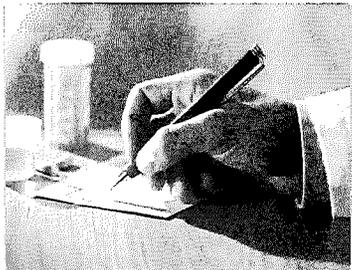
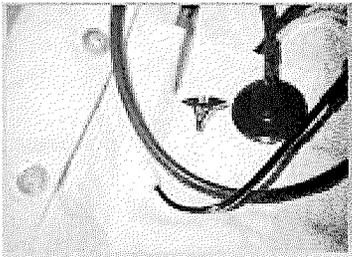
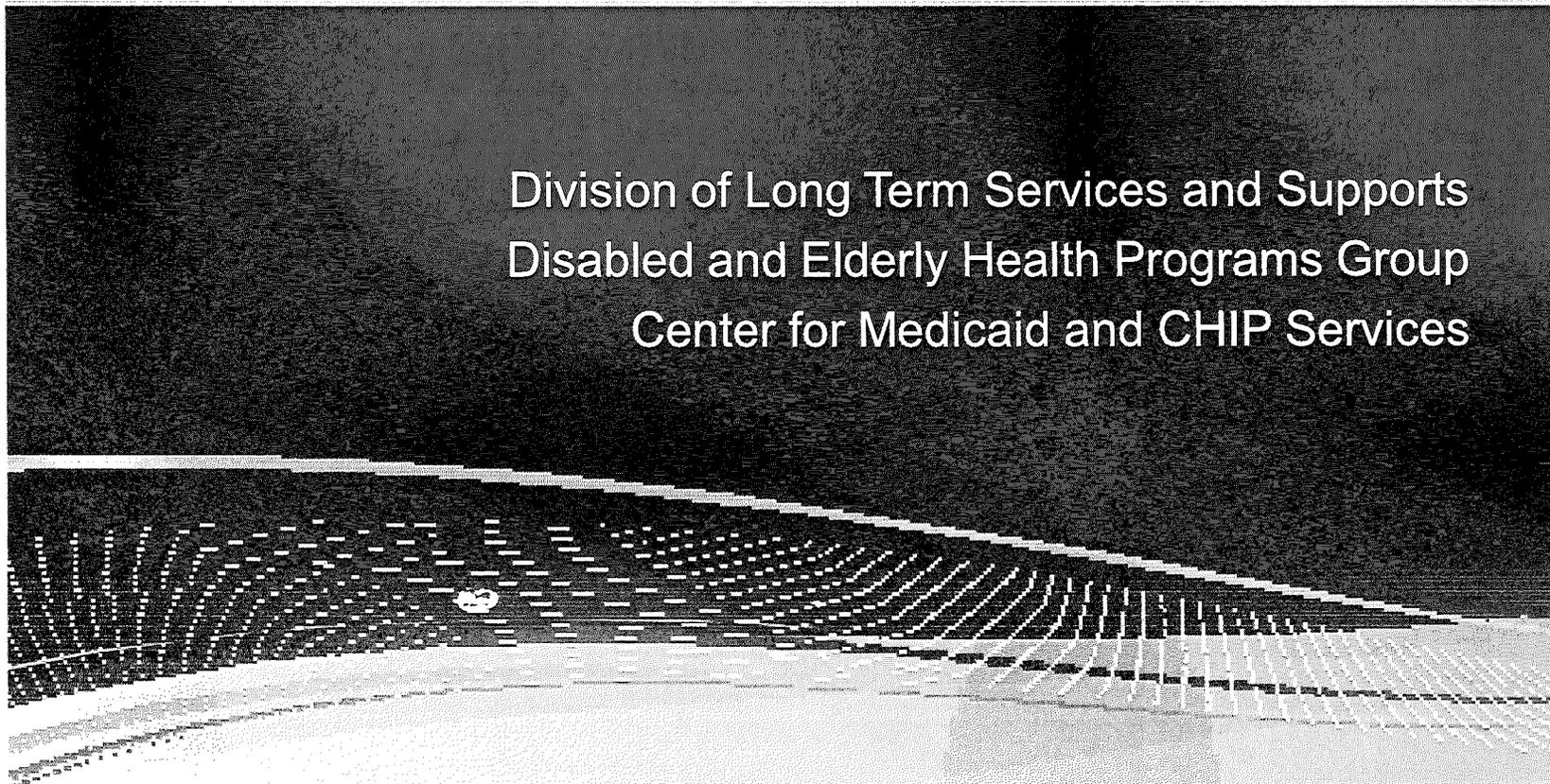




Rate Methodology in a FFS HCBS Structure



Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Training Objectives

This training consists of two topics:

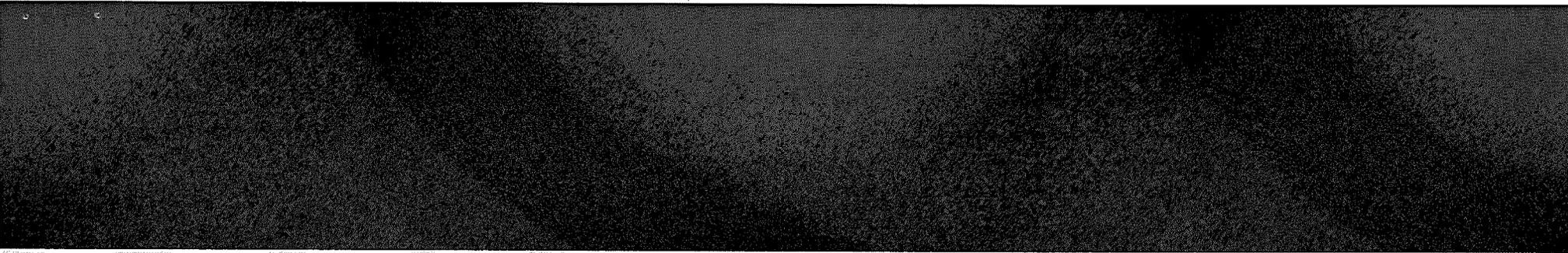
- **Topic 1: Technical Guide Instructions and Documentation**
 - Overview of guiding rules for rate setting methodology for §1915(c) waiver application
 - Review guidelines for completing Appendix I-2-a of the waiver application
- **Topic 2: Rate Setting Methodology and Fiscal Integrity**
 - Discuss basic elements of rate setting
 - Assess rate methodologies used with HCBS waiver services
 - Review benefits and risks of the rate methodology
 - Discuss fiscal integrity considerations for each rate setting methodology

Importance of Rate Setting

- Ensuring accurate and adequate reimbursement to providers of waiver services facilitates the right services being available to individuals receiving community-based long-term services and supports
- Simultaneously provides cost controls and projections for states

The Role of Innovation

- Various rate setting methodologies will be presented here, but states are encouraged to think broadly about the provision of HCBS and its role in payment reform initiatives
- CMS is available to provide technical assistance to states interested in exploring additional avenues to improving health outcomes and controlling cost



1915(c) Waiver Technical Guide Instructions and Documentation

Rate Setting in HCBS: Technical Guidance

Rate Determination Methods

- Payments for waiver services must be consistent with:
 - 1902(a)(30)(A) of the Social Security Act
 - “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”
 - 42 CFR 447.200– 205
 - “Plan must describe the policy and the methods to be used in setting payment rates for each type of service...”

Rate Setting in HCBS: Technical Guidance

Types of Rates that CMS discusses in Technical Guidance

- Prospective
- Retrospective (cost settlement of interim rates)
- Fee Schedule
- **Rates incorporate many factors and could include:**
 - Acuity
 - Geographic adjustment factors
- **FIVE types of rate setting and Fiscal Integrity methods to consider for each rate setting methodology will be discussed in Topic 2**
 - Others may be permissible as well, depending on the services involved

Technical Guide Instructions for Appendix I-2-a

- **Instructions note that the state must describe the following:**
 - **“Methods”** that are **employed** to “establish provider payment rates”
 - **Entities** that are **responsible** for rate determinations
 - **Opportunity** for **public comments** on rate setting
 - **Groupings** of services using the same rate setting methodology
 - Rate setting method must be described for **EACH** waiver service
 - For **1915(b)** and **(c) concurrent waivers**:
 - **Reference capitation rate methodology** in the 1915(b) waiver application and associated materials
 - **Participant Direction:**
 - If there is a difference in rates and/or methodologies for participant-directed services, discuss *how* the rate determination is different from provider managed services

Explanation of Data and Service Limits

- **Explain how frequently rates are being updated**
 - Identify the year of the last update
 - If the updates are done "as necessary," explain what conditions are sufficient to trigger a rate update
- **Rate setting methodology must be reviewed (and updated if appropriate) every 5 years in accordance with the renewal cycle**
 - If the rates are updated annually using a set of factors, explain the source of the factors
 - Explain why that factor is most appropriate for updating the rate
 - As with rate setting, factors should **not** go beyond 5 year cycle, no later than the *last approved year of the renewal*

Explanation of Data and Service Limits

Stay consistent with the service limits in Appendix C-1/C-3 service definitions

- Appendices I-2-a and C-1/C-3 should delineate the same information
 - **Example**
 - The C-1/C-3 tab states that the rates set for a given service are provided in 15 minute units, but I-2-a says the same service is paid as a daily rate. The two sections provide conflicting information

Additionally, the state should ensure that Appendices C-1 /C-3, I-2-a, and J-2-d (subcomponents, units of service, rates) align

- **Example**
 - Appendix J-2-d-i and J-2-d-ii can include “Component Cost” of service with each unique “Average Cost per Unit” and “Average Units per User”.
 - Table 1 below is an example of Appendix J-2-d-i.
 - Consider Unit descriptions, Average Units Per User and Avg. Cost / Unit follow descriptions from Appendices C-1/C-2 and I-2-a.

Explanation of Data and Service Limits

Table 1: Example of Appendix J-2-d-i

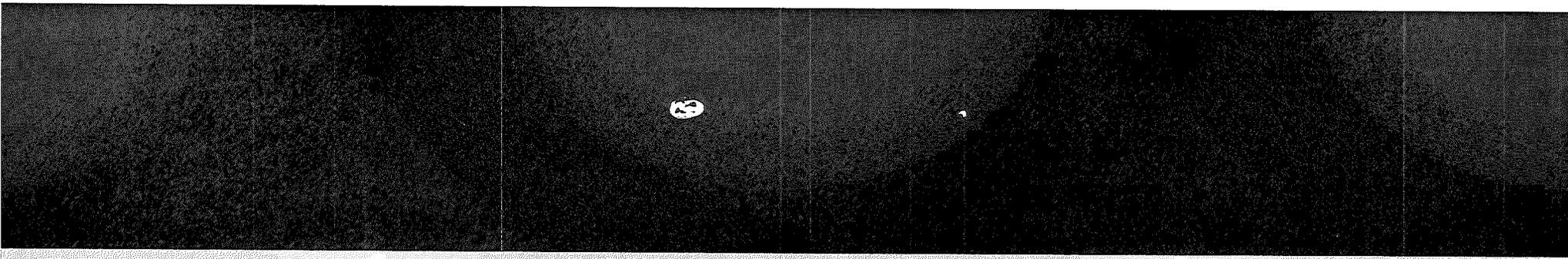
Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation						6,600.00
Day Habilitation - Level 1	Hourly	10	7.00	5.00	350.00	
Day Habilitation - Level 2	Daily	20	20.00	10.00	4,000.00	
Day Habilitation - Level 3	Daily	15	15.00	10.00	2,250.00	

Public Comment and Public Notification of Rates

- **Application language should meet public notification criteria per 42 CFR 441.304(d)(e) and (f) as well as 42 CFR 447.205**
 - Explain the public notification process
 - *Although public notification processes are described in the Transition Plan of the application, this is also a separate requirement for I-2-a.*
 - Specify the amount of stakeholder involvement in the rate setting process
 - Specify the web address where rates are publicly available and update this address as necessary
 - Provide as much detail as possible about how and when notifications are released
 - Explain how rates are communicated to individuals receiving services

Summary

- **We reviewed Rate Setting Methodology basic requirements according to the Technical Guide.**
 - Rate setting methodology description under Appendix I-2-a should specify:
 - Rate setting method for each service
 - Differences between agency-directed vs. self-directed service rate setting, if any
 - A review and update of the rate setting methodology and the trending basis every renewal period
 - Discussion of the method and trending basis
 - The public notification criteria
 - How the state communicates the rates to individuals



Rate Setting Methodology and Fiscal Integrity in HCBS Waivers

Rate Setting in HCBS – Overview

Rate Setting

- Process of determining how much a state will pay for the provider's service
- States can establish their own Medicaid provider payment rates
- Payment of services options commonly include fee-for-service or managed care (capitation) arrangements
- States can choose multiple methods for rate setting
- We will review five common rate setting methods, considerations, and fiscal integrity issues for each method
 - Other methods may be available, depending on the services involved

What is a Fee-For-Service System?

HCBS are often delivered in a fee-for-service delivery system:

- Individuals are served through a fee-for-service delivery system, where providers are reimbursed for each service (e.g., Personal Care, Respite, Supported Employment) based on a unit (e.g., 15-minutes, hour, per visit, day).¹
- States may develop their payment rates based on:
 - The costs of providing the service
 - A review of what commercial payers pay in the private market
 - A percentage of what Medicare pays for equivalent services
- Payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate

What is a Fee-For-Service System?

Fee-For-Service vs. Managed Care Capitated Rate

- Fee-For-Service
 - Fee-for-service payments could vary by:
 - Utilization of the service by individuals
 - Care level or acuity of the individuals
 - Staff costs (wages and benefits)
- Managed Care Capitated Rates:
 - Paid by PMPM (Per Member Per Month).
 - Managed care entities are paid a set amount for each individual member; providers are reimbursed based on a rate negotiated with the MCO
 - Acuity, level of care, risk of high utilization are factored into the PMPM rate
 - Health plans bear the risk

Common Basic Elements of a Rate in FFS

➤ **Base Data**

- Wages and benefits
- Cost to operate the facility (with the exception of residential service room and board costs) including taxes, administrative overhead costs, facility costs, equipment, and vehicle costs

➤ **Trend**

- What trending basis will the state use to calculate the rate?
- How will the state carry the rate forward in the future?

➤ **Geographic considerations**

- Rates consider various geographic areas in the state

➤ **Acuity and Level of Care**

- The state might consider splitting the rate of a service by intensity of care required

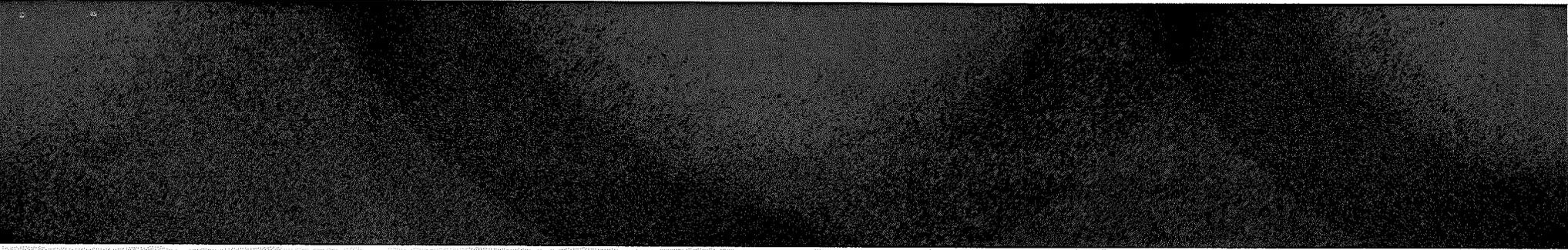
Types of FFS Rate Setting Methods

- Rate setting methods discussed today include:
 - Fee Schedule
 - Negotiated Market Price
 - Tiered Rates
 - Bundled Rates
 - Cost Reconciliation

(Note that other methods may be approvable, including milestone-based payments, outcome-based payments, etc.)

Trends in FFS Rate Setting Methods

- This training includes a list of the taxonomy categories most commonly associated with each rate setting method in state waiver applications
 - Based on data from renewal applications submitted between March 2015 and July 2016 that outlined rate setting methods in the state's initial submission
 - 70 renewal applications, 703 waiver services were analyzed
 - Each waiver service was assigned to an HCBS taxonomy based on the *CMS Medicaid HCBS Taxonomy Category and Subcategory Definitions* issued on February 28, 2014
 - If the state did not list a taxonomy category in the waiver application, a category was assigned during data analysis using the service descriptions in Appendix C-1/C-3 of the application



Fee Schedule

Fee Schedule Flat Rates

Definition

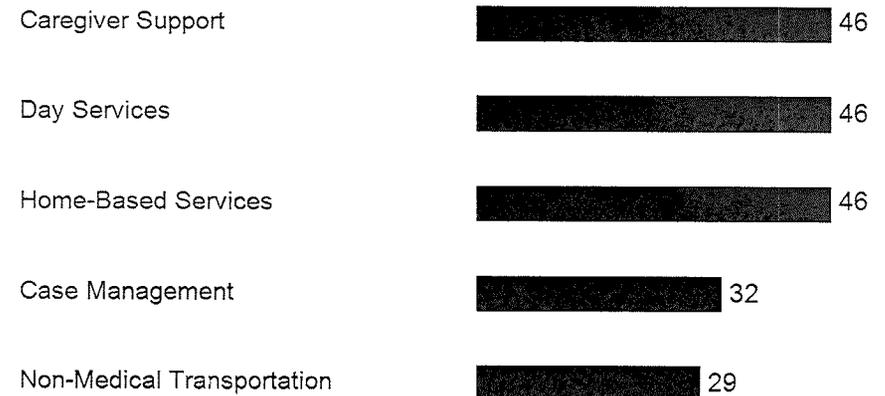
- Provider receives a fixed, pre-determined rate for a single service for a designated unit of time

Example

- Personal Care Services offered in certain adult waivers have a FFS rate of \$3.47/15 minutes.
- An individual requires 4 hours of Personal Care Services per day. For four hours of Personal Care Service per day, a provider bills 16 units at a rate of \$3.47 and receives a total of \$55.52

Top 5 Taxonomies Using a Fee Schedule Rate Setting Methodology

Based on 70 renewal applications with 703 total waiver services



Number of Waiver Services

Fiscal Integrity

- **Considerations for states choosing this type of rate setting**
 - Rates do not vary by client, acuity, or provider
 - **Salary Expectations**
 - Rates keep pace with proportional salary increases for direct support workers
 - Use Bureau of Labor Statistics (BLS) wage data (<http://www.bls.gov/bls/blswage.htm>), cost reports, HCBS survey data to judge average market wages
 - Factor into rates payroll taxes and FICA
 - **Product Costs**
 - Consider options if product costs are not already included in the fee schedule
 - Types: Individual goods (i.e. Durable Medical Equipment, Personal Emergency Response Systems, equipment purchases for environmental modifications)

Fiscal Integrity

➤ **Geographic considerations**

- Rates differ by area and can be partially based off average rates in a given area
- Rates can vary by cost of living or unemployment rates
- Types of rates that can be used:
 - Consumer Price Index (CPI) is from Bureau of Labor Statistics (BLS). See this link for the database available and further information:
<http://www.bls.gov/cpi/>
 - Consumer Price Index for all Urban Consumers (CPI-U)
 - Consumer Price Index for Urban Wage Earners (CPI-W)
 - Average Cost Data
- Cost of Living Adjustment (COLA) to adjust for geographic differences in rates

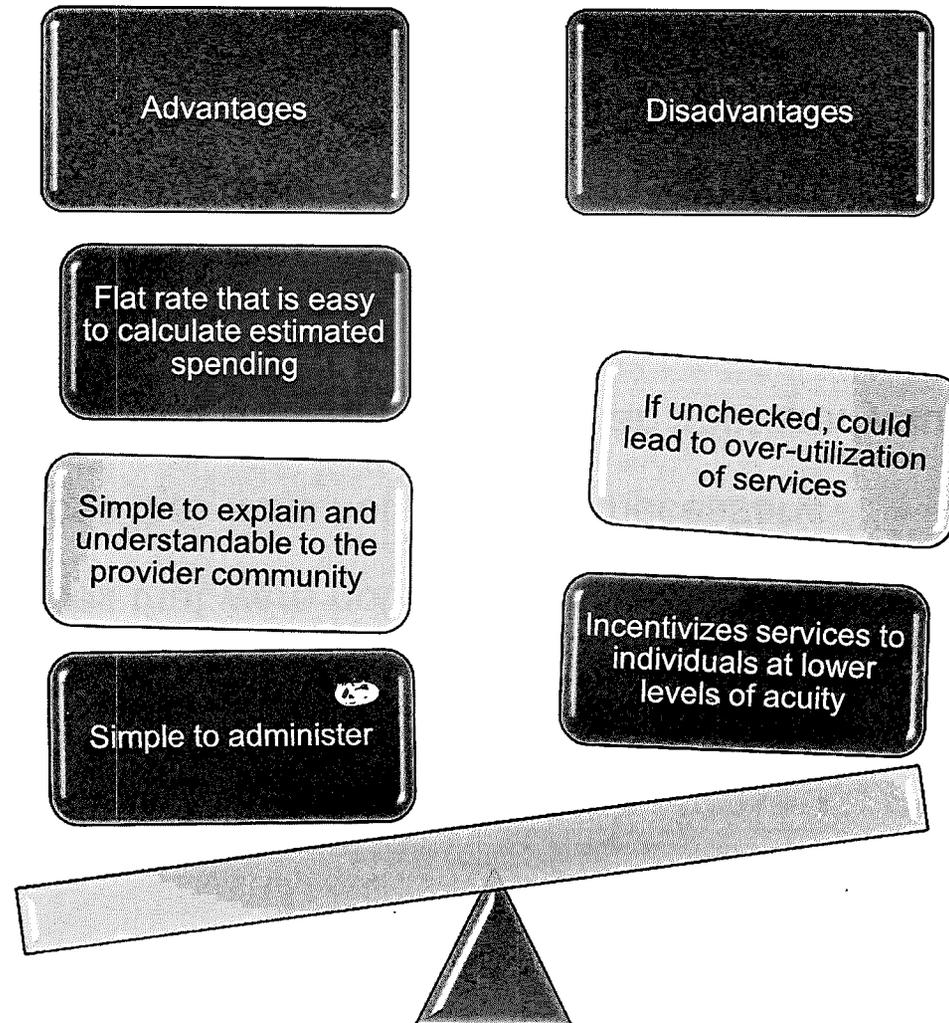
➤ **Direct and indirect care hours**

- Staffing needs of each service will vary and require examination to effectively assign the appropriate staff wage rate assumptions²
 - Proper staffing ratios
 - Supervisory, administrative, overhead, and operational expenses

Potential Risks

- Undocumented Services – irregular billing patterns, staff or individual reports fraud such as:
 - Billing for services that were not actually rendered;
 - Billing for services that were not medically necessary;
 - Billing for services that were performed by an improperly supervised or unqualified employee
- Rates are typically based on averages, but actual costs of individual providers can vary widely depending on:
 - Size, competitive wage rate, transportation costs, etc.
- Manual overrides of Medicaid automated payment system edits and faulty system logic
- Perceived low Medicaid rates might lead to access issues and shallow provider networks²

Fee Schedule Pros and Cons





Negotiated Market Price

Negotiated Market Price

Definition

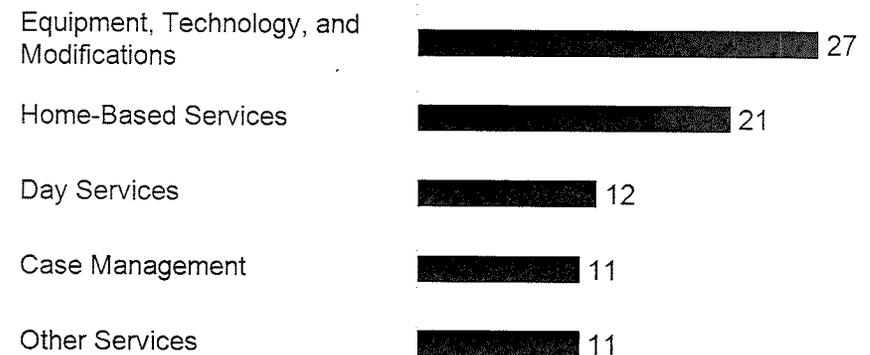
- Provider receives the market price of the service. There is an expectation that some negotiation will take place to reach an agreed upon market price

Example

- Each subcategory of service has its own material and labor costs, thus there is a unique price for each individual and each service
- If an individual needed a bathroom modified, the provider would bill 1 unit for the modifications at the negotiated market price

Top 5 Taxonomies Using a Negotiated Market Price Rate Setting Methodology

Based on 70 renewal applications with 703 total waiver services



Number of Waiver Services

Fiscal Integrity

- **Considerations for states choosing this rate method**
 - Rate ceiling considerations
 - Review comparable services
 - Review negotiated prices for other providers
 - Reconcile past years' claims and view trends
 - Skill level of providers might vary greatly
 - Consider possible geographic variations for:
 - Wages, demand, transportation costs and mileage

Fiscal Integrity

- **Negotiation of the rate – there are a number of different entities who can perform this task in different ways.**
 - Support brokers, an identified provider, or a group purchasing network are viable options.
 - The type of training the negotiator has is critical
 - One option to ensure consistency is to issue guidance for usual and customary charges
- **Option for rate setting when multiple categories of a service exist**
 - **Market Cost Methodology**
 - Used when there are multiple subcategories of a service such as Assistive Technology, Home Modifications, and Personal Emergency Response Systems²

Potential Risks

- Improper training of negotiators (both providers and Medicaid officials) leads to improper rate agreements
- DME and other products/services purchased through negotiated prices could greatly exceed average prices of such goods, if there is inadequate training or monitoring
- Lack of accountability in oversight, rate determinations and billing processes

Negotiated Market Price Pros/Cons

Advantages

- Flexibly covers multiple subcategories of a service such as:
 - Assistive Technology
 - Home Modifications
 - PERS
- Each subcategory above could include its own material and labor costs

Disadvantages

- Difficult for the state to establish guidance for negotiations
- Parameters for spending tends to localize spending at the upper limits

Tiered Rates

Tiered Rates

Definition

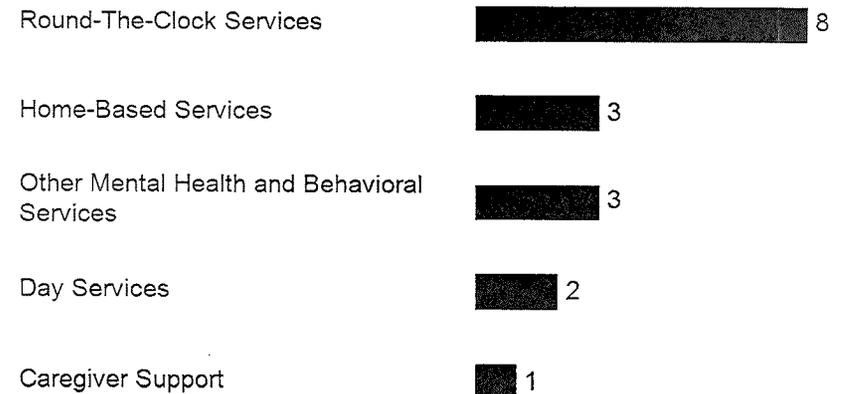
- Provider receives payment for one service in which the rate varies by an identified characteristic of the individual, the provider, or some combination of both
 - The characteristic of the individual is often identified by an assessment tool such as:
 - Supports Intensity Scale (SIS),
 - Inventory for Client and Agency Planning (ICAP) or
 - Another tool that classifies the individual's needs on an established scale

Example

- Rates for Supported Living Program offered in the HCBS waiver for Persons with Brain Injury are tiered by individual acuity for each particular provider

Top 5 Taxonomies Using a Tiered Rate Setting Methodology

Based on 70 renewal applications with 703 total waiver services



Number of Waiver Services

Use in FFS rate setting

- Tiers are typically set based on the average cost of varying factors, including use of personal care, support needs, skilled nursing, and behavioral needs
- Often paired with tiered Individual Budget Amounts (IBAs)
 - IBA factors:
 - An individual with a higher level of need = a higher budget
 - Considers higher level of need = could cost more and require more service

Use in FFS rate setting

Steps in developing the tiered rates:

- Determine professional costs for the core benefits
 - Most HCBS programs involve at least two types of professionals
- Determine service utilization for the core benefits
 - It varies by the individuals' health care needs, behavioral concerns and/or other acuity factors

Fiscal Integrity

- **Considerations for states choosing this rate method**
 - Analysis and interpretation of data collected through the assessment tools
 - Employ assessment results to determine the volume of services that may be authorized on a person's behalf
- **Salary Expectations**
 - Use BLS wage data, cost reports, HCBS survey data, payroll taxes, FICA, and non-billable work time
- **Geographic Considerations**
 - Rates differ by area and can be partially based off average rates in a given area
 - Use CPI-U, CPI-W, COLA to adjust for geographic differences in rates

Potential Risks

- Unreliability of assessment tools can undermine credibility of assessment results
 - Selecting a tool that does not align with state needs can lead to this problem
 - Results can also be skewed by not sufficiently addressing the needs of outliers

Tiered Rates: Pros and Cons

Benefits

- Tiered rates create incentives for providers to serve beneficiaries with higher service needs

Disadvantages

- Tier descriptions must be specific and precise.
- Tiers applied statewide may need to consider regional rates to reflect differences in direct care costs, particularly between urban and rural areas¹
- Greatly increases the number of rates to monitor in your payment system

Bundled Rates

Bundled Rates

Definition

- Provider receives a fixed, pre-determined rate for a pre-determined amount of time that includes the delivery of multiple services

Example

- The Supported Living Program offered on the HCBS waiver for persons with Traumatic Brain Injury is reimbursed using a bundled rate
- The payment includes Independent Living Skills Training (ILST), Personal Care, Homemaker, and other services

Taxonomy Using a Bundled Rate Setting Methodology

Based on 70 renewal applications with 703 total waiver services

Round-The-Clock Services

1

Number of Waiver Services

Fiscal Integrity

- **Considerations for states choosing this rate method**
 - For each condition, assess whether there are guidelines for constructing the bundle and if they are consistent with the requirements in the Technical Guide
 - Determine which service should be included / excluded from the bundle
 - Describe all of the individual components in the bundle and how they factor into the rate determination

Fiscal Integrity

- **Only a portion of cost items within the bundle fluctuate based on individual acuity**
 - Majority of direct care costs (such as RN's salaries and medical supplies) are acuity related given the relationship to high resource usage of higher acuity individuals
 - Administrative costs (such as salaries of administrative and executive level staff) are less sensitive to acuity than direct care costs

Potential Risks & Oversight Considerations

- Low levels of provider participation due to complex and lengthy process to implement and understand
- Requires that states can verify each unique service claimed in the bundle
- Consider creating state guidelines for bundled payments
- Guidelines for provider responsibilities if bundled services do not meet the individual's needs
- State needs to be able to document that services were actually provided

Pros and Cons of Bundled Rates

Advantages

- Useful in setting rates for services that are difficult to separate by components

Disadvantages

- Incentivizes providers to serve individuals with lower care needs and avoid individuals when their needs exceed the payment amount
- Incentivizes providers to set their internal admission and retention policy to balance acuity so that the rate meets the needs of an average individual
- More labor intensive to develop a bundled rate directly tied to the person's individualized service plan

Cost Reconciliation

Cost Reconciliation

Definition

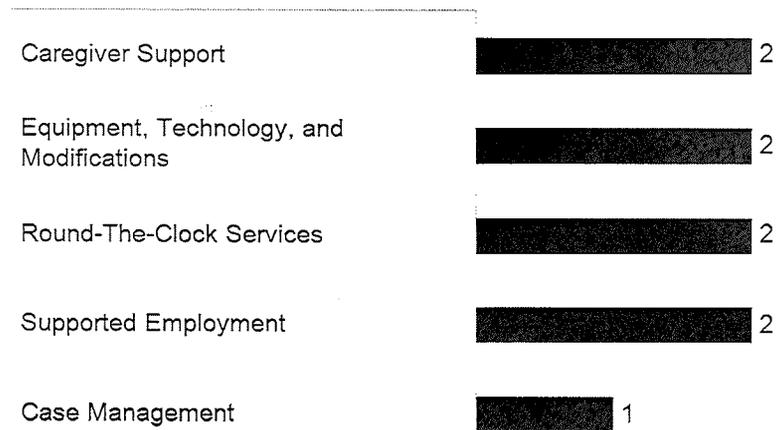
- Type of rate setting where providers are filing cost reports or cost surveys created by the state.
- Involves interim rates set by the state using the claims history information

Example

- The state compares costs incurred by the provider per cost report and reconciles against the interim rate.

Top 5 Taxonomies Using a Cost Reconciliation Rate Setting Methodology

Based on 70 renewal applications with 703 total waiver services



Number of Waiver Services

Fiscal Integrity

Interim rate development

- Wage information from Bureau of Labor Statistics, employee-related expenses (benefits)
- Administrative overhead / productivity adjustment for record keeping and other non-billable work tasks
- Capital costs
- Program experience and cost data reported from the prior fiscal year
- Interim rate total is compared to the billed charges total and the state must reconcile to actual costs
- If interim payment exceed actual costs, federal share of overpayment can be recouped via future off-sets or provider returns

Potential Risks

- Lengthy and cumbersome process of creating cost reports for providers
- Incorrect or inaccurate cost reports used
- Lag in reimbursement due to drawn out reconciliation process
- Higher- or lower-than-expected outlays realized during reconciliation

Oversight Considerations

- Challenges of a typical Fee Schedule³
 - Undocumented Services – irregular billing patterns, staff or individual reported fraud
- Need for effective regulations related to: service provider qualifications and standards and guidance to states addressing Medicaid payment systems' vulnerabilities
- Coordinating with providers who lack the infrastructure for keeping records and being able to reconcile claims with cost reports

Cost Reconciliation Pros and Cons

Pros

- Rates will reflect the actual administrative, staff, and care costs of operating the facility

Cons

- Developing cost reports will take time as there is no one set way to do this
- Educating the provider on completing the cost report and cost settlement process will add burden to the state and the provider in the first few years

Summary

- Basic, common elements that makes up a rate have been discussed
- Five common rate setting methodologies were reviewed
 - Fee Schedule
 - Negotiated Market Price
 - Tiered Rates
 - Bundled Rates
 - Cost Reconciliation

Summary

- There are options when choosing a rate setting methodology – however, each poses its own pros and cons
- There are many fiscal integrity considerations for the state to assess in each rate setting methodology

References

¹ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/fee-for-service.html>

² <http://www.ncbi.nlm.nih.gov/books/NBK53933/>

³ <https://oig.hhs.gov/oei/reports/oei-07-05-00320.pdf>

Resources

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>

Questions & Answers

For Further Information

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