Department of Health and Social Services
Frequently Asked Questions
Regulatory Changes Effecting Waiver Service Providers March 1, 2011

Question 1) Do I need to do anything to get paid the appropriate rate for services after March 1, 2011?

Answer 1) Generally the provider will not need to take additional actions. There are two notable exceptions:

- For Intensive Active Treatment and Nursing Oversight and Care Management billed under T2034, the unit of service has been standardized to a 15 minute unit. If other than a 15 minute unit has been authorized under a current POC the provider should check with SDS for conversion activities currently underway. After March 1, services under these two categories must be billed in 15 minute increments.
- For Adult Residential service (T2031/UR/US) the unit of service may need a modifier depending on the number of the provider's licensed beds. A provider's size is determined by the total number of licensed beds of all of the units operating under the same Employer Identification Number or Social Security Number (IRS tax identification number). A provider should bill the code related to its total size. Bill T2031 for a total licensed bed count of 17 or greater; T2031 US for total licensed bed count of 6 to 16; and T2031 UR for a total licensed bed count of 5 or fewer.

Question 2) When do I need to complete and send in the first financial data and cost survey?

Answer 2) The first financial data and cost surveys will relate to the first providers fiscal year that begins on or after January 1, 2011. Based on the three most common fiscal years the first will be:

- January 1, 2011 through December 31, 2011; cost report and financial data due nine months after year end or October 1, 2012;
- July 1, 2011 through June 30, 2012; cost report and financial data due nine months after year end or April 1, 2013; and
- October 1, 2011 through September 30, 2012; cost report and financial data due nine months after year end or July 1, 2013.

Question 3) Will there be an Excel version of the Cost Report made available for provider use?

Answer 3) Yes. The Department plans to make an Excel version of the Cost Survey available on the SDS website shortly before December 31, 2011.

Question 4) How do I find out what my average paid rate was for services provided July 1, 2009 through September 30, 2009 as processed by February 3, 2010?

Answer 4) Prior to March 1, 2011 you should contact Kevin Perron at Kevin.Perron@alaska.gov. After March 1, 2011 it may be necessary to contact the Medicaid Fiscal Agent (ACS). In that event emails to Kevin Perron may be forwarded to ACS for reply.

Question 5) Will technical assistance be provided when it is time to complete the Cost Survey?

Answer 5) Office of Rate Review staff is available to assist in the understanding of the department's requirements implemented in the new payment system.

Question 6) Where do we send the Cost Survey's and the Annual Report when complete?

Answer 6) When complete, please mail them to **Office of Rate Review, 3601 C. Street, Suite 978, Anchorage, Alaska, 99503** or they may be emailed to a dedicated email address yet to be established. The email address will be established later and providers will be notified through the SDS E-Alert system.

Question 7) When can we expect more information?

Answer 7) SDS is in the process of revising processes as necessary to implement the new payment structure.

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Question 8) How will our rate be determined if we start a new service after 10/1/09?

Answer 8) Providers that start providing and billing for a service that has no activity from dates of service July 1 through September 30, 2009 processed by February 3, 2010 will receive the payment rate shown on the Chart of Personal Care Attendant and Waiver Service Rates (Rate Chart) adjusted for the geographic differential.

Question 9) How will our rate be determined if we have claims with dates of service between 7/1/09 – 10/1/09 but they were processed after 2/3/10?

Answer 9) Claims with dates of service between 7/1/09 – 10/1/09, which were processed **after** 2/3/10 are not considered in the calculation of phase-in rates (7 AAC 145.520(h)). In that case the provider will receive the payment rate sho9wen on the Rate Chart adjusted for geographic differential.

Question 10) How will rate increases be put into effect? On the first FAQ it is stated "Generally the provider will not need to take additional actions". Please clarify. Do we continue billing and ACS will make all changes?

Answer 10) Prior to July 1 the Chart of Personal Care Attendant and Waiver Service Rates will be adjusted to include the rate of inflation. A revised Rate Chart will be posted on the Senior and Disability Website and forwarded to providers on the E-Alert system. The rates inside the Medicaid payment system will be adjusted for the new phase-in calculations and Rate Chart information effective for the claim dates of service July 1, 2011 and after.

Question 11) How do we submit costs for new plans of care?

Answer 11) For dates of service March 1, 2011 and after, plan of care costs will not be reported or necessary. SDS has recently modified its POC cost sheets (now referred to as Service Overview Forms) to reflect only provider, recipient, and service information. These edited forms have been recently posted via E-Alert and on the SDS website.

Question 12) When will we know what our rates will be, effective 3/1/11 and for 7/1/11? Who do we contact to get this information?

Answer 12) For providers with payments for dates of service July 1 through September 30, 2009 processed by February 3, 2010 the rates are posted on the Division of Senior and Disability Services website at: http://www.hss.state.ak.us/dsds/pdfs/Provider_Rates_With_History.pdf.

Providers without the historical payment activity are reimbursed based on rates found on the Rate Chart which can be found on the Division of Senior and Disability Services website at: http://www.hss.state.ak.us/dsds/grantservices/PDFs/Waivers/PCA%20Waiver%20Rate%20Chart.pdf. New rates for July 1, 2011 should be posted by the first or second week of June 2011.

Question 13) When will we know what the CMS market basket inflation rate will be for each year?

Answer 13) The Department of Health and Social Services, Office of Rate Review receives the licensed publication *Healthcare Cost Review* 4 times per year. The publication available 60 days prior to July 1st has typically been available mid-February. The Department anticipates providing a revised Rate Chart and rates for providers with 3rd quarter 2009 rate history no later than early June.

Question 14) There are some concerns with existing Prior Authorizations (PA) that already have dollars attached to the PA. Since we will be billing more dollars than are currently on the PA, will ACS's system allow for the additional dollars without denying reimbursement or services at the end of the waiver year?

Answer 14) Yes, provided there are still authorized units available on the PA.

Question 15) If we are audited on that PA will it be questioned due to the differing amount originally approved and the actual amount paid, due to the rate increases

Answer 15) After March 1, 2011 the prior authorization of amounts are unnecessary. Department auditors will be aware of the change. Other external auditors may need to be informed by the provider.

Question 16) After 6/30/11 and each year following, will the rates be adjusted for the market basket and then the phase-in adjustment (50/50; 75/25) and then adjusted for geographical difference?

Answer 16) Payment rates will be adjusted to accommodate an automated Phase-in annually.

- Rate Chart adjusted annually for inflation (see Q 13)
- Phase-in rate recalculated using revised Rate Chart prior to July of each year (50/50; 75/25). Revised rates placed in MMIS for processing.

Question 17) Per 7 AAC 145.520(j) the cost of room and board will be removed at $40.00 per day. How will this be applied or determined?

Answer 17) In the future after providers submit cost surveys in accordance with 7 AAC 145.535 the costs associated with room and board must be removed as non-reimbursable. The cost per day is defined as $40 per regulation. Each available bed day will be multiplied by $40 to arrive at a non-reimbursable room and board cost to be removed. Available bed days are the average number of licensed beds multiplied by the days of the year (365 or 366).

Question 18) Geographic differentials are determined based on the region in which provider is located. How is that applied? Examples: Main office in Soldotna with a local office in Valdez where is the provider located and main office in Fairbanks but all the services are provided in other regions or villages where is the provider located.

Answer 18) All geographic differentials are determined based on the location of the servicing city of the billing provider.

Question 19) 7 AAC 145.535(e) requires that a provider report in a manner consistent with GAAP unless otherwise specified in the cost survey instructions. Non GAAP accounting/reporting is not accurate. Thus the Chief Executive Officer would not ethically be able to sign that the cost survey is a true, correct, and complete statement. How can the CEO be expected to sign this document if it is not an accurate reflection of the costs based on GAAP?

Answer 19) A provider subject to Generally Accepted Accounting Principles (GAAP) must maintain their books and records in accordance with GAAP. Compliance with cost reporting requirements that may vary from the providers financial reporting under GAAP does not make the Cost Survey inaccurate. For example the Departments regulations require depreciable asset lives no shorter than IRS allowable lives. However GAAP will allow accelerated depreciation. The CFO can sign the Certification by Chief Executive Officer page representing the accuracy of the Cost Survey and its requirements that excludes accelerated depreciation.

The CFO is not attesting to the Cost Survey's accuracy in accordance with only GAAP. The CEO's certification asserts that the Cost Survey has been completed in accordance with the requirements in the Medicaid regulations. Therefore compliance with the regulatory requirements (GAAP and non-GAAP) is appropriate and accurate.

Example: differences between what may be reported under financial reporting under GAAP and what is reported for IRS purposes are not unusual. It does not mean that the IRS Tax Return is inaccurate. The responsible individual can sign the tax return without concerns of inaccuracy just because the IRS and Financial GAAP records are different.

Costs reported in accordance with GAAP on the Audited Financial Statements can be appropriately classified on the Cost Survey as non-reimbursable if the cost is not allowable for the Medicaid Waiver program. In that way all costs can be reported appropriately with the Medicaid regulations and match the amount of expense reported under GAAP in the financial statements.

Question 20) The reference to a 26% reduction in payments for assisted living home services when a recipient receives three or more days of adult day services is not in the current regulations. Is the reduction requirement still in effect?

Answer 20) No. The regulation which mandated the 26% reduction was in 7 AAC 145.520(l) (old 7 AAC 43.1058(h)(4). The current regulations do not contain that restriction; therefore there are no rate penalties for any weekly level of Adult Day services.