

**Medicaid Waiver Home and Community Based Services Rate Study
Background and Recommendations
Effective Health Design**

**Submitted to the
Alaska Association on Developmental Disabilities**

by

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Introduction

The purpose of the scope of work approved by the leadership of the Alaska Association on Development Disabilities (AADD) was to evaluate the background and history of the rate methodology in Alaska Administrative Code 7 AAC 145, and its implementation effectiveness for providers of Medicaid Waiver Home and Community Based Services (HCBS); Impact on access and sustainability of services to individuals who experience intellectual and developmental disabilities (IDD) across all regions of Alaska; and, Research rate methodologies that other states are utilizing and make recommendations of adjustment or replacement.

Alaska has a rich history of providing services for individuals who experience intellectual and developmental disabilities. Prior to statehood in 1959, there were no services for individuals who experienced developmental disabilities. Adults and children were sent outside to Morningside Hospital in Oregon. Morningside closed in 1960 and Alaska residents were relocated to Harborview Developmental Center in Valdez. Community-based services emerged in the late 1960s with the help of state and federal grants. In 1993, Alaska's Medicaid program obtained federal approval to offer home and community-based service waivers for individuals who meet institutional level of care. Waivers accelerated the move to supporting individuals in their home community. Alaska committed to intentionally closing Harborview Developmental Center in 1997 and continues to provide services for Alaskans with intellectual and developmental disabilities in the community of their choice.

The transition from primarily state and federal grant funded services to Medicaid, fee for service, categorically funded services has had some challenges. This report will provide a brief history of the evolution of the rate setting methodology for home and community-based services in Alaska will be presented. This will be followed by an in-depth review of the regulations governing home and community-based services dating back to the onset of Medicaid waivers in Alaska to present day. An exploration of unfunded mandates and subsequent cost containment measures instituted by providers is followed by highlights from other states regarding rate methodologies and acuity adjustments. Finally, limitations of the current rate setting methodologies with recommendations to strengthen the system occurs.

Section I – Background and history

Services for individuals with developmental disabilities have evolved over the past 30 years from provision primarily in state operated institutions to services in an individual's community of choice. The transition in Alaska culminated with the closure of Harborview, the state institution, in 1997. Home and community-based services prior to 1993 were funded through state grants with the unique quality of being individualized based on the service needs and desires of the individual and their family. Alaska joined many other states in applying for a 1915 c waiver with the Centers for Medicaid and Medicare services in 1993 to further expand funding options for home and community-based services. Reimbursement for services provided through the Medicaid waivers were individualized to a specific service recipient and determined based on the allowable direct service costs and allowable administrative and provider general costs associated with the provision of services. The administrative and general costs could not exceed 18% of the allowable costs and were approved by the managing state agency (the Division of Mental Health and Developmental Disability). Providers could also submit for a federally negotiated indirect rate which was honored by the state managing agency.

As AADD noted in “The Case for Rate Rebase”, the transition to national HCPCS codes in 2004 were accompanied by regulatory changes which encouraged providers to seek reimbursement from the Department of Health and Social Services via a cost-based, negotiated rate. These rates were aggregated across all services provided by each unique provider and were no longer individualized to each service recipient. It should be noted that the regulations in place in 2006 allowed for a request for an increase in the cost per unit of service via supporting documentation that the increase was necessary to protect the health, safety, or welfare of a recipient if without services the recipient was likely to suffer increased isolation, medical acuity, or immediate hospitalization. Further, increases were not allowed for increased administrative costs or changes in employment costs, including changes in salary or benefits.

The single state cost-based rate setting methodology for home and community-based services came into effect March 1, 2011. The methodology was based on recommendations from a 2007-2008 study conducted by Myers & Stauffer

(https://dhss.alaska.gov/dsds/Documents/docs/AK_HCBS_initial.pdf, Retrieved December 13, 2021). Rates were established in a single cost-based fee schedule with geographic differentials.

It should be noted the data used for the initial rates was generated from the Myers & Stauffer limited and inconclusive dataset with adjustments. Myers and Stauffer noted that 40% of provider numbers contributed cost survey information which represented 52% of Medicaid payments

(https://dhss.alaska.gov/dsds/Documents/pdfs/MS_AK_HCBS_Presentation_FINAL.pdf).

The initial rate chart which went into effect on March 1, 2011 consisted of rates that were inflated forward from the 2007 Myers and Stauffer rate chart to SFY2011. The original regulations required re-establishment of the rates every 4 years with annual inflation adjustments based on the Global Insights home health market basket index. The accompanying regulations also provided for a hold harmless clause for providers with rates above the chart rate and a stratified step up for providers with rates below the rate chart. The original rate chart was then inflation adjusted in July, 2011 with additional inflation adjustments in July, 2012, 2013, and 2014.

During the first scheduled rebasing due in 2014 and review of submitted cost survey data, the Office of Rate Review determined that there would be large rate fluctuations and that the data submitted on cost surveys was questionable. Additionally, the changeover in the MMIS system inhibited the ability of the Office of Rate Review to extract Medicaid data to compare cost survey data with MMIS claims data. The Commissioner for the Department of Health and Social Services determined the difficulties with MMIS and the significant fluctuations in rates would be too disruptive to the overall home and community-based system and instructed the Office of Rate Review and the Director of Senior and Disabilities Services to meet with stakeholders to discuss options. A workgroup consisting of representatives from the Office of Rate Review, Senior and Disabilities Services, and Medicaid waiver providers was tasked with developing a structural cost survey methodology that captured direct service costs, direct program support costs, and administrative and general costs. Additionally, the methodology needed to provide some level of predictability for the state as well as providers. Further, the methodology needed to include assurance that access to statewide services could be met. Finally, to provide assurance of the integrity of the cost data being submitted, a targeted number of providers would be required to submit data to capture either 90% of the Medicaid service units or 5 identified providers, whichever came first (https://dhss.alaska.gov/dsds/Documents/docs/Personal_Care_Assistant-

[Waiver_Rate_Setting_Methodology.pdf](#). Retrieved December 13, 2021). The methodology and promulgating regulations should have been implemented in July 2018 with the next rebasing of rates using the targeted listing of providers; however, due to the economic downturn in Alaska precipitated by a drop in oil prices and oil thru put, the Administration leadership determined rate increases and rebasing was not feasible. Cost containment emergency regulations were filed on July 1, 2019 to freeze the rates and disallow rebasing that year as scheduled. The Office of Rate Review had collected the cost survey information needed from the targeted list of providers but did not complete the work due to the emergency regulations.

Discussions with the Office of Rate Review held on December 14, 2021 indicate that the cost surveys being collected for calendar and fiscal year 2020 will be used to calculate rebasing scheduled for implementation in July 2022. The proposed rate chart will be calculated to include both the stop loss and access factor clauses as noted in the Personal Care Assistant and Waiver Rate Setting Methodology. It should be noted that the current methodology does not allow for an adjustment either up or down to exceed 5% based on the stop loss clause. The chart rates produced by the Office of Rate Review will be shared with department leadership for final approval and implementation. All adjustments would be subject to appropriation.

According to the State of Alaska Continuum of Care slide

(https://dhss.alaska.gov/dsds/Documents/pca/Continuum_Care_FY2019.pdf. Retrieved December 13, 2021), approximately 6% of the services managed by the Division of Senior and Disabilities Services are funded through state grants. 52% of the services managed by Division of Senior and Disabilities Services are funded through 5 home and community-based waivers. 63% of the funded services are affected by the current rate setting methodology when personal care assistant services are included in the analysis.

Section II: Rate changes 2011 – present

Regulations governing home and community-based payment rates have changed numerous times from the onset of home and community-based waivers to present time. The numbering system for governing regulations changed from 7 AAC 43.1050 to 7 AAC 43.1058 to 7 AAC 145.520. Copies of previous regulations must be requested from the State Law Library with the Alaska Court system. Instructions from the librarian at the Legislative Reference Library are as follows:.

“For prior registers I would refer you to either the State Archives (907-465-2270 or archives@alaska.gov) or the State Law Library (907-264-0585 or library@akcourts.gov). If you want to obtain more information on why a regulation was drafted or any public comment on the proposed regulations, the State Archives is the better source. The State Law Library is generally a bit more responsive if all you need is the version of a regulation which existed at a specific point in time.

The Legislative Reference Library archives information pertaining to Alaska statutes, which are generally listed in an “AS ##.##.###” format, and session laws which are usually referenced in a “§ # ch ## SLA year” format. Sometimes regulations are adopted or amended in direct response to state legislation, in which case I can assist with any legislative history documents that may be relevant, but I would need more detail on what you are looking for to determine if that is the case.”

Links to the regulation and corresponding Register numbers can be found in Appendix A.

Date	Calculation	Regulation	Comment
1993	Based on individualized allowable Direct service costs and approved A&G rate	7 AAC 43.1050 Amounts of Reimbursement for Home and Community-Based Services; Register 128	HCB waivers approved in Alaska
1995	Based on individualized allowable Direct service costs and approved A&G rate	7 AAC 43.1050 Amounts of Reimbursement for Home and Community-Based Waiver Services; Register 134	Changed Residential Supported Living arrangements reimbursement rates
2004	Rates were established in Alaska Medicaid	7 AAC 43.1050 (repealed) changed	Added language regarding family-directed respite

	Provider Billing Manual. No administrative and general expenses for out of home daily respite or family directed respite	to 7 AAC 43.1058 Amounts of Reimbursement for Home and Community-Based Waiver Services; Register 170	and approved location for out of home respite; added recipient monthly liability to pay for home and community-based services
2005	Providers paid either based on rate chart or allowable direct costs and allowable administrative and general expenses	7 AAC 43.1058 Amounts of Reimbursement for Home and Community-Based Waiver Services; Register 175	Defined list of restricted specialized medical equipment items
2006	Cost-based rates per provider or state rate chart	7 AAC 43.1058; Amounts of Reimbursement for Home and Community-Based Waiver Services; Register 178 and 179	Rates negotiated with each provider. Added language for increase to rate of reimbursement per individual need to protect health, safety, or welfare of the recipient
2007	Cost-based rates per provider or state rate chart	7 AAC 43.1058; Amounts of Reimbursement for Home and Community-Based Waiver Services; Register 182	Added cost of living percentage increase for residential supported living arrangements. Defined rates for recipients who change providers during their plan year. Further refined health and welfare requirements.
2008	Cost-based rates per provider or state rate chart	7 AAC 43.1058; Amounts of Reimbursement for Home and Community-Based Waiver Services; Register 186	
2010	Cost-based rates per provider or state rate chart. Increased rates for services on or after July 1, 2008 by four percent	7 AAC 145.520; Home and Community-Based Waiver Services; nursing facility and ICF/MR level	

		of care payment rates; Register 193	
2011	Statewide cost-based rate chart; annual inflation adjustments; every 4 year re-establishment; geographic differentials	7 AAC 145.520. Home and Community-Based Waiver Services payment rates; Register 197	Based on Myers and Stauffer 2007 rate study
March, 2018	Added targeted providers, access factor, stop loss. No inflation adjustment applied	7 AAC 145.525; Re-establishing and adjusting payment rates in the department's Chart of Personal Care Attendant and Waiver Services Rates; Register 225	States rates will be re-established every four years
October, 2018	Added Community First Choice service category	7 AAC 145.525; Re-establishing and adjusting payment rates in the department's Chart of Personal Care Services, Community First Choice Services and Waiver Services Rates; Register 227	
2021	Rates will be inflation adjusted every July 1st except July, 1, 2019	7 AAC 145.525; Re-establishing and adjusting payment rates in the department's Chart of Personal Care Services, Community First Choice Services and Waiver Services Rates; Register 236	The 1915 c waiver application indicates that new rates will be established July 1, 2022. The Office of Rate Review indicated they are in process of analyzing the submitted costs surveys on which new rates would be based

Section III: Unfunded mandates and provider cost containment measures

According to the U.S. Bureau of Labor Statistics, the consumer price index which represents changes in the prices of all goods and services purchased for consumption in the United States increased by 24.38% from 2011 to 2021 (https://www.bls.gov/data/inflation_calculator.htm). Additionally, the national medical care inflation rate has increased by 29.69%; however, the Alaska medical care consumer price index has increased 46.92% during this same time period (<https://data.bls.gov/pdq/SurveyOutputServlet>). Reimbursement rates for home and community-based services during this same time period have increased by 18% with adult day services and nursing oversight being outliers.

Rate information for dates of service charts dating from March 1, 2011 through June 30, 2022 can be found at the State of Alaska, Senior and Disabilities Services website (<https://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>). A review of these charts indicates annual inflation adjustments occurred in state fiscal years: 2012 – 2.2%, 2013 – 2.5%, 2014 – 2.4%, 2015 - 2.4%, 2019 – 2.5%, 2021 – 2.5%, and 2022 – 2.1%. Leaving state fiscal years 2016, 2017, 2018, and 2020 with no inflationary adjustments along with no rate re-establishment which should have occurred in 2014 and 2018.

While the inflationary adjustment of 18% from 2011 through 2021 provide a modicum of relief, providers of home and community-based and personal care services have reported state and federal mandates, regulatory changes, and other systemic changes or issues that have adversely affected their businesses and services. This list includes but is not limited to:

- Requirements under the Affordable Care Act to provide health insurance for employees not previously covered
 - Annual increases of 5-15%
- Completion of cost surveys for rate rebasing
 - Providers report from 80 to 120 hours of accounting work to complete the survey
- Electronic health records required under the American Recovery and Reinvestment Act
 - Providers report over 1000 hours of labor to develop and train with the addition of one FTE for ongoing maintenance
- Self-audits required under Alaska Medicaid Reform Bill SB74
 - Minimum of 80 hours per year to complete
- Conflict free care coordination
 - Added habilitation support staff
 - Quarterly reviews for care coordinators

- Centers for Medicare and Medicaid settings requirements
 - Increased administrative burden
- Backlog of the background check unit
 - \$90 per background check for each employee from janitor to psychologist
 - Added human resource position to track
 - Hand delivery of background check packets to ensure delivery
- MMIS conversion in 2013
 - Reports of substantial write-offs after reconciliation
 - Added at least 1 FTE for billing
- Electronic visit verification
 - \$1200 per month ongoing software fee
 - \$19,000 for purchase of software
 - Hired a full time EVV specialist
- State of Alaska minimum wage increase(s)
 - Impacts daily paid services such as group home
- Accreditation requirements
 - Impacts those providers serving individuals through behavioral health. While accreditation is not required for developmental disability services, accrediting agencies accredit all programs.
- Elimination of grant funding and transition to the Individualized Supports Waiver
 - Services for those not meeting level of care but continue needing support estimated at 10 hours per week for each individual
 - Providers reporting 78% less revenue generated between grant and ISW
- Increased training requirements
 - Added a full-time training coordinator
 - NCES 40 hour training requirement and certification for employment services
- Requirements for note review within 72 hours or 14 days
 - Increased document control from 1 FTE to 4 FTE's
- Cap on day habilitation hours

Compounding the above are increased expenses associated with the Covid-19 pandemic which have been somewhat offset by federal funding and other local grant sources.

Providers indicated high levels of stress and emotional fatigue for direct support and administrative staff. The tension in voices and body language was overly apparent. Long standing providers expressed discouragement with, to a lesser degree, the structure of the rate setting methodology, but more, the implementation. The lack of re-establishment and 4 years of no inflationary adjustments prior to the onset of the Covid-19 pandemic left many providers questioning whether they could continue providing any level of services or looking to further diversify their “book of business” in order to survive. Ironically, the Covid-19 pandemic brought

financial relief to most providers through available federal relief programs and local philanthropic relief grants.

Providers noted that the cost containment measures they have implemented to absorb the increased costs due to state and federal mandates, regulatory changes, and other systemic changes have begun to impact service delivery, quality of life for service recipients, and provider's ability to fully execute the Shared Vision. They further noted that there is no way to capture increased costs due to unfunded mandates with a fixed rate system. Costs must be lowered in other areas or reserves must be spent. Additionally, the cost containment measures employed by home and community-based service providers impact their ability to further the mission and service to beneficiaries of the Alaska Mental Health Trust Authority. It should be noted that providers indicated they continue to meet minimum standards of the conditions of participation for each service; however, even minimal standards have become difficult to maintain.

Senior and Disabilities Services has discouraged providers starting services prior to waiver approval in place; however, providers often begin services utilizing their own funding understanding the need and accepting the potential financial risk. This no longer occurs. Lines of service such as nursing oversight and employment for new recipients have been discontinued completely. Rural and remote service areas have been discontinued by some providers while others have had to eliminate outdoor subsistence funded activities not traditionally allowed as a Medicaid funded service. Providers using their own financial resources to support "mission-based" recipients has been discontinued.

Providers expressed difficulty in not only recruiting staff but also in retention resulting in annual turnover rates exceeding 30% for multiple years. While Covid-19 exacerbated the issue of recruitment and retention of staff, it should be noted that the multi-year reductions in items not directly related to service delivery have made it difficult to continue to foster a positive work environment. Retention research suggests that both extrinsic (wages, benefits) and intrinsic (culture, stability, positive work environment) rewards greatly influence worker job satisfaction (Cosgrove, 2020). Job satisfaction is directly related to retention. Providers have implemented

numerous cost containment measures which reduce the ability of providers to attract and retain staff. These include but are not limited to:

- Elimination of out of state training/travel
- Reduction in benefits
 - Reduction in number of paid holidays
 - Reduction in vacation and sick leave accrual rates
 - Annual holiday celebrations have been eliminated
 - Elimination of employee paid birthday
 - Reduction in 401 K contributions
 - Annual wage increases eliminated or reduced from 2.5% to 1.5%
 - Frozen positions
 - Increased out of pocket expenses for employee health benefits
 - Multiple changes in health insurance carriers and plans in an attempt to keep costs down
 - Eliminated or reduced to parttime program management positions
 - Eliminated company pride items such as shirts, scrubs, jackets
- No office staff increases for 2 years
- Greatly reduced or exhausted savings
 - Refinanced building loans
 - Pulled equity out of properties
 - Sold properties
 - Multi-year operating losses

Section IV: Limitations and observations of the current rate setting methodology

The current rate setting methodology is based on a cost survey developed by Myers and Stauffer in 2007. Allan Hansen, Principal, Myers and Stauffer indicated in an email exchange dated December 23, 2021 that, “The cost survey tool that was created for Alaska was also informed by experience that Myers and Stauffer had in other states around that time to perform similar surveys of cost of HCBS and/or PCA providers. My recollection from the time period is that we were specifically able to draw upon some cost survey experience in Iowa and Kansas.”.

Wenzlow, Eiken, and Sredl (2016) indicated that Medicaid expenditures for home and community-based services as a percentage of total expenditures for long term services and supports was 49.2% in 2007. The experience of states or contractors in developing cost surveys for home and community-based services would have been limited in 2007 when the Alaska specific cost survey was developed. Myers and Stauffer continues to conduct cost surveys and rate setting activities in several states. A review of the cost survey tools developed by Myers and Stauffer in 2020 for Connecticut (https://www.mslc.com/Connecticut/CT_Services_HCBS.aspx) and 2021 for Idaho (<https://www.mslc.com/Idaho/Downloads.aspx>) demonstrate a more robust and detailed cost survey tool than the Alaska cost survey (<https://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>) in discerning costs of home and community-based services.

The rate chart implemented in 2011 utilized the cost survey data collected from a limited set of home and community-based provider organizations. The rates calculated from the cost surveys were inflated forward from the original cost survey numbers. As previously noted, 40% of provider numbers contributed cost survey information which represented 52% of Medicaid payments. The largest provider of residential services reported that they did not submit information to Myers and Stauffer during the original cost survey collection period. Although, Myers and Stauffer indicated they provided assistance for providers in completing the cost survey, many providers in 2007 continued to be in a transitional stage from accounting systems based on grants to a fee for service Medicaid structure required under the waiver. This brings into question the reliability of the cost survey data upon which the original rates were set. Additionally, even with the smaller targeted group of providers submitting cost surveys (defined as 90% of the Medicaid service units or 5 providers identified, whichever comes first), the Office

of Rate Review expressed continued difficulty with getting information from providers specifically related to reconciliation and allocation methodology. Target list providers also expressed concern and frustration with the time intensity of completion of the cost surveys, the reconciliation demands from the Office of Rate Review months after submission, and the lack of available training for new financial staff in accurately completing the cost surveys.

The rate setting methodology allows for a stop-loss procedure which is described as a means of allowing Medicaid reimbursement rates to change in a predictable and controllable manner.

“The stop-loss procedure ensures that the Medicaid reimbursement rates for home and community-based Waiver services and personal care services, or the total allowable costs for services subject to special calculations, will never increase or decrease more than 5% during a rebasing. This creates fiscal predictability and more effective budget planning for both providers and the State. It also controls growth and contractions in the system by allowing changes to occur gradually over time.”

When the stop-loss procedure concept was introduced, the stakeholder group working on the methodology felt this would address the predictability factor lacking in previous iterations of the methodology; however, when re-establishment of rates did not occur in 2018 or any subsequent years since then, the stop-loss effectively capped any growth of the re-established rates to 5%. Re-establishment of rates is scheduled to occur in state fiscal year 2023. Assuming the cost surveys result in at least the 5% “access” factor described below, providers could expect no more than a 5% increase to all rates of reimbursement. This would increase rates from 2011 to 2023 by 23%, well below the consumer price index growth rates for 2021 noted previously let alone those yet to be determined consumer price index growth rates for 2022.

“To ensure that an adequate number of providers can operate under Medicaid reimbursement rates that are derived from target provider cost data, the allowable cost pools for each service are increased by 5% to generate the total allowable costs. This is efficient because the allowable cost pools are created from providers who deliver a majority of the Medicaid service units for home and community-based Waiver services and personal care services.”

The intent of the “access” factor was to allow for capacity building within the overall home and community-based service system and to recognize that providers who are reliant on Medicaid billing for the majority of the services provided will not have costs that exceed their reimbursement rate (i.e., no other revenue sources to cost shift to). Any increase in

reimbursement rates due to the access factor would be offset by the artificial cap of the stop-loss factor.

The rate setting methodology allows for exceptional rate changes should the department find convincing evidence that the rates do not allow for reasonable access to care. When queried, the Office of Rate Review indicated that since 2011, only one provider has requested a review of a rate based on the exceptional rate change provision. The request was specific to the implementation of electronic visit verification. As noted previously, it is difficult to capture increased costs due to unfunded mandates with a fixed rate system. Providers have implemented cost containment measures to absorb increased costs which have not directly impacted access to services. While the exceptional rate change provision on the surface is beneficial, in practical terms it is very difficult to implement.

The transition from services being funded solely by grants to those funded through categorical, fee for service Medicaid provided for an increase in the number of individuals with developmental disabilities being served since the introduction of Medicaid waivers in Alaska in 1993. The expansion of Medicaid waivers also saw growth in the number of home and community-based providers, offering choice for recipients. A consequence of both the grant to Medicaid funded services and the increase in the number of providers has been in the inability of providers to build capacity and infrastructure. Grant funding provided flexible resources that could be used in innovative ways to meet the needs of recipients while also providing stable revenue streams for providers. Increased numbers of providers, while offering choice, have resulted in the need for increased state oversight and compliance monitoring, reduction in caseloads for provider organizations which limits cost efficiencies related to “economies of scale”, and increased the administrative cost burden to the overall system. Further, the competition between the increased number of providers for a limited supply of workforce has driven wages up for direct support professionals, which on the surface is positive; however, without a corresponding increase in reimbursement rates, providers have had to implement the cost containment measures described previously. Finally, by having a fixed rate structure that has not significantly changed in the last 10 years coupled with regulatory changes that have

significantly affected provider's way of doing business bring into question the efficacy of the current rate setting methodology.

Section V: Rate and acuity methodologies across the United States

CMS Home and Community-Based Waiver technical guidance states that rate setting guidelines must ensure 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”. Additionally, rates can be prospective, retrospective, or based on a fee schedule. Further, the rate methodology must at a minimum be reviewed every five years with the waiver reapplication process. CMS lists several rate setting methods currently in practice:

- Fee schedule
- Negotiated market price
- Tiered rates
- Bundled rates
- Cost Reconciliation
- Milestone-based payments
- Outcome-based payments

A review of all 50 state 1915 c or 1115 waiver applications was conducted. The majority of rate setting descriptors included methodologies which consisted of an analysis of wages, employment related expenses, program indirect or program support, administrative and general with facility costs included in some states and separated as its’ own category in others. States that included acuity adjustments typically utilized a tiered system based on level of need.

Following are highlights from some states with interesting characteristics in their methodologies:

Colorado – Colorado has incorporated multiple methodologies to develop rates for home and community-based services. Colorado utilizes a rate setting methodology based on direct and indirect wages, urban specific wage increases, facility costs, administrative expenses, capital overhead expense. a budget neutrality adjustment is applied to the final determined rate. For transportation, specialized medical equipment, and supported employment job placement - case managers coordinate with providers and determine a market price that incorporates the client's needs, products required, and frequency of use. The department reviews and approves the market price determined and authorized by the case manager. Tiered rates are used to reimburse for those services for which the level of provider effort and the intensity of service are variables based upon the differing support needs of individuals. The difficulty of care factors been incorporated into the rate-setting model for rates. The department contracted with Healthcare Receivable Specialists Inc. (HRSI) to develop a methodology for the classification of individuals

into Support Levels and to develop a uniform rate model that builds provider payment rates based upon those Support Levels and other underlying cost components.

Connecticut – Connecticut establishes rates based on the direct support hourly wage and the additional components of supervision, employee benefits, indirect costs, administrative and general costs at the provider level, and the number of clients per the direct care staffing ratio. There is an additional component of hours of supports based on level of need for those rates calculated on a per diem basis. Payment adjustments are made to providers who experience unanticipated low attendance rates or extraordinary costs due to extreme weather conditions such as blizzards, hurricanes floods, etc.

Washington D.C. - Starting with the October 1, 2020 waiver amendment, DC requested and received CMS authority to automatically increase rates as necessary to account for any enacted DC or Federal legislation requiring a wage increase or that imposes fees or taxes that may ultimately affect the cost of providing waiver services. The methodology utilizes an administrative, support service wage, and paid time off factor which matches the ICF/IDD factors approved in the state plan. All rates are inflated with the same inflationary rate used by the ICF/IDD rate methodology.

Georgia – Georgia utilizes a prospective methodology that has evolved to consider current U.S. Bureau of Labor Wage Data by Area and Occupation statistics and other national market resources such as the Kaiser Family Foundation.

Hawaii – Hawaii conducted a rate study in 2016-17 by Burns & Associates, a national consultant experienced in developing provider reimbursement rates for HCBS waivers, Burns & Associates conducted another rate study in 2020. Development of rate models for each service that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and ‘productivity’ (i.e., billable time versus non-billable); staffing ratios; mileage; facility expenses; and agency program support and administration. Rates do not vary based on the provider.

Illinois - Rates are individualized based on the community integrated living arrangement (CILA) individualized rate determination model. The CILA Individual Rate Model sets rates based on the support need of the person to be served and the conditions under which the supports are to be provided. Reimbursement is founded on the principle of reasonable, predicted costs to support a person with developmental disabilities as determined by the Model, rather than the estimated costs that will be incurred as determined by a specific community agency or other entity. Using fixed cost center reimbursement rates based on system-wide provider cost report data where possible, and proxy values for expenses such as housing and transportation where necessary or appropriate, rates are produced for individuals that are the same across all providers given identical individual needs and conditions in which supports are provided. More information on Illinois rate setting can be found at <https://www.dhs.state.il.us/page.aspx?item=16043>.

Kansas - Kansas has used tiered rates to reimburse providers of many waiver services including day and residential supports. The initial rates were developed based on the recommendations of an actuarial contracted with by the State. Day Supports and Residential services fee for service rates are set with tiered rates. All other IDD services are reimbursed by a single rate. The rate setting statute requires an independent, professional review of the rate structures on a biennial basis resulting in a recommendation to the legislature regarding rate adjustments. The recommendation shall be adequate to support: A) A system of employee compensation competitive with local conditions, B) training and technical support to attract and retain qualified employees, C) a quality assurance process which is responsive to consumer's needs and which maintains the standards of quality service. This rate determination method is used for all IDD services regardless of whether the service is reimbursed through a tiered rate or a single rate.

Maine - Provider payment rates have been established through a variety of mechanisms, including consideration of historic cost and budget data, comparisons to rates paid for similar services in other programs, and targeted rate studies. The calculations were done under contract by Burns & Associates. Waiver services are reimbursed on a prospective, fee-for-service basis, Home Support: Agency Home Support Per Diem and Agency Home Support Per Diem Medical Add-on are components of Per Diem Home Support. The Published per diem rates for these services are based on 2007 cost data and vary based on the size of the home with a higher rate tier for members with more significant needs. The State's rate setting unit reviews rates on at least a semi-annual basis. In the event rates are found to be insufficient to ensure an adequate pool of providers, the unit will either adjust rates or engage in a new comprehensive rate study. The State may review rates more often in the event stakeholders raise access issues directly with state staff. The State also has several regular series of meetings with groups of providers and advocates, during which rate adequacy is routinely discussed.

Maryland - The hourly rate was developed using the Brick method. The Brick Method™ is a systemic approach to the development of set or published rates for different services funded by federal, state and county governments. It was originally developed to set rates in a way so that the rates would be responsive to the needs of individuals, and able to vary as those needs are different from one person to the next, or change over time. The wage component is based on the Bureau of Labor Statistics and includes the cost components employment related expenses, Program Support, Training, Transportation, and G&A with a service adjustment for no shows and will be billed in 15-minute increments.

Missouri - Residential Habilitation Services: Rates for Group Home (GH) settings, Individualized Supported Living (ISL) and Shared Living models are based on the individual's Rate Allocation Score (RAS), as derived from the Supports Intensity Scale (SIS).

Nebraska - Some services incorporate a tiered rate structure to compensate providers based on the acuity of the participant. The following services have tiered rates: Habilitative Workshop, Community Inclusion, Child Day Habilitation, and Residential Habilitation. The reimbursement for these services is tiered based on the participant's level of service need as determined by the Inventory for Client and Agency Planning (ICAP) assessment. The five reimbursement tiers are:

- o Basic-ICAP score 65+.
- o Intermediate-ICAP score 37-64.
- o High-ICAP score 12-36.
- o

Advanced-ICAP score 1-11. o Behavioral Risk Tier – based on results of a behavioral risk screen assessment by DDD clinical staff. Rate factors are adjusted for tiered services to account for different costs within the tiers. The assumed staffing ratios for direct labor are lowest for the basic tier and are increased to one-to-one for the behavioral risk tier, including overnight hours. Program support, administration, and the wage percentile of the Bureau of Labor Statistics classification are also graduated to account for the different cost structures within the tiers.

Minnesota - Added a 4.7% “competitive workforce factor” to all Disability Waiver Rate System frameworks. This change is effective Jan. 1, 2020. It will occur on a rolling basis, as service agreements begin or renew. The competitive workforce factor is described as a methodology to raise wage components in service rates to align with occupations that have similar education and training requirements.

Pennsylvania – Methodology includes a review of the cost of implementing Federal, State, and local statutes, regulations, and ordinances.

South Dakota - Methods employed to establish provider payment rates: Utilizing stakeholder input, the rate methodology establishes a prospective rate based on historical cost. The rate model utilizes cost components including salary, benefits, & operating costs. Cost reports are submitted by providers on an annual basis so the cost of providing the service can be analyzed & compared to modeled rate. If the rate is sufficient according to the cost reports, the proposed rate for the upcoming fiscal year increases based on appropriated inflation. If cost reports show that the cost of providing the service exceeds the modeled rate, the information is used to develop the rate for the following fiscal year.

Tennessee - For Supported Employment–Individual Services, fee for service job coaching rates are based on a prospective rate model that reflects a sufficient wage for the level of qualified staff required to deliver the service and all other reasonable and anticipated costs involved in providing the service. For job coaching, this prospective rate is then tiered into three distinct rates based on the level of fading achieved, taking into account the waiver participant’s level of disability and length of time the job has been held. Providers can earn the highest rate for achieving the highest fading targets, the mid-level rate for achieving the mid-level fading targets, and the base level rate for achieving the base level fading targets. Using this model, providers are appropriately incentivized to fade job coaching supports over time (a key quality metric for supported employment services) while the state can also ensure no waiver participant is excluded from participation in supported employment-individual services based on level of disability or newness to their job. To determine a waiver participant’s acuity tier for job coaching, the Level of Need system that has been in use to determine employment and day service reimbursement will continue to be used. Additionally, where an individual has a need for job coaching that is equal to or less than one hour per week, a monthly “Stabilization and Monitoring” payment will be used to encourage ongoing, effective monitoring of the waiver participant’s employment situations, with minimum monthly contact requirements that will allow for prevention of otherwise avoidable job losses or reductions in work hours.

Virginia - Engaged Burns & Associates, Inc. (B&A), a national consultant experienced in developing provider reimbursement rates for home and community based services, to conduct a

rate study. The rate study process began in 2014 and the same process is used in new rates. DBHDS identified policy goals that could be affected by the rates. These goals included providing adequate funding for direct support professionals' wages, benefits, and training to reduce turnover and professionalize the workforce; moving away from one-size-fits-all rates to better support members across the continuum of needs, including those transitioning from institutional settings; and encouraging individualized and person-centered supports, consistent with the home and community based services rule. Analysis was conducted to use Supports Intensity Scale® (SIS®) assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs. These seven levels, in turn, are cross-walked to four rate categories: low needs (level 1), modest needs (level 2), moderate to significant needs (levels 3 and 4), and highest needs (levels 5, 6, and 7).

Wyoming - In 2017, the Department of Health contracted with Navigant Consulting to conduct a rate study for Wyoming's (HCBS) waivers. The objectives of the rate model included in this study were to: •Recognize reasonable and necessary costs of providers •Standardize rates •Reflect participant needs •Increase transparency •Facilitate regular updates •Provide fiscal stability for providers and the state. The independent rate build-up methodology comprises direct care and indirect care components and uses assumptions about types of employees; wage rates; benefits; program support and administration costs; supervisor span of control; staffing patterns; and direct care work productivity factors. Some components vary between services while others are the same across the services. Productivity Adjustment: The rate model includes service-specific productivity factors to account for non-face-to-face time necessary to deliver services (planning, meetings, recordkeeping, etc.).

Section VI: Recommendations

AADD leadership requested recommended strategies for administrative and legislative action to update the current regulations and specific potential statutory addition for parity with hospital and nursing home rebasing requirements. The historical review of the development and implementation of the rate setting methodology along with review of rate setting methodologies utilized by other states has informed several recommendations:

Hospital and nursing home rebasing requirements

According to the Executive Director of the Office of Rate Review, the statutory reference for the 4 year rebasing timeline for hospitals is:

AS 47.07.074. Audits and Inspections.

(a) As a condition of obtaining payment under AS [47.07.070](#) , a health facility shall allow

(1) the department reasonable access to the records of medical assistance recipients and providers; and

(2) audit and inspection of the records by state and federal agencies.

(b) The department may establish the scope and timing of audits under this chapter. The department may provide that audits will be conducted less frequently than annually.

The specific language for payment rates for health facilities can be found at:

AS 47.07.070. Payment rates for health facilities.

(a) The department shall, by regulation, set rates of payment for health facilities under this chapter and [AS 47.25.120](#) — 47.25.300 in accordance with 42 U.S.C. 1396 (Title XIX, Social Security Act, Medical Assistance) and this section. A rate established under this section takes effect under [AS 44.62](#) (Administrative Procedure Act) but not until approved in writing by the commissioner. The commissioner may delegate the performance of these functions.

The statute does not state that health facilities will be rebased; however, the governing regulations 7 AAC 150.160 - Methodology and criteria for approval or modification of a payment rate states that the department will perform a rebasing no less than every four years.

The statute governing home and community-based services can be found at:

AS 47.07.045. Home and community-based services.

(a) The department may provide home and community-based services under a waiver in accordance with 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act), this chapter, and

regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. To supplement the standards in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment for the services.

The current governing regulations for payment rates for home and community-based services can be found at:

Section 7 AAC 145.525 - Re-establishing and adjusting payment rates in the department's Chart of Personal Care Services, Community First Choice Services and Waiver Services Rates

(a) On or after July 1, 2018, rates of payment in the department's *Chart of Waiver Services Rates*, adopted by reference in 7 AAC 160.900, will be re-established at least every four years using the department's *Personal Care Assistant and Waiver Rate-Setting Methodology*, adopted by reference in 7 AAC 160.900,

It should be noted that the regulatory language (7 AAC 145.520. Home and community-based waiver services payment rates) from 2011 (amended 3/1/2011, Register 197) also included a requirement for rates to be re-established at least every four years. Further, the most recently approved 1915 c waiver application for AK People with Intellectual and Developmental Disabilities effective July 1, 2021 states:

“Medicaid reimbursement rates for home and community-based waiver services are rebased at least every four years and are annually adjusted for inflation in non-rebase years. The inflation factor is determined using the CMS Home Health Agency Market Basket in Global Insight’s Healthcare Cost Review. The Commissioner of the Department determines through regulation when an inflation adjustment cannot be made in a specific fiscal year. “

“July 1, 2022, the Department will establish new rates for home and community-based waiver services.”

Recommendation: A legal opinion should be sought as to whether the current statutory language with governing regulation requires that re-establishment of home and community-based payment rates should occur and if not that the department is out of compliance for not having re-established rates since 2011. It should be noted that according to the Office of Rate Review Executive Director, “No health facilities rebasing was impacted by cost containment measures. As a result, each hospital has been rebased on schedule and received their adjusted rates.” .

further, the legal opinion should include a determination of whether re-establishment and rebasing are comparable terms. If not, suggested update of governing regulations to change the verbiage to rebase should occur.

Current Rate Setting Methodology

As noted, there are several limitations to the current rate setting methodology which include:

- Whether the tool adequately captures all of the costs associated with the delivery of home and community-based services
- The amount of time-lapsed since re-establishment of rates has occurred makes the rate re-establishment process obsolete
- The stop-loss factor artificially caps rate increases to 5%. This may have been an effective tool if the rates had been re-established on schedule, but they have not which results in suppression of rates over time
- The cost survey tool has not been evaluated for reliability
- Providers continue to have difficulty in accurately completing the cost survey
- Updates to the cost survey tool have not occurred

Recommendation: Submit formal request to the Department of Health and Social Services to conduct a rate study with a national consultant experienced in developing provider reimbursement rates to evaluate the current methodology and make suggestions for an alternative process. Potential contractors used by other states include: Optumus Consulting, Navigant Consulting, Burns & Associates, Myers & Stauffer, Public Consulting Group, EP&P consultant, Johnston, Villegas-Grubbs and Associates, and Healthcare Receivable Specialists Inc. Through a robust stakeholder engagement process identify the policy goals to be affected by the rates as the drivers of the methodology (e.g., implementation of Shared Vision). Areas that should be considered for inclusion include: acuity adjustments based on tiered levels of need for all habilitative services to recognize the need for more intensive staffing for individuals; competitive workforce factor to compete with other industry; include a productivity factor for (non)billable time; regular meetings with stakeholders, during which rate adequacy is routinely discussed; payment adjustments for providers who experience unanticipated low attendance rates or extraordinary costs due to extreme weather conditions such as snow, earthquakes, etc.; and, a review of the cost of implementing Federal, State and local statutes, regulations and ordinances.

Recommendation: Another approach to rate setting is to use modeling or the Brick method to build the rates from standardized, reliable sources. Rates for behavioral health services in Alaska are based on a modeling approach which uses standardized sources for wage information (e.g., Bureau of Labor Statistics, State of Alaska Department of Labor and Workforce Development, Alaska Psychiatric Institute, Division of Juvenile Justice, and Office of Children’s Services), the State of Alaska fringe percentage rate, program support costs, State of Alaska administrative and general percentage, productivity to account for billable time, and an adjustment for staffing ratios. A comparable calculation could be developed for home and community-based services using similar sources for wage calculation (Bureau of Labor Statistics lists average hourly wage for social and human service assistants at \$17.29, State of Alaska lists the comparable position group at \$21.03 per hour). An analysis to determine whether the other components of the wage calculation currently used by behavioral health are comparable to the home and community-based delivery system would need to occur. The Behavioral Health Association Executive Director indicated the upfront work to identify all possible Standard Occupational Classification codes used by community behavioral health providers was laborious but an effective exercise in developing the wage factor. Additionally, understanding the “clinical” reality of providing services is critical. The modeled rates could be analyzed and compared to provider submitted cost surveys. If cost reports show that the cost of providing the service exceeds the modeled rate, the information could be used to develop the rate for the following fiscal year.

Acuity Adjustments

States that have incorporated an acuity adjustment into their rate setting methodology have tiered systems based on the level of service need of the individual recipient typically defined through evaluation of a standardized assessment and observation by provider or family. Alaska’s current acuity rate system is allowed only for Residential Supported Living Services or Residential Habilitation Services in licensed assisted living homes.

“The recipient must have physical or behavioral needs requiring direct one-to-one support from direct care workers whose time is dedicated solely to providing services to that one recipient 24 hours a day, 7 days a week, in all environments. To request acuity rate, the care coordinator must first provide evidence of the need for this level of support.”

The requirements are further defined with the need for one-on-one staff, 24 hours per day 7 days per week and require a high level of documentation to substantiate the need. In essence, the acuity rate adjustment is an “all or nothing” structure. This type of system does not allow additional support for those service recipients with higher levels of need that do not meet the 24 hour per day demand on staff.

Staff of Senior and Developmental Disabilities, provider representatives, and advocates have discussed the need for a more equitable application of acuity adjusted rates based on levels of need that are not as stringently applied as the current system. The discussions as recently as 2016 discussed adopting the InteRAI suite of assessment instruments moving away from the current Inventory for Client and Agency Planning as a step towards authorizing service levels based on assessed need which includes acuity. Although Governor Dunleavy’s SFY23 budget provides an intent to move towards an alternative assessment tool (see statement below), the Director of Senior and Developmental Disabilities expressed doubt that any meaningful movement will occur in the upcoming fiscal year.

“Senior and Disabilities Services (SDS) will dedicate positions to include a Medicaid program specialist and research assistant as part of a system operations team. This team will help manage the implementation and integration of a new consumer assessment and resource allocation tool. Additional staff are necessary to incorporate use of these tools in the division processes and the existing case management system. This team will ensure the division can evaluate the tools effectively and use data to improve services. Implementing a new consumer assessment and resource allocation tool will allow the division to improve the benefit determination and service planning process for home and community-based services.”

Recommendation: While not ideal, it is recommended an analysis and assignment of tiered levels based on the most recent ICAP assessment occur. A starting point for analysis could be using a system similar to Nebraska which incorporates ICAP scores into their objective assessment process. Nebraska also uses an enhanced risk identification adjustor based on utilization and acuity-based risk screening. Recipients are assigned to one of four tiers using the ICAP scores. Those recipients with higher levels of need have access to an enhanced risk adjustor based on a seven tiered system.

Section VII: Strategies

Based on the stated recommendations, it is suggested that AADD leadership consider the following actions:

Update rate setting methodology – the current rate setting methodology for home and community-based services is outdated, does not capture costs brought on by regulatory changes, does not reflect levels of acuity/need, and has not been applied as designed (no re-establishment of rates, several years with no inflationary adjustment).

1. Legal opinion

- a. Question: Do the statute and regulations as written require re-establishment of home and community-based rates every four years?
 - i. If yes, seek immediate action from the Administration to rectify the lack of re-establishment of rates
 - ii. If no, seek legislative champion to amend the statute and direct the administration to change the governing regulations to mirror the health facility regulations
 1. Including:
 - a. updated rate study to occur with national consultant experienced in developing provider reimbursement rates for implementation by July 2024
 - b. Rate re-establishment of 2018 rates by the 5% “access” factor with inflationary adjustments for state fiscal years 2019 and 2021-2024.
- b. Question: Is re-establishment of rates defined the same as rebasing of rates
 - i. If no, request the regulations be updated to consistently state rebasing in regulation, documents adopted by reference in regulation, and waiver application to CMS

2. Evaluate the use of the ICAP for acuity adjusted rates of reimbursement

- a. Submit a request to the Alaska Mental Health Trust Authority to provide funding for a project coordinator to manage the work with Senior and Disabilities Services
- b. Based on current ICAP scores assign recipients to levels of support. Nebraska is an example state
 - i. Utilize research and data staff at SDS to calculate ranked scoring of service recipients
 - ii. Compare ranked scores to the “service reality” for a randomly selected group of service recipients
 - iii. Work with the Office of Rate Review to determine budget neutral tiers

3. Request the Department of Health and Social Services begin the process to evaluate the rate setting methodology
 - a. Submit a request to the Alaska Mental Health Trust Authority to provide funding to hire a national consultant experienced in developing provider reimbursement rates
 - i. Request stakeholder seat(s) on proposal development and proposal evaluation committees
 - ii. Potential considerations:
 1. Adopt methodology/equation utilized for behavioral health services
 - a. Analysis of SOC codes used by home and community-based service providers – CFO group?
 2. Adopt existing CMS approved methodology factors from other states
4. Evaluate adoption of a new assessment tool
 - a. Request stakeholder membership on the Senior and Disabilities team that *“will ensure the division can evaluate the tools effectively and use data to improve services. Implementing a new consumer assessment and resource allocation tool will allow the division to improve the benefit determination and service planning process for home and community-based services.”*
 - b. Review previous work completed by HCBS Strategies and the Inclusive Community Council related to the InterRAI.

Conclusion

Establishing rates for home and community-based services is complicated. The Centers for Medicare and Medicaid Services provides technical assistance and guidance for states in designing their respective rate setting methodologies while allowing multiple methodologies to be employed. Alaska opted to employ a rate setting structure based on cost surveys initially from all providers then modified in 2018 to a targeted group of providers that provide a large amount of each service category. The original rate study was conducted by Myers and Stauffer but as noted the data upon which rates were established was incomplete. The data from cost surveys that were to be used to re-establish rates in 2014 would have resulted in tremendous disruption to the delivery system and could not be verified by the State due to the MMIS conversion issues. Cost containment measures enacted by the Department of Health and Social Services precluded re-establishment of rates in 2018 as scheduled. Rates have been adjusted for inflation in seven of the last 11 fiscal years resulting in an 18% increase in the majority of rates which has not kept up with the consumer price index inflationary rates during this same time period.

The rate setting structure for home and community-based and personal care services has been rendered obsolete with the lack of re-establishment of rates and passage of time. Providers of home and community-based services have been unable to capture the increased costs brought on by state and federal mandates, regulatory changes, and other systemic changes due to the lack of formal re-establishment of rates since 2011. The cost survey tool itself was not validated which brings into question the reliability of the tool in accurately measuring the true cost of service provision. More detailed cost survey tools have been developed in subsequent years and are in place in other states. The accuracy of the cost survey data is further brought into question by the sophistication and experience of provider agencies who complete the cost survey to be used to re-establish rates.

Providers of home and community-based services have instituted numerous cost containment measures as a means of attending to rate constraints. The cost containment measures have had a direct impact on the ability of providers to attract and retain staff, both direct service and administrative. The current wages offered by home and community-based providers are not

competitive when compared with for example Anchorage based grocery stores that offer \$20.00 per hour to start. Additionally, the large number of providers competing for the same labor pool has resulted in additional administrative burden as direct service professionals “shop around” for higher wages and persuade the individuals they serve to move as well.

In summary, the current rate setting methodology for home and community-based services is outdated, does not capture costs brought on by regulatory changes, does not reflect levels of acuity/need, and has not been applied as designed (no re-establishment of rates, several years with no inflationary adjustment. The rate setting methodology for home and community-based services should be revisited as part of the re-establishment of new rates in SFY23. Contracting with a national consultant experienced in developing provider reimbursement rates to evaluate the current methodology and make suggestions for an alternative process should occur. The contractor should be instructed to incorporate a tiered structure for acuity based on the current assessment process in place in Alaska as waiting to adopt and evaluate an alternate assessment process would be time consuming and push a new rate setting methodology too far into the future for the home and community-based delivery system to survive.

Thank you for the opportunity to provide this report to the Alaska Association on Developmental Disabilities. Also, thank you to the staff of the Office of Rate Review and Senior and Disabilities Services who answered numerous questions about rate setting for both home and community-based services and health facilities. A special thank you to the leadership of the Association and to the members who shared their experiences with the rate setting methodology and the impact on services. Each of you has a significant role to play in the delivery of quality services for Alaskans who experience intellectual and developmental disabilities

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Appendix A: Governing Regulations

Register 128 – 175

https://drive.google.com/file/d/1UyXPM-j3DXfkWHzLUepWxGN-L_M8guO/view?usp=sharing

Register 178 - 182

<https://drive.google.com/file/d/1gY4TGctxC56NTAEGmqMRdB2xM2faIwwi/view?usp=sharing>

Register 183 – 197

<https://drive.google.com/file/d/15AYFTvDIFV7e-uVxUahFiGZrLaX9QxRZ/view?usp=sharing>

Register 225 - 236

https://drive.google.com/file/d/13oV7UwPS5Xk_nkGpT2vQQeRxqyKHByxN/view?usp=sharing