi and Washington DC spent less than 20 percent in 2005.

To overcome this "imbalance" states have been rebalancing the way Medicaid long term care services are delivered and financed. However, the institutional bias in Medicaid continues to create

[1] OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURES, et al. v. L. C., by zimring, guardian ad litem and next friend, et al. No. 98—536. Argued April 21, 1999–Decided June 22, 1999

barriers linked to Medicaid eligibility rules. To be eligible for HCB services waiver programs, applicants must meet both financial and functional eligibility criteria.

In February 2006 Congress enacted the Deficit Reduction Act (DRA) of 2005. This legislation adds the option for states to offer HCB services under the Medicaid state plan without requiring a waiver. It allows states to develop different functional eligibility definitions for institutional care and home and community-based services.

b. Quality management

Success of community-based programs, both waiver and state plan options, will be controlled by the ability of states and the federal government to build programs with sufficient provider capacity, which are affordable and cost effective. To promote successful programs, the Federal Centers for Medicare and Medicaid Services (CMS) is increasing its attention to improving waiver quality assurance.

In 2001 CMS initiated the National Quality Inventory Project (NQIP). The NQIP partners include the Center for Medicaid and State Operations Disabled and Elderly Health Programs Group (CMSO/DEHPG), the National Association of State Units on Aging (NASUA) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). The NQIP partners developed the HCBS Quality Framework, which serves to focus attention on desired outcomes in the dimensions of access, person-centered planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, outcomes and satisfaction and system performance.

There is a financial component inherent in the HCBS Quality Framework dimensions of provider capacity and capabilities and system performance. The Federal policy requirements with respect to Medicaid payments provide broad parameters to the states:

- States may generally not pay a provider more than the provider charges other third parties for the same service.
- Payments should, with certain exceptions, be linked to the actual delivery of a covered service to a particular beneficiary.
- Rates should attract sufficient HCB services providers to effectively serve waiver participants.
- States are to be prudent buyers and maintain financial integrity by assuring accountability, with payments being made promptly and in accordance with program requirements.

CMS has implemented protocols to guide the Regional Office reviews of state waiver programs. The protocol for Financial Integrity and Accountability requires the state to describe the rate setting methods used for each waiver service, to describe the basis for variation if rates are not uniform for every provider and to detail responsibility and oversight of the rate determination process.

This organized approach to the Federal waiver application review and the new quality measure process are to assure cost effectiveness and service verification and subjects the reimbursement methodologies to enhanced oversight.

C. Brief description - Alaska HCB services program

Alaska, like many states, is struggling with issues surrounding the provision of long term care services. These include a growing population of aged and disabled persons and escalating costs of health care. DHSS provides long term care services through an infrastructure of nursing facilities and Pioneer Homes. Through its Medicaid reimbursement policies and other grant financing, DHSS has also helped to foster a strong network of home and community based providers as an integral component of the long term care system in Alaska. Due to the geographical constraints and limited access to services, Alaska's long term care system utilizes multiple provider types to deliver care to the elderly with declining health and other recipients with physical or developmental disabilities. Using claims data from April 1, 2004 to March 31, 2005 we developed the following Chart 2.2 to illustrate provider type utilization. It summarizes payments to HCB providers by provider type for a recent one-year period. The vast majority of payments are to HCB agency and personal care provider types (41% and 43% respectively.) Payments to residential supported living providers and care coordinators account for an additional 11.2% and 3.8% respectively.

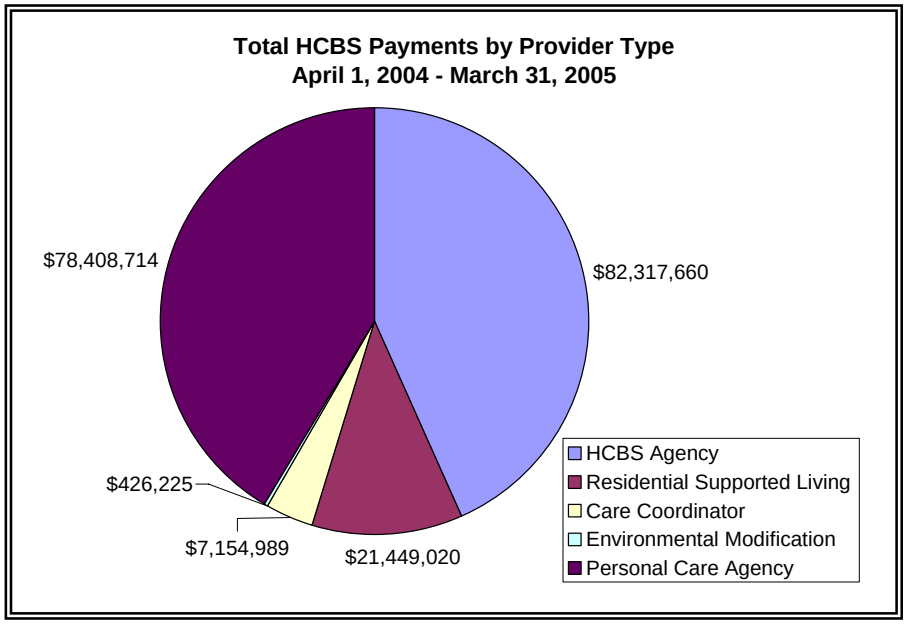

Chart 2.2

Home and community based programs provide a significant level of services for recipients in several eligibility categories: Older Alaskans (OA), Adults with Physical Disabilities (APD), Mental

Retardation and Developmentally Disabled (MRDD) and Children with Complex Medical Conditions (CCMC). These categories are collectively referenced as HCB waiver programs and provide eligible recipients with alternatives to institutional placement. Data from the Center for Medicaid and State Operations, Division of Financial Management has been charted to illustrate the percent of total expenditures by waiver. Additional home care services are offered through the Medicaid State Plan Personal Care Assistant Program to frail elderly recipients and functionally disabled and handicapped recipients of all ages. Chart 2.3 summarizes payments according to each of the four waiver HCB programs in the Alaska Medicaid system. The MRDD waiver accounts for the majority, 55%, of all HCB waiver programs expenditures. The Older Alaskans waiver is the second largest waiver program accounting for 25% of expenditures. The Adults and Physical Disabilities and Children with Complex Medical Conditions waivers are the smallest waiver programs and account for 13% and 7% respectively.

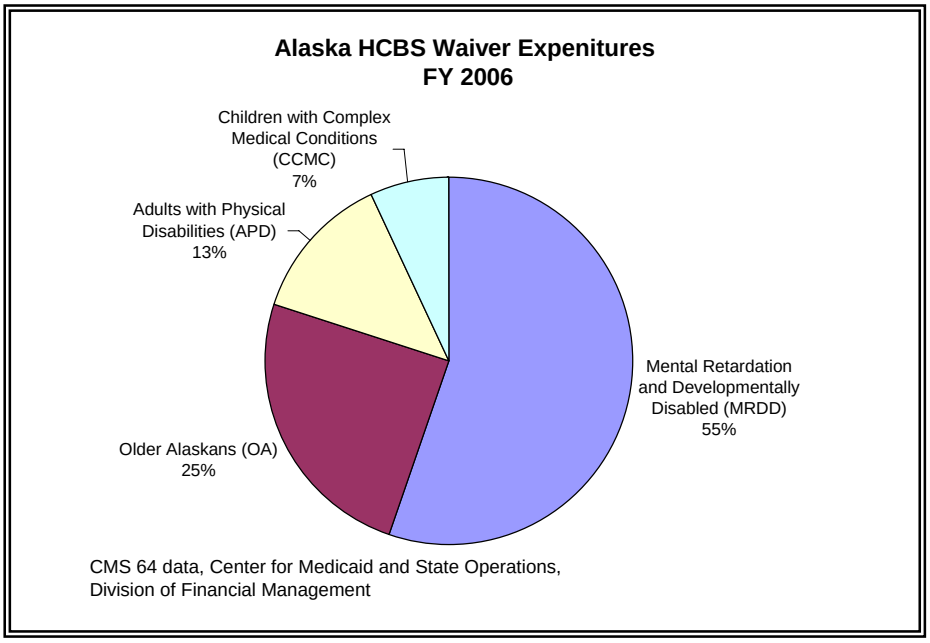

Chart 2.3

1. HCB Medicaid waivers

Medicaid recipients receiving services through the HCB waiver programs enter the home and community based system through referrals initiated by recipients, family members, community agencies, hospitals, nursing facilities or other caregivers. Specific pathways into the care system vary depending on the recipient's specific needs and other eligibility factors. DHSS staff typically performs an initial screening to determine financial eligibility and candidacy for the waiver programs (as defined in 7 AAC 43.1010). The type of assessment used varies with the specific waiver program being accessed. The matrix below provides an overview of the assessment tools that are used for the waiver programs.

Waiver Program	Assessment Tool Used
Older Alaskans (OA)	Consumer Assessment Tool (CAT)
Adults with Physical Disabilities (APD)	Consumer Assessment Tool (CAT)
Mental Retardation and Developmentally Disabled (MRDD)	Inventory for Client and Agency Planning (ICAP)
Children with Complex Medical Conditions (CCMC)	Nursing Facility Assessment Form for Children

Table 2.1

The applicable assessments are completed by a care coordinator or the Division of Senior and Disability Services' (DSDS) contractor and submitted to DSDS for review and approval.

Following a determination of level of care by DSDS, a care coordinator develops a written plan of care to address the specific needs of waiver eligible recipients. The plan of care with an accompanying cost worksheet provides a detailed plan of the specific services and the providers that will perform the services, the specific units of service to be rendered and the projected cost of each service. The plan of care is submitted to DSDS for review and approval. On going eligibility is determined through re-assessments performed annually. Plans of care are also revised and approved annually.

Numerous services are available through waiver programs. These services are provided by care coordinators, home and community based agencies, assisted living homes and environmental modification providers. An overview of provider types, available services and applicable waiver programs is included in the following sections.

Provider Type: Care Coordinator
Care coordinators serve as gatekeepers for waiver services. In addition to performing intake screening and assessment functions, they manage the waiver services through the development of a plan of care and on going care coordination that keeps them in contact with the recipient and the provider network responsible for the recipient's care.

Care Coordinator Waiver Services

Service	Regulatory Citation for Service Description and Restrictions	Applicable Waiver Programs
Screening	7 AAC 43.1041(b)(1)	APD OA MRDD CCMC
Initial assessment/ reassessment	7 AAC 43.1041(b)(2) / 7 AAC 43.1041(d)	APD OA MRDD CCMC
Plan of care development	7 AAC 43.1041(b)(3)	APD OA MRDD CCMC
On going care coordination	7 AAC 43.1041(c)	APD OA MRDD CCMC

Table 2.2

Provider Type: Home and Community Based Agency
Home and community based agencies provide a wide variety of services to waiver-eligible clients. Services are provided in multiple settings including the recipient's home, place of employment, community centers and in the community at large.

Home and Community Based Agency Waiver Services

Service	Regulatory Citation for Service Description and Restrictions	Applicable Waiver Programs
Chore services	7 AAC 43.1042	APD (10 hrs / wk) OA (10 hrs / wk) CCMC (5 hrs / wk) MRDD (5 hrs / wk)
Adult day services	7 AAC 43.1043	APD OA
Day habilitation	7 AAC 43.1045	APD MRDD CCMC

Service	Regulatory Citation for Service Description and Restrictions	Applicable Waiver Programs
Residential habilitation	7 AAC 43.1046	APD MRDD CCMC
Supported employment services	7 AAC 43.1047	APD MRDD CCMC
Intensive active treatment services	7 AAC 43.1048	APD MRDD CCMC
Respite care services	7 AAC 43.1049	APD OA MRDD CCMC
Transportation	7 AAC 43.1052	APD OA MRDD CCMC
Meals	7 AAC 43.1053	APD OA MRDD CCMC
Specialized Private Duty Nursing	7 AAC 43.1051	APD OA MRDD
Specialized medical equipment and supplies	7 AAC 43.1055	APD OA MRDD CCMC

Table 2.3

Provider Type: Assisted Living Home

Assisted living homes provide an alternative to institutionalized long term care facilities by providing services in a home-like setting. Waiver services provided by assisted living homes include: meals, housekeeping, transportation, assistance with activities of daily living (eating, bathing, dressing, grooming, toileting, transferring, walking, etc), laundry, medication monitoring and social activities.

Alaska's provider network of assisted living homes includes the six Pioneer Homes operated by DHSS. There are currently Pioneer Homes in Anchorage, Fairbanks, Juneau, Ketchikan, Palmer and Sitka. Pioneer Homes are licensed as assisted living facilities and provide assistance with activities of daily living to elderly Alaskans. For those residents that are eligible, certain Pioneer Home services are funded through the Older Alaskans waiver program.

Assisted Living Home Waiver Services

Service	Regulatory Citation for Service Description and Restrictions	Applicable Waiver Programs
Residential supported living services	7 AAC 43.1044	APD OA

Table 2.4

Provider Type: Environmental Modification Provider

Environmental modification providers make physical adaptations to the homes of recipients that are necessary for the health and safety of the recipient. These modifications enable the recipient to function with greater levels of independence in the home and thereby prevent placement in an institutional setting. Examples of environmental modifications include bathroom modifications to improve accessibility and stairway modification such as the installation of ramps and lifts.

Environmental Modification Provider Waiver Services

Service	Regulatory Citation for Service Description and Restrictions	Applicable Waiver Programs
Environmental modification	7 AAC43.1054	APD OA MRDD CCMC

Table 2.5

2. Personal Care Assistant Programs

In addition to the HCB waiver program, home care services are also offered through the Personal Care Assistant Program to frail elderly recipients and functionally disabled and handicapped recipients of all ages. There are two primary delivery models used in the personal care program: agency-based and consumer-directed. The agency-based model allows recipients to receive services through an agency that manages their care. The consumer-directed model requires that recipients manage their own care with administrative support from a personal care agency. The consumer-directed model was introduced in 2001 and the volume of services delivered through this model has increased substantially in recent years.

Eligibility for personal care services is determined via the Personal Care Assessment Tool (PCAT). The PCAT is administered by DSDS staff and results are used to develop a proposed service plan subject to DSDS approval. In the agency-based model, service plans are developed under the supervision of a registered nurse (RN); in the consumer-based model, service plans are developed by agency staff and the recipient without RN supervision. On going eligibility is determined through re-assessments performed annually. Service plans are also revised and approved annually.

Personal Care Agency Services

Service	Regulatory Citation for Service Description and Restrictions
Personal Care Services (consumer-directed or agency)	7 AAC 43.750, 7 AAC 43.752 and 7 AAC 43.755

Table 2.6

D. Background of Myers and Stauffer

Myers and Stauffer has 30 years experience conducting health care audit and consulting engagements for state agency clients. Our engagements have been conducted for a wide range of provider settings including nursing facilities, hospitals, physicians, pharmacies and other health care providers. The firm has particular expertise in the long term care field and has performed engagements for cost methodology development and analysis, cost report auditing, case mix reimbursement, rate-setting, time studies and waiver program analysis.

III. Development of a Rate Matrix

One of the components of the project was to provide an overview of the various methodologies that are used by the DHSS to reimburse providers for Medicaid and other related health care services. To present this comparison, Myers and Stauffer has prepared a comprehensive matrix of the reimbursement methodologies utilized by DHSS. The complete matrix is presented in Appendix B-2. A summary of the methodology for preparing the rate matrix and an overview of the findings are presented in this section of the report.

A. Description of activities

To prepare the rate matrix, Myers and Stauffer began by analyzing Medicaid paid claims data from a recent time frame. From the claims data, we determined the provider type codes used in the Medicaid Management Information System (MMIS) that had received payments for Medicaid services. This list of provider types has provided the primary basis for the structure of the rate matrix, although in some cases additional provider types that are not explicitly derived from the MMIS provider type classification system have been included. Through various discussions with DHSS staff and general experience with the Alaska Medicaid program, we divided the provider types into the Divisions and Offices within DHSS that have primary oversight over Medicaid operations for the provider type. The majority of provider types fall under the jurisdiction of the Division of Health Care Services (DHCS); others are under the jurisdiction of the Division of Senior and Disabilities Services (DSDS), the Division of Behavioral Health (DBH) and the Office of Children's Services (OCS).

Myers and Stauffer then reviewed the Alaska Statutes (AS) and Alaska Administrative Code (AAC) for relevant statutes and regulations relating to the reimbursement methodologies of the provider types. Medicaid provider billing manuals published by DHSS were also reviewed. All of the published material that was reviewed was summarized in a preliminary draft of the reimbursement methodology matrix.

The preliminary draft of the matrix was then sent to various staff in the Divisions and Offices cited above. Additionally, since the reimbursement methodologies for several providers types are significantly impacted by activities of the Office of Rate Review, staff in that office were also provided a preliminary draft of the matrix.

Myers and Stauffer also made telephone and e-mail contacts to staff in the respective Divisions and Offices to discuss the reimbursement methodologies of various provider types and receive feedback on the material in the preliminary draft. As needed, revisions were made to the matrix based on feedback from applicable staff that included additional written materials and verbal descriptions of the application of reimbursement methodologies for various provider types. In some cases, additional reimbursement methodologies relating to DHSS programs extraneous to Medicaid have been included because of their integral relationship to the reimbursement for related services provided under the Medicaid program.

B. Observations

The reimbursement methodologies employed for Medicaid and related services under DHSS are based on a wide variety of methodologies. These methodologies vary significantly both in terms of their derivation and also in terms of their level of sophistication.

Office of Rate Review

Although the reimbursement methodology matrix is presented with the provider types divided into categories for DHCS, DSDS, DBH and OCS, the rate-setting function for certain provider types is performed by the Office of Rate Review. Due to the cost-based methodology used for all of the provider types under the rate-setting jurisdiction of the Office of Rate Review, a separate discussion of the methodology for these providers is warranted.

Under AS 47.07.070, providers that meet the definition of "health care facility" are entitled to payment rates that are based on "reasonable costs related to patient care". Rates for provider types that meet the definition for a "health care facility" are set by the Office of Rate Review. For providers under the jurisdiction of DHCS, inpatient hospital, outpatient hospital, federally-qualified health centers (FQHC), ambulatory surgical centers (ASC) and birthing centers, reimbursement rates are determined by the Office of Rate Review. For providers under DSDS jurisdiction, nursing facilities have rates set by the Office of Rate Review. Finally, for providers under DBH jurisdiction, inpatient psychiatric hospitals have reimbursement rates set by the Office of Rate Review.

All providers meeting the definition of "health care facility" receive rates that are based on actual costs reported by the providers and potentially subjected to desk reviews and field audits. Due to the differences in the types of services rendered by these various providers, there are different ways that cost data is used to produce rates. The most common type of rate set by the Office of Rate Review is the calculation of per diem rates for the reimbursement of inpatient hospitals, nursing facilities and inpatient psychiatric hospitals. For outpatient hospitals, reimbursement rates are set via determination of aggregate cost to charge ratios to determine provider-specific reimbursement rates as a percent of billed charges. The FQHC are reimbursed on a "per encounter" basis at rates tied to reported provider costs.

In general, the Office of Rate Review collects cost data on an annual basis and reported costs are subject to desk review and field audits as deemed necessary by the Office of Rate Review. In practice, rates are typically re-based every four years with inflation factors used as a cost escalator for intervening years (with the exception of outpatient hospital).

Certain small providers under the jurisdiction of the Office of Rate Review (i.e., those with 4,000 or fewer acute care patient days) have the option of entering into a rate agreement in which the provider agrees to a specified rate for a period of four years with restrictions on the provider's right to appeal their rate during that time period (see 7 AAC 43.689(g)).

The Office of Rate Review also provides some technical assistance to the various Divisions and Offices for purposes of rate-setting. However, in the case of providers not meeting the definition of a "health care facility", the assistance rendered by the Office of Rate Review does not supplant the rate-setting responsibility of the respective Division or Office.

Division of Health Care Services

There are a wide variety of provider types under the jurisdiction of DHCS and therefore a wide variety of reimbursement methodologies are employed. Reimbursement rates for inpatient hospital, outpatient hospital, federally-qualified health centers (FQHC), ambulatory surgical centers (ASC) and birthing center providers fall under the rate-setting authority of the Office of Rate Review and were discussed previously.

Another reimbursement methodology widely used for physician and other professional services providers under the jurisdiction of DHCS is the Resource-Based Relative Value Scale (RBRVS). This methodology is derived from the reimbursement methodology used by Medicare for physician and other professional services. The RBRVS system is tied to the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding systems. Relative value units (RVUs) for applicable codes are defined for "work", "practice expense" and "malpractice expense". These RVUs are adjusted by a geographic practice cost index (GPCI) and summed. The sum of the adjusted RVUs is multiplied by a conversion factor to derive a rate. In theory, the methodology produces rates that are proportionate to the average cost inputs for providing the service. In certain cases, code modifiers have an impact on the payment rate.

In addition to physicians, several other professional services are reimbursed at rates that are derived from the RBRVS system. Typically, non-physician providers receive a percentage of the full RBRVS rate. Other providers with reimbursement tied to the RBRVS system include chiropractors, podiatrists, optometrists, nurse midwives, physical therapists, speech pathologists, occupational therapists, audiologists, advanced nurse practitioners, family planning clinics and radiology providers. Anesthesiologists are reimbursed based on a system of base units and time units closely related to the RBRVS system.

Several provider types under the jurisdiction of DHCS have reimbursement methodologies that are highly specific to the type of services being rendered. Dental services are reimbursed according to a dental fee schedule (with certain surgical procedure codes being reimbursed according to the RBRVS system). Independent laboratory services are reimbursed according to the laboratory fee schedule used by Medicare. Durable medical equipment (DME) and supplies and devices from a prosthetic and orthotics supplier are priced according to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule with state-specific rates set for certain other supplies not on the DMEPOS schedule. Pharmacy providers are reimbursed with a dispensing fee (originally derived from a study of pharmacy cost) and an allowance for drug ingredients (typically determined from the "Federal Upper Limit" price or as a discount from the "Average Wholesale

Price"). Ground and air ambulance services are limited based on allowances for base rates and mileage (the methodology is derived from Medicare). Dieticians, hearing aid providers and private duty nurses have fee schedules that are exclusively related to the specific services of these providers.

For several providers, billed charges or a percentage of billed charges, are the primary methodology used to define reimbursement rates. Dialysis facilities are paid at 100% of billed charges. Accommodation and transportation providers (i.e., taxis, airlines, hotels and restaurants) are paid at billed charges, although hotel and meal accommodations are subject to specified limits. Home health agencies are reimbursed at 80% of billed charges.

Division of Senior and Disabilities Services

For providers under the jurisdiction of DSDS, institutional providers (e.g., nursing facilities and swing bed providers) have reimbursement rates set by the Office of Rate Review. For the variety of home and community based (HCB) services under the jurisdiction of DSDS, the reimbursement methodologies vary based on provider type, but are significantly impacted by a "rate freeze" which is currently set to continue until July 1, 2008 per regulations at 7 AAC 43.1058(l).

A wide variety of services are provided by HCB services agency provider types. These include:

- Chore services
- Adult day services
- Day habilitation services
- Residential habilitation services
- Supported employment services
- Intensive active treatment services
- Respite care services
- Transportation services
- Meal services

Prior to the current rate freeze, a cost-based reimbursement methodology was used for these services. Regulations at 7 AAC 43.1058 define a cost-based reimbursement methodology based on allowable direct service costs and allowable administrative and general costs. In practice, providers submitted proposed budgets for each fiscal year that calculated cost rates. Rates for specific services to recipients were negotiated by agencies, case managers and DSDS on per recipient and per procedure code basis for each agency.

Although a cost reporting system had been established for HCB agencies, in practice the collection of cost data has effectively ceased with the advent of the rate freeze. Prior to the rate freeze, cost data

was collected from providers to set initial rates for a provider and to rebase rates at subsequent intervals.

Under the current rate freeze, providers have the option to enter into an aggregate rate agreement. The aggregate rate is determined as the average rate for all recipients as derived from historical claims data. The aggregate rates for an agency are calculated on a per procedure code basis and are the same for all recipients. If providers do not enter into an aggregate rate agreement, they receive the lesser of the aggregate rates or the rates derived from the individual budget amount approved for a specific recipient.

With the rate freeze, procedures are also in place to set rates for new providers or existent providers that begin to operate in a new region of the state. Additional policies set reimbursement rates in the case that a recipient transfers from one agency to another. Under the rate freeze, these rates are still based on aggregated historical expenditure data derived from an analysis of claims history, but there are limitations to allow for the lesser of multiple applicable rates to be used. Procedures are also in place to make exceptions to the rate freeze based on documented extraordinary circumstances meeting the criteria at 7 AAC 43.1058(r).

Rates for specialized private duty nursing services and specialized medical equipment regulations are also in place for persons receiving HCB waiver services.

Another significant provider type in the HCB system are assisted living homes providing residential supported living (RSL) services. Similar to HCB agencies, these RSL providers received cost-based reimbursement prior to the implementation of the current rate freeze. Prior to the rate freeze, RSL providers submitted cost reports for the determination of initial rates and at subsequent intervals. Cost data was reviewed and new cost-based facility rates were set periodically. Under the current rate freeze, provider cost data is not regularly collected from most providers.

Under the rate freeze, rates for RSL services are based on daily service rates established at 7 AAC 43.1058(h). The base rates vary depending on the number of residents in the facility and whether 24-hour awake staff is provided (the base rate categories are commonly referenced as "Adult Foster Care", "Adult Residential I" and "Adult Residential II"). The rates are adjusted for several factors including:

1. A decrease to the rate if the recipient also receives adult day care services.

2. An increase to the rate if the recipient's needs warrant hiring additional staff.

3. An adjustment to reflect regional differences in the cost of doing business. The adjustment is based on the region in which the provider is located. The regional adjustment factors are defined at 7 AAC 43.1058(h)(6).

4. An increase to the rate of $8.65 per day as defined at 7 AAC 43.1058(h)(7).

5. An adjustment for a cost of living percentage increase (subject to the availability of appropriations).

Environmental modification (EM) services are reimbursed at billed charges with a per recipient limit of $10,000 for a 36-month period. EM services are contracted via a procurement process.

Care coordinators perform screenings, assessments, plan of care development and on-going care coordination. Reimbursement for these services is currently defined in a fee schedule included in the Care Coordination section of the Alaska Medicaid Provider Billing Manual.

Personal care agencies provide personal care services through either an agency or consumer-directed model. Regardless of the service delivery model used, services are reimbursed at the maximum allowable rate of $21 per hour set directly by regulation (7 AAC 43.790). The Personal Care Agency section of the Alaska Medicaid Provider Billing Manual also defines a daily rate of $200 per day.

Myers and Stauffer has also provided some detail in the matrix regarding certain non-Medicaid services funded through DSDS including assisted living homes general relief and grant services. Although these services are distinct from their Medicaid counterparts (due to the nature of the services, Medicaid eligibility requirements or the waiting list for the MRDD waiver), it is significant to understand their interaction with HCB services reimbursed through Medicaid funding. In many cases, there is a significant overlap between the providers and recipients involved with both the Medicaid and non-Medicaid funding sources.

Division of Behavioral Health

Other than rates for institutional facilities that are set by the Office of Rate Review, reimbursement rates for DBH providers primarily have been set directly by regulations. This is in contrast to using regulatory means to define a methodology from which rates are derived. The precise dollar amount of the rates for day treatment facilities, substance abuse centers, and mental health clinics are defined within the Alaska Administrative Code and the regulations do not define a specific methodology used to derive the rate.

Office of Children Services

The primary Medicaid service that is reimbursed to providers under the jurisdiction of OCS are payments for behavior rehabilitation service (BRS) providers. The BRS Handbook, 2005 edition, published by OCS defines daily rates for each of four levels of care.

The funding situation for BRS providers is unique in that OCS bills for Medicaid services on behalf of BRS providers based on attendance documentation. BRS providers receive their direct funding through grants from OCS.

OCS also establishes rates for foster care services provided to youth in licensed foster care homes. Standard daily rates are set based on a review of U.S. poverty guidelines and legislative

appropriations. Standard rates are adjusted based on several factors including age and geographic location. Augmented rates are also available for children requiring additional care and supervision. Augmented rates are based on documented assessed need and legislative appropriations.

Child Care Assistance Program

CCAP provides assistance to eligible families to receive child care in licensed home providers, licensed group home providers, licensed child care centers, approved child care providers, approved relative child care providers and approved in-home care providers. Program rates are set by provider type, category of care and geographic area. Categories of care differentiate by child age and the units of time for which care is authorized. Rates are established based on a market rate survey of child care providers in the state and the availability of legislative appropriations.

C. Conclusions

As would be expected, there is significant variation in the reimbursement methodologies for the many Medicaid and related health care services reimbursed under DHSS. However, these methodologies can be grouped into several general categories:

1) Cost-based provider-specific rates (e.g., "health care facilities" under the rate-setting jurisdiction of the Office of Rate Review including hospitals, nursing facilities, ASC and FQHC).

2) Derivations of methodologies used under the Medicare program (e.g., physicians and other professional services providers with reimbursement based on he RBRVS methodology; independent laboratories, DME suppliers, prosthetics and orthotics suppliers and ground and air ambulance providers).

3) Methodologies closely related to billed charges (e.g., dialysis facilities, accommodation and transportation providers and home health agencies).

4) Rates set directly by regulation without a readily apparent methodology (e.g., personal care agencies, day treatment facilities, substance abuse centers and mental health clinics).

5) Rates set based on historical expenditure data (e.g., home and community based agencies and residential supported living providers since the rate freeze for those services).

6) Other provider types with fee schedules or methodologies specific to the services provided (e.g., pharmacy, dieticians, hearing aid providers, private duty nurses, environmental modification providers and care coordinators).

As DSDS and Myers and Stauffer continue with the process to develop rate methodology options for HCB services, there are several lessons that can be derived from the exercise of reviewing DHSS rate methodologies.

First, a review of the broad reimbursement methodologies presented above provides a very basic concept of the reimbursement options that are available for a rate system. As a very general starting point for options for an HCB services rate methodology, this list may be further narrowed by considering those options that specifically are not feasible for HCB services. For example, derivation of a methodology from an existent Medicare rate methodology is not a viable option since HCB services are not a significant component of Medicare covered services. Furthermore, rates based on billed charges may not be directly compatible with cost containment objectives of DSDS.

A second benefit to the analysis of DHSS reimbursement methodologies is to better understand the overlap of payments between providers and recipients. For example, recipients receiving HCB services may also be receiving several other types of related health care services. Additionally, many of the providers rendering HCB services may also be providing other services through the same organizational structure. For example, a provider of HCB services may also be a provider of substance abuse and/or mental health clinic services. Understanding the various ways that providers and recipients are interconnected to Medicaid and other related services reimbursed by DHSS will further the process of developing a fair and equitable rate methodology for HCB services.

IV. Evaluation of Recent Alaska Long Term Care Reports

A. Background and purpose

Several studies related to long term care issues have been conducted in Alaska. This project requests a comparison of three recent significant studies.

In April 2005, DHSS contracted with the Lewin Group and ECONorthwest to develop a long-term forecasting model of Medicaid spending for the State of Alaska. The report focused on the projected growth in total spending on Alaska's Medicaid program and the projected growth in state matching fund spending on the Medicaid program. The results of the study were published on February 15, 2006 in a final report, entitled "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025."

The DHSS and the Alaska Division of Senior and Disabilities Services (DSDS) jointly contracted with Public Consulting Group, Inc. in September 2005, for the purpose of reviewing and evaluating the programmatic and fiscal components of Alaska's long term care system. The evaluation focused on Alaska's long-term care system and development of recommendations for change over several future time periods. The results of that study were published in February 2006 in a final report, entitled "Alaska's Long Term Care and Cost Study Final Report."

Finally, a third report was commissioned by the Alaska Senate Finance Committee to analyze the Alaska Medicaid Program and to make recommendations for enhancing program accountability and cost containment while ensuring continued service delivery and access. The Pacific Health Policy Group performed the analysis, the results of which were published in January 2007 in a report entitled "Medicaid Program Review Final Report".

All three reports, although having different purposes and scopes, overlap in many areas with respect to Alaska's long-term care service delivery system.

B. Common findings and recommendations

For the purposes of this comparative analysis, the three reports will be referred to as the Lewin report, representing the "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025"; the PCG report, representing "Alaska's Long Term Care and Cost Study Final Report"; and the PHPG report, representing "Medicaid Program Review Final Report", respectively.

Two of the three reports (Lewin and PHPG) evaluated reimbursement and spending for the entire Medicaid program, which included long-term care, while the PCG report focused specifically on long-term care.

Myers and Stauffer found all three reports to be generally complementary of each other, providing three very distinct layers of focus and study. Namely, the Lewin report provides some fairly global *findings* related to long-term care spending within the context of the entire Medicaid program, while

the PHPG report addresses some fairly broad long-term care recommendations also within the context of the entire Medicaid program. In focusing exclusively on Medicaid long-term care, the PCG report provides the most recommendations and the most detail to demonstrate and support its findings. When studied together, all three reports provide a solid background needed to help foster additional change and to aid DHSS in advancing a successful Medicaid home and community based services reimbursement reform initiative.

The material contained in all three reports is extensive and informative, covering a myriad of issues and aspects related to Alaska's long-term care service delivery system. As we evaluated the information, we identified three common issues, which we then grouped into the following categories:

1) State matching funds for Personal Care and HCB Waiver;
2) Spending/reimbursement; and
3) Tribal health providers.

It is important to point out that we found most, if not all, of the long-term care related recommendations that were *not included* in the summary of common issues to be at least indirectly related to overall Medicaid personal care and HCB waiver program spending. Some examples of recommendations not included because they were not commonly addressed in all three reports are those related to quality assurance and quality improvement, care coordination, and performance of long-term studies and strategies. All of these, if fully developed and implemented, have the potential to clearly and positively impact Medicaid long-term care program performance and service delivery.

We elected to omit these and other infrastructure-related recommendations in order to focus this report on those common issues clearly and directly related to spending and reimbursement which have the most immediate and far-reaching impact. However, all findings and recommendations have value and should be considered when making future improvements to Alaska's long-term care program.

For each of the three issue categories, we identified one or more common findings and/or recommendations found in all three of the reports. For ease of review, we have summarized our findings and displayed them collectively in the summary matrix located in Appendix B-3

A review of the three common issues and the specific findings/recommendations from each report are presented below.

Issue 1: State matching funds for Personal Care and HCB

This issue addresses Alaska's use of state matching funds to provide Medicaid personal care and home and community-based (HCB) services offered through Medicaid waivers. With respect to HCB services, we are referring to the definition contained in the Lewin report (p.41), which includes:

Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals. Similarly, with respect to personal care, we are referring to personal care attendant services, including those that are agency-based and consumer-directed programs.

The Lewin report examined Medicaid spending and predicts an increase in state matching funds for Medicaid claims at a rate that will exceed the increase of the total Medicaid program. It particularly distinguishes significant growth expected in the personal care and HCB service categories.

The four recommendations contained in the PHPG report focus on several Medicaid program expansions to include consumer groups who are currently being funded with state-only dollars. These groups include: persons with chronic or life-threatening conditions who receive services through the Chronic and Acute Medical Assistance (CAMA) program, persons with developmental disabilities who are on the waiver waiting lists and/or who receive state-only assistance, and seriously mentally ill adults. PHPG recommends expansion of the DD waiver, changes in eligibility criteria, creation of a new waiver, or any combination of the three.

The PCG report provides ten related recommendations, which address the same general consumer groups as the PHPG report but also provides a number of ideas for increasing the federal Medicaid share and reducing the state-funded share. These include several strategies to improve eligibility determination and waiver management and to sustain grant-funded projects, perform studies of Pioneer Home costs, address waiver programs and financing issues and monitor accounting and financial functions.

Following is a summary of each specific finding and/or recommendation described above, along with some related narrative obtained from each of the reports to provide additional context.

Two findings from the Lewin report

Findings
1. An increasing share of the Medicaid burden will be shifted away from the federal government to the State. State matching funds for Medicaid claims are projected to increase at a faster rate than the total Medicaid Program (p. iii).
2. Among the five fastest growing Medicaid service categories, it is projected that over half of state matching funds will be spent on personal care and HCB Waiver services (p. iv).

Table 4.1

Four recommendations from the PHPG report

Recommendations	Related Findings
1. Alaska should consider expanding the Medicaid Program to include several groups currently being serviced with state-only dollars: CAMA; certain DD individuals; and seriously mentally ill adults (p. 34).	DHSS operates a state-funded program, known as Chronic and Acute Medical Assistance (CAMA), which serves as a payer of last resort for persons with chronic or life-threatening conditions. The qualifying conditions are consistent with the types of conditions covered in medically needy programs, as well as Section 1115a research and demonstration waiver programs, which can be used to secure federal matching funds while capping enrollment, state expenditures, or both (p. 3).
2. Move Personal Care to the HCB services waiver program, thereby requiring elderly/physically disabled applicants to undergo the comprehensive screen and have this service allocated in conjunction with others during the care planning stage, or as a lesser step, the state can strengthen care coordination between the waiver and Personal Care by making HCB services waiver case managers responsible for this activity (p.74, 82).	a. The two waiver programs for the elderly and the physically disabled offer limited in-home support services – chores and home delivered meals – making it difficult for many to remain safely in the residences without additional support from another source. Increasingly Alaska's elderly and disabled are seeking in-home support through the Personal Care Attendant service option (p. 4, 70). b. Alaska differs from many states in that it offers Personal Care Attendant services as a state plan option, thereby reducing Medicaid's ability to manage the benefit within a larger plan of care (p.74).
3. The state should consider extending Medicaid coverage to persons with DD, thereby securing federal matching dollars. This could be done by expanding the size of the waiver and adjusting eligibility criteria to include persons not eligible; or by creating a new waiver with services matching those available today through the state-only program. Alaska should explore opportunities for obtaining federal matching funds for services provided today through state-funded grants. A final option would be a Section 1115a research and demonstration waiver specifically for LTC or as part of a full restructuring of the program (p. 5, 77, 83).	Alaska is one of only a few states to serve its DD population completely outside of the institutional ICF/MR setting. At the same time, the state's DD waiver programs have extensive waiting lists. A significant number of services are provided with state-only dollars to persons on the DD waiver waiting list and persons with DD who do not qualify for the waiver. (p. 4-5, 75)

Recommendations	Related Findings
4. Extending Medicaid coverage to persons receiving state-funded DD services, either by enlarging the current waiver or creating a new waiver with services matching those available through the state-only program (p. 83).	The state could gain control over service costs – and obtain more operational flexibility – by replacing the traditional Medicaid program with a Section 1115a research and demonstration program. (p. 35)

Table 4.2

Ten recommendations from the PCG report

Recommendations	Related Findings
1. Ensure the timely determination of Medicaid eligibility (p. 43).	The General Relief Assisted Living service is paid for using 100% state general funds. The state needs to develop a process that ensures the quick determination of Medicaid eligibility for persons served in this program (p. 43, 101). Also, Medicaid eligibility should be quickly determined for all potentially eligible residents on admission to Pioneer Homes. This should include monitoring of the "spend-down" of residents' assets (p. 98).
2. Develop a strategy to sustain grant-funded pilot projects/services (p. 62).	Grant programs are unable to sustain themselves past the life of the grant, due to lack of infrastructure to track outcomes and effectiveness, waning interest from the funders, and absence of commitment through inclusion in the state's budget (p.62). Grant dollars … which are used to pilot new and innovative service approaches, do not appear to include a process to evaluate the success of the pilot, the outcomes achieved and whether or not the pilot should become an ongoing part of the base budget. Without this, the sustainability and importance of these pilots is not routinely reviewed. Also see pages 122-129.
3. Review the current waivers to determine what changes need to be made (p. 50-51).	This is a global recommendation that covers the 2006 waiver renewals, FFP enhancement strategies, TBI and ADRD, and more. A supports waiver would offer FFP for the services that are currently being offered through state-funded Core Services and free up state funds to serve more people on the waiting list (p.50-52).
4. Develop strategies to better manage the DD waiting list (p. 46-47).	Alaska's DD waiver waiting list includes individuals who: are already receiving CCMC waiver services; are already receiving full services through grant dollars; will never qualify for a waiver; are uninterested in waiver or grant services until some future date; and, only want respite care. Strategies could include: develop a Supports Waiver; use state dollars freed up by moving individuals to the Supports Waiver to serve more on the waiting list; efficiently manage the grants to maximize the number of individuals served; determine who has an immediate need for additional services on the waiting list; require additional appropriation to serve individuals on the waiting list; and facilitate a discussion with the legislature to determine an annual appropriation that would prevent substantial growth of the waiting list (p. 46-47).

Recommendations	Related Findings
5. Revise the state's level of care interpretations and implementation for the MRDD Waiver (p. 48).	Alaska currently interprets its LOC criteria in a manner which may be restrictive in terms of the types of services that individuals are able to receive. Part of the problem with the LOC determinations in Alaska, specifically in the MRDD waiver program, is a direct relation to the use of the ICAP as the tool to determine LOC (p. 48-49). The way in which current LOC definitions are applied in the MRDD waiver is a potential problem to Alaska's LTC system because it may limit how many people are able to qualify for the HCB services waivers. This limits access to federal matching dollars, and result in placement in more restrictive environments (p.110).
6. Monitor level of care criteria to ensure all individuals are receiving appropriate level and mix of LTC services (p. 48).	Alaska currently interprets its LOC criteria in a manner that may be restrictive in terms of the types of services that individuals are able to receive. The way in which current level of care definitions are applied in the MRDD waiver is a potential problem to Alaska's LTC system. This limits access to federal matching dollars and may result in placement in more restrictive settings (p.48-49).
7. Account levels and financial practices within DD grants need to be monitored and state responsibility for accounts consolidated under one financial unit to assure consistency of expenditures and reallocation of funds as needed (p. 62).	Some agencies are allowed to keep funds that go unspent, while people wait for services (p.62).
8. Conduct a separate study of financing issues (in Pioneer Homes) (p. 41).	The state should ensure that it is not spending general fund dollars in the Pioneer Homes unnecessarily; e.g. the issues of separately billing for pharmacy and other medical expenses, and the matter of patient SSI merit a separate study (p.41-42)
9. Ensure that Medicaid pays its share of Pioneer Home costs (p. 40).	Compared to other assisted living programs, Pioneer Homes are expensive, so the state must ensure that Medicaid pays its fair share of costs for residents; the Homes need to have new residents apply for Medicaid and watch for changes in income and assets (p.40). The state should also ensure that it is not spending general fund dollars unnecessarily, and conduct a separate study of financing issues, including reevaluation of the SSI ineligibility of Pioneer Home residents (p.97-98, 100).
10. Ensure PCA services are available throughout the rural areas (p. 44).	There is a need for more PCA services in the rural areas of the state to meet current unmet need and to address the cultural issues and values of Alaska's diverse population. Increase participation from tribal health providers to leverage 100% federal reimbursements. (p.44).

Table 4.3

Issue 2: Spending/reimbursement

This issue addresses a variety of findings and recommendations related directly to growth in long-term care spending and how to improve Medicaid spending efficiency and reimbursement methodologies to optimize Alaska's use of state funds. Although similar to Issue 1 described

previously, this issue provides recommendations that are much more specifically targeted to HCB waiver reimbursement methodologies and billing requirements.

The Lewin report finds that spending on long-term care services is growing at a pace that is considerably greater than overall Medicaid program growth. This finding is useful for establishing the framework for the recommendations contained in the other two reports.

The four spending/reimbursement recommendations contained in the PHPG report address improvements to waiver services for persons with Alzheimer's Disease and related dementias, changes in the reimbursement methodology for assisted living and residential and day habilitation providers, and implementation of a nursing facility provider tax to draw down additional federal funds to increase overall long-term care spending.

The sixteen recommendations contained in the PCG report address a variety of reimbursement issues, ranging from MMIS edits and audit improvements to imposition of a nursing facility provider tax to numerous recommendations that emphasize changes to Alaska's HCB waiver cost reporting requirements. The specific findings and recommendations of all three reports are provided in more detail as follows.

One finding from the Lewin report

Findings
1. Currently spending in Alaska on Medicaid LTC services is considerably less than one third of total Medicaid spending however the rate of growth in LTC spending 12% to 13% per year is significantly greater than spending growth for the entire Medicaid program (about 9%) (p. 88).

Table 4.4

Four recommendations from the PHPG report

Recommendations	Related Findings
1. Add new waiver service options targeted toward persons with Alzheimer's dementia as a lower-cost alternative to Pioneer Home placement. (p. 82-83)	Pioneer Homes are licensed as assisted living facilities, a lower level of care than skilled nursing, but increasingly serve a population that in other states would reside in the Alzheimer's units of nursing facilities or in less costly, Alzheimer's-oriented community care settings (p. 68).
2. Alaska has the equivalent of adult foster care providers within its large assisted living facility provider category. At a minimum, the state should move to tiered payment rates based on provider size, cost and complexity of care offered (p. 74).	A number of states provide adult foster care as a relatively low-cost service option within their waiver programs. Adult foster care families can be certified to care for persons with mild to mid-stage dementia, coupled with some physical deficits, and provide the foster care service in their homes. This service is especially appropriate for small, rural communities that lack facility-based alternatives (p.74).
3. Alaska should consider a provider tax for nursing facilities (p.74).	

Recommendations	Related Findings
4. Reimbursement of residential and day habilitation waiver providers (p.75).	Another factor pushing Alaska's costs higher appears to be the method used by DHSS to reimburse residential and day habilitation waiver providers. Payment rates, which are cost-based, are essentially negotiated on a provider-by-provider basis using self-reported and un-audited cost data. The data is not submitted in a uniform manner, but in whatever format the provider chooses. The result is high, and inconsistent payment rates (p. 75).

Table 4.5

Sixteen recommendations from the PCG report

Recommendations	Related Findings
1. Conduct Edit Review in the MMIS to quantify and fix the edits (p.57).	Edits are complicated and require the assistance of the state's fiscal intermediary to create and maintain them, and there is uncertainty as to how well the FI is able to keep up with program changes (p.57). Program policies now contain waiver restrictions that prevent payments for duplicate services, however, state staff was not always sure whether the edits were in place and working (p.106-107). Also see pages 115-121.
2. Agencies billing for multiple homes should submit an annual cost allocation plan to the state (p.55).	Providers that operate multiple homes should submit a cost allocation plan containing the per-home allocated costs. The rate-setting methodology relies on A&G percentages instead of using audited and allocated cost from a previous time period projected forward (p.55).
3. Auditing of submitted cost reports and waiver claims (p.54).	The state should have a program that ensures that services billed and paid were in fact provided for the clients (p.54).
4. Cap administrative expenses associated with a single client's care (p.55).	The state should not pay providers for unnecessary administrative costs and should put a capped dollar amount on the total amount of A&G that it will pay for any single person (p. 55).
5. Develop standardized methods for reimbursing residential habilitation costs based on collected cost reports (p.53-54).	The state lacks essential cost reporting to manage residential habilitation and day habilitation costs. Each provider submits their own costs on their own forms, and it is difficult to check to see if the costs are accurate or were actually incurred. Improvements are needed to uniformly collect provider costs and set rates in an economically and efficient manner (p.53-54).
6. Discourage the use of compression in residential habilitation and day habilitation (p.55).	The current rate setting methodology reimburses more than a per diem cost each day; the use of a "compression" factor adds a percentage to the rate (p. 55, 117).
7. Implement a standardized method of collecting habilitation costs from MRDD providers and pay providers in a consistent and equitable manner (p.52).	The state has little control over the millions of dollars spent for residential and day habilitation services. Providers submit budget detail forms for each client served which reflect self-reported selected costs. All MRDD and CCMC waiver services except daily respite are individually negotiated on each plan of care; chore services and supported employment rates also vary (p.52-53).

Recommendations	Related Findings
8. Regulated rates paid for residential supported living arrangements that are not authorized in regulations should be reviewed and adjusted (p.77).	No specific reference found.
9. The 26% discount used on the supported residential living arrangements per diem when three or more days of adult day care are used should also be applied to residential habilitation when three or more days of day habilitation are used (p.56).	If a resident is going to be absent from the home for significant periods, then the state should not pay the residential provider and the day habilitation provider for the same services on the same day (p.56).
10. Change 7 AAC 43.1055 regulating specialized medical equipment and supplies to require the reimbursement of average manufacturer's cost or that supplier must provide evidence of competitive bidding (p.57).	Providers of specialized medical equipment and supplies tell the state what the cost of the supplies will be, and there is no assurance that the state is paying the lowest cost (p.57).
11. Review treating all meal-related costs as being unallowable costs (p.40).	The Pioneer Home rate-setting methodology excludes all direct and indirect meal preparation related costs (p.40).
12. Revise the cost and reimbursement structure of the Pioneer Homes (p.39).	This is a global recommendation encompassing: conversion of Level I placement to Levels II and III; ensuring that Medicaid pays for eligible residents; reviewing treatment of meal-related costs as unallowable; taking Pioneer Home costs into account for Medicaid rate-setting; using actual patient days instead of licensed capacity; and conducting a separate study of financing issues (p.39-42).
13. Costs of operating the Pioneer Homes as identified in the Public Assistance Cost Allocation Plan (PACAP) should be taken into account in developing the Medicaid rate (p.41).	The Statewide Cost Allocation Plan (SWCAP) no longer isolates the Pioneer Homes as a cost center. Therefore, the SWCAP contains costs for the Pioneer Homes that are not included in Medicaid rate-setting (p.41, 99).
14. Use a consistent reimbursement methodology to pay for residential and day habilitation services in the MRDD Waiver (p.52).	Residential and day habilitation services are large parts of the budget, so efforts to end a widespread pattern of negotiated rates should be initiated (p.53).
15. Use actual patient days instead of licensed capacity in per diem.	Changes in licensed bed capacity have lagged the number of actual beds available in the Pioneer Homes, and the Pioneer Homes do not automatically bill for 14 days of respite care (p.41, 98-99).
16. Consider a provider assessment on nursing facilities (p.37).	Generation of additional nursing facility funds can be used to improve the quality of care in nursing facilities or fund technological changes to improve quality of care (p.37-38).

Table 4.6

Issue 3: Tribal health providers

This issue addresses the prominent role that Native Americans have in Alaska's long-term care service delivery system and funding. All three reports recognize several opportunities available to the DHSS to enhance the role of Tribal Health providers in its HCB waiver programs, streamline funding, improve services and quality of care, and reduce barriers.

The Lewin report recognizes ongoing efforts of collaboration between the DHSS and the Native communities and recommends further expansion of efforts to include long-term care services.

The PHPG report includes one specific recommendation that also addresses long-term care, but emphasizes opportunities that may be available through a managed care program approach.

Finally, the two recommendations in the PCG report similarly address global opportunities to increase federal funding through long-term care service enhancements, but also address expansion of personal care assistance to the rural areas. The specific findings and recommendations within each of the three reports is provided in more detail as follows.

One finding from the Lewin report

Findings
1. Native Americans are almost three times as likely to be enrolled in Alaska Medicaid as are non Natives. By working with tribal health providers to increase services such as LTC, DHSS can reduce state fund spending without reducing services. Such participation between DHSS and Native communities should continue. Currently, tribes are not very active in LTC, but they have expressed interest in LTC for their members (p.90).

Table 4.7

One recommendation from the PHPG report

Recommendations	Related Findings
1. The state should actively participate in establishing greater capacity among tribal providers, particularly with respect to LTC. Specifically, Alaska could pursue reorganization of the tribal health care delivery system as a managed care entity (p. 6, 90).	Native Alaskans account for nearly four in ten Medicaid beneficiaries, by far the largest Native American segment of any state Medicaid program. The population is overwhelmingly rural, with nearly six-in-ten living in villages with fewer than 300 residents. Given the isolation of many rural villages, access to community-based care is both essential and challenging. Although Alaska's Native population is younger on average than the state's general population, the need for LTC among AI/ANs is rising and will increase significantly in coming years. If the tribal system is unable to address AI/AN long-term care needs, the responsibility will fall to non-tribal providers, requiring additional state resources (p. 5, 84).

Table 4.8

Two recommendations from the PCG report

Recommendations	Related Findings
1. Ensure PCA services are available throughout the rural areas (p.44).	There is a need for more PCA services in the rural areas of the state to meet current unmet need and to address the cultural issues and values of Alaska's diverse population. Increase participation from tribal health providers to leverage 100% federal reimbursements. (p.44).
2. Work with tribal organizations (global recommendation).	Increase participation from tribal health providers to leverage 100% federal reimbursements. Opportunities exist for tribal health providers in the Northern and Western parts of the state to increase their provision of Medicaid LTC services. Alaska could work with 638 organizations to ensure that their costs are reimbursable with 100% federal fund match for Medicaid eligible persons. Individuals on waiver programs or waiting for waiver services could then transfer to one of these 638 providers, expanding their menu of services. Transfer should first be targeted to those consumers who have high-cost care plans, both on the MRDD waiting list and MRDD waiver program (p.18, 26, 44).

Table 4.9

C. Conclusions

In comparing the three reports, we found numerous commonalities in findings and recommendations, all of which are generally complementary. For the three common issues that we identified, we found there to be little duplication of information insofar as the reports each had a somewhat different focus and consequently provided varying levels of detail with respect to suggested long-term care program and service refinements.

The Lewin report has a generally different focus than the other two; namely, it was intended to study Medicaid Program spending overall in order to forecast projected spending in each Medicaid Program eligibility and service category over time. Rather than provide specific program or service spending recommendations, however, it provided a number of *findings* specific to long-term care/HCB waivers that we used to establish the three issues that were also addressed but further developed in the other two reports.

Recommendations contained in the PHPG report are especially useful in terms of the numerous opportunities identified to revise HCB waiver service definitions and program requirements to reduce the use of 100% state funds by securing additional federal match. Myers and Stauffer will carefully consider these specific recommendations in our analysis and development of Medicaid home and community based services reimbursement methodologies available to DHSS.

Recommendations contained in the PCG report target a number of refinements to cost reporting requirements that will be carefully considered and incorporated whenever possible as we make specific reimbursement recommendations for Alaska's HCB waiver program.

V. Evaluation of Six Comparable States

A. Description of activities

1. Rationale for selection of states

In selecting states to include for comparison purposes, Myers and Stauffer considered the rural and urban mix, population density and geographical challenges, as well as the size of the Native American populations. The States selected were Montana, New Mexico, North Dakota, South Dakota, Wyoming and Idaho. The states selected are largely rural and according to the 2000 US Census, have the lowest population densities in the United States. The six states rank from 44th to 49th in population density, with Alaska ranking 50th or the least densely populated state in the nation (see Chart 5.1). Idaho is in the same CMS region as Alaska, Region X.

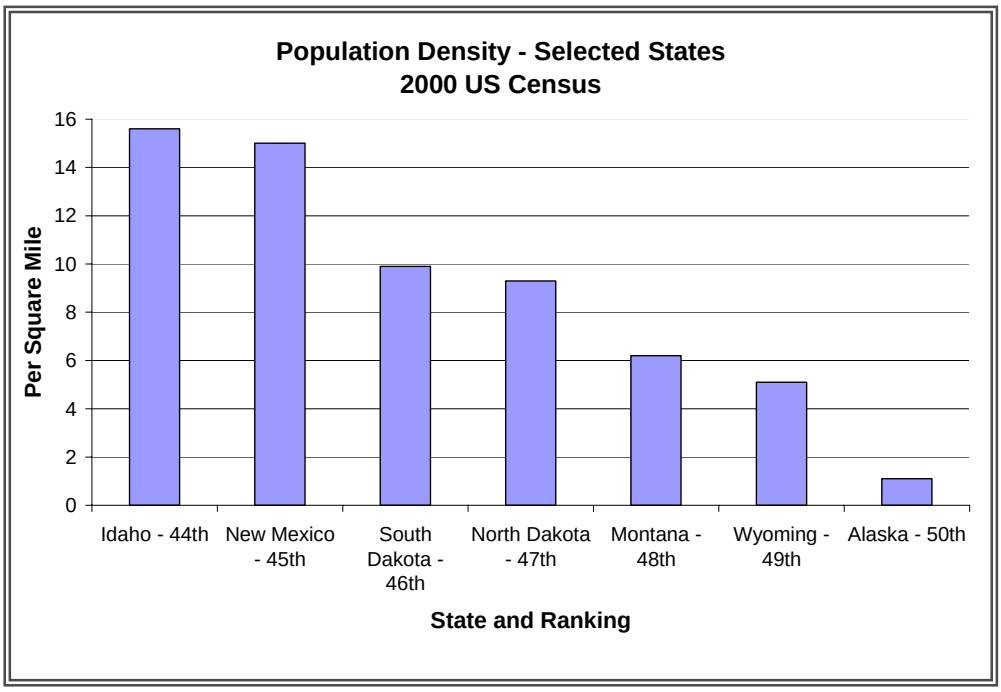

Chart 5.1

Although Alaska has significantly larger area than all of the comparison states, all face geographical challenges and have large frontier areas. The challenges associated with distances and geography complicate the management of long term care services.

The comparison states also have similarities with respect to their Native American populations. At 19% of the population, Alaska has the highest percentage of Native Americans. New Mexico, South

Dakota, North Dakota and Montana also have significant numbers of Native Americans (see Chart 5.2), and large reservation areas in their states. Although the native corporation organizational structure of Native Americans in Alaska is not identical to the tribal organization and reservation system used in the other states, there are shared issues relating to the coordination of services between tribal and state governments.

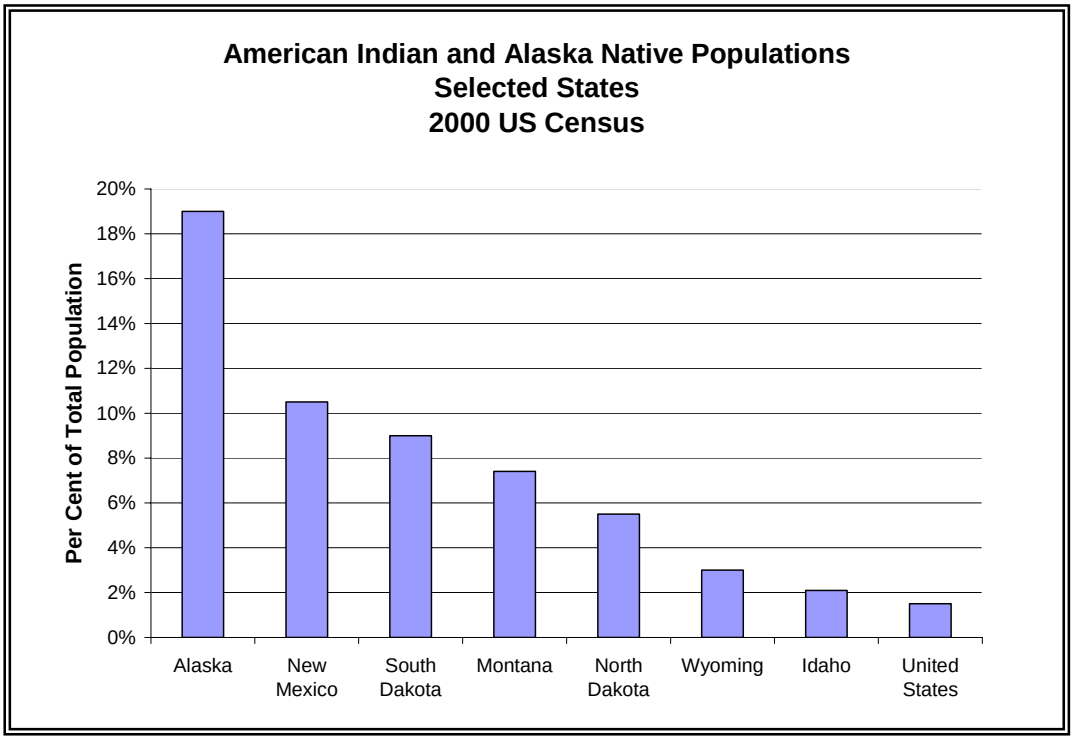

Chart 5.2

The six states selected for the comparison study each have unique characteristics. They also share, in varying degrees, many of the same challenges that Alaska faces including, the provision of services in a state with large land mass, frontier conditions, sparsely populated areas, diverse cultures and a growing aging population.

2. Obtaining data and contacting states

Myers and Stauffer obtained waiver information from the CMS website.[2] Information available at this site included the official name of the waiver program, the waiver authority and the date the waiver was originally approved. The implementation and expiration date of the waiver and a summary of the waiver and the covered services were also available.

[2] See www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp

When available, Myers and Stauffer reviewed the most recently available waiver applications. From those we developed a matrix summarizing the various waivers in the comparison states. The waiver matrix was later sent to contacts identified in each state. State contacts were asked to review the matrix and indicate any necessary corrections.

Myers and Stauffer also prepared an informal survey which was sent to each of the state contacts. This survey included nine additional reimbursement methodology questions for each waiver requesting additional details of the reimbursement methodologies. The additional questions inquired about the utilization of cost reports in the rate calculation, the procedures for collection of data necessary to set rates, the use of desk or on-site reviews, the use of rate adjustment factors and procedures to validate provision of services. The survey also requested copies or references for any available supporting documentation.

Myers and Stauffer encountered several challenges with obtaining a response to the survey from all of the comparison states. To date the following survey responses have been received:

- Wyoming: Elderly and Physically Disabled waiver.
- Montana: Severe Disabling Mental Illness (SDMI), Elderly and Physically Disabled and the Big Sky Bonanza waiver.
- South Dakota: MRDD, Family Support MR Children and the Elderly.
- North Dakota: MRDD, Aged and Disabled, Technology Dependent.
- Idaho: MRDD Child Aged and Disabled
- New Mexico: No surveys completed, but state staff have indicated that additional information is forthcoming.

The matrices developed for each state are included in Appendix B-7. As additional information is obtained from the comparison states, Myers and Stauffer is able to provide an update to the comparison matrix. Information from the surveys may assist in the development of the proposed reimbursement methodologies for the Alaska HCB program. As the rate methodology project continues, further questions may warrant obtaining additional input from or about the comparison states.

B. Programs growth and general statistics

The HCB services program has grown steadily both in terms of numbers of participants and in overall spending. In Chart 5.3 a comparison of HCB spending growth is presented for Alaska, the six comparison states and the United States. As indicated previously in the report (see Chart 2.1) total HCB expenditures in the United States went from a little over $8 billion in 1997 to almost $26 billion in 2006.

HCB expenditures in Chart 5.3 are stated as a percentage of the 1997 expenditure level. Five of the comparison states follow a growth pattern very similar to the national experience. However, Alaska and Idaho have experienced a much steeper growth curve, which is especially pronounced after 2000.

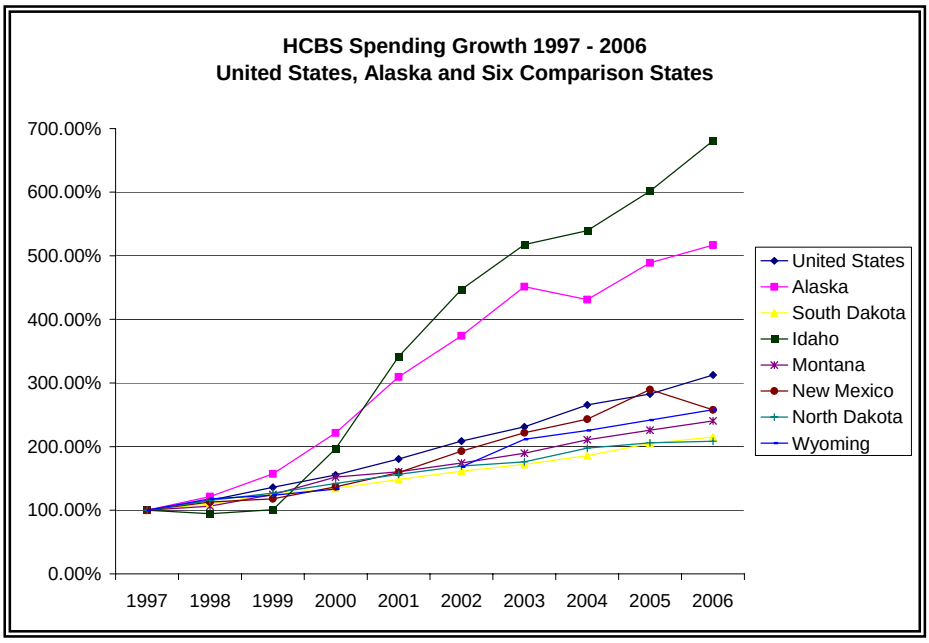

Chart 5.3

HCB spending growth reflects several national trends in the provision of long term care. States are working to rebalance resources and programs and to increase the numbers of people who receive services in the community. The proportion of Medicaid beneficiaries receiving HCB services has increased steadily. According to the AARP publication, "Across the States Profiles of Long-Term Care and Independent Living", by 2005 Medicaid long term care expenditures increased to $94.5 billion with 37% of expenditures for HCB services. However, expenditures for institutional care still exceed those for HCB services.

The following Chart 5.4 uses data obtained from the AARP State Profile report and illustrates the expenditures per person in the comparison states for nursing facilities, intermediate care facilities for mental retardation and HCB services.

Alaska, Wyoming, and New Mexico all spend more per person for HCB services than for institutional settings. New Mexico spent over two-thirds of its long term care budget on HCB services. One might conclude that these states have done a more successful job of balancing or right sizing their long term care programs. However, many factors contribute to the balance between home-based and institutional services including Medicaid eligibility rules and procedures, availability of community resources and state fiscal constraints. Additional review would be needed to form

further conclusions regarding the reasons for the varying mix of institutional and home-based services in the comparison states.

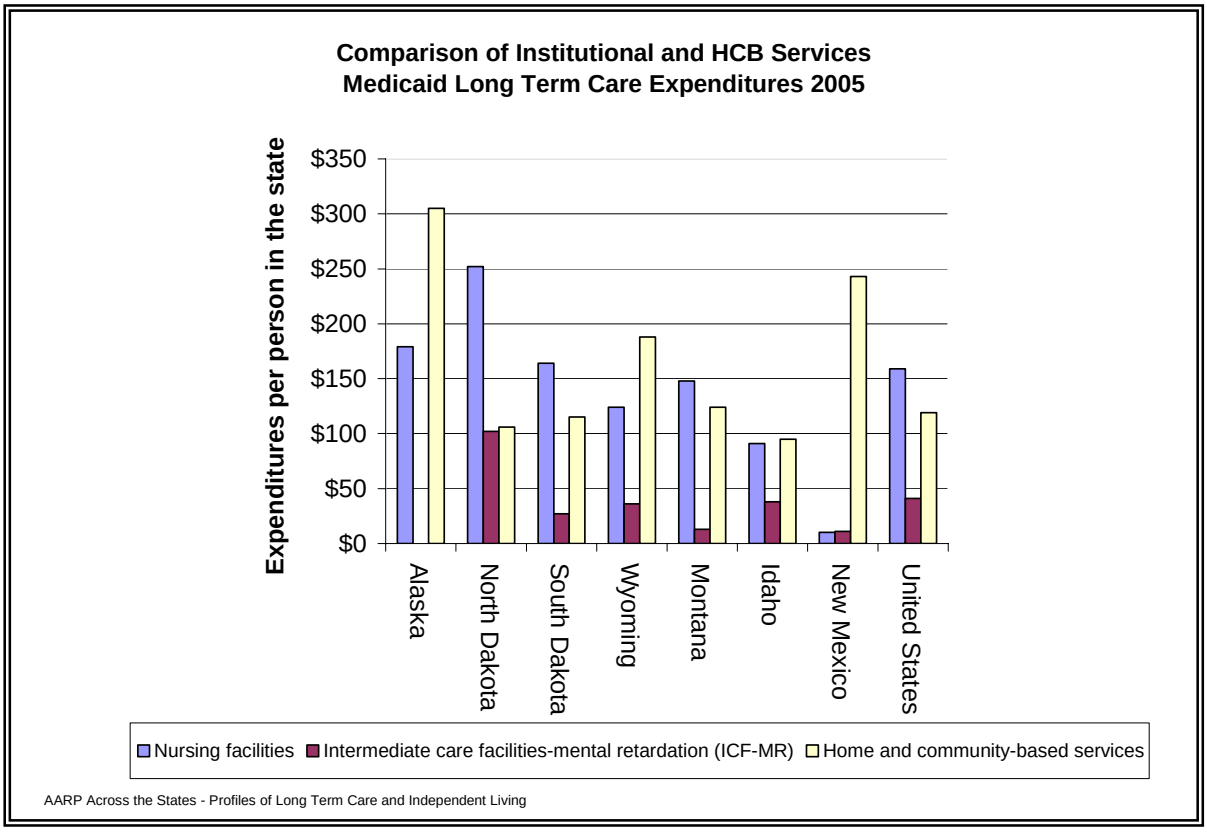

Chart 5.4

Although most Medicaid home-based services spending occur through HCB waiver programs, home-based services can be provided through several funding mechanisms. Chart 5.5 was developed with data from the AARP State Profiles report and displays the number of Medicaid HCB services participants per 1000 population in each state and the mix between home health, personal care and HCB waiver services.

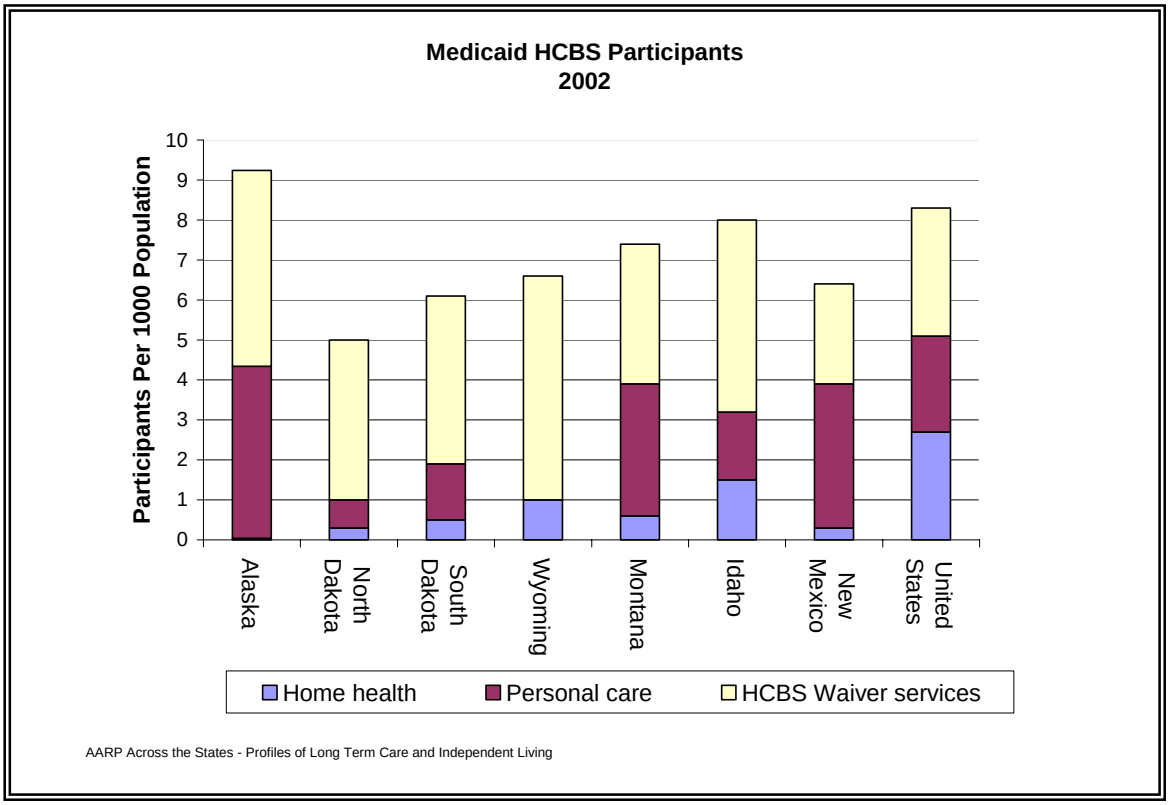

Chart 5.5

In Alaska 9.6 participants per 1000 population received home-based services. Of the 9.6, 4.9 participants per 1000 received HCB waiver services, 4.3 received personal care services and .04 received home health services. In the United States as a whole, the distribution of participants across home health, personal care and HCB waiver services is fairly even. In the comparison states, Montana's distribution matches most closely to Alaska but with fewer participants per 1000 population. In fact, all six of the comparison states have less participation per 1000 population than the United States average of 8.3.

C. Comparison of waivers by target populations, services and rate methodologies

Targeted populations

Under federal statute, state Medicaid programs must provide nursing home benefits to beneficiaries over age 21. Institutional services for individuals under age 22 or over age 65, in an intermediate care

facility for the mentally retarded (ICF/MR) is an optional Medicaid benefit. If a state opts to provide ICF/MR services, they must be offered statewide and meet comparability requirements.

Alternately, HCB waiver programs services is an optional Medicaid benefit. States, under the authority of section 1915(c) of the Social Security Act, can waive the requirements of "statewideness" and "comparability." HCB services waivers allow the state to provide specific services to specific target groups established through the waiver application approval process. States can also place limits on the number of people who will receive services.

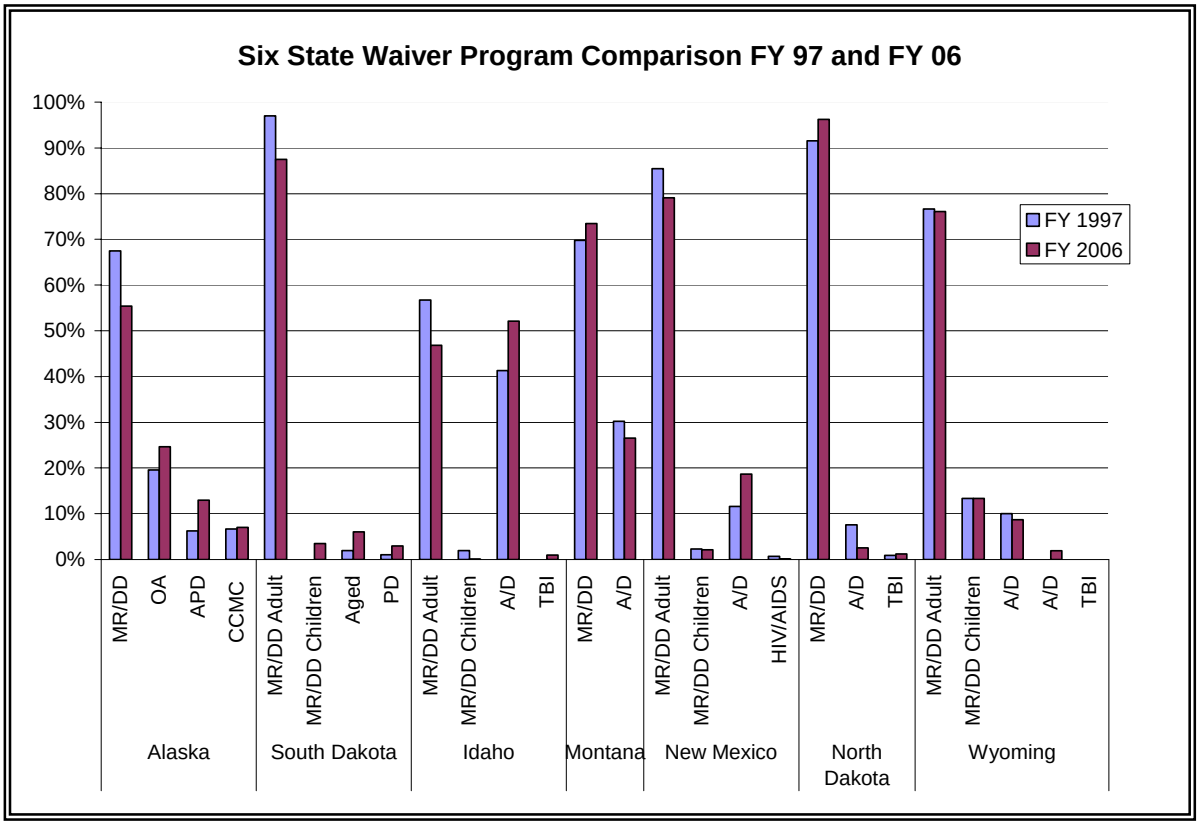

Chart 5.6

Each of the comparison states has at least one waiver serving individuals with MRDD. South Dakota has a Family Support waiver for MR Children and Wyoming and Idaho have separate MRDD waivers for children and adults. All the states also have waivers serving the aged and disabled, either as separate waivers or in a combined aged/disabled waiver. Other targeted populations include individuals with acquired brain injury, HIV/AIDS, and medically fragile children.

Chart 5.6 compares the percent of waiver dollars in each of the approved waivers, defined by target groups, in FY 97 and in FY 06. In all but Montana and North Dakota, the percent of expenditures for MRDD waivers decreased as the percent of expenditures in the aged and disabled waivers increased.

The waivers and target populations have been undergoing lots of change in the last couple of years. Waivers are being allowed to expire and the effected target populations are being combined into other waivers.

Recent trends for consumer direction are also impacting waivers in the comparison states. Self directed waivers are being added or self directed services are being added to existing waivers. Of the comparison states, New Mexico and Montana have the most prominent self-directed waivers. New Mexico is in the process of implementing the Mi Via NF and Mi Via MRDD waivers. Montana's Big Sky Bonanza waiver provides self-determination as an option for any of the consumers in the current waivers in a six county pilot program.

Services

Individuals with disabilities and seniors with functional limitations have diverse needs for assistance including housing, transportation, education, habilitation, light housekeeping, meal preparation, personal assistance and skilled nursing care. Although the general services are needed by people with a variety of disabilities, some services are specific to the disability addressed.

Since the early 1990's, CMS has used a standardized waiver application format. The current version is web-based and includes standard definitions of services either contained in statute or frequently offered by states in their waiver programs. The services a state may offer are not limited to those that appear in the standard format and states have significant flexibility in the design of their waiver programs. This potential variability among services must be considered in any comparison. Services with similar titles may appear to be the same, but have substantially different definitions. For example case management in the MRDD and Older Alaskan waivers application lists an average monthly cost of slightly over $200 while monthly case management services listed on the Montana MRDD waiver application list an average cost of $755. To help understand the variability, we have included the definition of the unit used and the cost per unit in our comparison matrix.

The following abbreviated tables identify and compare services offered under each state's waiver, one for the MRDD target populations and one for the aged and disabled populations. Details of the services are included in the matrix in Appendix B-7.

MRDD Waiver Services Comparison

Services	Alaska	Montana	Wyoming	South Dakota	New Mexico	Idaho	North Dakota
Case Management	X	X	X	X	X		X
Homemaker		X					X
Personal Care		X	X		X		
Adult Day Health						X	X
Residential Habilitation	X	X	X	X	X	X	X
Day Habilitation	X	X	X	X	X		
Prevocational Services		*	X				
Supported Employment	X	X	X	X	X	X	
Respite	X	X	X		X	X	X
Meals	X	X				X	
Intensive Active Treatment	X						
Specialized Supplies & Equipment	X	X	X	X		X	
Environmental Modifications	X	*	X		X	X	
Transportation	X	X			X	X	
Chore Services	X					X	
Specialized Private Duty Nurse	X	X			X		
Residential Supported Living			X		X		X
Personal Emergency Response System						X	
Companion		X					
Dietician		X	X		X		
Other Miscellaneous Services**		X	X	X	X	X	X

*In Montana Prevocational Services are bundled with Habilitation and Environmental Modifications are combined with Specialized Equipment

** Other Services include adult foster care, PT, OT, SLP, psychological services, community transitions, etc.

Chart 5.7

Aged and Disabled Waiver Services Comparison

Services	Alaska Disabled (APD)	Alaska Aged (OA)	Montana Aged and Disabled	Wyoming Aged and Disabled	South Dakota Disabled	South Dakota Aged	New Mexico Aged and Disabled	Idaho Aged and Disabled	North Dakota Aged and Disabled
Case Management	X	X	X	X	X		X	X	X
Homemaker			X			X	X	X	X
Personal Care			X	X	X			X	X
Adult Day Health	X	X	X	X		X	X	X	X
Residential Habilitation	X		X				X	X	X
Day Habilitation	X		X					X	
Prevocational Services			X						
Supported Employment	X		X					X	X
Respite	X	X	X	X		X	X	X	X
Day Treatment			X						
Pyschosocial Rehabilitation			X						
Meal Service	X	X	X	X		X		X	
Intensive Active Treatment	X								
Specialized Medical Equipment and Supplies	X	X	X		X	X		X	X
Environmental Modification	X	X	X				X	X	X
Transportation	X	X	X	X				X	X
Chore Services	X	X	X					X	X
Specialized Private Duty Nursing	X	X	X		X	X	X		X
Residential Supported Living Services	X	X	X			X		X	X
Personal Emergency Response System (PERS)			X	X	X	X	X	X	X
Substance Abuse Counseling			X						
Companion								X	
Dietician			X						
Other Misc. Services**			X	X	X		X	X	X

** Other Services include adult foster care, PT, OT, SLP, consumer preparation services, behavior consultation, crisis management, psychiatric consultation, etc.

Chart 5.8

Rate methodologies

We identified many different rate methodologies for the various services of the waivers in the comparison states. The following descriptions detail a few of those methodologies.

In the South Dakota waiver for the Elderly, rates for adult residential care and assisted living are based on the state wide average direct and non-direct care rates for nursing facility level of care times 55%. The rates for services in the MRDD waiver are developed using a regression analysis of reported costs and acuity as evaluated by the ICAP assessment. Rates for the Family Supports waiver are based on cost and time studies, with costs divided by possible billable units. These rates include an adjustment for geographical market differences.

In Idaho rates for many of the services in the DD and ISSH waivers are based on personal care service rates and then increased or decreased based on the necessary qualifications required to provide the waiver service, the supervision required, and agency costs associated with delivering the service. The state is currently changing the reimbursement methodology to a labor model that uses a Staff Support Hour (SSH) rate approach. This rate approach involves developing a single rate for a unit of staff time spent providing services for an individual.

For the MRDD waiver services in Montana, rates have been established through contract negotiations. However, the state is in the process of changing from the negotiated rates to a standardized fee-for-service system. With the exception of adaptive equipment, environmental modifications and transportation, the rate will be based on the amount of direct care staff time delivered to the consumer. The rates will have four standardized cost centers - direct care staff compensation, employee related expenses, program supervision and indirect expenses and general and administrative expenses. The standardized rates will be adjusted by a geographical factor, economy of scale factor and a holiday coverage factor. In Montana's waiver for Adults with Severe Disabling Mental Illness, services that are also available in the elderly/physically disabled waivers, are reimbursed at the rate established under the elderly/physically disabled program. This promotes parity between the waivers as many of the service providers are the same under both waivers.

In the North Dakota Aged and Disabled waiver, rates for all services (except case management, adult family foster care (AFFC) and transitional care), were initially established in 1990 based on cost report data. As new agency providers enroll, cost reports are collected to obtain direct, indirect and administrative costs. Individual provider rates are based on consideration of several factors including the minimum wage plus 30%, the mean wage being paid to individuals providing the service and Job Service information about the average salary paid for similar work. Both agency and individual provider rates can be increased by legislative action. Case management rates are based on the average salary paid to social workers in 1984. Adult Family Foster Care (AFFC) and Transitional Care rates are based on a formula and factor based system. Each allowable task, required to care for specific clients, is assigned a number of points. The points are totaled and then multiplied by a factor, unique to that specific service. The factor formula then calculates to a daily rate, subject to upper limits.

Rates for services in the New Mexico MRDD and Aged and Disabled waivers are based on a rate study that used incurred costs as the basis for analyzing rates. The hourly and unit costs are calculated and arrayed to develop rate recommendations. New Mexico is considering standardizing rates across all their different waivers, accounting for need, access and provider availability, similarity of services and the need to allocate limited resources.

In Wyoming, rates for the Elderly and Physically Disabled waiver are set to align with costs of similar services in the community. Any increases to rates require legislative action. The rates for services in the MRDD waiver are developed using a regression analysis of reported costs and acuity as evaluated by the ICAP assessment.

D. Observations

From the information reviewed from the comparison states, Myers and Stauffer has developed two significant observations.

First, similar to Alaska, many of the rates for HCB services are legacy based with minimal adaptations over time.

Several of the rates were linked to cost studies or negotiated rates originally established in the 1980's or early 1990's. Although some of the rates have been adjusted and inflated, they have not been re-based using more current data. Several of the state contacts could not account for methodology used to originally set reimbursement rates.

Second, there is a great deal of change impacting HCB waivers in the six comparison states. Several waiver programs are being allowed to expire and the target populations consolidated into other waiver programs. For example, the Traumatic Brain Injury waivers in Idaho and North Dakota recently expired, and the TBI target population was merged into the Aged and Disabled waivers. Other waiver consolidations include expanding the Aged waiver in South Dakota to cover non-elderly disabled individuals. Some of the consolidation of waivers may be the result of additional administrative burdens such as the additional quality statistics that must be reported to CMS.

At the same time certain waivers are being consolidated, new waivers are being established to provide options for self-directed services. Montana and New Mexico recently added the Big Sky Bonanza and Mi Via self-directed waivers respectively.

New Mexico and Idaho have begun the process of re-establishing their rate methodologies. Stated goals in their efforts include standardization of rates and rate methodologies across waivers and development of rates adequate to recruit sufficient workers while maintaining cost effectiveness.

Alaska is in a very similar position to many of the comparison states, dealing with a rate system that is linked to the past and complicated by several issues. At the same time, the state is attempting to develop standardized, equitable reimbursement methodologies in a rapidly changing environment.

VI. Plans for Future Work and Final Deliverable

A. Overview and guiding principles

The current report serves as a starting point for the process of recommending changes to the current reimbursement methodology for HCB services under the Alaska Medicaid program. There is significant work remaining to be done and will require ongoing collaboration between DSDS, the provider community, other stakeholders and Myers and Stauffer.

The potential for change in the reimbursement methodologies is of significant concern to the HCB services client and provider community. It is therefore important that the review of reimbursement methodologies be performed in a careful, methodical and professional manner. DSDS has indicated to Myers and Stauffer that the reimbursement methodologies developed through this project be fair, consistent, reasonable, understandable and defensible. The reimbursement changes should be in the best interest of the clients, the program, the providers and other stakeholders.

Several guiding principles will be followed during future activities related to this project:

- The project should include methodologies that are consistent, fair and reasonable.
- Decisions should be based on facts and not simply anecdotal accounts.
- To the greatest extent possible, caseworkers and caregivers should be unencumbered by the proposed reimbursement methodology so that the needs of clients remain the focus of their attention.
- Reimbursement methodologies must consider variability of providers, including issues of size, location and client mix.
- The reimbursement rates, provider reporting requirements and DSDS administrative tasks must be clearly defined in the proposed methodologies.

Using the preliminary work completed for this deliverable, including the analysis of DHSS reimbursement methodologies, the concepts and questions identified in the recent long term care studies and the six-state comparison information, Myers and Stauffer will collaborate with DHSS staff to complete the remaining project deliverables.

B. Reimbursement methodology options for consideration

A subsequent objective of the project will be to develop at least three different methodologies that would enable DHSS staff to set rates for home and community based agencies, assisted living homes, personal care agencies and other related provider types. As Myers and Stauffer continues with the project, feedback from DHSS and the provider community will help us to refine options to include in potential reimbursement methodologies for HCB services.

The methodologies recommended for Alaska must take into consideration the issues of access, native populations, the diverse needs of populations served, provider availability, grouping of similar

services, consistency, and accountability. The rate methodology should also create incentives for cost containment and efficient delivery of quality services. The proposed reimbursement methodologies should consider different ways that rates can be applied to providers, the inclusion of principles of cost reimbursement, acuity adjustments based on assessment results, geographic differentials, agency-specific adjustments such as for agency size, regulatory mechanisms for rate adjustments and incentives associated with quality indicators.

Evaluation of single statewide rates versus provider-specific ates

Myers and Stauffer will consider the different ways in which rates can be applied to the HCB provider community. There are varying levels of specificity at which rates can be applied to providers. Currently, DHSS applies rates to HCB and personal care services providers with multiple levels of rate specificity.

The simplest level of rate specificity is the application of a single statewide rate to all providers for delivering similar services. For example, all care coordinators are currently reimbursed at a single statewide rate for screening, assessment, plan of care development and on going monthly care coordination. Similarly, personal care agencies are all reimbursed at a single statewide hourly rate for personal care services.

However, other HCB services are not currently reimbursed under uniform statewide rates. Services provided through HCB agency providers are currently reimbursed on the basis of average rates aggregated from historical expenditure data. In the case of residential supported living services, rates are set regionally with several adjustment factors specific to individual providers and, in some cases, adjustments specific to individual residents. Prior to the rate freeze, individual cost reports submitted by each agency and assisted living home resulted in variable cost-based rates at individual providers.

In some cases, rate variability may be desirable to account for regional differences in cost and differing acuity of clients receiving treatment. However, it is also possible for variable rates to produce incentives for the inefficient delivery of services. All of these factors will be considered as Myers and Stauffer develops reimbursement methodology proposals for HCB services.

Evaluation of cost-based reimbursement and development of cost reporting guidelines

Consistent with the requirement of the Request for Proposal from DSDS, the methodologies that will be proposed by Myers and Stauffer will include elements of cost-based reimbursement. An advantage of cost-based reimbursement is that it can account for geographical and acuity related variations in cost that are beyond the control of a provider. This is particularly important in Alaska due to the high level of geographic diversity and the extreme isolation of some service areas. Cost-based reimbursement may also provide incentives to enhance the wage base of care workers, potentially leading to a more stable workforce. Conversely, cost-based reimbursement may remove some incentives for providers to control costs and provide services in an efficient manner. Determining

which services should be subject to cost-based reimbursement, and the precise mechanisms for determining rates from cost data will be a significant aspect of this project.

A significant component of the evaluation of cost-based reimbursement will be the development of cost reporting tools, instructions and accounting guidelines. It will be necessary to design cost reporting tools for applicable provider types to collect a sufficient level of information for rate setting purposes. Instructions for the cost reporting tools and accompanying accounting guidelines will also be necessary. A cost reporting system requires a sufficient level of written instructions and accounting guidelines such that providers can accurately and uniformly submit cost data. Instructions and guidelines must be customized to the specific accounting systems that are applicable to the provider type. Accounting guidelines are necessary to ensure that costs used for rate setting purposes are only those that are directly related to the provision of reimbursable services to Medicaid recipients. Accounting guidelines define allowable and non-allowable costs for rate setting purposes and will form the basis for desk review and audit programs to screen submitted cost data.

Acuity based reimbursement

DHSS has expressed an interest in the consideration of client acuity as a potential component of a proposed reimbursement methodology. Acuity-based reimbursement systems are already widely used by some payers, including Medicare and the Medicaid programs in some states for inpatient hospital services (i.e., diagnosis related groups), skilled nursing facilities (i.e., minimum data set and resource utilization groups) and most recently for home health services (i.e., outcome and assessment information set). In each of these systems, data relating to the diagnosis or assessment of the patient has a role in determining the provider's level of reimbursement. In general, higher acuity measurements are associated with greater resource requirements for patient care, and providers receive higher payments for patients with higher levels of acuity.

There are also some state Medicaid programs that use various forms of acuity-based systems in their HCB reimbursement models (e.g., the DOORs model used for individual budget caps in the developmental disability waivers in the Medicaid programs South Dakota and Wyoming). Potential advantages to acuity-based reimbursement models are potential simplification of the budgeting process and incentives for cost efficiency.

An acuity-based methodology would likely need to be closely tied with the assessment tools used to determine a recipient's waiver eligibility. The current assessment tools used in Alaska are the Consumer Assessment Tool (CAT), Inventory for Client and Agency Planning (ICAP) and the Personal Care Assessment Tool (PCAT). Potentially these assessment tools could also be part of a process used to determine acuity levels that would in turn be incorporated into the reimbursement methodology. Alternately, other assessment tools may need to be considered for developing a feasible acuity-based reimbursement system.

Geographic differentials

Myers and Stauffer will consider the possibility of geographic differentials for provider rates. Alaska is a state of wide geographic diversity. Service areas for HCB and personal care services range from the Anchorage metropolitan area to isolated villages. Geographic variability in labor and overhead cost is potentially a significant issue for the provider community. Currently, there are some home care services that are reimbursed via a single statewide rate with no geographic adjustment (e.g., services by care coordinators and personal care attendants). Other services currently include a regional adjustment (e.g., residential supported living).

A geographic differential in a rate setting methodology provides a midpoint between the simplicity of a single statewide rate and the complexity of reimbursement fully based on providers' individual costs. Geographic differentials could be derived from cost of living or wage indices already developed, or potentially may need to be derived specifically for HCB providers through a data collection and analysis process. Myers and Stauffer will review the need for geographic differentials in the rate setting methodology and will evaluate mechanisms that may be used to establish the geographic adjustment factors.

Agency size

Myers and Stauffer will evaluate the possibility of including agency size as a factor impacting the rate setting methodology. Agencies providing home and community based and personal care services in Alaska vary significantly in size. Some agencies geographically limit their practice to one community and others have developed expanded regional networks for providing services. Agency size may have a significant impact on the overall efficiency and cost structure of the agency.

Quality adjustments

Myers and Stauffer will consider a reimbursement component that is based on a measure of the quality of provider performance. Potentially, provider rates may be increased by an amount within a certain range based on a quality indicator for the provider. The quality indicator could be calculated as part of a quality review of each agency or quality could be measured through a "report card" score derived from satisfaction surveys completed by clients and/or clients' families.

Other rate adjustments and considerations

Myers and Stauffer will explore the inclusion of other rate considerations such as rate floors and profit add-ons. Rate floors are a minimum rate that providers would receive regardless of their actual costs. Profit add-ons enhance reimbursement rates by allowing providers to receive an increase in their rate if their actual costs are lower than a set maximum amount. The add-on is calculated as a percentage of the difference between the maximum amount and the provider's actual costs. Myers and Stauffer will collaborate with DSDS staff to ascertain other potential conditions for which rate adjustments may be appropriate.

Every aspect of a rate setting methodology must be reviewed to consider what incentives, intentional or otherwise, are being created. In addition to creating incentives for cost containment, it is also important that those incentives not impact negatively on the quality of services provided to clients. Perverse incentives that would unintentionally result in higher costs or lower quality must be avoided.

The proposed reimbursement methodologies must be in compliance with federal Medicaid statutes, regulations and other applicable policies. This includes the development of rates that are consistent with federal statutes at 42 USC 1396a(a)(30(A) that require the Medicaid program to "assure that payments 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 such care and services are available to the general population in the geographic area."

Stakeholder input

Feedback from the provider community and other stakeholders will be important as Myers and Stauffer proceeds with the process of developing proposals for HCB reimbursement. Following the lead of DSDS, Myers and Stauffer will interact with representatives of the provider community and other stakeholders to ascertain current concerns about potential reimbursement methodologies. We look forward to reviewing any innovative strategies that the provider community may be able to submit for consideration in the development of potential reimbursement methodologies.

C. Transition plan

As the project proceeds and multiple options for the reimbursement methodologies are narrowed down to the most ideal models, it will be necessary to develop a transition plan for the implementation of the new methodology.

The steps in the transition plan will be tailored to the methodology selected, but may include:

- Preparation of necessary changes to the rules and regulations.
- Updates to the waivers or state plan.
- Development of data collection tools (e.g., cost reports), instructions and appropriate review and audit routines.
- Development of manuals and training materials.
- Providing necessary training.
- Obtaining provider buy-in and support.
- Preparation of fiscal impact analyses.
- Determination of the potential need for a phase-in of the new methodology.
- Evaluation and development of any authorization and claims system changes.

- Development of management reports.

Provider and other stakeholder feedback will continue to be important during the development of the transition plan. In an effort to develop recommendations on the proposed reimbursement methodologies, Myers and Stauffer will obtain input and feedback from stakeholder groups such as AGENET, the Governor's Council on Disabilities and Special Education (GCDSEO), the Alaska Commission on Aging (ACOA), the Alaska Mental Health Trust Authority (AMHTA), the Alaska Association on Developmental Disabilities (AADD) and the Assisted Living Association of Alaska (ALAA).

D. Timeline

Several significant dates for future project activities have been established:

- November 8-9, 2007: Myers and Stauffer will participate in meetings in Anchorage with DHSS and representatives of various provider associations. Meetings are currently scheduled with Alaska Association on Developmental Disabilities (AADD) CFO workgroup, PCA provider association and the Assisted Living Association of Alaska (ALAA).
- December 31, 2007: Potential reimbursement methodologies will be presented by Myers and Stauffer in a draft report to DSDS.
- June 30, 2008: Final report to DSDS to present transition plan for a new HCB reimbursement methodology.

In addition to these scheduled activities, Myers and Stauffer anticipates additional interaction with DSDS, providers and stakeholder groups via meetings, teleconferences or other forums to discuss the issues associated with the transition to a new methodology for the reimbursement of HCB services.

VII. Appendix

A. Sources and Websites

1. Alaska Statutes
2. Alaska Administrative Code
3. Alaska Medicaid Provider Billing Manual (various sections)
4. "Alaska's Long Term Care and Cost Study Final Report", Public Consulting Group, Inc., February 2006.
5. "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025", the Lewin Group and ECONorthwest, February 15, 2006.
6. "Medicaid Program Review Final Report", the Pacific Health Policy Group (PHPG), January 2007.
7. "Across the States Profiles of Long-Term Care and Independent Living", American Association of Retired Persons Public Policy Institute, 2006
8. "Understanding Medicaid Home and Community Services: A Primer", George Washington University, Center for Health Policy Research, October 2000
9. US Census Bureau: Census 2000 Summary File
10. US Census Bureau: Census 2000 US States by Population Density
11. CMS 64 data, Centers for Medicaid and State Operations, Division of Financial Management – Medicaid HCBS Waiver Expenditures by Population and Medicaid HCBS Waiver Expenditures by State
12. "Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program", National Health Policy Forum, George Washington University, March 2006
13. Kaiser Family Foundation State Health Facts http://statehealthfacts.org
14. Centers for Personal Assistance Services http://pascenter.org/state_based_stats/medicaid_waiver
15. American Association of Retired Persons Research Center http://www.aarp.org/research
16. Centers for Medicare and Medicaid Services http://www.coms.hhs.gov/home/medicaid

B. Matrices

1. Summary of Key Federal Legislation on Home and Community-Based Services Waiver Programs
2. DHSS Rate Matrix
3. Three Common Long Term Care Issues
4. Six LTC Findings in Long Term Forecast of Medicaid Enrollment and Spending in Alaska
5. Ten Recommendations in Medicaid Program Review
6. Fifty Six Recommendations in Alaska Long Term Care and Cost Study Final Report
7. Six State Comparison Matrix

Appendix B 1

Summary of Key Federal Legislation on Home and Community-Based Services Waiver Programs	
OBRA 1981	Home and community-based waiver authority enacted at section 1915 (c) of the Social Security Act.
COBRA 1985	Provided option to offer expanded habilitation services (prevocational, supported employment, and educational services) to individuals who had previously been institutionalized. Abolished regulatory limit on HCB services expenditures. Changed renewal period from three years to up to five years. Expanded HCB services waiver program to persons who are ventilator dependent, require a hospital level of care, and enter the waiver program from a hospital.
OBRA 1986	Provided option to offer HCB waiver services to individuals who would otherwise be hospitalized. Added services for persons with chronic mental illness (day treatment, partial hospitalization, psychosocial rehabilitation, and clinic services). Permitted cost estimates specific to an individual with a particular illness/injury when discharged from an institution to the waiver.
OBRA 1987	Section 1915 (d) HCB services waiver authority for individuals age 65 and older enacted. (No states currently operate programs under this waiver authority, although it remains in law.*) Eliminated the requirement for a prior institutional stay to make expanded habilitation services available. Allowed waiver of 1902(a)(10)(C)(i)(lll) (deeming of income and resources) for the medically needy. Modified cost neutrality requirements to permit waiver costs for persons with MRDD who had resided in nursing homes to be compared with the typically higher costs that would be incurred in an ICF/MR.
TMRA 1988	Permitted population-specific cost estimates without regard to whether the individual had a prior institutional stay.
OBRA 1990	Permitted states to use ICFs/MR that were terminated from participating in Medicaid for cost comparisons. Permitted coverage of a portion of costs of rent and food for a live-in personal caregiver. Eliminated restriction on number of hours of respite care.
BBA 1997	Removed requirements for prior institutionalization in order to receive supported employment services.
DRA 2005	Permitted states to offer HCB services as a benefit under the Medicaid state plan effective January 1, 2007. States may establish needs-based criteria for determining eligibility for HCB services and use more stringent criteria for institutional care. States may cap the number of individuals that receive HCB services and establish waiting lists. Added new Medicaid state plan option for self-directed personal assistance services (known as cash and counseling) for the elderly and disabled. Authorized a "Money Follows the Person" demonstration to officer enhanced matching funds to states to transition individuals from institutional to HCB settings.

**Only Oregon used this waiver authority. After the cold bed requirement was removed in 1994, Oregon converted its program to a 1915(c) waiver. Spending growth limitations in 1915(d) are tied to growth of the age 65 and older population and are more restrictive that section 1915(c) cost neutrality requirements.*

DHSS Rate Matrix

Division of Health Care Services

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DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF HEALTH CARE SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
01 17	INPATIENT HOSPITAL AW BED PROVIDER	Inpatient hospital services	Prospective per diem payment rate established not less than annually by the Department (see 7 AAC 43.685(b)). Rates are based on reporting (7 AAC 43.679) of allowable reasonable costs (7 AAC 43.686). Reporting of costs and other information is subject to facility audits and desk reviews (7 AAC 43.693). Further rate calculations are based on classification of a facility as a proportionate (7 AAC 43.677) or disproportionate (7 AAC 43.687) share hospital. The current practice of the Office of Rate Review is to re-base rates at least every four years. An inflation adjustment is applied to the rate for interim years between re-basing. Small facilities (4,000 or fewer acute care patient days) can elect to enter into a four year rate agreement with the Department (see 7 AAC 43.689(g) for the rate calculation methodology). The rate of payment for out-of-state hospitals is the Medicaid rate used by the state where the hospital is located or, if no Medicaid rate has been established, the Medicare rate for the hospital, or if no Medicare rate has been established, the Blue Cross rate will be used. Hospital specific reimbursement agreements may be negotiated for unique expertise or specialized services not available in Alaska.	7 AAC 43.360 (8/7/1996); 7 AAC 43.380 (2/2/2005); 7 AAC 43.670 - 7 AAC 43.709 (effective/amended dates vary)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	Inpatient/Outpatient Hospital section (page I-22).			

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04	OUTPATIENT HOSPITAL	Outpatient hospital services	Prospective payment rate established not less than annually by the Department. The payment rate is expressed as a percentage of charges (see 7 AAC 43.685(c)). Reimbursement is based on a percentage of the allowed amount at the rate established by the Department. Rates are based on reporting (7 AAC 43.679) of allowable reasonable costs (7 AAC 43.686). Reporting of costs and other information is subject to facility audits and desk reviews (7 AAC 43.693). Further rate calculations are based on classification of a facility as a proportionate (7 AAC 43.677) or disproportionate (7 AAC 43.687) share hospital. The current practice of the Office of Rate Review is to re-base rates at least every four years. It is assumed that the billed charges will reflect inflation, therefore an inflation adjustment is not applied to the rate for interim years. Small facilities (4,000 or fewer acute care patient days) can elect to enter into a four year rate agreement with the Department (see 7 AAC 43.689(g) for the rate calculation methodology). The rate of payment for out-of-state hospitals is the Medicaid rate used by the state where the hospital is located or, if no Medicaid rate has been established, the Medicare rate for the hospital, or if no Medicare rate has been established, the Blue Cross rate will be used. Hospital specific reimbursement agreements may be negotiated for unique expertise or specialized services not available in Alaska.	7 AAC 43.420 (8/7/1996); 7 AAC 43.360 (8/7/1996); 7 AAC 43.380 (2/2/2005); 7 AAC 43.670 - 7 AAC 43.709 (effective/amended dates vary)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	Inpatient/Outpatient Hospital section (page I-22).			
		Laboratory services	Medicare fee schedule in 42 CFR 405.515.	7 AAC 43.420 (8/7/1996); 7 AAC 43.360 (8/7/1996); 7 AAC 43.670 - 7 AAC 43.709 (effective/amended dates vary)	AS 47.05.010 (2005)	Inpatient/Outpatient Hospital section (page I-22).			

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05	IHS INPATIENT HOSPITAL	Inpatient hospital services	Per diem rate published annually in the Federal Register.			IHS/Tribal Facility Services section (page E-10).			
07	IHS OUTPATIENT HOSPITAL	Outpatient hospital services	Encounter rate published in the Federal Register.			IHS/Tribal Inpatient Hospital section (page D-9).			
08	IHS CLINIC	Tribal clinic services	Per visit encounter rate published by the Indian Health Service.			IHS/Tribal Facility Services section (page A-12).			
06	ESRD FACILITY	End Stage Renal Disease (ESRD) dialysis facility services	The current reimbursement rate established by the Department is 100% of billed charges.			End Stage Renal Disease Dialysis Facility section (page III-6).			
20 21 22	PHYSICIAN/OSTEOPATH - INDIVIDUAL PHYSICIAN/OSTEOPATH - GROUP OSTEOPATH - INDIVIDUAL	Physician services	Fee schedule established using the RBRVS methodology. Work, practice expense and malpractice expense RVU components are derived from the Medicare RBRVS system. Each RVU is adjusted by a geographic practice cost index (GPCI) defined in 7 ACC 43.108(b). The sum of the adjusted RVUs is multiplied by a conversion factor of $49.90 (7 AAC 43.108(b)(3)) to derive the fee amount. Fees for anesthesiology services are based on $42.90 times the number of base units for anesthesiology services plus $36.00 times the number of time units (see 7 AAC 43.108(d)). Provisions for reimbursement of procedures that do not have an established RVU are also defined at 7 AAC 43.108. Out-of-state providers are reimbursed at the lowest of: 1) billed charges; 2) 70 percent of the fee schedule rate established using the RBRVS methodology defined at 7 AAC 43.108; 3) the rate identified in a fee schedule established under Medicaid regulations for a provider type or service not covered under 7 AAC 43.108; 4) the rate established by the Medicaid agency in the state where the service was provided.	7 AAC 43.108 (3/29/2007); 7 AAC 43.150 (12/2/2005)	AS 47.05.010 (2005)	Physician Services section (page I-19); Table I.(a); Table I.(b).		2/12/2007	
		Laboratory services	Medicare fee schedule in 42 CFR 405.515.	7 AAC 43.125 (8/7/1996)	AS 47.05.010 (2005)	Physician Services section (page I-20); Table I.(a); Table I.(b).		2/12/2007	

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24 25	CHIROPRACTOR - INDIVIDUAL CHIROPRACTOR - GROUP	Chiropractic services	Fee schedule established using the RBRVS methodology defined at 7 AAC 43.108.	7 AAC 43.910 (5/5/1999); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Chiropractic Services section (page I-5); Table I-3.		2/15/2007	
28 29	PODIATRY PODIATRIST GROUP	Podiatry services	Fee schedule established using the RBRVS methodology defined at 7 AAC 43.108.	7 AAC 43.453 (12/2/2005); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Podiatry Services section (page I-6); Table I-3.(a); Table I-3.(b).		2/14/2007	
30 31	DENTIST - INDIVIDUAL DENTIST - GROUP	Dental services	Alaska Medicaid regulations at 7 AAC 43.600 state that payment will be made using the same methodology as that used for physicians at 7 AAC 43.040. The provider billing manual further states that oral surgery services are reimbursed using the RBRVS methodology defined at 7 AAC 43.108. Other dental services are reimbursed using the rates listed in Table I-3 and Table I-4 of the provider billing manual.	7 AAC 43.600 (3/29/2007); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Dental services section (page I-7); Table I-3; Table I-4.		2/24/2006	
32	DIETICIAN	Nutrition services	Alaska Medicaid regulations at 7 AAC 43.454 state that reimbursement will be made at the lesser of the charge to the general public or $50 for the first 30 minutes of an initial assessment, $25 for each additional 15 minutes of the initial assessment, and $17.50 for each 15 minutes of service following the initial assessment.	7 AAC 43.454 (3/3/2001); 7 AAC 43.924 (3/3/2001)	AS 47.05.010 (2005)	Nutrition Services section (page I-5); Table I-4 (page I-4). The maximum allowable rates defined at Table I-4 (effective date 8/1/2003) differ from the rates defined at 7 AAC 43.454.		8/1/2003 (effective date of most recent fee schedule)	
35 75 77	OPTOMETRIST OPTICIAN VISION GROUP	Vision services	Fee schedule established using the RBRVS methodology defined at 7 AAC 43.108. The reimbursement amounts for the dispensing and fitting of contanct lenses ($80) and eyeglasses ($30) are established at 7 AAC 43.642.	7 AAC 43.642 (9/29/2005); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Vision Services section (page I-7); Table I-4.(a); Table I-4.(b).		2/14/2007	

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38	NURSE MIDWIFE	Nurse midwife services	85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108. For a normal vaginal delivery performed at a free-standing birth center, reimbursement is based on 85 percent of the RBRVS rate plus 50 percent of the statewide average Alaska Medicaid allowed amount for a normal vaginal hospital birth with a one day length of stay during the calendar year ending 12 months before the beginning of the rate year.	7 AAC 43.942 (12/2/2005); 7 AAC 43.108 (3/29/2007); 7 AAC 43.944 (9/30/2007)	AS 47.05.010 (2005)	1) Direct Entry Midwife Services section (page I-5); Table I-3.(a); Table I-3.(b). 2) Advanced Nurse Practitioner/Nurse Midwife section (page I-18); Table I-3.(a); Table I-3.(b).		1) 2/14/2007 2) 2/12/2007	
		Laboratory services	Medicare fee schedule in 42 CFR 405.515.	7 AAC 43.942 (12/2/2005); 7 AAC 43.125 (8/7/1996)	AS 47.05.010 (2005)	1) Direct Entry Midwife Services section (page I-5); Table I-3.(a); Table I-3.(b). 2) Advanced Nurse Practitioner/Nurse Midwife section (page I-18); Table I-3.(a); Table I-3.(b).		1) 2/14/2007 2) 2/12/2007	
39	INDP PHYSICAL THERAPIST	Physical therapy services	85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108. Reimbursement for out-of-state services is based on the Medicaid rate in the state in which the service is provided.	7 AAC 43.921 (7/11/2002); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Outpatient Therapies section (page I-7); Table I-4.(a); Table I-4.(b).		2/15/2007	
40	SPEECH PATHOLOGIST	Speech pathology services	85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108.	7 AAC 43.926 (12/2/2005); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Outpatient Therapies section (page I-7); Table I-5.(a); Table I-5.(b).		2/15/2007	
41	OCCUPATIONAL THERAPIST	Occupational therapy services	85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108.	7 AAC 43.923 (12/2/2005); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Outpatient Therapies section (page I-7); Table I-6.(a); Table I-6.(b).		2/15/2007	
37	OUTPAT PHYSICAL OR SPEECH THERAPY CENTER	Outpatient therapy services	Refer to provider types 39, 40 and 41	Refer to provider types 39, 40 and 41	Refer to provider types 39, 40 and 41	Outpatient Therapies section (page I-7); Table I-3.(a); Table I-3.(b).		2/15/2007	

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
42	AUDIOLOGIST	Hearing services	For services and items that have an established RVU, reimbursement is based on 85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108. For services and items that do not have an RVU established for Medicare, reimbursement is based on 80 percent of billed charges for the first nine billings. Thereafter, a maximum allowable fee will be established based on the 50th percentile of the first 10 billings.	7 AAC 43.927 (1/11/2006); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Hearing Services section (page I-22 to I-23); Table I-2(a) (CPT Fee Schedule for Audiology Services); Table I-2(b) (HCPC Fee Schedule for Audiology Services). No established RVU - The billing manual indicates that for services with no established RVU, reimbursement is based on 85 percent of 80 percent of billed charges for the first nine billings. Thereafter, a maximum allowable fee will be established based on 85 percent of the 90th percentile of the first 10 billings. HCPCS codes - For services billed with HCPCS codes, reimbursement is based on 100 percent of the amount indicated in the most current published hearing fee schedule. For services and items that do not have an established fee listed or priced by CMS, reimbursement is based on 80 percent of billed charges for the first nine billings. Thereafter, a maximum allowable fee will be established based on the 50th percentile of the first 10 billings.		2/16/2007	
43	HEARING AID SUPPLIER	Hearing aid services	For services and items that have an established RVU, reimbursement is based on 85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108. For services and items that do not have an RVU established for Medicare, reimbursement is based on 80 percent of billed charges for the first nine billings. Thereafter, a maximum allowable fee will be established based on the 50th percentile of the first 10 billings.	7 AAC 43.927 (1/11/2006); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Hearing Services section (page I-22 to I-23); Table I-3 (HCPC Fee Schedule for Hearing Aid Dealer Services). HCPCS codes - For services billed with HCPCS codes, reimbursement is based on 100 percent of the amount indicated in the most current published hearing fee schedule. For services and items that do not have an established fee listed or priced by CMS, reimbursement is based on 80 percent of billed charges for the first nine billings. Thereafter, a maximum allowable fee will be established based on the 50th percentile of the first 10 billings.		2/16/2007	

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DIVISION OF HEALTH CARE SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
51	RURAL HEALTH CLINIC	Primary care services, ambulatory services and mental health services provided by a Rural Health Clinic (RHC)	Per visit rate based on the clinic's reasonable costs calculated prospectively and consistent with 42 U.S.C 1396a(bb)(1) - (5). Alternatively, the department and RHC can make an agreement for the clinic to be reimbursed at a prospective per visit rate calculated in accordance with the provisions of 7 AAC 43.860(g). The current practice of the Office of Rate Review is to re-base rates at least every four years. An inflation adjustment is applied to the rate for interim years between re-basing.	7 AAC 43.860 (3/18/2006); 7 AAC 43.866 (7/11/2002)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	FQHC/RHC section (page I-9).			
		Primary care services, ambulatory services and mental health services provided by a Federally Qualified Health Center (FQHC)	Per visit rate based on the clinic's reasonable costs calculated prospectively and consistent with 42 U.S.C 1396a(bb)(1) - (5). Alternatively, the department and FQHC can make an agreement for the clinic to be reimbursed at a prospective per visit rate calculated in accordance with the provisions of 7 AAC 43.860(g) and 7 AAC 43.872(b). The current practice of the Office of Rate Review is to re-base rates at least every four years. An inflation adjustment is applied to the rate for interim years between re-basing.	7 AAC 43.860 (3/18/2006); 7 AAC 43.872 (7/11/2002); 7 AAC 43.873 (7/11/2002)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	FQHC/RHC section (page I-9).			
54	FAMILY PLANNING CLINIC	Family planning services	85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108.	7 AAC 43.830 (5/5/1999); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Family Planning Clinic section (page I-6); Table I-2.(a); Table I-2.(b). The billing manual states that laboratory services are reimbursed according to the Medicare fee schedule.		2/15/2007	
55	AMBULATORY SURGICAL CTR	Outpatient surgical care services	Prospective per-procedure payment rate established not less than annually by the Department.	7 AAC 43.885 (8/7/1996) 7 AAC 43.670 - 7 AAC 43.709 (effective/amended dates vary)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	Ambulatory Surgical Care section (page I-4 to I-5).			

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DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF HEALTH CARE SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
58	PRIVATE DUTY NURSING AGENCY	Private duty nursing services	Lesser of the amount charged to the general public or $80 per hour for registered nurse or advanced nurse practitioner services and $75 per hour for licensed practical nurse services. For out-of-state private duty nursing agencies, reimbursement is based on the Medicaid rate in the state in which the service is provided.	7 AAC 43.456(f) (4/28/2005)	AS 47.05.010 (2005)	Private Duty Nursing section (page I-6).			
59	HOSPICE	Hospice services	Medicaid rates established annually by CMS (7 AAC 939(b)). If the hospice is part of nursing facility, the reimbursement rate is 95 percent of the nursing facility rate (7 AAC 939(c)).	7 AAC 43.939 (8/13/1995)	AS 47.05.010 (2005)	Hospice Care section (page I-10 to I-12). The billing manual states that the rates are prospective rates that are adjusted for regional differences in wages. CMS publishes an annual change to the Medicaid hospice payment rates. Page I-10 of the billing manual lists the federal fiscal year 2006 Medicaid hospice rates for the four categories of care (routine home care daily rate, continuous home care hourly rate, inpatient respite care rate, general inpatient care rate).			
60	HOME HEALTH AGENCY	Home health services	80 percent of billed charges.	7 AAC 43.805(c) (4/28/2005)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	Home Health Services section (page I-6).			
66	EPSDT SCREENS	EPSDT services	Fee schedule established using the RBRVS methodology defined at 7 AAC 43.108. All providers (both physician and non-physician providers) are reimbursed for EPSDT services at 100 percent of the RBRVS fee schedule rate.	7 AAC 43.452(g) (3/3/2001); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	EPSDT Services section (page I-11); Table I-4; Table I-5. The billing manual indicates that in some instances, the services are reimbursed at the rate established under 7 AAC 43.557 for inpatient psychiatric hospitals.		1/26/2007	

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
68	ADV. NURSE PRACTITIONER	Advanced nurse practitioner services	85 percent of the RBRVS fee schedule rates established under 7 AAC 43.108. Out-of-state services are reimbursed at the lesser of the Medicaid rate in the state in which the service is provided or 80 percent of the amount the provider charges to the general public.	7 AAC 43.922 (3/3/2001); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	Advanced Nurse Practitioner/Nurse Midwife section (page I-18); Table I-3.(a); Table I-3.(b).		2/12/2007	
		Laboratory services	Medicare fee schedule in 42 CFR 405.515.	7 AAC 43.922 (3/3/2001); 7 AAC 43.125 (8/7/1996)	AS 47.05.010 (2005)	Advanced Nurse Practitioner/Nurse Midwife section (page I-18); Table I-3.(a); Table I-3.(b).		2/12/2007	
70	PHARMACY	Pharmacy services	1) For drugs with a Federal Upper Limit (FUL), reimbursement is based on the FUL plus a dispensing fee. 2) For drugs without an established FUL, reimbursement is based on the Estimated Acquisition Cost (EAC) plus a dispensing fee. EAC is defined as the average wholesale price (AWP) minus 5%. Upon request, pharmacies must provide data related to the cost of dispensing. Dispensing fees are calculated from pharmacy cost data using a formula based on prescription volume, Medicaid prescription volume and store square footage. Lacking dispensing cost data, the pharmacy receives the minimum dispensing fee. Prescriptions packaged as unit dose receive the maximum dispensing fee. Prescriptions dispensed for certain "high technology" drugs receive the maximum dispensing fee plus a preparation fee of $10 per 15 minutes.	7 AAC 43.591 (4/14/2007)	AS 47.05.010 (2005)	Pharmacy section (page I-12 to I-15).			
71	PROSTH & ORTH SUPPLIER	Dispensing of prosthetics and orthotics	For items that are priced by CMS, reimbursement is based on 100 percent of the DMEPOS Fee Schedule 2006 1st Quarter established by CMS. Provisions for reimbursement of items that are not priced by CMS are defined at 7 AAC 43.1920(c).	7 AAC 43.1920 (7/2/2006)	AS 47.05.010 (2005)	DME & Supplies section (page I-30 to I-32); Table I-5 (HCPCS Fee Schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies). The billing manual indicates that for items that are priced by CMS, reimbursement is based on 100 percent of the first quarter 2005 fee schedule established by CMS.		Table I-5 has an effective date of 1/1/2007 and a publishing date of 6/7/2007.	

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
76	DME SUPPLIER	Dispensing of durable medical equipment and supplies	For items that are priced by CMS, reimbursement is based on 100 percent of the DMEPOS Fee Schedule 2006 1st Quarter established by CMS. Provisions for reimbursement of items that are not priced by CMS are defined at 7 AAC 43.1920(c). Skin care items are reimbursed based on the average wholesale price plus 10 percent. Incontinence supplies are reimbursed based on the Incontinence Supplies Fee Schedule. Provisions for reimbursement of rental items are defined at 7 AAC 43.1945. Provisions for home infusion therapy services are defined at 7 AAC 43.1970(c).	7 AAC 43.1920 (7/2/2006); 7 AAC 43.1945 (1/11/2006); 7 AAC 43.1970(c) (1/11/2006)	AS 47.05.010 (2005)	DME & Supplies section (page I-17 and page I-30 to I-32); Table I-1 (HCPC Fee Schedule for Incontinence Supplies); Table I-2 (Procedure Codes: Specialized Medical Equipment and Supplies); Table I-3 (Procedure codes: Home Infusion Therapy Services); Table I-5 (HCPC Fee Schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies).		Tables I-1 and I-5 have an effective date of 1/1/2007 and a publishing date of 6/7/2007. Tables I-2 and I-3 have an updated date of 01/2006.	For an item to be reimbursed at an amount that exceeds the maximum allowable payment rate, the provider must submit a prior authorizatioin request along with the Manufacturer's Suggested Retail Price (MSRP), the provider's actual cost and the provider's normal billed charge. The reimbursement rate is based on the lesser of the billed rate or 40% over cost. For unpriced items that require prior authorization, the provider is required to submit the MSRP for the item. Reimbursement for the unpriced item is based on 80% of the MSRP.
80	INDP LABORATORY	Lab services	Medicare fee schedule in 42 CFR 405.515.	7 AAC 43.125 (8/7/1996)	AS 47.05.010 (2005)	Independent Laboratory section (page I-4); CPT Fee Schedule for Independent Laboratory Services; HCPC Fee Schedule for Independent Laboratory Services. The billing manual states that the professional component of diagnostic laboratory services is reimbursed according to the RBRVS. Other services are reimbursed at the lesser of billed charges or a percentage of the Medicare-established fee schedule.		2/16/2007	
81	PORTABLE X-RAY PROVIDERS	X-ray services	Alaska Medicaid regulations at 7 AAC 43.940 state that reimbursement will be made in accordance with 7 AAC 43.040. The provider billing manual further states that reimbursement will be based on 100 percent of the fee schedule established using the RBRVS methodology defined at 7 AAC 43.108.	7 AAC 43.940 (12/2/2005); 7 AAC 43.108 (3/29/2007)	AS 47.05.010 (2005)	X-ray Services section (page I-4).			

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DIVISION OF HEALTH CARE SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
82	GROUND AMBULANCE	Transportation services	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 includes maximum allowable base rates and per mileage amounts for both urban and rural services.		1/1/2005 (effective date of most recent version of Table I-3 available online)	
83	TAXI	Transportation services	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 indicates that taxi services are reimbursed based on billed charges.		1/1/2005 (effective date of most recent version of Table I-3 available online)	
84	OTHER TRANS	Transportation services	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 includes a maximum allowable base rate (and per mileage amount for rural services) for wheelchair van services. Table I-3 indicates that other transportation services (including train and ferry) are reimbursed based on billed charges.		1/1/2005 (effective date of most recent version of Table I-3 available online)	
85	AIRLINE	Transportation services	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 indicates that commercial/charter airline transportation services are reimbursed based on billed charges.		1/1/2005 (effective date of most recent version of Table I-3 available online)	
86	AIR AMBULANCE	Transportation services	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 includes maximum allowable base rates and per mileage amounts for both urban and rural services.		1/1/2005 (effective date of most recent version of Table I-3 available online)	

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
88 89	HOTEL/RESTAURANT HOTEL	Lodging	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 includes a maximum allowable rate of $89 for lodging.		1/1/2005 (effective date of most recent version of Table I-3 available online)	
		Meals	Billed charges, except as specified in Table I-3 of the transportation and accommodations section of the Alaska Medicaid Provider Billing Manual.	7 AAC 43.517 (4/28/2005)	AS 47.05.010 (2005)	Transportation/Accommodation Services section, Table I-3 (page I-17 through I-19). Table I-3 includes a maximum allowable rate of $36 for meals.		1/1/2005 (effective date of most recent version of Table I-3 available online)	

NOTE 1> In several instances, the reimbursement methodologies described in the Alaska Medicaid regulations and provider billing manuals include a reference to Alaska Medicaid regulation 7 AAC 43.040. This regulation states that a provider will be reimbursed at the lowest of 1) billed charges; 2) the rate identified in the fee schedule established in the regulations for the applicable provider type or service; or 3) the provider's lowest charge that is advertised, quoted, posted, or billed for that unit of service and provided on the same date regardless of the payment source or method of payment.

Abbreviations:
RBRVS - Resource Based Relative Value Scale
RVU - Relative Value Unit

DHSS Rate Matrix

Division of Senior and Disabilities Services

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DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF SENIOR AND DISABILITIES SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
11 16	SNF/ICF FACILITY SWING BED PROVIDER	Skilled nursing facility and intermediate care facility services	Prospective per diem payment rate established not less than annually by the Department (see 7 AAC 43.685(e)). Rates are based on reporting (7 AAC 43.679) of allowable reasonable costs (7 AAC 43.686). Reporting of costs and other information is subject to facility audits and desk reviews (7 AAC 43.693). A recipient's income, exclusive of the authorized allowance for personal incidental needs, must be offset as a credit against the established daily rate. The current practice of the Office of Rate Review is to re-base rates at least every four years. An inflation adjustment is applied to the rate for interim years between re-basing. Small facilities (15,000 or fewer Medicaid nursing facility days) can elect to enter into a four year rate agreement with the Department (see 7 AAC 43.689(g) for the rate calculation methodology). Payment for care in out-of-state facilities will be made under the general provisions of the rules established by the Medicaid state agency in the state where the facility is located.	7 AAC 43.215 (8/7/1996); 7 AAC 43.240 (8/7/1996); 7 AAC 43.670 - 7 AAC 43.709 (effective/amended dates vary)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	Long-term Care section (page I-14)			

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DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF SENIOR AND DISABILITIES SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
46	HOME AND COMMUNITY BASED	Chore services Adult day services Day habilitation services Residential habilitation services Supported employment services Intensive active treatment services Respite care services Transportation services Meals services The individual procedure codes used to bill Medicaid for HCB agency services have varying units of measure. Most of the procedure codes are reimbursed based on either a 15 minute unit, an hourly unit, or a daily unit of service. Units of reimbursement for travel services is on the basis of per one-way trip and meals on the basis of per meal. For Medicaid billing purposes, residential habilitation services are broken down into multiple procedure codes that are based on the type of service provided (e.g., in-home support, shared care, foster care, supported living, group home habilitation).	Alaska Medicaid regulations at 7 AAC 43.1058(f) state that reimbursement will be based upon: 1) Rates established in Table I-4 of the Home and Community Based Agency section of the Alaska Medicaid Provider Billing Manual. The June 2003 revision of Table I-4 is adopted by reference. -OR- 2) Allowable direct service costs and allowable administrative and general costs. Alaska Medicaid regulations at 7 AAC 43.1060 define allowable and non-allowable costs. According to 7 AAC 43.1060 a provider seeking an administrative and general cost rate must submit: a) Proposed budget for the provider's next fiscal year that sets out all anticipated funding sources and amounts. b) Calculation of the administrative and general cost rate. Administrative and general costs will not be reimbursed for out-of-home daily respite care services, family-directed respite services, meals services and any services provided by a home and community-based services provider acting as an organized health care delivery system under 42 CFR 447.10.	7 AAC 43.1058 (6/23/2007); 7 AAC 43.1060 (8/24/2006)	AS 47.05.010	Home and Community-based Agency section (page I-7); Table I-4 (page I-13 to I-14). Table I-4 has an updated date of June 1995. The listed procedure codes are not the codes currently used to bill Medicaid and the maximum allowable amount for each service is "as approved". The June 2003 revision of Table I-4 that is referenced in the regulations could not be located.			Prior to the rate freeze (see 7 AAC 43.1058(l)), rates were negotiated by social workers on a per recipient and per procedure code basis for each agency. Since the rate freeze, providers have had the option of entering into an aggregate rate agreement. The aggregate rate for an agency is calculated on a per procedure code basis and is the same for all recipients. The aggregate rate is based on an average rate for all recipients that is calculated using historical data.

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
46	HOME AND COMMUNITY BASED (HCB) (continued)		Until 7/1/2008, no increases in the unit rate determined under the methodology of 7 AAC 43.1058 will be approved (7 AAC 43.1058(l)). Exceptions to the rate freeze may be made for providers of residential supported living or residential habilitation services upon written request and approval of the director of the division. The need for the rate increase, according to allowable reasons, must be documented (7 AAC 43.1058(r)). Alternatively, a provider may seek reimbursement based upon a rate equal to the provider's average rate for the service during the last fiscal year (7 AAC 43.1058(o)). If the provider is expanding into a new area, rates are set at the lesser of the provider's average rate for other areas or the average rate of all other providers of service in the new area or the provider's cost-based rate under 7 AAC 43.1060 (7 AAC43.1058(p)). For providers of family habilitation home services or group home habilitation services, the daily rate may also be calculated by dividing the estimated annual cost by 342 (7 AAC 43.1058(n)). If a provider takes of an existing recipient's plan of car, the rate is based on the lesser of the rate already calculated for the recipient for the remainder of the plan-of-care year or the provider's cost-based rate (7 AAC 43.1058(q)).						Prior to the rate freeze, cost data was collected from providers during the calculation of the agency's initial rates and at subsequent intervals. The cost data would be reviewed for reasonableness and verified with various sources when possible. Without the current rate freeze, new cost-based rates would be periodically re-calculated. With the current rate freeze, very little cost data is actually being collected from existing providers.
		Specialized private duty nursing services	Lesser of the amount charged to the general public or $80 per hour for registered nurse or advanced nurse practitioner services and $75 per hour for licensed practical nurse services.	7 AAC 43.1058(d) (6/23/2007); 7 AAC 43.456(f) (4/28/2005)	AS 47.05.010 (2005)	Private Duty Nursing section (page I-6).			
		Dispensing of specialized medical equipment and supplies	For specialized equipment and supplies for which the Department has issued a price, reimbursement is based on the maximum allowable amounts specified in the Specialized Medical Equipment Fee Schedule 2006. For items that do not have an established price, reimbursement is based on 80 percent of billed charges for the first nine billings. Thereafter, a maximum allowable fee will be established based on the 50th percentile of the first 10 billings.	7 AAC 43.1058(c) (6/23/2007)	AS 47.05.010 (2005)	Table I-2 of the DME & Supplies section includes maximum allowable amounts for specialized medical equipment and supplies. The table was last updated in January 2006.	Specialized Medical Equipment Fee Schedule 2006.		

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
47	RES. SUP. LIVING ARRANGEMENTS	Residential supported living services	Base daily service rates that are defined at 7 AAC 43.1058(h). The base rates vary depending on the number of residents in the facility and whether 24-hour awake staff is provided (the base rate categories are commonly referenced as "Adult Foster Care", "Adult Residential I" and "Adult Residential II"). The rates are adjusted for several factors including: 1) A decrease to the rate if the recipient also receives adult day care services. 2) An increase to the rate if the recipient's needs warrant hiring additional staff. 3) An adjustment to reflect regional differences in the cost of doing business. The adjustment is based on the region in which the provider is located. The regional adjustment factors are defined at 7 AAC 43.1058(h)(6). 4) An increase to the rate of $8.65 per day as defined at 7 AAC 43.1058(h)(7). 5) An adjustment for a cost of living percentage increase (subject to the availability of appropriations). Until 7/1/2008, no increases in the unit rate determined under the methodology of 7 AAC 43.1058 will be approved (7 AAC 43.1058(l)). Exceptions to the rate freeze may be made for providers of residential supported living or residential habilitation services upon written request and approval of the director of the division. The need for the rate increase, according to allowable reasons, must be documented (7 AAC 43.1058(r)). Alternatively, the daily rate may be calculated by dividing the estimated annual cost by 342 (7 AAC 43.1058(n)).	7 AAC 43.1058(h) (6/23/2007); 7 AAC 43.1058(n) (6/23/2007)	AS 47.05.010 (2005)	Residential Supported Living/Assisted Living Homes section (page I-4). The billing manual states that rates will be negotiated on a per recipient per provider per waiver year basis.			Prior to the rate freeze (see 7 AAC 43.1058(l)), rates were negotiated by social workers on a per recipient basis for each provider. Since the rate freeze, providers have had the option of entering into an aggregate rate agreement. The aggregate rate for an agency is the same for all recipients. The aggregate rate is based on an average rate for all recipients that is calculated using historical data. Prior to the rate freeze, cost data was collected from providers during the calculation of the facilities' initial rates and at subsequent intervals. The cost data would be reviewed for reasonableness and verified with various sources when possible. Without the current rate freeze, new cost-based rates would be periodically re-calculated. With the current rate freeze, very little cost data is actually being collected from existing providers.

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48	ENVIRONMENTAL MODIFICATIONS	Environmental modification services	100% of billed charges not to exceed $10,000 per recipient over a 36-month period. Exceptions to the $10,000 limit are detailed at 7 AAC 43.1054(c)(5). If the provider acts as an organized health care delivery system under 42 CFR 447.10 for the purpose of overseeing the purchase of an environmental modification for a recipient, the provider will be reimbursed an administrative fee of 2% of the billed charges or $50, whichever is greater.	7 AAC 43.1054(c) (5/15/2004); 7 AAC 43.1058(e) (6/23/2007)	AS 47.05.010 (2005)	Environmental Modifications section (page I-6).			
61	CARE CO-ORDINATION AGENCY	Screenings Assessments Plan of care development Ongoing care coordination	Maximum allowable amount specified in Table I-5 of the Home and Community Based Waiver Services: Care Coordination section of the Alaska Medicaid Provider Billing Manual. Alaska Medicaid regulations at 7 AAC 43.1058(b)(2) state that the June 2003 revision of Table I-5 is adopted by reference.	7 AAC 43.1058(b) (6/23/2007)	AS 47.05.010 (2005)	Care Coordination section (page I-9); Table I-5 (page I-13). Table I-5 has an effective date of 11/10/1993 and the listed procedure codes are not the codes currently used to bill Medicaid. The June 2003 revision of Table I-5 that is referenced in the regulations could not be located.		11/10/1993	
95	PERSONAL CARE AGENCY	Personal care services	Maximum allowable rate of $21 per hour.	7 AAC 43.790 (4/11/2007);	AS 47.05.010 (2005)	Personal Care Agency section (page I-12); Table I-4 (page I-19). In addition to the rate included in the regulations of $21 per hour, Table I-4 also includes a daily rate of $200 per day. The procedure codes listed in Table I-4 are not the codes currently used to bill Medicaid.	Consumer Directed and Agency Based Personal Care Assistant Services Crosswalk. The crosswalk lists the procedure codes currently used for billing personal care services. The crosswalk lists the reimbursement rates as $21 per hour (billed in 15 minutes increments) and $200 per day.		

NOTE 1> In several instances, the reimbursement methodologies described in the Alaska Medicaid regulations and provider billing manuals include a reference to Alaska Medicaid regulation 7 AAC 43.040. This regulation states that a provider will be reimbursed at the lowest of 1) billed charges; 2) the rate identified in the fee schedule established in the regulations for the applicable provider type or service; or 3) the provider's lowest charge that is advertised, quoted, posted, or billed for that unit of service and provided on the same date regardless of the payment source or method of payment.

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MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
Non-Medicaid Services									
N/A	Assisted Living Homes General Relief	Housing and food service. Protective services Personal assistance Supportive services	A minimum daily rate of $70, effective July 1, 2002 is set at 7 AAC 47.470(b)(3). Per 7 AAC 47.470(c), this rate is regionally adjusted for all regions other than Anchorage and the southeast region by adjustment factors ranging from 1.04 to 1.38 depending on region. Per 7 AAC 47.470(d) the minimum daily reimbursement rate may be adjusted by the Department based on review of the consumer price index and cost-of-living differentials. Per 7 AAC 47.471, the minimum daily rate may be augmented if a resident requires assistance with four or more activities of daily living or if the resident otherwise requires a significantly higher level of care. The augmented rate is $7 per day for each additional activity of daily living not to exceed $22 per day. For residents requiring higher levels of care due to substance dependency, severe mental health impairment, major health impairment or other factors described in 7 AAC 47.471(a)(1) through (4), the augmented rate is $15 per day (if factors of 7 AAC 47.471(a)(1) through (4) are combined with ADL assistance needs, the maximum augmented rate is $22 per day). For an emergency placement (up to 31 days), an augmented rate of $10 per day will be paid (not to exceed a total augmented rate of $22). Additional augmented rates of $7 per day to $35 per day are authorized by 7 AAC 47.472 for recipients with certain mental health needs determined by a local community mental health center. Specific augmented rates are associated with persons designated in Categories I through III as defined in 7 AAC 47.472(d).	7 AAC 47.460 (6/28/2002); 7 AAC 47.470 (6/27/2004); 7 AAC 47.471 (4/24/2004); 7 AAC 47.472 (6/24/2004)	AS 47.25.195 (2005)				

Appendix B 2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF SENIOR AND DISABILITIES SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
N/A	Grant services	DSDS makes grants to nonprofit organizational partners across Alaska. Grant funds come from various sources including the U.S. Administration on Aging, the Alaska Mental Health Trust Authority, and state general funds. Many of the services provided through these grant programs are similar to the services provided through the Home and Community Based (HCB) waiver program. Individuals eligible to receive services through the grant programs include those with needs similar to HCB waiver recipients, but do not qualify for the waiver program. Services are also provided through the grant programs to individuals on the Developmental Disabilities (DD) waiver program waiting list. Grant programs include: -Home and Community Based Care grants (e.g., adult day services, senior in-home services, national family caregiver support program). -Alaska Mental Health Trust Authority (MHTAAR) grants. -Nutrition, Transportation, and Support Services grants.	In general, grant payments are made at an amount authorized by the Department. During each state fiscal year, the Department will authorize payment of costs only to the extent of money allocated in the state budget for the grant program for that fiscal year. The Department will determine the amount of money, if any, that it will keep in reserve at a particular time, based on the portion of the fiscal year that remains and the demand for services of the program that the Department expects during the balance of the fiscal year (7 AAC 78.315 and 7 AAC 81.220). <u>Chapter 78</u> Chapter 78 of the Alaska Administrative Code defines the provisions for grant services rendered by a state agency, a political subdivision of the state, or a nonprofit organization. Grantees are required to submit a clearly stated budget with the initial grant proposal that documents the costs associated with the goals, strategies, and, if applicable, allocation of resources among target populations, geographic areas, or communities (7 AAC 78.100(1)(F)). Provisions for reallocation of grant money between budget categories are defined at 7 AAC 78.260. Allowable costs that the grantee may use grant money to pay for are defined at 7 AAC 43.160. Each year of the grant, the grantee must submit a budget for that one-year period and a one-year plan specifying the services to be delivered and performance measures. Financing for a grant project is approved annually for additional years contingent upon the continued need for the grant project service, the availability of grant money, the grantee's satisfactory performance during the previous grant year, and whether continuation of the financing is consistent with public health and welfare (7 AAC 78.140).	Chapter 78 - including 7 AAC 78.100 (6/24/2004); 7 AAC 78.140 (6/24/2004); 7 AAC 43.160 (6/24/2004); 7 AAC 78.190 (6/24/2004); 7 AAC 43.200 (6/24/2004); 7 AAC 43.210 (6/24/2004); 7 AAC 43.260 (6/24/2004); 7 AAC 43.315 (6/24/2004)	AS 47.40.041		Grant services information included on the DSDS website (http://www.hss.state.ak.us/dsds/grantservices.htm)		

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DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF SENIOR AND DISABILITIES SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
N/A	Grant services (continued)	Grant services (continued) -Senior Residential Services (to fund two rural senior assisted living residences). -Community Developmental Disabilities Grant Program (CDDG). This program also funds Core Services which are offered to individuals on the DD waitlist. Core Services are limited to $3,000 per individual. -Short-Term Assistance & Referral Programs (STAR). Many individuals on the DD waitlist access STAR services.	Chapter 78 (cont.) Grantees must submit financial and progress reports in accordance with the requirements of the grant agreement (7 AAC 78.200). In addition, the grantee must ensure that a fiscal audit of the grantee's operations under the grant program is performed by an independent certified public accountant (7 AAC 78.210). Chapter 81 Chapter 81 of the Alaska Administrative Code defines the provisions for grant services that are rendered to an individual. A provider may receive payment from the Department for services provided under a provider agreement if the Department has authorized the amount of payment the provider can receive for services based on: (A) an individualized service plan; (B) a schedule of fees specific to the grant program; or (C) a periodic rate per individual (7 AAC 81.040) A provider may not request payment for services under Chapter 81 if the provider has a grant under Chapter 78 to provide the same service.	Chapter 81 - including 7 AAC 81.040 (6/24/2004); 7 AAC 81.220 (6/24/2004)					

DHSS Rate Matrix

Division of Behavioral Health

Appendix B 2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF BEHAVIORAL HEALTH PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory basis; last amended or other effective date	Statutory Basis; Effective Date	Alaska Medicaid Provider Billing Manual citation - (summarize any additional reimbursement specifications)	Other applicable documents	Date of last rate calculation (if applicable)	other criteria used based on non-published internal criteria
02 03	INPATIENT PSYCHIATRIC HOSPITAL STATE INPAT PSYCHIATRIC HOSP (SPECIALTY CODE 00)	Inpatient psychiatric services provided in an inpatient psychiatric hospital facility	Prospective per diem payment rate established not less than annually by the Department (see 7 AAC 43.685(b)). Rates are based on reporting (7 AAC 43.679) of allowable reasonable costs (7 AAC 43.686). Reporting of costs and other information is subject to facility audits and desk reviews (7 AAC 43.693). Further rate calculations are based on classification of a facility as a proportionate (7 AAC 43.677) or disproportionate (7 AAC 43.687) share hospital. The current practice of the Office of Rate Review is to re-base rates at least every four years. An inflation adjustment is applied to the rate for interim years between re-basing. Small facilities (4,000 or fewer acute care patient days) can elect to enter into a four year rate agreement with the Department (see 7 AAC 43.689(g) for the rate calculation methodology).	7 AAC 43.570 (8/7/1996); 7 AAC 43.670 - 7 AAC 43.709 (effective/amended dates vary)	AS 47.05.010 (2005); AS 47.07.070 - AS 47.07.075 (effective/amended dates vary)	Inpatient Psychiatric Services section (page I-13).			
03	STATE INPAT PSYCHIATRIC HOSP (SPECIALTY CODE 99)	Inpatient psychiatric services provided in a residential psychiatric treatment center	Per diem rate established by the Department based on periodic review of appropriate cost studies.	7 AAC 43.557 (3/26/2003); 7 AAC 43.570 (8/7/1996)	AS 47.05.010 (2005)	Inpatient Psychiatric Services section (page I-13). The billing manual indicates that the per diem rate established by the Department is $325 (this section of the billing manual was last updated 05/2005).			
		Therapeutic transition days at a residential psychiatric treatment center	$211 per day (rate established directly by regulation).	7 AAC 43.557(e) (3/26/2003)	AS 47.05.010 (2005)	Inpatient Psychiatric Services section (page I-13).			
10	DAY TREATMENT FACILITY	Day treatment services	$150 per day (minimum of 6 hours per day) (rate established directly by regulation). $100 per half day (minimum of 3 hours per day (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Day Treatment Services section (page I-17); Table I-3.	Day Treatment Services Crosswalk. The crosswalk indicates that effective 1/1/2004, the appropriate procedure code used to bill Medicaid for day treatment services is H2012. The crosswalk indicates that the reimbursement rate for procedure code H2012 is $25 per hour.		
36	DRUG ABUSE CENTER	Assessment and diagnosis services (procedure code H0001)	$50 per service (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			

Appendix B 2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF BEHAVIORAL HEALTH PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory basis; last amended or other effective date	Statutory Basis; Effective Date	Alaska Medicaid Provider Billing Manual citation - (summarize any additional reimbursement specifications)	Other applicable documents	Date of last rate calculation (if applicable)	other criteria used based on non-published internal criteria
36	DRUG ABUSE CENTER (continued)	Outpatient individual counseling (procedure code CDADK)	$50 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $50 per hour is listed in Table I-7 as $12.50 per 15 minutes.			
		Outpatient group counseling (procedure code H0005)	$20 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $20 per hour is listed in Table I-7 as $5 per 15 minutes.			
		Outpatient family counseling (procedure code T1006)	$45 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $45 per hour is listed in Table I-7 as $11.25 per 15 minutes.			
		Outpatient care coordination services (procedure code H0006)	$30 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $30 per hour is listed in Table I-7 as $7.50 per 15 minutes.			
		Outpatient rehabilitation treatment services (procedure code T1012)	$40 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $40 per hour is listed in Table I-7 as $10 per 15 minutes.			
		Intensive outpatient services (procedure code H0015)	$45 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $45 per hour is listed in Table I-7 as $11.25 per 15 minutes.			
		Intermediate services (procedure code H0022)	$50 per hour (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7. The reimbursement rate of $50 per hour is listed in Table I-7 as $12.50 per 15 minutes.			
		Medical evaluation for a recipient seeking methadone treatment (procedure code H0002 HF)	$300 per evaluation (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			
		Intake physical for a non-methadone recipient (procedure code H0002)	$150 per physical (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			
		Treatment plan review for a methadone recipient (procedure code T1007)	$30 per review (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			
		Medication management services (procedure code 90862)	$35 per visit (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			

Appendix B 2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF BEHAVIORAL HEALTH PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory basis; last amended or other effective date	Statutory Basis; Effective Date	Alaska Medicaid Provider Billing Manual citation - (summarize any additional reimbursement specifications)	Other applicable documents	Date of last rate calculation (if applicable)	other criteria used based on non-published internal criteria
36	DRUG ABUSE CENTER (continued)	Dispensing of methadone or antabuse (procedure code H0020)	$10 per visit (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			
		Urinalysis drug screen (procedure code 80100)	Medicare fee schedule in 42 CFR 405.515.	7 AAC 43.746 (2/23/1994); 7 AAC 43.125 (8/7/1996)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			
		Detoxification services (procedure code H0013)	$150 for each consecutive 24-hour period (rate established directly by regulation).	7 AAC 43.746 (2/23/1994)	AS 47.05.010 (2005)	Behavioral Health section (page I-57 to I-58, page I-63); Table I-7.			
93	MENTAL HEALTH CLINIC Specialty 69: Community Mental Health Clinic Specialty 99: Mental Health Physician Clinic Mental health clinic services are reimbursable to both community mental health clinics and mental health physician clinics. Mental health rehabilitation services (indicated by *) are reimbursable only to community mental health clinics.	Intake assessment (procedure code H0031)	$85 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(b); Table I-5(b). The reimbursement rate of $85 per hour is listed in the tables as $21.25 per 15 minutes.			
		Psychiatric assessment (procedure codes 90801 and 90802)	$230 per assessment (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(a); Table I-5(a).			
		Psychological testing and evaluation services (procedure codes CDBAQ and CDBAS)	$85 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(b); Table I-5(b). The reimbursement rate of $85 per hour is listed in the tables as $21.25 per 15 minutes.			
		Crisis intervention services (procedure code S9484)	$75 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(b); Table I-5(b).			
		Individual and family psychotherapy (procedure codes 90804, 90810, 90847)	$80 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(a); Table I-5(a). The reimbursement rate of $80 per hour is listed in tables as $40 per 30 minutes.			
		Group psychotherapy (procedure codes 90849 and 90853)	$45 per session (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(a); Table I-5(a). The reimbursement rate is listed in tables as $22.50 per 30 minutes.			
		Pharmacologic management services (procedure code 90862)	$75 per visit (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(a); Table I-5(a).			
		Functional assessment (initial or semi-annual) (procedure code CDBAP)*	$50 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c); Table I-5(c). The reimbursement rate of $50 per hour is listed in the tables as $12.50 per 15 minutes.			
		Individual skill development (procedure code CDAEP)*	$50 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c); Table I-5(c). The reimbursement rate of $50 per hour is listed in the tables as $12.50 per 15 minutes.			

Appendix B 2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
DIVISION OF BEHAVIORAL HEALTH PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory basis; last amended or other effective date	Statutory Basis; Effective Date	Alaska Medicaid Provider Billing Manual citation - (summarize any additional reimbursement specifications)	Other applicable documents	Date of last rate calculation (if applicable)	other criteria used based on non-published internal criteria
93	MENTAL HEALTH CLINIC (continued)	Group skill development (procedure code CDAKQ)*	$30 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c); Table I-5(c). The reimbursement rate of $30 per hour is listed in the tables as $7.50 per 15 minutes.			
		Family skill development (procedure code CDABF)*	$50 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c). The reimbursement rate of $50 per hour is listed in the table as $12.50 per 15 minutes.			
		Recipient support services (procedure code CDACM)*	$20 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c); Table I-5(c). The reimbursement rate of $20 per hour is listed in the tables as $5 per 15 minutes.			
		Case management services (procedure code T1016)*	$50 per hour (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c); Table I-5(c). The reimbursement rate of $50 per hour is listed in the tables as $12.50 per 15 minutes.			
		Medication administration services (procedure codes H0033 and H0033 HK)*	$20 per day when administered on the premises of the clinic. $30 per day when administered off-site. (Rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c); Table I-5(c).			
		Mental health rehabilitation services provided within a foster home or residential setting to recipients under 21 years of age (procedure code H0018)*	$171 per day (rate established directly by regulation).	7 AAC 43.729 (12/16/2005)	AS 47.05.010 (2005)	Behavioral Health section (page I-38 to I-43, page I-63); Table I-4(c).			

NOTE 1> Alaska Medicaid regulations at 7 AAC 43.040 include general reimbursement guidelines applicable to all enrolled providers. According the 7 AAC 43.040, a provider will be reimbursed at the lowest of 1) billed charges; 2) the rate identified in the fee schedule established in the regulations for the applicable provider type or service; or 3) the provider's lowest charge that is advertised, quoted, posted, or billed for that unit of service and provided on the same date regardless of the payment source or method of payment.

NOTE 2> For mental health clinic services that are provided out-of-state, reimbursement is based on the Medicaid rate in the state where the service was provided (7 AAC 43.729((a)(10).

DHSS Rate Matrix

Office of Children's Services

Appendix B-2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
OFFICE OF CHILDREN'S SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
34	BEHAVIORAL REHABILITATION SERVICES PROVIDERS (the provider type description included in the Medicaid Management Information System for these providers is "DD REHAB CENTER")	Behavioral rehabilitation services	Daily rate identified in the Behavioral Rehabilitation Services Handbook, 2005 edition. The daily rates do not include room and board.	7 AAC 43.481(c) (12/16/2005); 7 AAC 43.729(c) (12/16/2005)	AS 47.05.010 (2005)		Behavioral Rehabilitation Services Handbook, 2005 edition. Page 21 of the handbook lists the four levels of care and the daily rate applicable to each level of care. Pages 3 and 21 of the handbook indicate that the Office of Children's Services (OCS) bills Medicaid on behalf of the providers based on attendance sheets submitted by the providers to OCS. The providers receive funding through grant payments from OCS.		

NOTE 1> Alaska Medicaid regulations at 7 AAC 43.040 include general reimbursement guidelines applicable to all enrolled providers. According the 7 AAC 43.040, a provider will be reimbursed at the lowest of 1) billed charges; 2) the rate identified in the fee schedule established in the regulations for the applicable provider type or service; or 3) the provider's lowest charge that is advertised, quoted, posted, or billed for that unit of service and provided on the same date regardless of the payment source or method of payment.

Appendix B-2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
OFFICE OF CHILDREN'S SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
Non-Medicaid Services									
N/A	Foster Care	Foster care services provided to youth in a licensed foster home	Reimbursement is based on a standard daily rate. The department may propose to the legislature each year a standard rate for child foster care after reviewing the current United States Health and Human Services Poverty guidelines for an Alaska family unit of one and the current state cost-of-living differentials determined by the Department of Administration. Based on legislative appropriations, the department will establish a standard rate. The standard rate currently in effect is $23.84 per day, which is based on the 1993 poverty guideline. The standard rate is to assist in meeting the costs for food, clothing replacement, shelter, utilities, use of household furnishings, daily supervision, personal items, grooming, school supplies, recreation, toys, activities, usual transportation, allowance and other items that are normal and usual in the care and supervision of a child. The standard rate is adjusted by percentage for age as follows: 90% for birth through 29 months; 80% for 30 months through 11 years; 95% for 12 years through 19 years. Reimbursement for emergency shelter status is based on 120% of the standard rate. The standard rate is also multiplied by a geographic cost-of-living differential. Reimbursement will be made for the day of admission of the child, but not for the day of departure. Reimbursement will be made for a period up to 15 days for a child's temporary absence due to medical or psychiatric placement, home visit, or detention. Reimbursement will be made for up to 5 days for an unapproved absence of the child. A foster parent may receive reimbursement for damages and loss up to $5,000 if the 6 criteria listed at 7 AAC 53.110(a) are met.	7 AAC 53.030 to 7 AAC 53.140 (3/31/2005)	AS 47.05.010 (2005); AS 47.14.010; AS 47.14.100	N/A	Child Protective Services manual; Augmented care worksheet; Village rate table; Incremental rate request for FY2009; Analysis prepared by Don Schmidt		

Appendix B-2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
OFFICE OF CHILDREN'S SERVICES PROVIDERS

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
N/A	Foster Care (continued)		In addition to the standard base rate, a foster parent may receive additional reimbursement for ongoing direct costs. The department will authorize payment of ongoing direct costs based upon documented need and the availability of appropriations from the legislature. Reimbursement for ongoing direct costs is determined on a case-by-case basis. The goods and services that may be approved for reimbursement as ongoing direct costs are detailed at 7 AAC 53.050(b) and Section 6.2.2.7 of the Child Protective Services manual. A foster parent may also receive an augmented rate for a child that requires additional care and supervision beyond the basic care. The department will approve an augmented rate based on documented assessed need and the availability of appropriations from legislature. Section 6.2.2.3.A of the Child Protective Services manual defines two levels of augmented care: specialized foster care and structured foster care. Specialized foster care is reimbursed at $7.50 per day above the base rate. Structured foster care is reimbursed at $15.00 per day above the base rate. NOTE: The Division of Juvenile Justice (DJJ) establishes the rates for DJJ foster homes. The rates established by DJJ are reimbursed through OCS. The standard rate paid to a foster parent residing in another state and caring for a child in department custody is the foster care rate established by the city, county, or state in which the foster parent resides. The department may authorize reimbursement for ongoing direct costs or an augmented rate for specialized care.						

DHSS Rate Matrix

Child Care Assistance Program

Appendix B-2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
CHILD CARE ASSISTANCE PROGRAM

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
N/A	Child Care Assistance Program (CCAP)	The child care assistance program is designated as the Parents Achieving Self-Sufficiency (PASS) program. There are three categories of assistance: PASS I, PASS II and PASS III (the categories are defined at 7 AAC 41.012). A family is eligible to participate in the child care assistance program if each parent in the family is participating in an eligible activity (eligible activities are defined at 7 AAC 43.310) and the family's monthly income is at or below the maximum allowed under 7 AAC 41.335. Provisions for family income determination are defined at 7 AAC 41.325. Providers eligible to participate in the child care assistance program include licensed home providers, licensed group home providers, licensed child care centers, approved child care providers, approved relative child care providers, and approved in-home care providers.	The program rate for each category of care is established in the Child Care Assistance Program Rate Schedule. The rates in the schedule are set out by provider type, category of care and geographical area. The categories of care differentiate by age group of the child and the unit(s) of time for which care is authorized. The rate schedule also differentiates between full-time and part time monthly enrollment; and full-day, partial day and hourly attendance. Rates are established based on information obtained through a market rate survey of child care providers in the state and the availability of appropriations. If the department determines that available appropriations are insufficient to provide full program benefits for participating families or to add new eligible families, the department may take one or more of the actions defined at 7 AAC 41.050. A participating family must contribute a percentage of its income toward the eligible cost of care in an amount determined in the Family Income and Contribution Schedule. The amount is based on family size and income level, and based on a sliding fee schedule. A participating provider must ensure that a rate charged by a provider to a family participating in the program is not higher than the rate charged to other families for the same service. After deducting a family's co-payment, the department or designee shall pay the balance of the cost of child care to a participating provider on behalf of the participating family for the child care provided up to the program rates established in the Child Care Assistance Program Rate Schedule.	Chapter 41 - including 7 AAC 41.025 (6/23/2006); 7 AAC 41.030 (6/23/2006); 7 AAC 41.050 (6/23/2006); 7 AAC 41.245 (6/23/2006); 7 AAC 41.300 (6/23/2006); 7 AAC 41.310 (6/23/2006); 7 AAC 41.325 (6/23/2006); 7 AAC 41.330 (6/23/2006); 7 AAC 41.335 (6/23/2006); 7 AAC 41.345 (6/23/2006) 45 CFR 98.42; 45 CFR 98.43	AS 47.25.001; AS 47.25.021; AS 47.25.031; AS 47.25.041; AS 47.25.051	N/A	Child Care Assistance Program Policy and Procedure Manual; Child Care Assistance Program Rate Schedule; Family Income and Contribution Schedule	4/1/2006	

Appendix B-2

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RATE MATRIX
CHILD CARE ASSISTANCE PROGRAM

MMIS Provider Type Code	Provider Type Description	Services	Overview of Reimbursement Methodology	Regulatory Basis (last amended or other effective date)	Statutory Basis (effective date)	Alaska Medicaid Provider Billing Manual Citation - (summarize any additional reimbursement specifications)	Other Applicable Documents	Date of Last Rate Calculation (if applicable)	Other Criteria Used Based on Non-published Internal Criteria
N/A	Child Care Assistance Program (CCAP) - continued		The maximum payment for a child during a month is equal to the full-time monthly enrollment rate plus the part-time monthly enrollment rate for the category of care and the type of facility where care is provided. The total eligible cost of care for a family choosing in-home child care is limited to a monthly maximum that is equal to two times the minimum hourly wage established under AS 23.10.065, multiplied by 210. A child with special needs as described in 7 AAC 57.940 who is under 13 years of age may qualify for a supplemental program rate as determined by the department. Child care assistance regulations allow for an enhanced/higher child care assistance rate to be paid to licensed providers who meet higher quality standards than those required for licensing (7 AAC 43.030). However, the enhanced rate has never been implemented. A licensed child care facility participating in the child care assistance program may also be eligible to participate in a child care grant program. The grant money may only be used for operation of the facility.						

Appendix B 3

Three Common Long Term Care Issues among All Three Reports **Issue 1: State Matching Funds for Personal Care and HCB Waiver**		
Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 (The Lewin Group and ECONorthwest)	**Medicaid Program Review** (The Pacific Health Policy Group)	**Alaska Long Term Care and Cost Study July 2006** (Public Consulting Group)
Findings	**Recommendations**	**Recommendations**
1. An increasing share of the Medicaid burden will be shifted away from the federal government to the State. State matching funds for Medicaid claims are projected to increase at a faster rate than the total Medicaid Program (p.iii). 2. Among the five fastest growing Medicaid service categories, it is projected that over half of state matching funds will be spent on personal care and HCB Waiver services (p. iv).	1. Alaska should consider expanding the Medicaid Program to include several groups currently being serviced with state-only dollars: CAMA; certain DD individuals; and seriously mentally ill adults (p.34). 2. Move Personal Care to the HCBS waiver program, thereby requiring elderly/physically disabled applicants to undergo the comprehensive screen and have this service allocated in conjunction with others during the care planning stage. Or as a lesser step, the state can strengthen care coordination between the waiver and Personal Care by making HCBS waiver case managers responsible for this activity. (p.74, 82). 3. The state should consider extending Medicaid coverage to persons with DD, thereby securing federal matching dollars. This could be done by expanding the size of the waiver and adjusting eligibility criteria to include persons not eligible; or by creating a new waiver with services matching those available today through the state-only program. Alaska should explore opportunities	1. Ensure the timely determination of Medicaid eligibility (p.43). 2. Develop a strategy to sustain grant-funded pilot projects/services (p.62). 3. Review the current waivers to determine what changes need to be made; i.e., a supports waiver would offer FFP for the services that are currently being offered through state-funded Core Services and free up state funds to serve more people on the waiting list (p.50-52). 4. Develop strategies to better manage the DD waiting list (p.46-47). 5. Revise the state's level of care interpretations and implementation for the MR/DD Waiver (p. 48). 6. Monitor level of care criteria to ensure all individuals are receiving appropriate level and mix of LTC services (p.48). 7. Account levels and financial practices within DD grants need to be monitored and state responsibility for accounts consolidated under one financial unit to assure consistency of expenditures and reallocation of funds as needed (p.62).

Appendix B 3

Three Common Long Term Care Issues among All Three Reports Issue 1: State Matching Funds for Personal Care and HCB Waiver		
Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 (The Lewin Group and ECONorthwest)	**Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005** (The Lewin Group and ECONorthwest)	**Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005** (The Lewin Group and ECONorthwest)
Findings	**Findings**	**Findings**
	for obtaining federal matching funds for services provided today through state-funded grants. A final option would be a Section 1115a research and demonstration waiver specifically for LTC or as part of a full restructuring of the program (p.5, 77, 83). 4. Extending Medicaid coverage to persons receiving state-funded DD services, either by enlarging the current waiver or creating a new waiver with services matching those available through the state-only program (p. 83).	8. Conduct a separate study of financing issues (in Pioneer Homes) (p.41). 9. Ensure PCA services are available throughout the rural areas (p.44). 10. Ensure that Medicaid pays its share of Pioneer Home costs (p.40).

Appendix B 3

Three Common Long Term Care Issues among Three Reports **Issue 2: Spending/Reimbursement**		
Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 (The Lewin Group and ECONorthwest)	**Medicaid Program Review** (The Pacific Health Policy Group)	**Alaska Long Term Care and Cost Study** **July 2006** (Public Consulting Group)
Findings	**Recommendations**	**Recommendations**
1. Currently, spending in Alaska on Medicaid LTC services is considerably less than one third of total Medicaid spending, however the rate of growth in LTC spending, 12% to 13% per year, is significantly greater than spending growth for the entire Medicaid program (about 9%) (p. 88).	1. Add new waiver service options targeted toward persons with Alzheimer's dementia as a lower-cost alternative to Pioneer Home placement (p.82-83). 2. Alaska has the equivalent of adult foster care providers within its large assisted living facility provider category. At a minimum, the state should move to tiered payment rates based on provider size, cost and complexity of care offered (p. 74). 3. Alaska should consider a provider tax for nursing facilities (p.74). 4. Reimbursement of residential and day habilitation waiver providers (p.75).	1. Conduct Edit Review in the MMIS to quantify and fix the edits (p.57). 2. Agencies billing for multiple homes should submit an annual cost allocation plan to the state (p.55). 3. Auditing of submitted cost reports and waiver claims (p.54). 4. Cap administrative expenses associated with a single client's care (p.55). 5. Develop standardized methods for reimbursing residential habilitation costs based on collected cost reports (p.53-54). 6. Discourage the use of compression in residential habilitation and day habilitation (p.55). 7. Implement a standardized method of collecting habilitation costs from MR/DD providers and pay providers in a consistent and equitable manner (p. 52). 8. Regulated rates paid for residential supported living arrangements that are not authorized in regulations should be reviewed and adjusted (p.77).

Appendix B 3

Three Common Long Term Care Issues among Three Reports **Issue 2: Spending/Reimbursement**		
Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 (The Lewin Group and ECONorthwest)	**Medicaid Program Review** (The Pacific Health Policy Group)	**Alaska Long Term Care and Cost Study** **July 2006** (Public Consulting Group)
Findings	**Recommendations**	**Recommendations**
		9. The 26% discount used on the supported residential living arrangements per diem when three or more days of adult day care are used should also be applied to residential habilitation when three or more days of day habilitation are used (p.56). 10. Change 7 AAC 43.1055 regulating specialized medical equipment and supplies to require the reimbursement of average manufacturer's cost or that supplier must provide evidence of competitive bidding (p.57). 11. Review treating all meal-related costs as being unallowable costs (p.40). 12. Revise the cost and reimbursement structure of the Pioneer Homes (p.39). 13. Costs of operating the Pioneer Homes as identified in the Public Assistance Cost Allocation Plan (PACAP) should be taken into account in developing the Medicaid rate (p.41). 14. Use a consistent reimbursement methodology to pay for residential and day habilitation services in the MR/DD Waiver (p.52). 15. Use actual patient days instead of licensed capacity in per diem. 16. Consider a provider assessment on nursing facilities (p.37).

Appendix B 3

Three Common Long Term Care Issues among Three Reports **Issue 3: Tribal Health Providers**		
Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 (The Lewin Group and ECONorthwest)	**Medicaid Program Review** (The Pacific Health Policy Group)	**Alaska Long Term Care and Cost Study** **July 2006** (Public Consulting Group)
Findings	**Recommendations**	**Recommendations**
1. Native Americans are almost three times as likely to be enrolled in Alaska Medicaid as are non-Natives. By working with tribal health providers to increase services such as LTC, ADHSS can reduce state fund spending without reducing services. Such participation between ADHSS and Native communities should continue. Currently, tribes are not very active in LTC, but they have expressed interest in LTC for their members (p.90).	1. The state should actively participate in establishing greater capacity among tribal providers, particularly with respect to LTC. Specifically, Alaska could pursue reorganization of the tribal health care delivery system as a managed care entity (p. 6, 90).	1. Ensure PCA services are available throughout the rural areas. Increase participation from tribal health providers to leverage 100% federal reimbursements. (p.44). 2. Work with tribal organizations (global recommendation) to increase participation from tribal health providers to leverage 100% federal reimbursements. Opportunities exist for tribal health providers in the Northern and Western parts of the state to increase their provision of Medicaid LTC services. Alaska could work with 638 organizations to ensure that their costs are reimbursable with 100% federal fund match for Medicaid eligible persons. Individuals on waiver programs or waiting for waiver services could then transfer to one of these 638 providers, expanding their menu of services. Transfer should first be targeted to those consumers who have high-cost care plans, both on the MRDD waiting list and MRDD waiver program (p.18, 26, 44).

Appendix B 4

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 (The Lewin Group and ECONorthwest) Six (6) Findings Specific to Long Term Care
Findings
1. On a per-recipient basis, spending on Medicaid services for seniors is substantially higher than spending for children. As this portion of the population grows rapidly over the next 20 years, Medicaid spending will also grow rapidly (p. i). This change will affect the mix of benefits that Medicaid provides and/more importantly, the cost (p.39).
2. The 65 and older population in Alaska is projected to grow rapidly, almost tripling from 43,000 to 124,000 between 2005 and 2025 (p. ii). Medicaid enrollment for this population is projected to grow at a greater annual rate than the population (p. v).
3. An increasing share of the Medicaid burden will be shifted away from the federal government to the State. State matching funds for Medicaid claims are projected to increase at a faster rate than the total Medicaid program (p. iii).
4. Among the five fastest growing Medicaid service categories, it is projected that over half of state matching funds will be spent on personal care and HCB Waiver services. These are two of the most important Medicaid service categories for Alaska's seniors (p. iv).
5. Native Americans are almost three times as likely to be enrolled in Alaska Medicaid as non-Natives (p. vi). Working with Native communities to provide health care for their tribal members is a current strategy of DHSS. By working with tribal health providers to increase services such as LTC, DHSS can reduce state fund spending without reducing services. Such participation between DHSS and Native communities should continue. Currently, tribes are not very active in LTC, but they have expressed interest in LTC for their members (p.90).
6. Currently, spending in Alaska on Medicaid LTC services is considerably less than one third of total Medicaid spending, however the rate of growth in LTC spending, 12% to 13% per year, is significantly greater than spending growth for the entire Medicaid program (about 9%) (p. 88).

Appendix B 5

Medicaid Program Review (The Pacific Health Policy Group) 10 Findings and Recommendations	
Recommendations	**LTC-Related Findings**
1. Alaska should consider expanding the Medicaid Program to include several groups currently being serviced with state-only dollars: CAMA; certain DD individuals; and seriously mentally ill adults (p. 34).	1. DHSS operates a state-funded program, known as Chronic and Acute Medical Assistance (CAMA), which serves as a payer of last resort for persons with chronic or life-threatening conditions. The qualifying conditions are consistent with the types of conditions covered in medically needy programs, as well as Section 1115a research and demonstration waiver programs, which can be used to secure federal matching funds while capping enrollment, state expenditures, or both (p. 3).
2. Implement a comprehensive pre-admission screening instrument for the elderly/physically disabled portion of long-term care (p. 4, 74, 82).	
3. Move Personal Care to the HCBS waiver program, thereby requiring elderly/physically disabled applicants to undergo the comprehensive screen and have this service allocated in conjunction with others during the care planning stage. Or as a lesser step, the state can strengthen care coordination between the waiver and Personal Care by making HCBS waiver case managers responsible for this activity. (p.74, 82).	3.a. The two waiver programs for the elderly and the physically disabled offer limited in-home support services – chores and home delivered meals – making it difficult for many to remain safely in the residences without additional support from another source. Increasingly AK's elderly and disabled are seeking in-home support through the Personal Care Attendant service option (p. 4, 70). 3.b. Alaska differs from many states in that it offers Personal Care Attendant services as a state plan option, thereby reducing Medicaid's ability to manage the benefit within a larger plan of care (p.74).
4. The state should consider extending Medicaid coverage to persons with DD, thereby securing federal matching dollars. This could be done by expanding the size of the waiver and adjusting eligibility criteria to include persons not eligible; or by creating a new waiver with services matching those available today through the state-only program. Alaska should explore opportunities for obtaining federal matching funds for services provided today through state-funded grants. A final option would be a Section 1115a research and demonstration waiver specifically for LTC or as part of a full restructuring of the program (p. 5, 77, 83).	3. Alaska is one of only a few states to serve its DD population completely outside of the institutional ICF/MR setting. At the same time, the state's DD waiver programs have extensive waiting lists. A significant number of services are provided with state-only dollars to persons on the DD waiver waiting list and persons with DD who do not qualify for the waiver. (p. 4-5, 75)

Appendix B 5

Medicaid Program Review (The Pacific Health Policy Group) 10 Findings and Recommendations	
Recommendations	**LTC-Related Findings**
5. The state should actively participate in establishing greater capacity among tribal providers, particularly with respect to LTC. Specifically, Alaska could pursue reorganization of the tribal health care delivery system as a managed care entity (p. 6, 90).	4. Native Alaskans account for nearly four in ten Medicaid beneficiaries, by far the largest Native American segment of any state Medicaid program. The population is overwhelmingly rural, with nearly six-in-ten living in villages with fewer than 300 residents. Given the isolation of many rural villages, access to community-based care is both essential and challenging. Although Alaska's Native population is younger on average than the state's general population, the need for LTC among AI/ANs is rising and will increase significantly in coming years. If the tribal system is unable to address AI/AN long-term care needs, the responsibility will fall to non-tribal providers, requiring additional state resources (p. 5, 84).
6. Add new waiver service options targeted toward persons with Alzheimer's dementia as a lower-cost alternative to Pioneer Home placement. (p. 82-83)	5. Pioneer Homes are licensed as assisted living facilities, a lower level of care than skilled nursing, but increasingly serve a population that in other states would be residents in the Alzheimer's units of nursing facilities or in less costly, Alzheimer's-oriented community care settings (p. 68).
7. Extending Medicaid coverage to persons receiving state-funded DD services, either by enlarging the current waiver or creating a new waiver with services matching those available through the state-only program. (p. 83)	6. The state could gain control over service costs – and obtain more operational flexibility – by replacing the traditional Medicaid program with a Section 1115a research and demonstration program. (p. 35)
8. Alaska has the equivalent of adult foster care providers within its large assisted living facility provider category. At a minimum, the state should move to tiered payment rates based on provider size, cost and complexity of care offered (p. 74).	A number of states provide Adult Foster Care as a relatively low-cost service option within their waiver programs. Adult foster care families can be certified to care for persons with mild to mid-stage dementia, coupled with some physical deficits, and provide the foster care service in their homes. This service is especially appropriate for small, rural communities that lack facility-based alternatives (p.74).
9. Alaska should consider a provider tax for nursing facilities (p.74).	

Appendix B 5

Medicaid Program Review (The Pacific Health Policy Group) 10 Findings and Recommendations	
Recommendations	**LTC-Related Findings**
10. Reimbursement of residential and day habilitation waiver providers (p.75).	Another factor pushing Alaska's costs higher appears to be the method used by DHSS to reimburse residential and day habilitation waiver providers. Payment rates, which are cost-based, are essentially negotiated on a provider-by-provider basis using self-reported and un-audited cost data. The data is not submitted in a uniform manner, but in whatever format the provider chooses. The result is high, and inconsistent payment rates (p. 75).

Appendix B 6

Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 31 Recommendations for Administrative Actions Related to Program Activities	
Recommendations	**Findings**
1. Complete integration of senior and disabilities services under DSDS (p. 24).	While the two service areas of aging and disabilities are now organized under the same administrative entity, these two service systems still appear to operate in separate silos; it appears that there is a lack of understanding of the roles and functions as well as the similarities and differences among the two service areas and the populations served (p.24).
2. Conduct a statewide LTC strategic planning process (p. 24).	One key document that was found missing was a statewide strategic plan for LTC. This is necessary to ensure that Alaska's service system continues to be responsive to its consumers' needs, to providers, and to all other stakeholders (p.24-25).
3. Develop usable management reports from the MMIS (p. 27).	DHSS currently lacks the infrastructure to track and develop detailed data reports of LTC capacity, provisions, and utilization. There is no computerized database of assessments, providers and plans of care that can summarize the number of providers or activities of daily living levels that individuals in different care settings have. It is also difficult to study specific populations or geographical regions (p. 27).
4. Address the perception of Pioneer Homes in Alaska's LTC system (p.39).	There is a perception among private providers that Pioneer Homes receive more funding and attention from the state system than other assisted living facilities, so the state needs to develop a strategy to clarify the role of Pioneer Homes in Alaska's LTC system (p. 39). PCG, however, found no objective evidence to support the claim/perception (p.94).
5. Conduct Edit Review in the MMIS to quantify and fix the edits (p.57).	Edits are complicated and require the assistance of the state's fiscal intermediary to create and maintain them, and there is uncertainty as to how well the FI is able to keep up with program changes (p.57). Program policies now contain waiver restrictions that prevent payments for duplicate services, however, state staff was not always sure whether the edits were in place and working (p.106-107). Also see pages 115-121.
6. Continue to use the Eden Model in the Pioneer Homes (p. 39).	The Eden Model provides a care setting that focuses on quality of life by creating better social and physical environments, making the Pioneer Homes very desirable living settings (p. 39, 95).
7. Ensure the timely determination of Medicaid eligibility (p.43).	The General Relief Assisted Living service is paid for using 100% state general funds. The state needs to develop a process that ensures the quick determination of Medicaid eligibility for persons served in this program (p.

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Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 31 Recommendations for Administrative Actions Related to Program Activities	
Recommendations	**Findings**
	43, 101). Also, Medicaid eligibility should be quickly determined for all potentially eligible residents on admission to Pioneer Homes. This should include monitoring of the "spend-down" of residents' assets (p. 98).
8. Evaluate and make changes to the care coordination system (p. 30).	Objective care coordination is the first line of quality and cost control in LTC programs. One reason that the cost of personal care services expanded so fast was the lack of "gate keeping" in the administrative operation of the program; programs lacking statewide and consistently applied care coordination cost more money. The State's current practices of having regional or central office staff review higher cost or long hour cases is helpful but cannot be the main or sole method of cost control and quality review (p. 30). There is no care coordination for personal care services, but there is for waiver programs. The consumer-directed Personal Care program lacks the oversight that care coordination potentially provides. The OA/APD waivers do not have an in-home service option, except for limited chore and meal service, causing waiver recipients to rely heavily on PCA services (p. 50). There is no consistent care coordination across the waivers (p.115).
9. Develop a strategy to sustain grant-funded pilot projects/services (p.62).	Grant programs are unable to sustain themselves past the life of the grant, due to lack of infrastructure to track outcomes and effectiveness, waning interest from the funders, and absence of commitment through inclusion in the state's budget (p.62). Grant dollars … which are used to pilot new and innovative service approaches, do not appear to include a process to evaluate the success of the pilot, the outcomes achieved and whether or not the pilot should become an ongoing part of the base budget. Without this, the sustainability and importance of these pilots is not routinely reviewed. Also see pages 122-129.
10. Develop a universal screening and referral tool (p. 28).	The state does not utilize one universal tool to screen and refer consumers to services. The current assessment forms vary across providers, making the assessment much more cumbersome and time-consuming and increasing the difficulty of having a uniform process for provider audits and any potential investigations of fraud, abuse and neglect (p. 28).
11. Enhance quality assurance (p. 28-29).	As the LTC service system continues to grow, it will be critical to the quality of services for the quality assurance process to become more comprehensive.

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Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 31 Recommendations for Administrative Actions Related to Program Activities	
Recommendations	**Findings**
	The state will need to ensure adequate staffing required by such a geographically diverse state, develop a clearer definition regarding what the QA process should encompass, define the role of QA within the LTC service delivery system, and the benchmarks and QI's the state wants to measure (p. 28-29).
12. Create objective, independent care coordination (p.52).	Care coordination for individuals on the MR/DD, OA, and APD Waivers is currently completed by care coordinators who are hired by the agencies that provide the service (p. 52). There are a myriad of concerns and perceptions which directly relate to the plan of care development, implementation, and assurance of quality (p. 111).
13. Add provision for consumer-directed PCA to MR/DD Waiver (p. 49).	Currently consumers enrolled on the MR/DD waiver use a substantial amount of supported living services, which may be due in part to the absence of PCA services on the waiver. The state should consider the interface of consumer-directed personal care services with the Medicaid State Plan PCA services, and clarify the definitions of in-home services and PCA services to ensure that the definitions are distinct and do not overlap (p. 49-50).
14. Enhance quality assurance and continuous quality improvement for PCA services (p. 44).	The PCA program has shown tremendous growth in Alaska over the past several years and needs to develop a comprehensive QA and QI process that addresses the rural and individualized nature of PCA services (p.44-45).
15. Develop access to substance abuse and mental health services (p.31).	A significant number of LTC consumers have co-occurring substance abuse and mental health service needs, and a lack of coordination of these services with LTC services results in individuals not receiving all necessary treatment (p.31-32). Among other things Alaska should actively monitor Michigan's PACE Program. PACE is particularly important because it allows for access to mental health and substance abuse services (p.34).
16. Consolidate residential rehabilitation codes (p. 56).	The differences between residential shared care, foster care, and group homes procedure codes are subtle and the codes have marginal differences among them; they do not represent different services, service locations, or provider types because the same provider and services are provided in each (p. 56).
17. Enhance provider requirements (p. 32).	All assisted living facilities are licensed under the same category and all providers, regardless of facility size, are held to the same licensing standards. Enhance provider requirements to ensure that quality requirements are

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Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 31 Recommendations for Administrative Actions Related to Program Activities	
Recommendations	**Findings**
	appropriate to the number of people served and the size of the setting in which services are provided (p. 32). All provider qualifications need to be reviewed to ensure that they are appropriate to the type of waiver service provided, but are not so stringent that they serve as a deterrent to actual provision of the service due to unnecessarily burdensome requirements. In addition, quality standards should be improved, and service limitations reviewed (p.112).
18. Rewrite service description of intensive active treatment/therapy (p. 56).	The wording of the intensive active treatment/therapy service does not clearly identify it as a professional service, document the list of professionals that can bill for services, set time limits on how long such a treatment will be paid, or require that the service, if covered by Medicaid, should be billed as a state plan service (p.56-57)
19. Review the current waivers to determine what changes need to be made (p. 50-51).	This is a global recommendation that covers the 2006 waiver renewals, FFP enhancement strategies, TBI and ADRD, and more. A supports waiver would offer FFP for the services that are currently being offered through state-funded Core Services and free up state funds to serve more people on the waiting list (p.50-52).
20. Develop strategies to better manage the DD waiting list (p. 46-47).	Alaska's DD waiver waiting list includes individuals who: are already receiving CCMC waiver services; are already receiving full services through grant dollars; will never qualify for a waiver; are uninterested in waiver or grant services until some future date; and, only want respite care. Strategies could include: develop a Supports Waiver; use state dollars freed up by moving individuals to the Supports Waiver to serve more on the waiting list; efficiently manage the grants to maximize the number of individuals served; determine who has an immediate need for additional services on the waiting list; require additional appropriation to serve individuals on the waiting list; and facilitate a discussion with the legislature to determine an annual appropriation that would prevent substantial growth of the waiting list (p. 46-47).
21. Develop a strategy for workforce recruitment and retention (p.32).	There is a shortage of LTC direct service staff across the state, especially in rural areas. Direct service staff have become difficult to recruit and retain, resulting in consumers not receiving the service they need in some of the more rural and isolated parts of the state. Also, salaries paid by the state are

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Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 31 Recommendations for Administrative Actions Related to Program Activities	
Recommendations	**Findings**
	not comparable to private employers (p. 32-33).
22. Monitor the development of rural PACE models in the lower 48 (p.34).	A federal model for LTC services that has potential benefit to Alaska is PACE (p.34). Among other things Alaska should actively monitor Michigan's PACE Program. PACE is particularly important because it allows for access to mental health and substance abuse services (p. 15).
23. Revise the state's level of care interpretations and implementation for the MR/DD Waiver (p. 48).	Alaska currently interprets its LOC criteria in a manner that may be restrictive in terms of the types of services that individuals are able to receive. Part of the problem with the LOC determinations in Alaska, specifically in the MR/DD waiver program, is a direct relation to the use of the ICAP as the tool to determine LOC (p. 48-49). The way in which current LOC definitions are applied in the MR/DD waiver is a potential problem to Alaska's LTC system because it may limit how many people are able to qualify for the HCBS Waivers, access to federal matching dollars. The current process may not aid in the avoidance of placement in more restrictive environments (p.110).
24. Pioneer Homes should convert Level I beds and make changes necessary to accommodate more Level II and Level III residents (p. 39).	The demand for Level I placements in Pioneer Homes has steadily dropped throughout the 1990s, while the demand for higher levels of care exceeds the number of available placements (p. 39, 96-97).
25. Review LTC statewide capacity and demand to assess the need for an addition or reduction in the number of nursing facility and assisted living facility beds (p.76).	No specific reference found.
26. Review LTC statewide capacity and demand to assess the need for an addition or reduction in the amount of community-based LTC services (p.76).	No specific reference found.
27. Enhance infrastructure for LTC service delivery to meet the determined level of need (p.76).	No specific reference found. Alaska's system of LTC is without a single point of entry. A service methodology with a single point of entry could be implemented in Alaska and would greatly enhance their residents' access to services. Alaska should also consider the utilization of online service assessments, as the launch of this technology would assist DHSS in managing one of its many challenges, the rural geography of the State (p. 14).
28. Conduct a strategic planning process every 3-5 years to re-establish the	This recommendation is part of the bigger statewide LTC strategic planning

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Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 31 Recommendations for Administrative Actions Related to Program Activities	
Recommendations	**Findings**
goals and needs of the LTC system (p.25).	process recommendation (p.24-27).
29. Conduct a reimbursement methodology feasibility study every 5 years to assess "reasonableness" and areas for improvement in the existing methodology (p.76).	No specific reference found.
30. Monitor service definitions in all waivers to ensure that definitions are up-to-date and keep pace with CMS changes (p.30).	Current DHSS service categories and service definitions are very broad; it is difficult to have clear expectations and understanding by staff and stakeholders (p.30). Certain waiver service definitions were suggested, including: supported employment; personal care; day habilitation; and adult day care. These definitions should be clear and provide flexibility and access (p.111-112).
31. Monitor level of care criteria to ensure all individuals are receiving appropriate level and mix of LTC services (p.48).	Alaska currently interprets its LOC criteria in a manner that may be restrictive in terms of the types of services that individuals are able to receive. The way in which current level of care definitions are applied in the MR/DD waiver is a potential problem to Alaska's LTC system because it may limit how many people qualify for the HCBS waivers, access federal matching dollars and avoid placement in more restrictive settings (p.48-49).

Appendix B 6

Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 12 Recommendations for Administrative Actions Related to Reimbursement Methods	
Recommendations	**Findings**
1. Agencies billing for multiple homes should submit an annual cost allocation plan to the state (p.55).	Providers that operate multiple homes should submit a cost allocation plan containing the per-home allocated costs. The rate-setting methodology relies on A&G percentages instead of using audited and allocated cost from a previous time period projected forward (p.55).
2. Auditing of submitted cost reports and waiver claims (p.54).	The state should have a program that ensures that services billed and paid were actually provided for the clients (p.54).
3. Cap administrative expenses associated with a single client's care (p.55).	The state should not pay providers for unnecessary administrative costs and should put a capped dollar amount on the total amount of A&G that it will pay for any single person (p. 55).
4. Develop standardized methods for reimbursing residential habilitation costs based on collected cost reports (p.53-54).	The state lacks essential cost reporting to manage residential habilitation and day habilitation costs. Each provider submits their own costs on their own forms, and it is difficult to check to see if the costs are accurate or were actually incurred. Improvements are needed to uniformly collect provider costs and set rates in an economically and efficient manner (p.53-54).
5. Discourage the use of compression in residential habilitation and day habilitation (p.55).	The current rate setting methodology reimburses more than a per diem cost each day; the use of a "compression" factor adds a percentage to the rate (p. 55, 117).
6. Implement a standardized method of collecting habilitation costs from MR/DD providers and pay providers in a consistent and equitable manner (p.52).	The state has little control over the millions of dollars spent for residential and day habilitation services. Providers submit budget detail forms for each client served, which reflect self-reported selected costs. All MR/DD and CCMC waiver services except daily respite are individually negotiated on each plan of care; chore services and supported employment rates also vary (p.52-53).
7. Regulated rates paid for residential supported living arrangements that are not authorized in regulations should be reviewed and adjusted (p.77).	No specific reference found.
8. Account levels and financial practices within DD grants need to be monitored and state responsibility for accounts consolidated under one financial unit to assure consistency of expenditures and reallocation of funds as needed (p.62).	Some agencies are allowed to keep funds that go unspent, while people wait for services (p.62).
9. The 26% discount used on the supported residential living arrangements per diem when three or more days of adult day care are	If a resident is going to be absent from the home for significant periods, then the state should not pay the residential provider and the day habilitation

Appendix B 6

Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) 12 Recommendations for Administrative Actions Related to Reimbursement Methods	
Recommendations	**Findings**
used should also be applied to residential habilitation when three or more days of day habilitation are used (p.56).	provider for the same services on the same day (p.56).
10. The recommendations raised in the APS Healthcare billing audit of March 2005 need to be systematically addressed (p.35).	The findings of the APS audit contain 17 "excellent" recommendations for strengthening the PCA and waiver programs (p.35).
11. Conduct a separate study of financing issues (in Pioneer Homes) (p.41).	The state should ensure that it is not spending general fund dollars in the Pioneer Homes unnecessarily; e.g. the issues of separately billing for pharmacy and other medical expenses, and the matter of patient SSI merit a separate study (p.41-42)
12. Change 7 AAC 43.1055 regulating specialized medical equipment and supplies to require the reimbursement of average manufacturer's cost or that supplier must provide evidence of competitive bidding (p.57).	Providers of specialized medical equipment and supplies tell the state what the cost of the supplies will be, and there is no assurance that the state is paying the lowest cost (p.57).

Appendix B 6

Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) Four (4) Recommendations for Program Expansion and/or New Programs	
Recommendations	**Findings**
1. Develop capacity for crisis beds and/or crisis response teams in rural areas (p.33).	Individuals residing in the rural areas are forced to either travel to the urban centers or not receive adequate care when they experience a health crisis. Crisis placements would be able to provide a level of care that does not currently exist in the community; their purpose would be to provide necessary services anywhere between a minimum of a few hours to a maximum of seven days. Establish crisis response teams to supplement crisis placements or as a stand-alone service (p.33).
2. Ensure PCA services are available throughout the rural areas (p.44).	There is a need for more PCA services in the rural areas of the state to meet current unmet need and to address the cultural issues and values of Alaska's diverse population. Increase participation from tribal health providers to leverage 100% federal reimbursements. (p.44).
3. Expand community service options for senior citizens (p.36).	Seniors do not have the appropriate service mix that supports them to stay in their homes, especially during the day. The state needs to expand services to include companion care services to be provided in the home setting, reevaluate the 10 hour limit per week on respite care, and expand the number and responsibilities of Senior Centers (p.36-37). Alaska also needs to ensure that services are provided to individuals who qualify under the ADRD category and that appropriate services are developed to meet the needs of this growing population (p.113).
4. Revise specific service definitions and expand types of covered services. For example, add a waiver for persons who have traumatic brain injuries.	Current service categories and definitions are very broad, so it is difficult to have clear expectations and understanding by staff and stakeholders involved with the systems. For example, all non-institutional LTC settings in Alaska are currently licensed as assisted living facilities, fostering a lack of clarity regarding specific facility setting expectations (p.30-31). The incidence of TBI in Alaska is 28% higher than the national rate, yet the array of LTC services available to the TBI population is limited and does not address the specific needs and complex care necessary to serve them. One specific gap is the lack of community-based services specifically gauged to meet their needs (p.112).

Appendix B 6

Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) Nine (9) Recommendations for Cost Savings	
Recommendations	**Findings**
1. Review treating all meal-related costs as being unallowable costs (p.40).	The Pioneer Home rate-setting methodology excludes all direct and indirect meal preparation related costs (p.40).
2. Revise the cost and reimbursement structure of the Pioneer Homes (p.39).	This is a global recommendation encompassing: conversion of Level I placement to Levels II and III; ensuring that Medicaid pays for eligible residents; reviewing treatment of meal-related costs as unallowable; taking Pioneer Home costs into account for Medicaid rate-setting; using actual patient days instead of licensed capacity; and conducting a separate study of financing issues (p.39-42).
3. Costs of operating the Pioneer Homes as identified in the Public Assistance Cost Allocation Plan (PACAP) should be taken into account in developing the Medicaid rate (p.41).	The Statewide Cost Allocation Plan (SWCAP) no longer isolates the Pioneer Homes as a cost center. Therefore, the SWCAP contains costs for the Pioneer Homes that are not included in Medicaid rate-setting (p.41, 99).
4. Use a consistent reimbursement methodology to pay for residential and day habilitation services in the MR/DD Waiver (p.52).	Residential and day habilitation services are large parts of the budget, so efforts to end a widespread pattern of negotiated rates should be initiated (p.53).
5. Use actual patient days instead of licensed capacity in per diem.	Changes in licensed bed capacity have lagged the number of actual beds available in the Pioneer Homes, and the Pioneer Homes do not automatically bill for 14 days of respite care (p.41, 98-99).
6. Ensure that Medicaid pays its share of Pioneer Home costs (p.40).	Compared to other assisted living programs, Pioneer Homes are expensive, so the state must ensure that Medicaid pays its fair share of costs for residents; the Homes need to have new residents apply for Medicaid and watch for changes in income and assets (p.40). The state should also ensure that it is not spending general fund dollars unnecessarily, and conduct a separate study of financing issues, including reevaluation of the SSI ineligibility of Pioneer Home residents (p.97-98, 100).
7. Consider a provider assessment on nursing facilities (p.37).	Generation of additional nursing facility funds can be used to improve the quality of care in nursing facilities or fund technological changes to improve quality of care (p.37-38).

Appendix B 6

Alaska Long Term Care and Cost Study Final Report (Public Consulting Group) Nine (9) Recommendations for Cost Savings	
Recommendations	**Findings**
8. Work with tribal organizations (global recommendation).	Increase participation from tribal health providers to leverage 100% federal reimbursements. Opportunities exist for tribal health providers in the Northern and Western parts of the state to increase their provision of Medicaid LTC services. Alaska could work with 638 organizations to ensure that their costs are reimbursable with 100% federal fund match for Medicaid eligible persons. Individuals on waiver programs or waiting for waiver services could then transfer to one of these 638 providers, expanding their menu of services. Transfer should first be targeted to those consumers who have high-cost care plans, both on the MRDD waiting list and MRDD waiver program (p.18, 26, 44).
9. Expand estate recovery opportunities (p.20).	To maximize estate recoveries, Alaska needs to: eliminate the minimum asset threshold for recovery; permit probate initiation on behalf of the state as a creditor; require attorneys to notify CHDS about probate; expand the definition of probate in the State Medicaid Plan; and improve the MMIS system (p.20-21).

Appendix B 7
Waiver Services Comparison Matrix

State	Alaska									
Waiver	MR/DD 0260.90.R2					Older Alaskans 0261.90.R2				
New Application or Renewal						Renewal				
Effective Date	7/1/2006	6/30/2011				7/1/2006	6/30/2011			
Contact Person	Barbara Knapp	(907) 465-3358				Barbara Knapp	(907) 465-3358			
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	1252	12	per month	$207.46	X	2580	12	per month	$213.50
Homemaker										
Home Health Aide										
Personal Care										
Adult Day Health (Adult Day Services)						X	183	171	per 1/2 day	$39.05
Habilitation										
Residential Habilitation	X	501	306	per diem	$233.54					
		651	5576	per 15 minutes	$7.05					
Day Habilitation	X	613	1515	per 15 minutes	$8.12					
Expanded Habilitation Services										
Prevocational Services										
Supported Employment	X	401	1257	per 15 minutes	$8.50					
Education										
Respite - per day	X	313	14	per diem	$250.00	X	190	14	per diem	$258.11
- per hourly unit		513	2080	per 15 minutes	$5.17		808	972	per 15 minutes	$5.21
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service	X	63	173	per meal	$10.67	X	806	179	per meal	$10.67
Intensive Active Treatment	X	138	9	per treatment	$398.50					
Specialized Medical Equipment and Supplies	X	526	3	per item	$575.98	X	905	3	per item	$187.87
Environmental Modification	X	75	1	per project	$10,000.00	X	79	1	per project	$10,000.00
Transportation	X	526	179	per ride	$12.45	X	1124	109	per ride	$14.39
Chore Services	X	175	450	per 15 minutes	$6.49	X	602	773	per 15 minutes	$4.68
Specialized Private Duty Nursing	X	1	100	per hour	$106.75	X	156	140	1 visit 15 minutes	$20.00
Residential Supported Living Services						X	1029	354	per 1/2 day	$123.92
Personal Emergency Response System (PERS)										
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	Alaska									
Waiver	MR/DD 0260.90.R2					Older Alaskans 0261.90.R2				
New Application or Renewal						Renewal				
Effective Date	7/1/2006	6/30/2011				7/1/2006	6/30/2011			
Contact Person	Barbara Knapp	(907) 465-3358				Barbara Knapp	(907) 465-3358			
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician										
Other Misc. Services										
Rate Information										
Notes										

Appendix B 7
Waiver Services Comparison Matrix

State	Alaska									
Waiver	Adults with Physical Disabilities 0262.90.R2					Children with Complex Medical Conditions 0263.90.R2				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2006	6/30/2011				7/1/2006	6/30/2011			
Contact Person	Barbara Knapp	(907) 465-3358				Barbara Knapp	(907) 465-3358			
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	1655	12	per month	$213.50	X	285	12	per month	$209.51
Homemaker										
Home Health Aide										
Personal Care										
Adult Day Health (Adult Day Services)	X	176	93	per 1/2 day	$39.05					
Habilitation										
Residential Habilitation	X	11	234	per diem	$218.79	X	55	325	per diem	$178.85
		34	4497	per 15 minutes	$8.24		145	3546	per 15 minutes	$8.04
Day Habilitation	X	23	996	per 15 minutes	$8.87	X	55	1450	per 15 minutes	$8.58
Expanded Habilitation Services										
Prevocational Services										
Supported Employment	X	9	1236	per 15 minutes	$7.42	X	8	624	per 15 minutes	$7.15
Education										
Respite - per day	X	118	9	per diem	$250.00	X	73	10	per diem	$250.00
- per hourly unit		725	972	per 15 minutes	$5.06		175	1600	per 15 minutes	$5.11
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service	X	526	179	per meal	$10.67	X	3	10	per meal	$10.22
Intensive Active Treatment	X	4	2	per treatment	$1,683.39	X	275	4	per treatment	$1,124.20
Specialized Medical Equipment and Supplies	X	780	3	per item	$216.64	X	55	3	per item	$3,122.21
Environmental Modification	X	83	1	per project	$10,000.00	X	27	1	per project	$10,000.00
Transportation	X	739	109	per ride	$15.24	X	15	34	per ride	$107.31
Chore Services	X	545	773	per 15 minutes	$4.56	X	15	642	per 15 minutes	$7.15
Specialized Private Duty Nursing	X	134	140	per visit	$20.00					
Residential Supported Living Services	X	365	354	per diem	$123.92					
Personal Emergency Response System (PERS)										
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	Alaska									
Waiver	Adults with Physical Disabilities 0262.90.R2					Children with Complex Medical Conditions 0263.90.R2				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2006	6/30/2011				7/1/2006	6/30/2011			
Contact Person	Barbara Knapp	(907) 465-3358				Barbara Knapp	(907) 465-3358			
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician										
Other Misc. Services										
Rate Information										
Notes										

Appendix B 7
Waiver Services Comparison Matrix

State	South Dakota									
Waiver	MR/DD 044.90.R3.01					Elderly 0189.90.R2.01				
New Application or Renewal	Renewal					Renewal				
Effective Date	2/20/2003	2/19/2008				10/1/2006	09/31/11			
Contact Person	Carol Ruen	(605) 773-3438	carol.ruen@state.sd.us			Jaci Casanova-Keller	(605) 773-3656	Jaci.casanova-keller@state.sd.us		
	Rate Information					Rate Information				
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	2405	82.69	per hour	$33.49					
Homemaker						X	260	331	unit not defined	$16.50
Home Health Aide										
Personal Care										
Adult Day Health (Adult Day Services)						X (Adult Day Care)	12	828	unit not defined	$4.07
Habilitation										
Residential Habilitation	X	2263	980.12	per hour	$20.90					
Day Habilitation	X	1960	394.35	per hour	$27.48					
Expanded Habilitation Services										
Prevocational Services										
Supported Employment	X	763	223.42	per hour	$21.14					
Education										
Respite - per day						X	20	149	unit not defined	$16.50
- per hourly unit										
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service						X	130	252	per meal	$5.25
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X	1649	348.3	unit not defined	$1.31	X-Equipment Supplies	125 300	8 8	per month per month	$75.00 $104.86
Environmental Modification										
Transportation										
Chore Services										
Specialized Private Duty Nursing						X	260	58		$32.68
Residential Supported Living Services						X (Adult residential care)	800	252	days	$20.97
Personal Emergency Response System (PERS)						X	110	8	months	$36.70
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	South Dakota									
Waiver	MR/DD 044.90.R3.01					Elderly 0189.90.R2.01				
New Application or Renewal	Renewal					Renewal				
Effective Date	2/20/2003	2/19/2008				10/1/2006	09/31/11			
Contact Person	Carol Ruen	(605) 773-3438	carol.ruen@state.sd.us			Jaci Casanova-Keller	(605) 773-3656	Jaci.casanova-keller@state.sd.us		
	Rate Information					Rate Information				
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician										
Other Misc. Services	Nursing, Other medically-related (direct therapies, treatment and services)	2373	73.41	per hour	$33.72					
Rate Information						Adult Residential Care and Assisted Living rates are based on the state wide average direct and non-direct care rates for nursing facility level of care times 55%. The room and board is SSI plus a $20 disregard less $60 per month for personal needs. The room and board is subtracted from the total. Homemaker and Private duty nursing rates were established in the mid-1990's and inflated by legislative direction. Inflation is based on the CPI. Supplies are limited to $100 monthly.				
Notes										

Appendix B 7
Waiver Services Comparison Matrix

State	South Dakota									
Waiver	Assisted Daily Living Services #SD.03 (Base # SD 0264.90.R2)					Family Support (MR Children) 0338.90.R1				
New Application or Renewal	Amendment to a Renewal					Renewal				
Effective Date	7/12/07 (6/1/07)					6/1/2007	5/31/2012			
Contact Person	Denise White	(605) 773-3195	denise.white@state.sd.us			Donna Olivier	(605) 773-3438	Donna.olivier@state.sd.us		
	Rate Information					Rate Information				
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	130	30	per 15 minute	$14.25	X	721	98	15 minute	$15.71
Homemaker										
Home Health Aide										
Personal Care	X - attendant	130	5200	per 15 minute	$4.53	X	29	74.35	per hour	$17.83
Adult Day Health (Adult Day Services)										
Habilitation										
Residential Habilitation										
Day Habilitation										
Expanded Habilitation Services										
Prevocational Services										
Supported Employment						X				
Education										
Respite - per day						X				
- per hourly unit										
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service										
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X	17	1095	per unit	$0.60	X				
Environmental Modification						X				
Transportation										
Chore Services										
Specialized Private Duty Nursing	X	35	100	per 15 minute	$8.43					
Residential Supported Living Services										
Personal Emergency Response System (PERS)	X	21	12	per month	$39.59					
Substance Abuse Counseling										
Medication Administration										
Companion						X				

Appendix B 7
Waiver Services Comparison Matrix

State	South Dakota									
Waiver	Assisted Daily Living Services #SD.03 (Base # SD 0264.90.R2)					Family Support (MR Children) 0338.90.R1				
New Application or Renewal	Amendment to a Renewal					Renewal				
Effective Date	7/12/07 (6/1/07)					6/1/2007	5/31/2012			
Contact Person	Denise White	(605) 773-3195	denise.white@state.sd.us			Donna Olivier	(605) 773-3438	Donna.olivier@state.sd.us		
	Rate Information					Rate Information				
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician						X (nutritional supplements)				
Other Misc. Services	Consumer preparation specialist	120	30	per 15 minute	$9.03	Vehicle Modification				
Rate Information						Rates for support coordination are based on cost and time studies. The costs are divided by possible billable units. The rate is $14.25 per hour inflated annually. Personal, respite, companion care and supported employment are negotiated rates. The rates include geographical market differences.				
Notes						Details for Supported Employment, Respite, Specialized Medical Equipment and Supplies, Environmental Modification, Companion and nutritional supplements were not available on the waiver information received.				

Appendix B 7
Waiver Services Comparison Matrix

State	Idaho									
Waiver	MR/DD Child 40187.90.02					MR/DD Adult				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2004	6/30/2009				10/1/2002	10/1/2007			
Contact Person	Mary Beth Wells	(208) 364-1955				Mary Beth Wells	(208) 364-1955			
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)										
Homemaker										
Home Health Aide										
Personal Care										
Adult Day Health (Adult Day Services)	X	1	20	per hour	$6.00	X	2009	455	per hour	$6.66
Habilitation										
Residential Habilitation	X	20	340	per day	$273.71	X	2143	298	per day	$74.39
Day Habilitation										
Expanded Habilitation Services										
Prevocational Services										
Supported Employment	X	10	240	per hour	$21.00	X	145	614	per hour	$23.32
Education										
Respite - per day	X	10	48	per day	$53.39	X	35	286	per hour	$9.42
- per hourly unit										
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service	X	2	520	per meal	$5.23	X	3	636	per meal	$5.81
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X	1	1	each	$3,000.00	X	3	1	each	$3,000.00
Environmental Modification	X	1	1	each	$3,000.00	X	12	1	each	$3,000.00
Transportation	X	20	1800	per mile	$0.35	X	57	4364	per mile	$0.39
Chore Services	X	1	24	per hour	$8.00	X	3	94	per hour	$8.88
Specialized Private Duty Nursing										
Residential Supported Living Services										
Personal Emergency Response System (PERS)	X	1	10	per month	$38.14	X	2	10	per month	$38.14
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	Idaho									
Waiver	MR/DD Child 40187.90.02					MR/DD Adult				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2004	6/30/2009				10/1/2002	10/1/2007			
Contact Person	Mary Beth Wells	(208) 364-1955				Mary Beth Wells	(208) 364-1955			
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician										
Other Misc. Services	Skilled nursing, behavior consultation / crisis management	10	24	per visit	$32.00	Skilled nursing, behavior consultation / crisis management	153	19	per hour	$23.32
Rate Information										
Notes										

Appendix B 7
Waiver Services Comparison Matrix

State	Idaho				
Waiver	Aged and Disabled 0076.90R3A.02				
New Application or Renewal	Renewal Amendment				
Effective Date	10/1/2006	9/30/2008			
Contact Person	Christine Baylis	(208) 364-1891			
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X	824	15	per hour	$43.03
Homemaker	X	65	10	per hour	$11.43
Home Health Aide					
Personal Care	X (Attendant Care)	2680	731	per hour	$14.20
Adult Day Health (Adult Day Services)	X	75	201	per hour	$6.49
Habilitation					
Residential Habilitation	X	20	725	per diem	$64.38
Day Habilitation	X	20	50	per hour	$7.96
Expanded Habilitation Services					
Prevocational Services					
Supported Employment	X	20	40	per hour	$19.25
Education					
Respite - per day					
- per hourly unit	X	130	241	per hour	$11.43
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service	X	1522	198	per meal	$5.66
Intensive Active Treatment					
Specialized Medical Equipment and Supplies	X	385	2	per piece	$105.68
Environmental Modification	X	50	2	per job	$2,250.21
Transportation	X	900	325	per mile	$0.39
Chore Services	X	223	47	per hour	$11.54
Specialized Private Duty Nursing					
Residential Supported Living Services	X (Adult Residential Care)	1274	320	per diem	$52.51
Personal Emergency Response System (PERS)	X	1782	10	per month	$37.64
Substance Abuse Counseling					
Medication Administration					
Companion	X	30	702	per hour	$5.80

Appendix B 7
Waiver Services Comparison Matrix

State	Idaho				
Waiver	Aged and Disabled 0076.90R3A.02				
New Application or Renewal	Renewal Amendment				
Effective Date	10/1/2006	9/30/2008			
Contact Person	Christine Baylis	(208) 364-1891			
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician					
Other Misc. Services	Skilled nursing RN, Skilled nursing LPN, behavior consultation / crisis management, psychiatric consultation	1220 2645	51 41	per hour per hour	$24.24 $21.17
Rate Information					
Notes	TBI waiver expired 9/30/2006 and services are now included in the Aged and Disabled Waiver				

Appendix B 7
Waiver Services Comparison Matrix

State	Montana									
Waiver	MR/DD MT- 0208.90.R2					Adult DD				
New Application or Renewal	Renewal									
Effective Date	7/1/2005									
Contact Person	Perry Jones	(406) 444-5662	pjones@mt.gov							
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	"family supports coordination"	389	12	per month	$754.66					
Homemaker	X	79	104	per hour	$11.32	X				
Home Health Aide										
Personal Care	X	6	335	per hour	$13.66	X				
Adult Day Health (Adult Day Services)										
Habilitation										
Residential Habilitation	X	1721	335	per day	$73.08	X				
Day Habilitation	X	1435	224	per 6-hour day	$48.40	X				
Expanded Habilitation Services										
Prevocational Services	X (are bundled with day habilitation)					X				
Supported Employment	X	295	224	per hour	$30.57	X				
Education						X				
Respite - per day						X				
- per hourly unit	X	412	260	per hour	$10.25					
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service	X	12	295	per meal	$4.20					
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X	100	1	per item	$2,179.00	X				
Environmental Modification	X (combined with specialized equipment)					X				
Transportation	X	1529	468	per 1-way trip	$4.13	X				
Chore Services										
Specialized Private Duty Nursing	X	40	242	per 1/2 hour	$11.56	X				
Residential Supported Living Services										
Personal Emergency Response System (PERS)										
Substance Abuse Counseling										
Medication Administration										
Companion	X (see note)	50	335	per hour	$11.60	X				

Appendix B 7
Waiver Services Comparison Matrix

State	Montana									
Waiver	MR/DD MT- 0208.90.R2					Adult DD				
New Application or Renewal	Renewal									
Effective Date	7/1/2005									
Contact Person	Perry Jones	(406) 444-5662	pjones@mt.gov							
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X	1	4	per hour	$26.94					
Other Misc. Services	Adult foster care, assisted living, PT, OT, SLP, psychological services, community transition					"social / leisure / recreational outings, health / health safety / health maintenance and education services"				
Rate Information	Rates have been established through contract negotiations. The state is moving from the negotiated rate to a standardized fee-for-service system. With the exception of adaptive equipment, environmental modifications and transportation, the rate will be based on the amount of direct care staff time delivered to the consumer. The rates will have four standardized cost centers - direct care staff compensation, employee related expenses, program supervision and indirect expenses and general and administrative expenses. The standardized rates will be adjusted by a geographical factor, economy of scale factor and a holiday coverage factor.									
Notes	If approved by CMS, community transition is added in year 3 of the renewal. Adult foster support, adult companion services, assisted living services, and residential training support are added in year 4.					Renewal for this waiver not found. The original effective date was 9/1/01 which would have expired 8/31/04.				

Appendix B 7
Waiver Services Comparison Matrix

State	Montana									
Waiver	Elderly and Physically Disabled					Adults with Severe Disabling Mental Illness (SDMI)				
New Application or Renewal	Renewal					New				
Effective Date	7/1/2006	6/30/2011				12/1/2006	11/30/2009			
Contact Person	Cecilia Cowie Robin Homan	(406) 444-4150	ccowie@mt.gov	rhoman@mt.gov		Lou Thompson	(406) 444-9657	lothompson@mt.gov		
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	2550	15	per day	$147.00	X	125	269	per day	$10.00
Homemaker	X	750	773	per 15 minutes	$3.00	X	32	772.97	per 15 minute	$3.96
Home Health Aide										
Personal Care	X	1300	1293	per 15 minutes	$3.00	X	3 53	218.3 1292.82	per day per 15 minute	$9.50 $4.38
Adult Day Health (Adult Day Services)	X	50	2005	per 15 minutes	$2.00	X	2	2005.28	per 15 minute	$1.99
Habilitation										
Residential Habilitation	X	53	276	per diem	$105.00	X	1	275	per day	$141.56
Day Habilitation	X	6	54		$40.00	X	9	53.5	per day	$74.20
Expanded Habilitation Services										
Prevocational Services	X	20	431	per hour	$7.00	X	10	431.84	per hour	$7.06
Supported Employment						X	4	16	per 15 minute	$10.75
Education										
Respite - per day	X	90	774	per 15 minutes	$2.00	X	1	155.55	per day	NH rate up to $153.78
- per hourly unit						X	6	17.4	per 15 minute	$3.96
Day Treatment	X	6	54		$40.00	X	50	56	per visit	$51.66
Partial Hospitalization										
Pyschosocial Rehabilitation	X	6	56		$13.00					
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service	X	500	155		$4.00	X	21	155.07	per meal	$5.13
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X	600 200	7 93		$192.00 $6.00	X Equipment Supplies	23 4	6.61 93.34	per item per item	$192.03 $5.75
Environmental Modification	X	120	2	per service	$2,420.00					
Transportation	X	1500	817	per mile	$0.21	X Mile Trip	64 3	817.06 117.20	per mile per trip	$0.22 BX14 $12.16
Chore Services	X	150	2	per service	$190.00	X	6	1.89	per job	$189.80
Specialized Private Duty Nursing	X	600	947	per 15 minutes	$5.00	X	15	946.77	per 15 minute	$5.13
Residential Supported Living Services	X (Adult residential care and supported living)	60	255	per diem	$134.00	X adult residential care supported living	26 1	261.48 254.94	per day per day	$63.35 208.00
Personal Emergency Response System (PERS)	X	720	9	per month	$34.00	X install monthly	11 29	1.30 9.07	each per month	$100.00 $69.00
Substance Abuse Counseling	X	1	32	per 15 minutes	$11.25	X	50	16	per 15 minute	$11.25
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	Montana									
Waiver	Elderly and Physically Disabled					Adults with Severe Disabling Mental Illness (SDMI)				
New Application or Renewal	Renewal					New				
Effective Date	7/1/2006	6/30/2011				12/1/2006	11/30/2009			
Contact Person	Cecilia Cowie Robin Homan	(406) 444-4150	ccowie@mt.gov	rhoman@mt.gov		Lou Thompson	(406) 444-9657	lothompson@mt.gov		
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X	10	5		$14.00	X	2	5	per visit	$25.00
Other Misc. Services	PT, OT, SHL, RT, behavior programming, cognitive rehab, community residential rehab and specialized child care, habilitation aide, independent advisor and fiscal management					OT, habilitation aide, Illness management and recovery, wellness recovery action plan, independent advisor and financial management				
Rate Information						If the waiver services are the same as the waiver services available in the elderly/physically disabled waiver, the same rates are used in the SDMI HCBS Waiver. This promotes parity in the waivers as many of the service providers are the same for both waivers. For the two mental health services (WRAP and IMR), the registration rate for WRAP training was used. For IMR, the current rate for professional mental health providers (established for the state plan Medicaid program which is calculated using RBRVS methodology) was used.				
Notes	The available application form did not include Appendix J2 with details on the number of users, average units per user, the definition of a unit and average cost per unit.									

Appendix B 7
Waiver Services Comparison Matrix

State	Montana				
Waiver	Big Sky Bonanza (Self-Directed Services)				
New Application or Renewal	New				
Effective Date	4/1/2006	3/31/2009			
Contact Person	Robin Homan	(406) 444-4131	rhoman@mt.gov		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)					
Homemaker	X	25	140	per 15 minute	$3.03
Home Health Aide					
Personal Care	X (personal assistant services)	25	7500	per 15 minute	$3.80
Adult Day Health (Adult Day Services)	X	5	2260	per 15 minute	$1.94
Habilitation					
Residential Habilitation					
Day Habilitation	X	5	134	per hour	$16.12
Expanded Habilitation Services					
Prevocational Services					
Supported Employment					
Education					
Respite - per day					
- per hourly unit	X	7	1000	per 15 minute	$3.03
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service	X	6	161	per meal	$5.00
Intensive Active Treatment					
Specialized Medical Equipment and Supplies	X	5	1	per item	$1,000.00
Environmental Modification	X	4		per job	$4,000.00
Transportation	X	25	1124	per mile	$0.13
Chore Services	X	20	1	per job	$250.00
Specialized Private Duty Nursing	X	6	268	per 15 minute	$5.56
Residential Supported Living Services					
Personal Emergency Response System (PERS)	X monthly rent installation	12 12	9 1	per month per item	$69.00 $100.00
Substance Abuse Counseling	X	1	32	per 15 minute	$11.25
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	Montana				
Waiver	Big Sky Bonanza (Self-Directed Services)				
New Application or Renewal	New				
Effective Date	4/1/2006	3/31/2009			
Contact Person	Robin Homan	(406) 444-4131	rhoman@mt.gov		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician					
Other Misc. Services	Consumer directed goods and services, RT, PT, OT, SL & A, Independent advisor, financial management				
Rate Information	Community support, private duty nursing, RT, PT, OT, SP&A rates are based on rates established in other HCBS waivers or the state plan. Adult day health, habilitation, nutrition, consumer directed goods and services, specialized medical equipment and supplies, PERS, and environmental modification rates are the lower of the providers usual and customary charges or negotiated rates. Independent advisor and financial management services are the lower of other states rates or negotiated rates.				
Notes					

Appendix B 7
Waiver Services Comparison Matrix

State	North Dakota									
Waiver	MR/DD					Aged and Disabled - 0273.90R2				
New Application or Renewal						Renewal				
Effective Date						4/1/2007	3/31/2012			
Contact Person	Mike Marum	(701) 328-8977	somarm@nd.gov			Nancy Nikolas	(701) 328-4631	sonikn@nd.gov		
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	3588	48	Unit not defined	$19.09	X	400	4	per month	$105.60
Homemaker	X	22	650	per 15 minute	$3.22	X	100	466	per 15 minute	$3.16
Home Health Aide										
Personal Care						X (Attendant Care)	3	35040	per 15 minute	$3.23
Adult Day Health (Adult Day Services)	X	8	329	per 1/2 day	$25.82	X	2	86	per 1/2 day	$21.63
Habilitation										
Residential Habilitation	X	1940	321	per day	$90.00	X	53	260	per day	$92.04
Day Habilitation										
Expanded Habilitation Services										
Prevocational Services										
Supported Employment							2	202	per 15 min.	$4.93
Education										
Respite - per day										
- per hourly unit	X	14	1502	per 15 minute	$2.70	X	90	905	per 15 minute	$3.06
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service										
Intensive Active Treatment										
Specialized Medical Equipment and Supplies						X	5	1	per item	$500.00
Environmental Modification						X	4	1	per job	$4,000.00
Transportation						X	50	189	per trip	$2.05
Chore Services						X	40	50	per 15 minute	$2.87
Specialized Private Duty Nursing						X (Nurse Management)	3	800	per 15 minute	$10.70
Residential Supported Living Services	X Family Support Services	695	321	Units not defined	$27.90	X (Transitional living)	10	286	per day	$44.17
Personal Emergency Response System (PERS)						X	130	10	per month	$27.75
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	North Dakota									
Waiver	MR/DD					Aged and Disabled - 0273.90R2				
New Application or Renewal						Renewal				
Effective Date						4/1/2007	3/31/2012			
Contact Person	Mike Marum	(701) 328-8977	somarm@nd.gov			Nancy Nikolas	(701) 328-4631	sonikn@nd.gov		
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician										
Other Misc. Services	Family training Adult foster care	700 37	300 340	Units not defined	$18.97 $ 33.46	Adult foster care	22	258	per day	$50.50
Rate Information						For all services except case management, adult family foster care (AFFC) and transitional care, rates were initially established in 1990 based on cost reports. New cost reports are provided at enrollment for agency providers that include direct, indirect and administrative costs. Rates must be under predetermined limits, currently $4.48 per 15-minute unit. Individual provider rates are established after considering the minimum wage plus 30%, the mean wage being paid to individuals providing the service and Job Service information regarding the average salary paid for similar work. Currently the limit is $2.77 per 15-minute unit. Both agency and individual provider rates are increased by legislative action. Case management rates are based on the average salary paid to social workers in 1984. AFFC and transitional care rates are based on a formula and factor based system.				
Notes						The prior TBI waiver has been incorporated into this renewal request. The new title is Home and Community Based Services Waiver.				

Appendix B 7
Waiver Services Comparison Matrix

State	North Dakota					North Dakota				
Waiver	Technology Dependent					Medically Fragile Children				
New Application or Renewal	New					New				
Effective Date	8/1/2007	7/31/2010				9/1/2007	8/31/2010			
Contact Person	Nancy Nikolas	(701) 328-4631	sonikn@nd.gov			Debra Balsdon	(701) 328-8936	sobald@nd.gov		
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	3	12	per month	$103.28					
Homemaker										
Home Health Aide										
Personal Care	X (Attendant Care)	3	35040	per 15 minute	$2.77					
Adult Day Health (Adult Day Services)										
Habilitation										
Residential Habilitation										
Day Habilitation										
Expanded Habilitation Services										
Prevocational Services										
Supported Employment										
Education										
Respite - per day						X (Institutional Respite)	1	14	per day	$150.00
- per hourly unit										
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service										
Intensive Active Treatment										
Specialized Medical Equipment and Supplies						X	5	1	per item	$1,308.00
Environmental Modification						X	2	1	per item	$810.50
Transportation						X	20	3	trips*	$306.50
Chore Services										
Specialized Private Duty Nursing	X (Nurse Management)	3	800	per 15 minute	$9.76					
Residential Supported Living Services						X (In-Home Support)	25	432	per hour	$19.12
Personal Emergency Response System (PERS)										
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	North Dakota					North Dakota				
Waiver	Technology Dependent					Medically Fragile Children				
New Application or Renewal	New					New				
Effective Date	8/1/2007	7/31/2010				9/1/2007	8/31/2010			
Contact Person	Nancy Nikolas	(701) 328-4631	sonikn@nd.gov			Debra Balsdon	(701) 328-8936	sobald@nd.gov		
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician						X (Nutritional Supplements)	4	185	per item	$2.42
Other Misc. Services						Pediatric Specialty Services	3	4	per office visit	$1300.00
						Individual and Family Counseling	3	16	per 15 minutes	$27.50
Rate Information	See rate description under Aged and Disabled waiver									
Notes						* Definition for "trip" not available.				

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	MR/DD				
New Application or Renewal	Renewal				
Effective Date	7/1/2006	6/30/2011			
Contact Person	Cathy Stevenson	(505) 827-2574	Cathy.Stevenson@state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X	2499	12	per month	$254.13
Homemaker					
Home Health Aide					
Personal Care	X (Companion)	1668	1500	per 15 min	$3.50
Adult Day Health (Adult Day Services)					
Habilitation					
Residential Habilitation	X (Community Living and Independent Living Intensive)	125 55	11 10	per month per month	$1701.6 $2455.13
Day Habilitation	X (Multiple levels and outlier payment rates)			per 15 min	$2.14 - $3.77
Expanded Habilitation Services					
Prevocational Services					
Supported Employment	X (Multiple levels and exceptions)			per 15 min per day	$2.02 - $7.00 $37.00
Education					
Respite - per day					
- per hourly unit	X	1398	2400	per 15 min	$3.45
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service					
Intensive Active Treatment					
Specialized Medical Equipment and Supplies					
Environmental Modification	X	30	944	each	$10.00
Transportation	X (non medical)	216 16	1892 252	per mile per pass	.33 .99
Chore Services					
Specialized Private Duty Nursing	X (LPN RN)	0 4	0 93	per 15 min per 15 min	$6.16 $10.84
Residential Supported Living Services	X (Awake and asleep support - multiple levels and outlier rates)			per day	$87.66 - $296.92
Personal Emergency Response System (PERS)					
Substance Abuse Counseling					
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	MR/DD				
New Application or Renewal	Renewal				
Effective Date	7/1/2006	6/30/2011			
Contact Person	Cathy Stevenson	(505) 827-2574	Cathy.Stevenson@state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X (nutritional counseling)	15	8	per visit	$41.37
Other Misc. Services	Goods and services, supplemental dental, PT, OT, SPL, Community Access, Behavioral support, Personal plan facilitation, Crisis supports				
Rate Information	Rates are based on a rate study. The study was designed to use incurred costs as the basis for analyzing rates. A cost survey instrument is completed, desk and field reviewed. Hourly and unit costs are calculated and arrayed to develop rate recommendations.				
Notes	New Mexico is considering standardizing rates across the different waivers. Standardized rates would consider issues such as access, provider availability, grouping of similar services, the rural nature of New Mexico, the diverse and complex needs of the populations served and the need to allocate limited resources.				

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Aged Disabled				
New Application or Renewal	Renewal				
Effective Date	7/1/2006	6/30/2011			
Contact Person	Marise McFadden	(505) 476-4706	Marise.McFadden @state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X	2159	26	per hour	$49.74
Homemaker	X*	1868	1132	per hour	$13.79
Home Health Aide					
Personal Care					
Adult Day Health (Adult Day Services)	X	13	1594	per 15 min	$1.97
Habilitation					
Residential Habilitation	X (assisted living)	229	278	per day	$49.74
Day Habilitation					
Expanded Habilitation Services					
Prevocational Services					
Supported Employment					
Education					
Respite - per day					
- per hourly unit	X**	980	110	per hour	$13.05
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service					
Intensive Active Treatment					
Specialized Medical Equipment and Supplies					
Environmental Modification	X	119	504	each	$9.85
Transportation					
Chore Services					
Specialized Private Duty Nursing	X (LPN RN)	106 607	241 100	per 15 min per 15 min	$5.91 $10.59
Residential Supported Living Services					
Personal Emergency Response System (PERS)	X (regular and high need)	840 363	9 7	per month per month	$35.46 $39.40
Substance Abuse Counseling					
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	**New Mexico**				
Waiver	**Aged Disabled**				
New Application or Renewal	**Renewal**				
Effective Date	**7/1/2006**	**6/30/2011**			
Contact Person	**Marise McFadden**	**(505) 476-4706**	Marise.McFadden @state.nm.us		
		Rate Information			
		# users - projected	**Avg units per user**	**Units**	**Avg cost/unit**
Dietician					
Other Misc. Services	*Homemaker supplemental hours 232 users, 247 average per hour units with average cost of $13.79 ** LPN Respite 2 users, 454 average 15 min units with average cost of $5.91 and RN Respite 4 users, 758 average 15 min units with average cost of $10.59 Other services PT, OT, SLP, Installation of ERS				
Rate Information	Rates are based on a rate study. The study was designed to use incurred costs as the basis for analyzing rates. A cost survey instrument is completed, desk and field reviewed. Hourly and unit costs are calculated and arrayed to develop rate recommendations.				
Notes	New Mexico is considering standardizing rates across the different waivers. Standardized rates would consider issues such as access, provider availability, grouping of similar services, the rural nature of New Mexico, the diverse and complex needs of the populations served and the need to allocate limited resources.				

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	HCBS for Individuals with HIV/AIDS				
New Application or Renewal	Renewal				
Effective Date	7/1/2005	6/30/2010			
Contact Person	Consuelo Trujillo Judith Parks	(505) 827-3186	sadi.trujillo@state.nm.us	judith.parks@state.nm.us	
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X	50	31	per month	$405.03
Homemaker					
Home Health Aide					
Personal Care	X (Homemaker/ Personal Care)	42	1074	per hour	$16.20
Adult Day Health (Adult Day Services)					
Habilitation					
Residential Habilitation					
Day Habilitation					
Expanded Habilitation Services					
Prevocational Services					
Supported Employment					
Education					
Respite - per day					
- per hourly unit					
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service					
Intensive Active Treatment					
Specialized Medical Equipment and Supplies					
Environmental Modification					
Transportation					
Chore Services					
Specialized Private Duty Nursing	X (LPN RN)	2 19	4 143	per 15 min per 15 min	$41.52 $49.62
Residential Supported Living Services					
Personal Emergency Response System (PERS)					
Substance Abuse Counseling					
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	HCBS for Individuals with HIV/AIDS				
New Application or Renewal	Renewal				
Effective Date	7/1/2005	6/30/2010			
Contact Person	Consuelo Trujillo Judith Parks	(505) 827-3186	sadi.trujillo@state.nm.us	judith.parks@state.nm.us	
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician					
Other Misc. Services					
Rate Information					
Notes	New Mexico is considering standardizing rates across the different waivers. Standardized rates would consider issues such as access, provider availability, grouping of similar services, the rural nature of New Mexico, the diverse and complex needs of the populations served and the need to allocate limited resources.				

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Medically Fragile Children				
New Application or Renewal	Renewal				
Effective Date	7/1/2005	6/30/2010			
Contact Person	Consuelo Trujillo Judith Parks	(505) 827-3186	sadi.trujillo@state.nm.us	judith.parks@state.nm.us	
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X	250	10	per month	$405.03
Homemaker					
Home Health Aide	X	16	1106	per hour	$16.20
Personal Care					
Adult Day Health (Adult Day Services)					
Habilitation					
Residential Habilitation					
Day Habilitation					
Expanded Habilitation Services					
Prevocational Services					
Supported Employment					
Education					
Respite - per day	X	1	1	per day	$312.89
- per hourly	X (LPN	59	195	per hour	$27.75
unit	RN)	66	194	per hour	$42.13
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service					
Intensive Active Treatment					
Specialized Medical Equipment and Supplies					
Environmental Modification					
Transportation					
Chore Services					
Specialized Private	X (LPN	12	3103	per hour	$27.75
Duty Nursing	RN)	13	307	per hour	$42.13
Residential Supported Living Services					
Personal Emergency Response System (PERS)					
Substance Abuse Counseling					
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Medically Fragile Children				
New Application or Renewal	Renewal				
Effective Date	7/1/2005	6/30/2010			
Contact Person	Consuelo Trujillo Judith Parks	(505) 827-3186	sadi.trujillo@state.nm.us	judith.parks@state.nm.us	
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X (Nutritional counseling)	21	6	per hour	$41.52
Other Misc. Services	Respite - home health, PT, OT, SLP, and Psychosocial counseling				
Rate Information					
Notes	New Mexico is considering standardizing rates across the different waivers. Standardized rates would consider issues such as access, provider availability, grouping of similar services, the rural nature of New Mexico, the diverse and complex needs of the populations served and the need to allocate limited resources.				

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Mi Via NF				
New Application or Renewal	New				
Effective Date	10/1/2006	9/30/2009			
Contact Person	Marise McFadden	(505) 476-4706	Marise.McFadden@state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X (Intensive)	15	9	per hour	$50.00
Homemaker					
Home Health Aide					
Personal Care	X (Homemaker/ Companion)	481	1294	per hour	$14.00
Adult Day Health (Adult Day Services)	X	4	744	per hour	$8.00
Habilitation					
Residential Habilitation	X (Community Living)	5	357	per day	$175.00
Day Habilitation	X (Adult Day)	4	744	per hour	$13.00
Expanded Habilitation Services					
Prevocational Services					
Supported Employment	X	2	127	per hour	$27.00
Education					
Respite - per day					
- per hourly unit	X	7	438	per hour	$15.00
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service					
Intensive Active Treatment					
Specialized Medical Equipment and Supplies					
Environmental Modification	X	31	499	each	$10.00
Transportation					
Chore Services					
Specialized Private Duty Nursing	X (For adults)	199	34	per hour	$37.00
Residential Supported Living Services	X (assisted living)	53	266	per day	$53.00
Personal Emergency Response System (PERS)	X	466	7	per month	$31.00
Substance Abuse Counseling					
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Mi Via NF				
New Application or Renewal	New				
Effective Date	10/1/2006	9/30/2009			
Contact Person	Marise McFadden	(505) 476-4706	Marise.McFadden@state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X (Nutritional counseling for adults)	1	4	per hour	$40.00
Other Misc. Services	Behavior support consultation, community access, {PT, OT and SLP (adults and children)} and goods and services				
Rate Information	Individual budgetary allotments with a suggested range of rates for services				
Notes	New Mexico is considering standardizing rates across the different waivers. Standardized rates would consider issues such as access, provider availability, grouping of similar services, the rural nature of New Mexico, the diverse and complex needs of the populations served and the need to allocate limited resources.				

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Mi Via ICF/MR				
New Application or Renewal	New				
Effective Date	10/1/2006	9/30/2009			
Contact Person	Cathy Stevenson	(505) 827-2574	Cathy.Stevenson@state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services					
Case management (Care Coordination)	X (Intensive)	58	2	per hour	$52.00
Homemaker					
Home Health Aide					
Personal Care	X (Homemaker/ Companion)	42	543	per hour	$14.00
Adult Day Health (Adult Day Services)	X	1	281	per hour	$8.00
Habilitation					
Residential Habilitation	X (Community Living)	430	341	per day	$130.00
Day Habilitation	X (Adult Day)	338	814	per hour	$12.00
Expanded Habilitation Services					
Prevocational Services					
Supported Employment	X	300	224	per hour	$20.00
Education					
Respite - per day					
- per hourly unit	X	456	499	per hour	$14.00
Day Treatment					
Partial Hospitalization					
Pyschosocial Rehabilitation					
Clinic Services					
Live-in Caregiver					
Other and Extended State Plan Services					
Meal Service					
Intensive Active Treatment					
Specialized Medical Equipment and Supplies					
Environmental Modification	X	11	586	each	$10.00
Transportation					
Chore Services					
Specialized Private Duty Nursing	X (For adults)	4	157	per hour	$31.00
Residential Supported Living Services	X (assisted living)	1	266	per day	$53.00
Personal Emergency Response System (PERS)	X	1	7	per month	$31.00
Substance Abuse Counseling					
Medication Administration					
Companion					

Appendix B 7
Waiver Services Comparison Matrix

State	New Mexico				
Waiver	Mi Via ICF/MR				
New Application or Renewal	New				
Effective Date	10/1/2006	9/30/2009			
Contact Person	Cathy Stevenson	(505) 827-2574	Cathy.Stevenson@state.nm.us		
		Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X (Nutritional counseling for adults)	4	4	per hour	$43.00
Other Misc. Services	Behavior support consultation, community access, {PT, OT and SLP (adults and children)} and goods and services				
Rate Information					
Notes	New Mexico is considering standardizing rates across the different waivers. Standardized rates would consider issues such as access, provider availability, grouping of similar services, the rural nature of New Mexico, the diverse and complex needs of the populations served and the need to allocate limited resources.				

Appendix B 7
Waiver Services Comparison Matrix

State	Wyoming									
Waiver	DD Adult - 0226.90.R2					Elderly and Physically Disabled				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2004	6/30/2009				7/1/2006	6/30/2011			
Contact Person	Jamie Staunton	(307) 777-5660	jstaun1@state.wy.us			Greg Gruman Vereen Bebo	(307) 777-6531	(307) 777-7366	ggruma@state.wy.us	vbebo@state.wy.us
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	1229	10	per month	$200.00	X	980	293	per day	$7.87
Homemaker										
Home Health Aide										
Personal Care	X	62	2784	per 15 minute	$3.79	X (Attendant Care)	923	826	per 15 minute	$3.75
Adult Day Health (Adult Day Services)						X	124	2200	per 15 minute	$2.00
Habilitation										
Residential Habilitation	X	814	321	per day	$134.93					
Day Habilitation	X	781	221	per day	$107.12					
Expanded Habilitation Services										
Prevocational Services	X	156	200	per day	$96.82					
Supported Employment	X	183	144	per day	$76.22					
Education										
Respite - per day										
- per hourly unit	X	139	618	per 15 minute	$2.80	X	60	576	per 15 minute	$3.25
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service						X	960	325	per meal	$5.00
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X New Pre	45 18	1 1	per year per year	$3228 $543					
Environmental Modification	X New Pre	7 10	1 1	per year per year	$3094 $118					
Transportation						X	230	90	per 1-way trip	$2.00
Chore Services										
Specialized Private Duty Nursing										
Residential Supported Living Services	X (In Home Support)	120	192	per hour	$30.90					
Personal Emergency Response System (PERS)						X Installation Service	160 930	1 12	per install per month	$70.00 $45.00
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	Wyoming									
Waiver	DD Adult - 0226.90.R2					Elderly and Physically Disabled				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2004	6/30/2009				7/1/2006	6/30/2011			
Contact Person	Jamie Staunton	(307) 777-5660	jstaun1@state.wy.us			Greg Gruman Vereen Bebo	(307) 777-6531	(307) 777-7366	ggruma@state.wy.us	vbebo@state.wy.us
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X	45	234	per 15 minute	$10.00					
Other Misc. Services	PT, OT, psychological therapy, respiratory therapy, Speech, Hearing, & Language (SHL) Therapy, skilled nursing, complex skilled nursing, case management assessment					Skilled nursing, self help assistant, care coordinator fiscal management				
Rate Information						Rates are set to align with costs of similar services in the community. Increases require legislative action.				
Notes										

Appendix B 7
Waiver Services Comparison Matrix

State	Wyoming									
Waiver	MR/DD Child					Acquired Brain Injury				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2005	6/30/2010				7/1/2004	6/30/2009			
Contact Person	Beverly Swistowicz	(307) 332-4892 or	(307) 777-3321	bswist@state.wy.us		Beverly Swistowicz	(307) 332-4892 or	(307) 777-3321	bswist@state.wy.us	
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Statutory Services										
Case management (Care Coordination)	X	730	11.6	per month	$200.00	X				
Homemaker	X	250	596	per 15 minute	$2.75					
Home Health Aide										
Personal Care	X	13	1770	per 15 minute	$2.75	X				
Adult Day Health (Adult Day Services)										
Habilitation										
Residential Habilitation	X	46	335	per day	$85.00	X				
Day Habilitation						X				
Expanded Habilitation Services										
Prevocational Services						X				
Supported Employment						X				
Education										
Respite - per day						X				
- per hourly unit	X	546	3031	per 15 minute	$2.75					
Day Treatment										
Partial Hospitalization										
Pyschosocial Rehabilitation										
Clinic Services										
Live-in Caregiver										
Other and Extended State Plan Services										
Meal Service										
Intensive Active Treatment										
Specialized Medical Equipment and Supplies	X New Repair	282 50	1 1	per year per year	$3443 $1540					
Environmental Modification	X New Repair	86 36	1 1	per year per year	$10115 $5500					
Transportation										
Chore Services										
Specialized Private Duty Nursing										
Residential Supported Living Services										
Personal Emergency Response System (PERS)										
Substance Abuse Counseling										
Medication Administration										
Companion										

Appendix B 7
Waiver Services Comparison Matrix

State	Wyoming									
Waiver	MR/DD Child					Acquired Brain Injury				
New Application or Renewal	Renewal					Renewal				
Effective Date	7/1/2005	6/30/2010				7/1/2004	6/30/2009			
Contact Person	Beverly Swistowicz	(307) 332-4892 or	(307) 777-3321	bswist@state.wy.us		Beverly Swistowicz	(307) 332-4892 or	(307) 777-3321	bswist@state.wy.us	
		Rate Information					Rate Information			
		# users - projected	Avg units per user	Units	Avg cost/unit		# users - projected	Avg units per user	Units	Avg cost/unit
Dietician	X	20	20	per 15 minute	$10.00	X				
Other Misc. Services	Special family habilitation home residential trainer, case management assessment, respiratory therapy, psychological therapy, skilled nursing					PT, OT, Vision Therapy, speech, hearing and language, cognitive retraining, skilled nursing				
Rate Information						No details for the various service breakdowns. Maximum 100 individuals served through this waiver. Age covered 21-64.				
Notes										