**Alaska Association on Developmental Disabilities – November 2021**

**The Case for Rate Rebase – Home and Community Based Services (HCBS)**

**The Origin of the current Rate Methodology:**

Prior to 2004, HCBS providers were approved an individualized rate of reimbursement for most recipients of Medicaid waiver services when the Plan of Care was approved. Transition to national HCPCS billing codes in July 2004 also ushered in aggregate rates for each provider for each service category. This era was punctuated with ongoing State of Alaska fiscal challenges. The primary cost containment strategy being provider rate freezes until a cost-based methodology was developed. Expected to expire in June 2005, these rate freezes were extended twice more until July 2008.

Long term studies funded by the Alaska Mental Health Trust Authority and the State of Alaska, specifically, the Public Consulting Group report (February 2006) and the Lewin Group & ECONorthwest report (February 2006) fell short of the Division of Senior and Disabilities Services Regulations and Policy Workgroup’s expectations to provide any rate methodology. The Senate Finance Committee also received the Medicaid Program Review prepared by The Pacific Health Policy Group (January 2007) which warned that traditional cost containment actions may be unavoidable in the face of short-term fiscal shortfalls but often have unintended consequences in other service areas. Consequently, the State of Alaska contracted Myers & Stauffer LC in the summer of 2007 to develop a rate setting process for Medicaid home and community based rates. Providers were invited to participate in forums, in summer 2008 to pilot a detailed cost survey tool using FY2007 financial data and expense allocations, then followed by a full survey in fall 2008.

In December 2008, Myers and Stauffer LC presented recommendations for a rate methodology. The response rate of 40% of provider numbers represented 52% of Medicaid payments. Assisted living homes response rate was 9% of provider number representing 25% of Medicaid payments, which Myers and Stauffer deemed “inconclusive cost findings” based on the response rate. An example of rate chart calculated using the weighted average of these cost survey results was also shown. Myers and Stauffer recommended a phase-in aggregated rate over 4 years and inflation increases at the Medicare Home Health Agency Market Basket Index, followed by periodic cost surveys.

**Regulations Implemented:**

In June 2009, Commissioner William Hogan announced the final phase of the process with publicly noticed proposed regulations (targeting January 2010 as the effective date). Under this proposal, rates would likely be rebased in 2012 with inflationary increases in rates between 2010, 2011 and 2012.

Proposed Regulations for Medicaid Coverage and Payment 7 AAC 125, 7 AAC 130, 7 AAC 145 and 7 AAC 160 were issued for public review on March 31, 2010, finally becoming effective on March 1, 2011. Standard rate charts, including Assisted Living Homes were based on the “inconclusive” data gathered by Myers and Stauffer LC. The regulations stated that on or after January 1, 2014 rates of payment “will be re-established at least every four years” based on the results of provider cost surveys. The following chart compares rate related actions over the next decade:

|  |  |  |  |
| --- | --- | --- | --- |
| **State Fiscal Year**  **(July – June)** | **Rate Inflationary Adjustment** | **Provider Cost Survey and/or Annual Report** | **Comments** |
| 2011 - 2012 | 2.2% | Submitted to ORR |  |
| 2012 - 2013 | 2.5% | Submitted to ORR |  |
| 2013 – 2014 | 2.2% | Suspended | MMIS conversion failure, Cost Survey regulations reworked by ORR |
| 2014 – 2015 | 2.4% | Suspended | **Rate Rebase expected: did not occur**  MMIS conversion failure, Cost Survey regulations reworked by ORR |
| 2015 – 2016 | 0% | Submitted to ORR |  |
| 2016 – 2017 | 0% | Submitted to ORR |  |
| 2017 - 2018 | 0% | Submitted to ORR |  |
| 2018 – 2019 | 2.5% | Submitted to ORR | **Rate Rebase expected: did not occur** |
| 2019 – 2020 | 0% | Submitted to ORR | COVID-19 pandemic impact March 2020 |
| 2020 - 2021 | 2.5% | Submitted to ORR | COVID-19 pandemic |
| 2021 – 2022 | 2.1 % | Not yet due | COVID-19 pandemic |
| 2022 - 2023 |  |  | **Rate Rebase expected** |

**The Consequences and Action Needed:**

During this same decade, numerous unfunded mandates and significant cost increases have increased the expenses of Medicaid providers. For example, the Affordable Care Act, Workers Compensation insurance rates, Group Health insurance rates, increased Federal, State and Self-Audit requirements, COVID-19 mitigation costs for vaccines, PPE and testing are among many economic pressures that currently impede the ability of providers to increase wages to attract and retain qualified workforce.

For a variety of reasons outside provider’s control, the rate setting methodology has failed to adjust reimbursement in alignment with the real costs of doing business in Alaska over the past decade. Faced with unprecedented workforce shortages and wage market pressures, it is time to exercise the provisions of 7 AAC 145.545 and to apply American Rescue Plan Act federal matching allocation to increasing rates pending a system review and recommendation for a viable rate methodology:

Section 7 AAC 145.545 - Exceptional changes to payment rates for personal care services and home and community-based waiver services

**(a)** If application of the methodology in the department's *Personal Care Assistant and Waiver Rate-Setting Methodology,* adopted by reference in 7 AAC 160. 900, results in a rate in the *Chart of Personal Care Services, Community First Choice Services and Waiver Services Rates,* adopted by reference in 7 AAC 160.900, that does not allow reasonable access to quality care provided by an efficiently and economically managed provider, the department may increase the rate if

**(1)** the department finds by clear and convincing evidence that the rate established using the department's *Personal Care Assistant and Waiver Rate-Setting Methodology,* adopted by reference in 7 AAC 160.900, does not allow for reasonable access to quality care provided by an efficiently and economically managed provider; and

**(2)** increasing the rate is in the public interest.

**(b)** In determining whether increasing the rate is in the public interest, the department will consider at least

**(1)** the necessity of the rate increase to allow reasonable access to quality care provided by an efficiently and economically managed provider;

**(2)** the assessment of continued need for the services in the community;

**(3)** whether providers have taken effective steps to adopt effective strategies to alleviate or avoid the future need for exceptional changes to payment rates;

**(4)** whether Medicaid recipients will lose access to Medicaid services available to the general public in the same geographic area if exceptional changes to payment rates are not made;

**(5)** the availability of other resources to providers; and

**(6)** other factors relevant to assess reasonable access to quality care provided by an efficiently and economically managed provider.

*7 AAC 145.545*

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