



Alaska Department of Health and Social Services Rate Adjustment Methodology Project for Behavioral Health Services and Home and Community-Based Services

Prepared for the Alaska Department of
Health and Social Services

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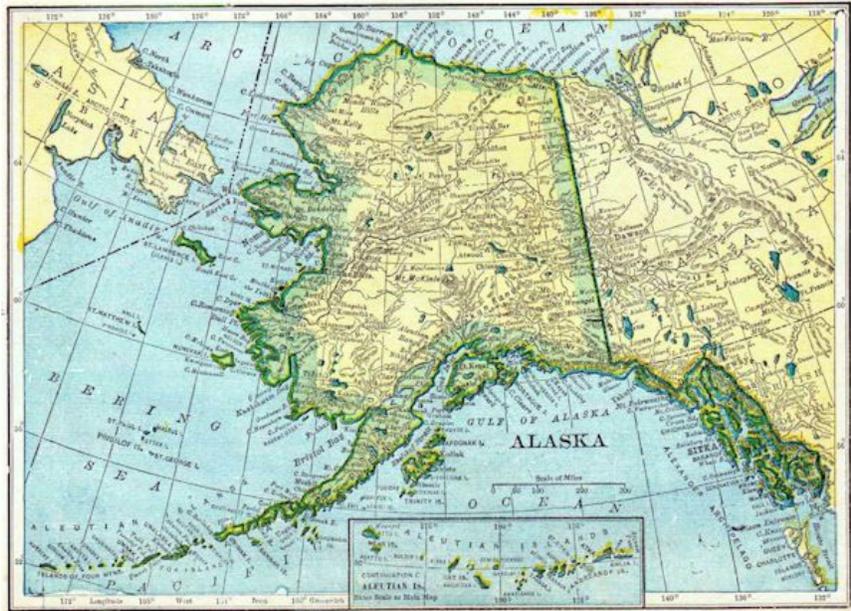


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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

BACKGROUND AND PROJECT OVERVIEW

The Alaska Department of Health and Social Services (DHSS) is in the process of reviewing the reimbursement methodologies for home and community based, personal care assistant and behavioral health services. Myers and Stauffer has been engaged by DHSS to perform research of the reimbursement methodologies and recommend revisions to incorporate acuity adjustment strategies into the rate setting process. For the behavioral health services portion of the project, Myers and Stauffer collaborated with Parker Dennison and Associates, Ltd. The current review focused on mechanisms that allow acuity adjustments for services and individuals where an acuity adjustment is feasible and reasonable. Of particular concern is that costs incurred by providers to care for individuals vary with the individuals' needs. The goal of acuity adjustment is to set rates that have a greater correlation between the cost of providing services and the rate paid to providers for the service.

In addition to incorporating the concept of acuity adjustment into the rate methodology, an additional focus of the project is to incorporate elements of cost-based reimbursement into the rate-setting process for behavioral health services. The incorporation of cost-based reimbursement should be done in tandem with the evaluation of acuity adjustments and should include innovative alternatives to the current fee-for-service payment methodologies.

Home and community based and personal care assistant services were the subject of a previous rate methodology revision implemented by DHSS. Accordingly, for home and community based services and personal care assistant services, the current project is limited to an evaluation of the feasibility of acuity adjustment.

SPECIAL TERMS USED IN THIS REPORT

Throughout this report there are several terms that are used frequently and are defined here for the purpose of clarity.

A **cost report** is an instrument used to collect financial and other statistical data from Medicaid providers for the purpose of determining the unit cost of Medicaid reimbursable services. The types of data collected on a **cost report** include overhead expenses, labor expenses, revenues, utilization statistics and other data needed to establish unit cost for individual service types. A **cost report** is sometimes referred to as a **cost survey**, but generally the two terms are synonymous. Whether referred to as a **cost report** or a **cost survey**, submission of data through an approved instrument

may be mandatory or voluntary depending upon applicable state policies and regulations.

An **acuity adjusted rate** refers to a reimbursement rate which is based on a measure of the severity of the individual's health status. As compared to rates which are not acuity adjusted, an **acuity adjusted rate** may be higher or lower than the average rate to reflect severity of health status that is higher or lower than an average measure of severity.

OVERVIEW OF RATE METHODOLOGIES

There are a wide variety of strategies that state Medicaid programs can use to design their rate setting methodologies. Some rates are provider-independent and are not directly linked to the costs incurred by a specific provider to render services. One form of provider independent rates is a "price", which may be loosely linked to provider costs via analysis of actual provider cost data or through the process of modeling the cost inputs for a hypothetical provider. Provider-dependent rates are linked to the historical or projected costs of the specific provider for which a rate is being set. Provider-dependent rates can be retrospective, in which an interim rate is paid based on cost estimates, but is later settled to actual historical costs incurred by the provider. Alternately provider-dependent rates can be prospective, in which rates are established and paid without a subsequent settlement to the provider's actual cost experience. Prospective rates are typically established using past costs trended forward.

Each of these reimbursement methodologies comes with its own set of advantages and disadvantages. Provider-independent price-based systems potentially can encourage provider efficiency, but tend not to reward providers for the provision of specialized services. Retrospective provider-dependent systems tend to be highly inflationary and are currently falling out of favor with governmental payers.

For most reimbursement methodologies, cycles of rate-rebasing and inflation adjustments should be established to occur at appropriate, regular and consistent intervals in order to best maintain a proper balance between rates and provider cost while maintaining incentives for provider efficiency.

The current reimbursement methodologies used by DHSS for home and community based, personal care assistant and behavioral health services are predominately based on provider-independent rates. However, for home and community based services, DHSS is currently transitioning providers away from reimbursement based on individual budgets, later aggregated and averaged at the provider level resulting in a type of provider-dependent rate. Once the transition is complete, rates for home and community based services and personal care assistant services will reflect provider-

independent rates based on statewide provider cost with geographic adjustments applied. The current rate methodology for behavioral health services is primarily based on single statewide rates. Although there is currently not a mechanism for ongoing cost data collection, within the last five years, DHSS has performed some limited scale cost data collection from selected providers who volunteered for the process. This process resulted in the update of rates for most behavioral health services.

Consistent with federal Medicaid principles of economy and efficiency, the fundamental rationale for acuity-based rate adjustments is to ensure that rates are based on the costs of providing services. Inherent in this rationale is an assumption that as the acuity of an individual increases, the cost to provide services increases as well. The current methodology for home and community based services includes a limited application of acuity adjustment in the form of an “all or nothing” rate which is significantly higher and is applied to a limited number of high needs individuals in assisted living or group home settings. The process to qualify an individual with high needs for the acuity payment rate is viewed by many stakeholders as cumbersome which presents barriers to its application. Additionally, the current process is perceived to lack the flexibility to account for the wide spectrum of acuity present in waiver populations. DHSS currently does not use any form of acuity adjustment to *rates* for behavioral health services although providers do have the ability to tailor the units of services delivered to the needs of each individual.

RECOMMENDATIONS FOR BEHAVIORAL HEALTH SERVICES

After reviewing the current rate methodologies and evaluating concerns from DHSS and stakeholders, Myers and Stauffer offers two primary recommendations to DHSS for behavioral health services. The first recommendation is to implement a rate evaluation process that is based on historical cost collected from providers and normative data derived from other sources. This process should include an analysis of regional cost variances among behavioral health providers. The cost collection process could potentially lead to a rebasing of the rates of service for some of the currently defined behavioral health services. Such a rebasing would occur simultaneously to the potential incorporation of geographic adjustment factors and acuity adjustments for certain services. The second primary recommendation is the consideration of revisions to the rate methodology for behavioral health services to develop methods to introduce acuity adjustment. This is a complicated issue and will require evaluation of several options to determine the approach that best meets the needs for DHSS.

To implement the collection of provider cost data, our recommendation includes the development of a cost reporting methodology. Components of this process include:

- Development of a cost report instrument in collaboration with stakeholders.
- Implementation of the cost report instrument initially in a voluntary pilot survey process.
- Development of cost finding procedures and application of normative data to calculate cost per unit of service for currently defined behavioral health services.
- Analysis of cost per unit data and development of algorithms to derive rates based on cost data including the potential application of geographic adjustments.
- Selection of the most appropriate rate calculation algorithm and development of official rate-setting policies and regulations to include requirements for provider participation in the cost reporting process.
- Implementation of a full scale cost collection with survey data reviewed for completeness, accuracy and reasonableness.
- Application of the cost finding algorithms to calculate provider-specific cost per unit of service.
- Rates are set based on the first cycle of cost reporting with potential adjustment on an annual basis using an inflation factor.
- After a specified period (e.g., two to four years), another cycle of cost reporting is performed and rates are rebased according to the established rate calculation algorithms.

Simultaneous to the development of a cost collection process, the recommendation to implement acuity adjustment to rates will require several steps and decision points.

The steps are to:

- Assess the objectives of an acuity adjustment mechanism and the corresponding services or target populations to be subject to an acuity adjustment.
- Select and implement an appropriate acuity tool.
- Select reimbursement options, including possible new service definitions (e.g., bundled services), and corresponding rates that will reflect a form of acuity reimbursement.
- Ensure information system capabilities.
- Develop acuity adjusted rates based on provider cost data and normative data.
- Incorporate pilot steps as appropriate throughout the process.

An important step in the process of developing an acuity adjustment mechanism for behavioral health services will be defining which services will be subject to some form of acuity adjustment. Not all services are ideally suited to acuity adjustment for a

variety of reasons. The behavioral health services which are the most appropriately suited to an acuity rate adjustment methodology are the various rehabilitation services. With respect to the services or target populations to be subject to an acuity adjustment, Myers and Stauffer recommends that the initial focus should be on children receiving rehabilitation services. Specifically, the services recommended for initial inclusion are:

- Recipient support services
- Therapeutic behavioral health services for children
- Daily behavioral rehabilitation services

Rehabilitation services that are already being reimbursed through per diem rates lend themselves naturally to an acuity model of tiered rates. However, inclusion of individuals receiving high levels of rehabilitation services through codes reimbursed with 15 minute units could also be incorporated into a per diem model with a limited number of tiers and corresponding rates that are adjusted for acuity. Effectively, this would incorporate a “bundled service reimbursement” option with the tiers reflecting an acuity adjustment.

For an acuity tool, the CASII for children and adolescents and the LOCUS for adults are strong candidates for the role of an acuity tool to divide the population of behavioral health recipients into meaningful level of care categories. Such category assignments would not only be useful for differentiating reimbursement levels based on acuity, but the tool would also provide other useful clinical benchmark data to the Division of Behavioral Health for the purpose of monitoring overall program effectiveness.

However, the time and cost to implement new acuity tools in the behavioral health program is not insignificant and presents a substantial barrier to the implementation of an acuity adjustment methodology for behavioral health services in the near term. Implementation of the CASII and LOCUS would most likely require a time frame of several years and costs associated with survey tool licensing, training and a data collection infrastructure.

In order to bring about an acuity adjustment methodology for behavioral health services within a shorter timeline and at lesser cost, DHSS should consider resources that are more readily available. One option that has the potential to meet this need is the use of data derived from the Alaska Screening Tool (AST). The AST is administered to individuals entering the behavioral health system which ideally makes data available for assigning appropriate reimbursement rates relatively quickly after an individual’s entry into the behavioral health system. Additionally, the questions of the AST measure several domains that are potentially relevant to a measurement of acuity.

Based on preliminary modeling by Myers and Stauffer, several of the measurements of the AST including depression, risk of harm and substance abuse in the population of children and adolescents demonstrate positive indications that they could be used as the basis for an acuity adjustment mechanism for rehabilitation services.

However, there are issues relating to the AST data collection process that would need to be resolved. These include increasing the availability of AST to a broader portion of the Medicaid population and ensuring that AST data is submitted with valid personal identifiers for matching to Medicaid records. Additionally, the fact that the AST is administered by providers will need to be considered since tying the AST to reimbursement would create an inherent conflict of interest. Finally, a mechanism for repeated administrations of the AST would be needed to track changes in an individual's acuity over time.

Throughout the implementation of an acuity adjustment mechanism for behavioral health services, the inclusion of pilot steps and the involvement of stakeholders including providers, clients and families, is recommended. Additionally, care needs to be taken to ensure that revisions to the payment methodology are compatible with applicable information systems used by DHSS. For behavioral health services this includes compatibility with both Alaska Automated Information Management System (AKAIMS) and the Medicaid Management Information System (MMIS) operated by DHSS. Since DHSS is currently in the process of updating its MMIS, the evaluation of system capabilities potentially will need to include the current MMIS as well as the new MMIS under development.

RECOMMENDATIONS FOR HOME AND COMMUNITY BASED SERVICES

For home and community based services, DHSS has transitioned providers to a cost-based rate methodology with ongoing cost reporting to periodically update the cost-based rates. Additionally, the program has implemented assessment tools for the eligibility screening process. These assessments provide a baseline level of data which has the potential to be transformed into a mechanism to drive the acuity adjustment process. This combination of factors should make the implementation of acuity adjusted rates for home and community based services more easily achievable than the previously described process for behavioral health services.

The steps that are part of the acuity development process for home and community based services are to:

- Clarify target services and refine objectives for acuity adjusted rates.
- Select and implement an assessment tool.

- Determine reimbursement options to use.
- Ensure information system capabilities.
- Develop acuity adjusted rates (e.g., rates for tiers).
- Incorporate pilot steps as appropriate throughout the process.

An initial step in the process to establish acuity adjustment for rates for home and community based services is identification of services for which an acuity adjustment is appropriate. Based on the nature of the various services offered in the waiver programs and the current units of measure associated with those services, Myers and Stauffer has identified several services as being the most conducive to an acuity adjustment to rates. These are services that are reimbursed according to daily (or per half day) rates including assisted living home services, residential habilitation, respite and adult day care.

For many services reimbursed based on units of time, Myers and Stauffer does not recommend the implementation of an acuity adjustment mechanism. This includes personal care assistant services which are reimbursed using 15 minute time units. For these services, differences in acuity are essentially accounted for in the service authorization process currently in place. Individuals with higher needs are authorized additional units of services with payment differentials to providers automatically applied by the existing reimbursement methodology.

DHSS will need to make decisions regarding assessment tools to be utilized in the acuity adjustment process for home and community based services. Several potentially useful tools not currently in use by the state of Alaska are discussed in this report. However, the currently utilized Consumer Assessment Tool (CAT) and Inventory for Client and Agency Planning (ICAP), with the possible use of supplemental questions, should be strongly considered by DHSS. Although not currently used for acuity assignment, they provide DHSS with a valuable set of data which could support a tiered reimbursement system. Existing data that DHSS has collected on the CAT and ICAP assessments should be studied to develop and refine methods of defining needs that have a meaningful relationship to service cost differences.

There are several options available to DHSS for setting acuity-based rates. These options include tiered rates, case mix adjustment and base rates plus add-ons. A preponderance of states are using tiered rates. The tiered rate approach provides a reasonably simple method to set rates that create incentives for providers to serve residents with higher needs. Myers and Stauffer recommends that DHSS give strong consideration to a tiered rate approach for home and community based services using provider cost data already gathered or in the process of being gathered through current

cost reporting processes. The establishment of acuity adjusted rates can be supplemented with the use of normative data if needed.

Throughout the process of the implementation of an acuity adjustment mechanism for home and community based services, the inclusion of pilot steps and the involvement of stakeholders is recommended. Additionally, care needs to be taken to ensure that revisions to the payment methodology are compatible with applicable information systems. DHSS may want to consider refinements to the current approaches being used to collect, maintain and analyze assessment data from the CAT and ICAP. More robust data warehousing and analytical capabilities will promote better decision support and cost prediction capabilities. Of equal importance, the methodology must be compatible with the processes of the current MMIS as well as the new MMIS which is under development.

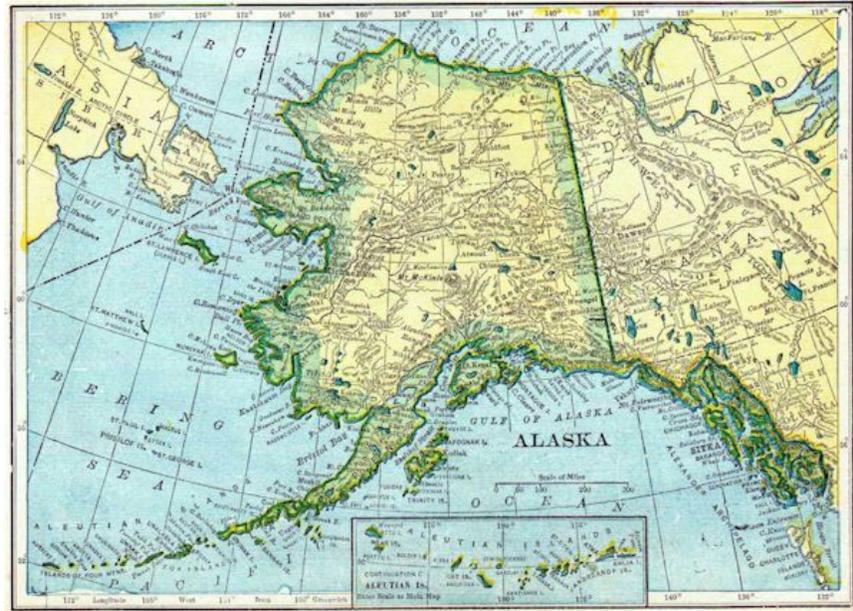
FUTURE STEPS

Myers and Stauffer has developed these rate methodology options after careful consideration of discussions with DHSS staff and other stakeholders and review of current rate-setting and program policies. The options presented for behavioral health services and home and community based services are being presented to DHSS for further review and discussion. As needed, the Myers and Stauffer project team will be available to answer DHSS' questions regarding the recommendations or to discuss alternative rate-setting concepts that were not included in the recommendations. Myers and Stauffer will continue to advise and assist DHSS as it considers the adoption of the proposed recommendations, including specific components and potential refinements or clarifications necessary to reflect the needs of DHSS. Myers and Stauffer will also participate in additional provider meetings, should DHSS wish to involve stakeholders further in the deliberation process.

After DHSS has determined which rate setting methodology best meets its objectives, Myers and Stauffer will work with DHSS to design and facilitate implementation of the new rate methodology. This phase of the project will include developing the procedures and data processing tools that state and provider staff will need to accomplish the rate setting process. Myers and Stauffer will develop an assessment of staffing needs to implement the rate setting process and develop an implementation time line. Any other necessary infrastructure that will be needed to implement the new rate setting methodology will be assessed.

Recommendations adopted by DHSS will be evaluated for their impact on the programs and services. This evaluation will include administrative cost, system changes, implementation timing and claims payment. The evaluation will consider fiscal impact from both the perspectives of DHSS as well as providers. Fiscal models

will be built from available data including provider cost data, MMIS claims data and assessment tool scores.



PART 1

INTRODUCTION

PART 1 INTRODUCTION

PROJECT OVERVIEW

The Alaska Department of Health and Social Services (DHSS) has contracted with Myers and Stauffer to perform several tasks relating to evaluating and revising Medicaid reimbursement methodologies for the provision of home and community based, personal care assistant and behavioral health services. A primary goal of the project is to introduce mechanisms into the rate methodology that allow for an acuity adjustment. This should produce a greater correlation between the cost of providing services and Medicaid reimbursement received.

For home and community based and personal care assistant services, DHSS recently transitioned the reimbursement methodology to one based on provider cost, aggregated at the statewide level and then adjusted to reflect geographic cost differences. DHSS is implementing the new rate methodology according to a gradual “phase-in” methodology that will transition providers from a previous rate methodology which for many providers was based on individual budgets. For home and community based and personal care assistant providers, the primary purpose of the project is to evaluate the feasibility of acuity adjustment for provided services and to develop methodologies to implement such an adjustment mechanism.

For behavioral health service providers, the project addresses two primary concerns relating to the current reimbursement methodology. One goal is to evaluate the rate methodology for behavioral health services and assess the need to adjust those rates to more accurately reflect the costs incurred to provide services. A transition to an updated cost based rate methodology would include development and implementation of a cost data collection process and a methodology for the calculation of rates.

Simultaneous to the assessment of cost data, a second project goal for behavioral health services is to evaluate the potential for rate adjustments that reflect the acuity of individuals being served. Methods of acuity adjustment may include innovative alternatives to the current fee-for-service payments used by the program. A significant objective of the development of an acuity adjustment process for rates would be to help meet the needs of certain priority populations in the state with high behavioral health needs.

Initially, the focus of the project has been a review of current reimbursement methodologies used by DHSS for home and community based, personal care assistant and behavioral health services. Part of this review process has included meetings with applicable DHSS staff including individuals from the Office of Rate Review (ORR), the Division of Senior and Disabilities Service (DSDS) and the Division of Behavioral

Health (DBH). Additionally, Myers and Stauffer staff have met with other stakeholders including Medicaid providers.

This report presents information regarding the review of the current methodologies for reimbursement of home and community based, personal care assistant and behavioral health services with comparisons to selected best practices in other state Medicaid programs. Concerns expressed by DHSS staff and other stakeholders regarding the current methodology are also included in this report. Additionally, this report presents general recommendations for revisions to the current rate methodologies with guidelines for a course to follow to implement those recommendations.

An upcoming component of this project is to perform data collection and analysis relating to the cost of providing behavioral health services. Data regarding the cost to provide services could be used to more closely align rates for the current service package defined by DHSS. Additionally, cost data would be integral to the development of alternative service package implementations that will help DHSS to meet its objectives to adjust rates for client acuity, to improve the service delivery system and client outcomes. Regardless of the implementation of the cost data in the framework of the currently defined service package or in alternative implementations, the use of cost data will assist DHSS to maintain fiscal responsibility and create a high level of legal defensibility for provider rates.

Later stages of the project will include more refined working models and detailed descriptions of the preferred rate methodologies selected by DHSS for home and community based services, personal care assistant services and behavioral health services. Myers and Stauffer will participate in further meetings with DHSS staff and other stakeholders to refine the methodologies and work to design and facilitate implementation of the new rate system. The accepted methodology will be modeled and the fiscal impact to DHSS and providers will be determined.

RATE METHODOLOGIES

GENERAL RATE DEVELOPMENT

Medicaid is a significant payer for home and community based services, personal care assistant services and behavioral health services, which makes the rate methodologies used for reimbursement extremely important. Under federal Medicaid law, states have considerable latitude to develop their own methods and standards for reimbursement of Medicaid services. Congress has periodically intervened to modify the broad guidelines within which states operate and the Centers for Medicare and Medicaid Services (CMS) has used its regulatory authority to restrict certain state practices.

The primary federal limitations on reimbursement policy require compliance with the following:

- Medicaid payments must be consistent with efficiency, economy and quality of care.
- Payments must be 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.
- Providers must accept Medicaid reimbursement as payment in full except for any beneficiary cost sharing amounts provided for by the state.

The process of developing a reimbursement methodology is complex. Reimbursement system design is an accumulation of decisions regarding a number of policy options and should take into consideration the issues of access to services, the native populations, the diverse needs of populations served, provider availability, the grouping of similar services, consistency and accountability. The methodologies should create incentives for cost containment and efficient delivery of quality services.

At a high level, reimbursement rates can be divided in the categories of “provider independent” rates and “provider dependent” rates.

Provider Independent Rates

Rates not based on a particular provider’s costs are *provider-independent rates* and include flat rate and pricing systems. In these systems, providers are reimbursed according to a set flat rate or an established price regardless of their individual cost experience.

Flat rates are typically established by determining available dollars within the state budget for a particular service and dividing by a projection of case load or anticipated units of service.

Prices may be developed through the creation of a hypothetical provider and determining necessary inputs and market prices for those inputs or based on benchmarks, such as means, medians or percentiles of the cost experience of the provider group.

To ensure the delivery of quality care, prices must be set at levels that allow most providers to cover their costs, but not so high as to provide excessive margins. The State must be willing to permit providers flexibility in spending and the ability for some low cost providers to retain reasonable margins without excessive reporting requirements and controls.

Some advantages of pricing systems are:

- They create incentives for providers to control costs.
- States are also better able to forecast future expenditures.

However, these systems tend not to create incentives for providers to provide services beyond the industry norm.

Provider Dependent Rates

Systems that link a provider's specific cost to the rate paid to that provider are *provider-dependent rate* systems. There is considerable variability in the design of provider-dependent rates. Provider-dependent rates can either be retrospective or prospective in nature.

Retrospective systems establish an interim rate, using cost estimates, which will be used to make payments during the rate period. After the rate period ends and actual cost experience is determined, there is an adjustment made from interim rates to actual cost experience. In recent years, there has been a trend by both state and federal governments to move away from retrospective reimbursement systems.

Prospective systems typically use past costs trended forward to establish reimbursement rates. Prospective systems can also incorporate various upper limits or ceilings. The rates for most of these systems are based on cost information submitted by the providers. The rate calculation uses allowable costs, as defined by the state, frequently divided into cost centers or cost components. Examples of typical cost centers include direct service costs, indirect costs and general and administrative costs.

Cost-based reimbursement methodologies frequently limit the costs incorporated into the rate through rate ceilings or rate targets. Ceilings are intended to limit rate growth and may vary in the methods of calculation. Some are linked to percentiles, medians or medians plus an add-on percentage. Target rates are another method of limiting rate increases.

THE ROLE OF COST DATA IN RATE SETTING

There are several ways in which cost data collected from providers can be used in a rate-setting process. These approaches include methods based on "budgeted cost" and methods based on "historical cost".

BUDGETED COST

Budgeted cost reporting refers to the forecasting of expenses a provider expects to incur in order to provide care to a specified client or a group of clients. While there are some advantages to the use of budgeting, there are significant limitations to this practice. Budgeting has the advantage of being customized to specific clients and is highly flexible in the ability to anticipate expenses that will arise in the future even if certain expenses have not occurred in the past. However, this flexibility is also a serious limitation because it introduces highly subjective and non-standardized accounting practices that often result in inaccurate cost projections and inequity in reimbursement among providers.

HISTORICAL COST

Historical cost reporting refers to the collection of costs that have already been incurred by a provider. This is typically accomplished via a standardized reporting tool that collects expense, statistical and other relevant information from a defined fiscal cycle that has already concluded. Historical cost reporting is based upon actual expenditures and has significant advantages over a budgeting process because it can be accomplished using highly standardized methods. In historical cost reporting, providers are required to report financial data that has been maintained in accordance with established and generally accepted accounting procedures. Historical cost reporting requires a high level of accountability from providers because reported cost data must be supported by financial records and other documentation, which can be verified via a desk review or field audit. Cost finding techniques are also highly standardized, significantly limiting subjective decisions on the part of providers and rate-setting staff. One disadvantage of historical cost reporting is that it is less responsive to anticipating future expenses.

DEVELOPMENT AND FREQUENCY OF COST DATA COLLECTION

If historical data is used in rate setting or in the verification of an alternative rate development method, the performance of the data collection is a critical aspect. A key component of the cost collection methodology is the development of a cost reporting tool. The tool should be customized to be relevant to the particular providers and services yet general enough to allow for differences in organizational structures, scope of services offered and the level of accounting sophistication. Cost tools should collect information on ownership structures and demographics, detailed expenses incurred during the fiscal year, adjustments or reclassification of the expenses, statistical data for cost allocations and any other data pertinent to the rate calculation.

The primary objective of cost data collection is to determine the cost of providing services on a per unit basis for each provider. The standards and algorithms applied to the cost data to accomplish this objective can be referred to as the cost finding methodology.

One required standard would be the frequency at which collection of the cost reports are repeated. Although an interval of one year would develop an ideal data set for trend analysis, an annual cost reporting process could create a significant increase in administrative burden on both providers and state agencies.

When evaluating the frequency of cost data collection the specific use of the data should be considered. For example, data collection could be less often if the data was only to verify rates developed from market data and benchmarks not directly linked to provider costs. An inflation factor could be used to adjust the base rates for interim years in which cost reporting is not required.

A typical interval for cost data collection is between two and four years but can be adjusted based on state-specific requirements and preferences. Periodic cost reporting can help evaluate the reasonableness of rates and collect new cost data to address inflationary pressures that impact the cost of providing services and changes to methods of service delivery. More frequent rebasing has the advantage of more quickly incorporating new costs that are incurred by providers into reimbursement rates paid to providers.

RATE ADJUSTMENTS

Rate adjustments can be applied to the rates to account for differences in costs that are outside of the control of the providers, such as prevailing wage rates in various areas or other geographical differences. Rate adjustments can also cover costs that were not included in the base such as program requirements mandated after the cost reporting period (e.g., increases to the minimum wage rates). Rate adjustments can also be used to incentivize certain behaviors such as maintaining a given occupancy, caseload or productivity level.

Acuity adjustments are designed to appropriately reimburse for services according to the level of care provided. As a general principle, the acuity adjustment is intended to provide additional reimbursement for a unit of service for clients with greater needs and can be used to incentivize access to specialized care for populations that are difficult to serve. Implementing an acuity adjustment requires a method to assess the different levels of need and a method to link to reimbursement. Cost differences need to be measured and incorporated into the rate adjustment.

Ideally, an acuity adjustment should be objective and easy to administer. The factors that determine the acuity adjustment should be consistent regardless of the individuals involved in the determination.

CURRENT RATE METHODOLOGIES

An initial focus for the project has been a review of current reimbursement methodologies used by DHSS for home and community based, personal care assistant and behavioral health services.

While faced with extraordinary challenges of geography, weather, workforce, cultural diversity and highly geographically dispersed population, Alaska's Medicaid program is endeavoring to best meet the needs of its population in times of challenging resources and growing needs. As a subset of this overall challenge, meeting the needs of seniors, individuals with disabilities and individuals with behavioral health needs is particularly complex. DHSS has developed programs and fostered a provider community to help address these needs. Although many of the programs initially were developed through state funding sources, Medicaid funding is currently a significant financial component of these programs. This allows the state of Alaska to leverage federal funding opportunities to benefit individuals needing services. It has also required the state to develop reimbursement methodologies that are compatible with federal Medicaid policies.

BEHAVIORAL HEALTH SERVICES

Like most states, Alaska's Medicaid behavioral health benefit is characterized by a broad spectrum of services, each with its own service definition, associated provider qualifications and rate. Reimbursement units are similarly diverse, with a combination of 15 minute units, hourly and/or daily increments.

Medicaid behavioral health benefits are typically complicated. Depending on the specific nature of the service, they may be claimed federally under different sections of the Medicaid state plan including clinic, rehabilitation option and targeted case management. Each of these components has their own unique federal requirements and limitations. In the past decade, in an effort to expand recovery focused services and maximize federal financial participation, most states have expanded the use of the rehabilitation option within Medicaid. Under CMS' insistence, they have a preponderance of services reimbursed in 15 minute units on a fee-for-service basis.

A majority of the behavioral health services reimbursed by Alaska Medicaid are currently linked to time-based units of service. Notable examples include comprehensive community support services for adults, therapeutic behavioral health

services for children, recipient support services and case management. Other services, such as residential behavioral rehabilitation services, are reimbursed using per diem rates.

The current rate methodology is primarily based on single statewide rates. Although there is currently not a mechanism for ongoing cost data collection, in recent years DHSS has performed some limited scale cost data collection from selected providers who volunteered for the process. Cost data from community mental health agencies was collected and reviewed during 2006 and 2007. Additionally, cost data from residential psychiatric treatment centers (RPTCs) was collected and analyzed in 2011. These cost analyses resulted in the update of rates for most behavioral health services.

DHSS recently implemented integrated regulations for behavioral health and substance abuse services including changes to service definitions and requirements. These modifications were implemented in the last quarter of 2011 and included changes that impacted some Medicaid billing procedures for behavioral health services.

Comments expressed during the interactions with DHSS staff and other stakeholders can be grouped into two primary concerns as well as several secondary issues. One significant concern is that the present system of service delivery and reimbursement rates does not adequately incentivize providers to work with certain individuals with high behavioral health needs. Consequently, these individuals are at high risk for placement outside of community settings in locations such as the Alaska Psychiatric Institute (API) or in out-of-state settings. The second primary concern, largely expressed by members of the behavioral health provider community, is a desire for an ongoing mechanism to measure costs for specific services to evaluate rates.

Additional areas of concern cited by DHSS staff or stakeholders include:

- Potential for overutilization of services.
- Difficulty in recruiting and retaining qualified staff.
- Lack of a geographic adjustment factor in the current rate structure.

HOME AND COMMUNITY-BASED SERVICES AND PERSONAL CARE ASSISTANT SERVICES

Due to the geographical constraints and limited access to services, Alaska's long term care system utilizes multiple provider types to deliver care to the elderly with declining health and other individuals with physical or developmental disabilities. Home and community based programs provide a significant level of services for clients in several eligibility categories: Alaskans living independently (seniors and

individuals with physical disabilities), adults with physical and developmental disabilities, intellectual and developmental disabilities (IDD) and children with complex medical conditions (CCMC). These categories provide clients with alternatives to institutional placement. Additional home care services are offered through the personal care assistant program to frail elderly individuals and functionally disabled and handicapped individuals of all ages.

The reimbursement methodologies for home and community based services and personal care assistant services were recently reviewed by DHSS and significant changes were implemented. Prior to 2010, services provided by home and community based agencies had been reimbursed based on agency-specific and client-specific rates derived from a process of submitting financial budgets and cost projections to the DSDS. Rates for assisted living homes had been subject to a cost-based rate development process. Rates for home and community based agencies and assisted living homes had been subject to a rate “freeze” which led to aggregated rates for all clients within a single provider. Significant concerns existed regarding the disparity of rates among providers. In contrast, rates for care coordinators and personal care agencies were subject to a single statewide fee schedule.

Beginning in 2007, DHSS evaluated the reimbursement methodology for home and community based services and personal care services. As a result, the decision was to implement prospective rates with a basis in historical cost reporting. Rates would incorporate inflation adjustments in years between cost study cycles along with adjustments for regional cost differences. Currently, DHSS is in the process of gradually transitioning rates from the previous basis to its newly adopted cost basis and is collecting cost data for future rebasing of the rates.

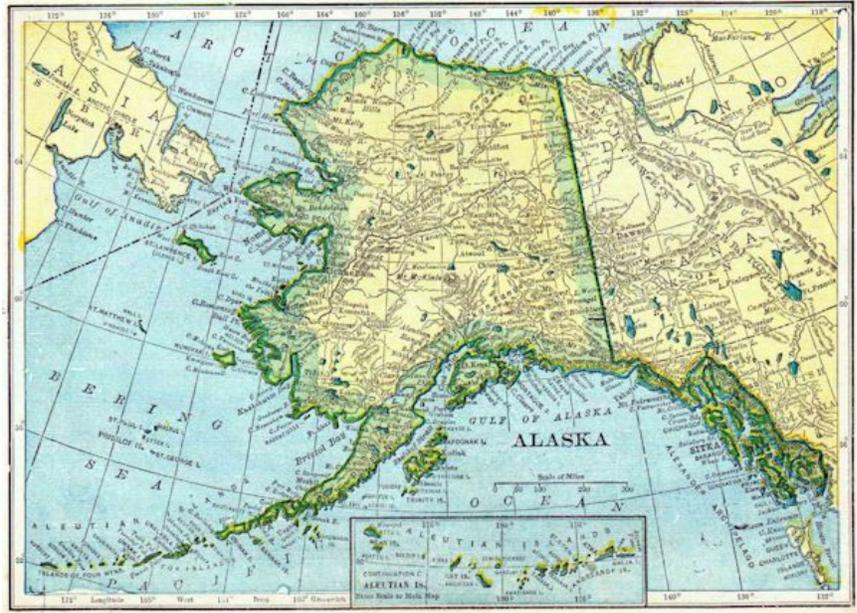
With a limited exception, the current rate methodology does not include an adjustment to rates based on an individual’s acuity. The current mechanism to allow for a higher rate based on acuity, described in 7 AAC 130.267, is for individuals with atypically high needs. It requires submission of documentation to justify significantly higher levels of services with a subsequent review by DHSS staff. This current method for an “acuity payment” has only been used for a very limited number of individuals.

Discussions with DHSS staff and other stakeholders indicated dissatisfaction with the current limited acuity payment mechanism for several reasons. The documentation collection process is perceived to be onerous creating a significant impediment to providers attempting to seek the high acuity rate. Additionally, the “all or nothing” approach is perceived to be an inefficient use of resources that does not adequately reflect the fluctuation in the needs of individuals over time.

Discussions regarding individuals with high needs focused on two areas of concern:

- High needs associated with a physical or medical condition.
- High needs associated with certain behaviors.

The behavioral issues seemed to be a primary concern. They were considered to be transitory in many cases and were not well suited to the current acuity payment mechanism. The current acuity process requires that providers establish a sustained pattern of high needs to receive approval of a higher acuity payment. This methodology is not flexible and does not accommodate future changes in an individual's behavior.



PART 2

BEHAVIORAL

HEALTH SERVICES

PART 2 BEHAVIORAL HEALTH SERVICES

OVERVIEW

Through discussions with DHSS and interactions with other stakeholders, a primary concern with the rate methodology for behavioral health services has become apparent. There is a need to establish a meaningful relationship between the cost incurred by providers to deliver services and the Medicaid reimbursement received for those services. This includes the need for approaches to develop a rate methodology that more adequately incorporates the principle of acuity adjustment into the rate methodology in innovative ways.

COST-BASED RATE EVALUATION

The first primary component to the development of rate methodology options is a service cost evaluation process based on historical cost collected from providers and normative data derived from other sources. This process should include an analysis of regional cost variances among behavioral health providers. The cost reporting process could potentially lead to a rebasing of the rates of service for some of the currently defined behavioral health services. Such a rebasing would occur simultaneously to the potential incorporation of geographic adjustment factors and acuity adjustments for certain services. Potential approaches to acuity adjustment will be more fully described later in this section.

NEED FOR HISTORICAL COST DATA FOR RATE EVALUATION AND RATE-SETTING

One of the primary obstacles currently facing DHSS as it considers alternative methods for the reimbursement of behavioral health services is the lack of detailed information regarding the actual costs incurred by providers. Perhaps the most common theme presented during stakeholder meetings with behavioral health providers is that reimbursement rates should be based on the actual cost to render services to clients. This theme was echoed by DHSS staff, but with the caveat that implementation of cost-based rates should be coordinated with the implementation of acuity adjustment mechanisms.

To address the current lack of reliable cost data, a comprehensive methodology to collect costs incurred by behavioral health providers is recommended. A simplified outline of the cost reporting approach is as follows:

- A cost reporting methodology is developed.
- The cost reporting methodology is tested in a voluntary pilot process and refined.

- Cost finding procedures are developed and normative data is applied to calculate cost per unit of service for currently defined behavioral health services. Additionally, upper limits to allowable cost may be set based on productivity, occupancy, caseloads and reasonable overhead allowances.
- The distribution of cost per unit of service from all providers is reviewed and various approaches to deriving rates from the data are modeled. This would include analysis of regional cost differences and the potential application of geographic adjustments to rates.
- The most appropriate rate calculation algorithm is selected and steps are taken to formalize the approach as the official rate-setting method.
- Procedures and regulations for a full scale cost collection are developed and implemented. The regulations would include requirements for provider participation in the cost reporting process.
- The full scale cost collection is implemented and cost data is submitted by providers and reviewed by DHSS.
- Cost finding algorithms are applied to calculate provider-specific cost per unit of service. Rates are set based on the first cycle of cost reporting.
- Going forward, rates could be adjusted annually on the basis of an inflation factor.
- After a specified period (e.g., two to four years), another cycle of cost reporting is performed and rates are rebased according to the established rate calculation algorithms.
- The rate-setting cycle continues with periodic rebasing of rates derived from a cost reports and inflation adjustments for interim years.

DEVELOPMENT OF A COST REPORTING METHODOLOGY

A cost reporting methodology needs to be developed that meets the rate-setting objectives of DHSS. The process to develop an effective cost report should include interaction between DHSS, providers and the stakeholder community. Issues to consider in designing the cost collection methodology include development of a cost reporting instrument, standards for allowable cost and cost-finding procedures. Additionally it will be necessary to determine the timing of the initial cost reporting cycle and timing for future cycles of cost collection.

A key component of the cost reporting methodology will be the process of developing an appropriate cost reporting tool in collaboration with stakeholders. The cost report instrument should be customized to be relevant to behavioral health providers in Alaska, but should also be general enough to allow for differences in organizational structure, scope of services offered and level of accounting sophistication that occurs

within the provider community. During the development of the cost report instrument, it will be important to consider the objectives (i.e., rates for specifically defined services) to ensure that the cost report instrument is capable of providing sufficient data to meet those goals.

Typically, the information collected by a cost reporting tool would include:

- Provider ownership structure, fiscal year cycle and demographical information including disclosure of entities under common ownership or control.
- Detail of expenses incurred during the fiscal year, separated into applicable cost reporting categories. Typically, special attention is given to capturing salary and wage expenses into applicable categories.
- Adjustments and/or reclassifications of expenses necessary to accommodate cost reporting standards.
- Statistical information necessary to perform applicable cost allocations and other cost finding algorithms. This may include square footage statistics for the allocation of certain building costs, utilization statistics by payer source and service category, revenues by payer source and service category and other measures that may provide a reasonable basis for the allocation of overhead expenses.
- Any other information that may be relevant to develop accurate calculations of the cost of providing services.
- A declaration by the owner and/or preparer that all information reported is accurate and complete.

In conjunction with the process of developing a cost report instrument, the manner in which cost data will be used and the objectives for that cost data should be considered. The primary objective for the cost data is to calculate the average cost of providing services on a per unit basis for each provider. The standards and algorithms that will be applied to the cost data to accomplish that objective can be collectively referred to as the cost finding methodology.

Many behavioral health providers provide multiple types of client services. Some of these services are covered by Medicaid and others are not. In a cost finding exercise, it is typical to establish “cost centers” associated with the major categories of services and to isolate the costs associated with those cost centers. The cost centers of primary interest to the rate-setting exercise are those associated with Medicaid services for which rates need to be set. However, the process of cost finding may also require establishing cost centers for non-covered services in order to accurately isolate allowable costs within the cost centers for covered services.

COST REPORT DISTRIBUTION, REVIEW AND ANALYSIS PROCEDURES

Myers and Stauffer recommends the use of a pilot cost reporting process to develop an initial cost reporting instrument and then make further refinements to the instrument based on feedback from providers who are willing to participate in the pilot process. The pilot cost reporting process can also be used to analyze an initial set of cost data and model various approaches to setting rates which can later be formalize through policy and regulatory language. The pilot process will also provide an opportunity to evaluate the financial impact and time burden that the cost reporting process itself will have on providers. The process could be used to provide insight into how many providers already have audited financial statements to serve as a basis for cost report submissions and the cost implications for those providers that may need to enhance their current level of accounting services.

After a cost report instrument is developed, piloted and a cost-finding methodology is determined, plans should be made to implement the cost reporting process. Similar to the current approach that DHSS employs for cost reports of providers of home and community based services, the behavioral health provider cost data collection would be performed on a periodic basis (e.g., every two, three or four years or other time interval determined to be appropriate). The cost reporting process of cost report instrument distribution, data collection and data analysis would occur on a scheduled basis for all providers over a period of approximately six to twelve months. Providers would report cost data from their most recently completed fiscal year. The cost reporting tool, its accompanying instructions and cost reporting guidelines would be distributed to providers with a specified due date for completion. Completed cost reports would be submitted to DHSS and be subject to review and audit procedures.

Analysis of the cost data can also result in decomposition of costs into components of interest to DHSS, including labor for direct support staff, administrative and general, training and travel costs. Based on the variation observed in those categories, there may be some interest in modeling rates that place limits on certain components of cost. For example, rates could be constructed that allow for all of the observed labor cost attributed to direct support staff, but place reasonable limits on certain aspects of administrative costs. Additionally, upper limits to allowable cost may be set based on productivity, occupancy, caseloads and reasonable overhead allowances.

During either the pilot or first full cycle of a cost collection process for behavioral health providers, the analysis of the cost data will take on special significance. During this analysis period, DHSS will get its first comparison of the current reimbursement rates to various benchmarks of the cost data. Myers and Stauffer recommends that a rate calculation algorithm not be established until after data from the first cost reports

have been analyzed and *pro forma* rates have been modeled. After the cost data has been analyzed and rates modeled, the process for deriving provider rates could then be formalized via regulation promulgation. In subsequent iterations of the cost reporting process, the rate determination would be based on the process established during the first cycle of cost report collection.

The frequency at which the cost reporting cycles would be repeated will need to be determined. Myers and Stauffer recommends an interval of two to four years. The interval for cost reporting cycle should be set as appropriate according to DHSS preferences and requirements. More frequent rebasing has the advantage of more quickly incorporating new costs that are incurred by providers into the reimbursement rates paid. It is realistic to expect that implementation of a cost reporting cycle from beginning to end could take six months or longer for cost report instrument distribution, data collection, review and data analysis. For interim years in which a cost reporting cycle is not performed, an escalating factor could be used to adjust the base rates established from the cost data. Escalating factors are typically tied to inflation indices that are considered appropriate for the industry.

REGIONALIZATION OF RATE DEVELOPMENT

A common concern expressed by behavioral health providers was the perception that differentials in cost throughout the state creating impediments to providing services. In a previous rate methodology engagement for home and community based services, similar comments were expressed by that provider community. This concern was subsequently acknowledged by DHSS through its incorporation of a geographic rate differential in its methodology for setting rates for providers of home and community based services.

The need and feasibility for price differentials tied to regions may not become apparent until after an initial behavioral health provider cost reporting process has been performed and the cost data analyzed. The use of regional rates would be indicated if the analysis of the cost data shows meaningful differences in provider cost based on region.

If the concept of geographic rate differentials is adopted, the use of normative data may provide a simpler alternative rather than relying on cost report data to produce the geographic differentials to be applied. For example, the Alaska Department of Labor recently commissioned an update to the “Alaska Geographic Differential Study” which is used by the state to determine cost of living differentials applied to state employee salaries. The factors from this study are also currently used by DHSS in the rate methodology for home and community based services.

Through the adoption of a cost data collection methodology for providers of behavioral health services, DHSS will be better positioned to evaluate the current rates for services. They will be more prepared to address the additional complexities associated with the introduction of acuity adjustment for behavioral health service rates.

MECHANISMS FOR ACUITY ADJUSTMENT TO RATES

The second primary component in the consideration of revisions to the rate methodology for behavioral health services is the development of methods to introduce acuity adjustment. This is a complicated issue and will require evaluation of many options to determine the approach that best meets the needs for DHSS.

GENERAL PRINCIPLES OF ACUITY ADJUSTMENT AND PROCESS FOR A BEHAVIORAL HEALTH ACUITY ADJUSTMENT

There are several primary components to developing an acuity adjustment mechanism for reimbursement rates. First an appropriate tool is needed to evaluate recipient needs. Additionally, there needs to be a methodology for grouping recipients with similar levels of acuity. Finally methods need to be established to link the costs associated with providing services to clients in the respective acuity classification.

The specific approach to developing acuity adjusted rates for behavioral health services will involve multiple components with several decisions needing to be made to create the most ideal system. Steps that potentially need to be made as part of the acuity adjustment mechanism development process are to:

- Assess the objectives of an acuity adjustment mechanism and the corresponding services or target populations to be subject to an acuity adjustment.
- Select and implement an appropriate acuity tool.
- Select reimbursement options, including possible new service definitions, and corresponding rates that will reflect a form of acuity reimbursement.
- Ensure information system capabilities.
- Develop acuity adjusted rates based on provider cost data and normative data.
- Incorporate pilot steps as appropriate throughout the process.

Depending on the level of complexity desired for the system, the process of implementing an acuity adjustment to the rate methodology may be a long-term project requiring significant direction from DHSS and inclusion of stakeholders in the evaluation process. For the near-term, less complicated options are potentially

available allowing DHSS the possibility of including acuity adjustment in the rate methodology in a shorter development timeframe.

Consistent with federal Medicaid principles of economy and efficiency, the fundamental rationale for acuity-based rate adjustments is to ensure that rates are based on the costs of providing services. Inherent in this rationale is an assumption that as the acuity of an individual increases, the cost to provide services increases as well. However, to be defensible, states have an obligation to test this assumption or run the risk of simply increasing system costs with no corresponding increase in the provision of the appropriate intensity of services to the consumer. There must be a clear linkage to documented cost changes that consistently and reliably correspond to the assessed levels of acuity. Failure to document and test this linkage is likely to result in the Medicaid program effectively paying for core costs twice; once in the base rate and a second time as part of the acuity adjustment.

ASSESS SERVICES TO BE SUBJECT TO AN ACUITY ADJUSTMENT

An important step in the process of developing an acuity adjustment mechanism for behavioral health services will be defining which services will be subject to some form of acuity adjustment. Not all services are ideally suited to acuity adjustment for a variety of reasons.

Behavioral health services provided to individuals under the Medicaid benefit can be broadly categorized into several categories. The vast majority of Medicaid behavioral health services payments are for rehabilitation services. Significantly, rehabilitation services include:

- Case management
- Recipient support services
- Therapeutic behavioral health services for children
- Comprehensive community support services for adults
- Daily behavioral rehabilitation services

A second major category of behavioral health services are clinical services which include various psychotherapy services, psychological testing, pharmacologic management and provision of various screenings, assessments and interviews.

The behavioral health services which are the most appropriately suited to an acuity rate adjustment methodology are the various rehabilitation services. Typically, rehabilitation services are provided on a regular, often daily, basis and the staff qualifications for providing the services are relatively low (e.g., behavioral health clinical associates). In contrast, clinical services are typically provided less frequently

and the staff qualifications are higher (e.g., physician, mental health professional clinician, etc.).

The unit of service is also an important consideration in any reimbursement system. Units of service for rehabilitation services are defined in several ways including per diem or smaller time-based units (typically, 15-minute units). The units of service associated with the various behavioral health services is a significant factor in determining which services are appropriate for an acuity adjustment for rates. The broader the unit of service, the more important an acuity adjustment becomes. The behavioral health services that are the most appropriate for acuity adjustment are those that are reimbursed on a per diem basis.

With the exception of daily behavioral rehabilitation services, which are reimbursed on a per diem rate, the remaining behavioral health rehabilitation services are reimbursed using 15 minute units. However, daily behavioral rehabilitation service essentially consists of the same rehabilitation services that can be separately reimbursed using the codes with 15 minute units. In some cases, the circumstances of individuals receiving rehabilitation services that are billed through the per diem code are substantially similar to the individuals receiving rehabilitation services that are billed through codes with 15 minute units.

According to Medicaid claims data from calendar year 2011, there were just over 500 children receiving 30 or more days of service for which the per diem rehabilitation rate was paid to a community mental health clinic provider (i.e., Alaska Medicaid provider numbers starting with “MH”). Additionally, there were just over 300 children receiving 30 or more days of service for which the per diem rehabilitation rate was paid to a behavioral rehabilitation service provider (i.e., Alaska Medicaid provider numbers starting with “BR” that are administered through the Office of Children’s Services).

For some individuals receiving behavioral health services, the per diem reimbursement codes were not used, but they received a high level of rehabilitation services that were billed through per 15 minute codes. For example, there were almost 300 individuals for which per diem codes were not billed in 2011, but received 30 or more days of rehabilitation services through codes billed with 15 minute units for an average of 8 or more hours per day. The significant majority of these individuals were children. Based on the current rates of payment for the most significantly used rehabilitation services for children that are reimbursed using 15 minute units, it is often the case that the provision of rehabilitation services through codes using 15 minute units exceeds the reimbursement amount for the per diem rate.

For these reasons the development of an acuity adjustment mechanism for behavioral health services would be ideally focused on children receiving rehabilitation services through the per diem reimbursement codes and should also consider the inclusion of at least some children receiving rehabilitation services through codes reimbursed using 15 minute units when the level of rehabilitation services exceeds a certain threshold.

BEHAVIORAL HEALTH ACUITY-RELATED TOOLS

Measurement of support needs is critical in implementing acuity adjusted rate methodologies. Additionally, this can serve as a tool for empowering consumers and holding providers accountable. There various measurement instruments designed to serve different purposes. The first step in selecting an instrument should be to assess the purpose that best describes the state’s intention and goal for the system.

TYPES OF INSTRUMENTS

Screening instruments are typically short questionnaires that are given directly to adults, children and their families. These tools will indicate whether there is a need for further mental health assessment and follow-up. These are often used in schools or physician’s offices to help non-mental health professionals identify individuals with mental health needs.

The state of Alaska has adopted its own screening tool, the “Alaska Screening Tool” (AST) which was developed by the Division of Behavioral Health (DBH) in collaboration with the providers and other stakeholders in Alaska. The tool is intended to screen for depression, anxiety and other mental health risks; substance abuse; co-occurring disorders, FASD and TBI. All providers that receive grants from DBH are expected to administer the AST and submit data via the Alaska Automated Information Management System (AKAIMS).

Along with the AST, Alaska providers are expected to use the “Client Status Review” (CSR) to collect information on an individual’s quality of life. The initial CSR supplements information obtained from the AST to better inform a provider’s intake assessment process. The CSR is intended to be repeated every 90 to 135 days for both adults and children and again at discharge. Subsequent uses of the CSR can be used to monitor a person’s quality of life over time.

Working together, the AST screens for symptoms and the CSR establishes a baseline measurement for quality of life. Subsequent administrations of the CSR measures changes to quality of life brought about by the interventions that have been implemented. Administration of the AST and the CSR are reimbursable services under the newly implemented Medicaid policies effective in the last quarter of 2011.

A significant amount of work has been put into the AST and CSR tools. They were designed as support instruments for the screening process, important in determining the need for further assessment and as a means to measure program performance via reported changes in quality of life. Some consideration should be given to whether these tools, perhaps with some modifications, could be used to successfully stratify the set of individuals receiving behavioral health services by acuity. These tools already capture some of the defining characteristics that have been used by DHSS to describe populations that would benefit from an acuity adjustment process. For example, the tools include components intended to identify individuals with homelessness, residence in a nursing facility or assisted living facility, legal involvement, substance abuse, FASD and TBI. These tools also have the advantage of currently being incorporated into program requirements and Medicaid reimbursement policy. Data from the AST and CSR is already being captured and maintained through the AKAIMS system. However, the tools' ability to serve as a predictor of an individuals' resource utilization and level of care needs has not been well established. If DHSS determined that these tools are not viable permanent options, several other instruments are available for consideration.

Level of care instruments are decision-support tools intended to assist a clinician in determining the appropriate location and best level of structure to meet the needs of the individual. Typically, scores are correlated to defined service types and locations. These instruments will provide general guidance but are rarely used as a singular determination of placement. In situations where a specifically recommended level of care is not available, these tools err on the side of recommending a more intensive level of care. With Alaska's wide ranging service availability, due to geographic and population limitations, this may result in a disproportionate representation in more restrictive and more expensive care not fully supported by medical necessity.

In addition, tools often have validity only when applied to specific populations. For example, the widely used and well received Level of Care Utilization Scale (LOCUS) for adults has proven valid and reliable as a decision support tool for determining level of care recommendations for persons with primary mental illness and co-occurring physical health and substance use issues. However, for persons with developmental disabilities, dementia or behavior problems unrelated to the mental illness, it has not proven adequate in its precision. The Child and Adolescent Service Intensity Instrument (CASII), which is the version developed for youth, does specifically include developmental disabilities, including autism, in its applied usages. In the case of children, it is critical to consider that the location of service provision is often as dependent on the available service array and the family's capacity as it is on the child's symptoms. Lastly, many tools have not been researched to determine validity when applied across cultural groups. There is especially infrequent research applied to

specific Native populations. This does not preclude the use of the tools with these populations but does suggest appropriate review to ensure the desired results.

FACTORS TO CONSIDER WHEN SELECTING TOOLS

There are many instruments to choose from and there are pros and cons to all. Factors to consider in selection are:

- Tools should be statistically sound and normalized in a comparable population.
- Administering tools should be time efficient.
- Tools should be designed to be repeated at intervals of 90 to 120 days and at points of significant exacerbation to capture changes.
- Given a typically high turnover rate among provider staff, tools should have a low training burden for providers.
- Tools and assessment processes should be culturally compatible. This may require focused piloting with specific groups and modifications in methods.
- The entire process should be cost effective.
- At a minimum, results must be part of an information system to track and report results. Ideally, the entire assessment tool should be web enabled or otherwise integrated into the system and results immediately available to consumers, families and providers. In Alaska, AKAIMS would be the logical platform on which to build.
- Tools should capture the perspective of multiple stakeholders (i.e., adults, provider, parent, teacher and child).
- The results of the assessment should have clear value and support the achievement of the desired outcomes from the perspective of the consumer, family, provider and state authority.
- Scoring should not be overly complex or require specific expertise (other than training on the tool) and ideally should be automated.

TOOLS FOR CHILDREN AND ADOLESCENTS

There are a variety of tools available for children and adolescent populations. Two of these, the Child and Adolescent Service Intensity Instrument (CASII) and the Early Childhood Service Intensity Instrument (ECSII) have been identified by the Division of Behavioral Health to be potentially of interest.

The CASII is a standardized tool that provides a determination of the appropriate intensity of services needed by a child or adolescent (ages 6 to 18). It was developed by the American Academy of Child and Adolescent Psychiatry. The CASII assesses the service intensity needs of children and adolescents presenting with psychiatric,

substance use and/or developmental concerns. Some of the factors taken into consideration include family, cultural considerations, community supports, environmental concerns, medical and behavioral health co-morbidities, safety concerns and responses to interventions. It is currently used in over 20 states for a variety of services. States that currently utilize the CASII include Wyoming, Minnesota and Nevada.

The ECSII is a standardized tool that determines intensity of service need for infants, toddlers and children from ages 0 to 5 years. It was also developed by the American Academy of Child and Adolescent Psychiatry. The tool is applied to young children with emotional, behavioral and/or developmental needs. The ECSII is based on the concept of “service intensity” as opposed to the traditionally defined “level of care”. Because young children and their families often require services in multiple contexts, the scope of the service plan is more important. Service intensity involves multiple factors including the frequency and quantity of services, the extent to which multiple providers or natural supports are involved and the level of care coordination required.

Other assessment tools for children and adolescents are also available. Briefly, these include:

- Ohio Scales.
- Child and Adolescent Needs and Strengths (CANS).
- Peabody Treatment Progress Battery (PTPB).
- Strengths and Difficulties Questionnaire (SDQ).
- Devereux Early Childhood Assessment (DECA).

TOOLS FOR ADULTS

A variety of tools are also available for adult populations. One of these, the Level of Care Utilization Scale (LOCUS) has been identified by the Division of Behavioral Health to be potentially of interest.

The LOCUS was developed by the American Association of Community Psychiatrists, exclusively for an adult population. It was designed to provide a common language and set of standards to make judgments and recommendations around level of care placement decisions. It was developed with flexibility allowing it to work across the nation within different service systems and assess addiction and physical health co-morbidities. It evaluates the consumer from six dimensions and is broadly viewed as being very recovery-focused and well received by clinicians and is used in Nevada and Connecticut.

The Community Mental Health (CMH) assessment system has been developed by interRAI¹ to complement the Mental Health and the Home Care systems. The CMH is designed to be used for community-based individuals with a broad range of mental and physical health needs. It is designed for all adults aged 18 and over in community mental health settings including those with dual diagnoses. It is very extensive and is comprised of over 15 domains. It is part of a broader suite of assessment tools including home care, assisted living and long term care facilities. One advantage to DHSS with the use of the interRAI product is that the entire suite of assessment tools available could provide resources not only for behavioral health services, but also home and community based services.

Other assessment tools for adults are also available. Briefly, these include:

- Multnomah Community Ability Scales (MCAS).
- Adult Needs and Strengths Assessment (ANSA).

SELECTION AND IMPLEMENTATION OF AN ACUITY TOOL

Implementing a level of care decision support or functional assessment tool is a significant endeavor especially where staff qualifications are highly variable, cultural diversity is extensive and disability populations substantially overlap – all of which is the case in Alaska. Steps in the process to select and implement a tool include:

- Determine the purpose for implementing a clinical measurement instrument.
- Review several instruments for consideration. This should include evaluation of the role of the currently utilized Alaska Screening Tool (AST) and Client Status Review (CSR).
- Engage a group of providers, consumers and consumer advocates or family members to help in the instrument selection process. Early stakeholder involvement and buy-in is critical.
- Consider how a system can be developed to give immediate access of data to providers, consumers and families.
- Discuss the concepts of clinical measurement and outcomes measurement frequently to prepare providers.
- Establish a plan for ensuring that providers can be paid for the completion of the instruments. This may require a time study to determine average time to complete all facets of the assessment. Developing a procedure rate rather than

¹ interRai is a collaborative committed to improving care for persons who are disabled or medically complex through a system of assessment instruments developed to work together to form an integrated health information system.

a time-based rate is often desirable as it can incorporate document completion and assists in cost prediction and control.

- Address additional provider policy implications in collaboration with a stakeholder group.
- Hold an initial series of training that is conducted by the instrument developers. Additional training can usually be done via telephone and the Internet. Consider investing the time and expense of creating a “train-the-trainer” model.
- Get feedback from providers and families regarding the initial use of the instruments.
- Require use of the instruments in policies related to service provision and payment.
- Offer training to providers every six months for the first two years of implementation or until the instrument is well established in the system.
- Engage peer and family run organizations in an effort to educate families on the importance of clinical measurement. This will assist in driving change through grassroots support as well as from state direction.

Prior to linking the results from a specific assessment tool to changes in rates, additional systems should be established to ensure ongoing reliability of scoring. There are multiple methods that states typically employ for this purpose including:

- Contracting with an independent organization that has no conflict of interest with actual service delivery to conduct all level of care assessments.
- Using qualified state staff to conduct assessments.
- Certifying providers to administer assessments. This method typically requires completion of training, a staff-specific competency review, maintenance of adequate numbers of certified staff and maintenance of all associated records for potential review.
- Performing quality reviews to sample provider records and assessments to determine accuracy. The results could be linked to post payment review on an individual case (e.g., revocation of an acuity premium). Alternatively, the results of the sample review could be extrapolated across the entire agency to estimate overpayments associated with acuity premiums or used to establish an overall accuracy rate for the organization with non-monetary implications.

Failure to employ consistent and credible reliability reviews could negatively impact overall system costs as the system creates incentives for scores indicating high acuity.

REIMBURSEMENT OPTIONS

To build acuity adjustment factors into rates for behavioral health services, there are multiple options for structuring rates. Behavioral health service delivery systems can be structured to include a variety of reimbursement methodologies that best meet the needs of consumers and assure the availability of an appropriate array of providers and services. Reimbursement structures can also be used or modified to encourage service development or to shape a system to better meet the objectives of the payer.

By coordinating the development of new reimbursement options with the cost data collection process the relationship between the cost to deliver services and the corresponding rates is preserved. This can foster a rate methodology that is effectively adjusted for acuity. Documentation, contact levels and other requirements vary across reimbursement methodologies and are typically prescribed in service definitions, state Medicaid administrative rules, provider service agreements and manuals.

Although there are a wide variety of reimbursement options available to state Medicaid programs for their behavioral health programs, not all of these options are well-suited to the state of Alaska and the structure of its behavioral health program. For this report, the reimbursement options most likely to be successful in the Alaska Medicaid program are highlighted and include fee-for-service reimbursement, bundled reimbursement, case rate reimbursement and onsite/offsite rate differentials.

FEE-FOR-SERVICE REIMBURSEMENT

Fee-for-service reimbursement is the primary structure currently in place for Medicaid behavioral health services in Alaska with fee schedules detailing the amount paid for each unit of service. Units are primarily time-based, such as for 15 minutes and per diem. In some cases, procedure codes are paid on a per event basis such as for psychiatric assessments or medication management. Fee-for-service reimbursement is the most common reimbursement system for Medicaid behavioral health services and most systems retain at least some services or population groups that are reimbursed on a fee-for-service basis. Fee-for-service reimbursement maximizes accountability for the quantity of services provided but is typically disliked by providers due to the administrative costs of documentation and compliance. It also incentivizes production of additional units of service but does nothing to encourage successful treatment efficacy or overall outcomes. Fee-for-service typically requires documentation for each service billed, although a single note may be permitted for a block of time billed under a single procedure code, provided that the note reflects activities appropriate for the amount of time billed.

A fee-for-service reimbursement system based on discrete units of time inherently provides a form of “acuity adjustment” to reimbursement. During periods of higher need or “acuity”, medical necessity justifies the provision of more units of service and/or for a longer duration thereby intensifying the service. Assuming appropriate and current cost-based methods were used to establish the rate for the base 15 minute unit, reimbursement will continue to reflect the time and cost of the service activity during this period of more intense consumer utilization. Assuming the provider is billing their services accurately, they would effectively be receiving a form of acuity adjustment.

BUNDLED SERVICE REIMBURSEMENT

Acuity-based rate adjustments can be effectively applied in a fee-for-service reimbursement environment with various “bundled” rates such as per-diems and monthly rates. In this case, bundled refers to a collection of activities and interventions that are provided over a longer span of time such as a day or month and are billed as a single service code and unit. As an example, case management is a collection of inter-related activities including assessment, planning, referral, linkage and follow up. Those activities may be provided in small increments of time spread throughout a month for a given individual, but are billed as a single one-month charge. A state may establish multiple tiers of intensity of case management that is based on analysis of actual utilization bands. The intensity of case management utilization bands could then be linked to a clinical assessment tool shown to have validity for this function and a different monthly rate could be set based on the actual costs to deliver the expected utilization intensity.

CASE RATE REIMBURSEMENT

A case rate is a flat amount paid for a specified unit of time for a defined array of services. For example, a case rate could be per day, per month or for an episode of care (from admission through discharge or transition to a specified lower level of care). A case rate typically applies to a level of care or grouping of services and includes risk for how much care a person may require, but does not include the risk for how many persons seek services.

Case management is a service that is often reimbursed on a monthly case rate. Care coordination is currently structured as a case rate for disability service populations in Alaska. Other state Medicaid programs have adopted case rates in their behavioral health case management services. For example, in March 2012, the state of Missouri issued a Request for Proposal (RFP) for specialized care management services for youths with severe and complex behavioral health needs with reimbursement on a

daily case rate for the number of days the youth was enrolled each month. Eligible youths would be referred by the state agency, indicating that control over eligibility for the program and case rate will be determined by the state. Providers would be required to participate in random moment in time studies that will allow activities to be split into Medicaid and non-Medicaid portions for purposes of determining the proportion of the rate that can be claimed to Medicaid. The RFP includes specific information about provider qualifications, as well as other case management programs for youth.

A case rate for case management or care coordination may be a useful structure for Alaska to help youths who are in residential settings transition back into community settings or could be targeted toward those with medical needs or cognitive impairments to assist with coordination and access across service providers. Once targeted populations have been identified which may benefit from enhanced or specialized care management, a review of Medicaid SPA or waiver opportunities can be completed and implementation plans can be developed.

Alternative reimbursement methodologies, such as bundled service reimbursement or case rate reimbursement, typically include minimum contact levels with corresponding documentation required to provide evidence that the contacts were made. Service definitions or billing rules may also include requirements for the proportion of contacts that occur in the community or natural settings or limitations on which services can be provided on the same day.

ONSITE/OFFSITE RATES

Some states have chosen to modify fee-for-service rates to implement higher rates for services provided outside of a provider's office. The offsite premiums are reflective of the increased costs and reduced productivity associated with offering services in natural settings such as consumer residences or schools.

The state of Illinois offers offsite fee-for-service rates that are approximately 16% higher for offsite services than services in providers' offices. In its capitated reimbursement model for behavioral health services, the state of Arizona allows for offsite encounters at rates up to 200% higher than office-based services.

Offsite rate premiums based on increased costs and lower productivity rates may be very helpful in Alaska for some types of services. This would encourage services in a natural setting for difficult to serve clients such as youths with behavioral problems who are at risk for out of home placements. Cost analysis should be performed to determine the appropriate amount of the premium.

ENSURE INFORMATION SYSTEM CAPABILITIES

In order to successfully implement a revision to the payment methodology for behavioral health services to include adjustments for acuity, DHSS will need to consider the capabilities of its information system. This evaluation should include AKAIMS and its ability to collect, maintain and analyze clinical and service data. Additionally, the payment methodology will need to be capable of being processed by the MMIS. DHSS is currently in the process of updating its MMIS. Accordingly, the evaluation of system capabilities potentially will need to include the current MMIS as well as the new MMIS which is under development.

DEVELOP ACUITY ADJUSTED RATES

Acuity adjusted rates for service packages that are developed in the previously described steps can incorporate cost data obtained from providers gathered pursuant to the cost reporting process. With respect to the currently defined behavioral health services, the purpose of the cost reporting process was to evaluate and potentially rebase the rates. The rebasing process could potentially lead to changes in the rates for current services based on an analysis of cost incurred to provide those services. Rebased rates for specific services may be higher or lower than the rates currently used. For newly defined services created during the acuity development process, the rates would essentially be built up based on the cost associated with the components of the service as identified in the cost report data. Depending on the status of the cost report development process at the time that cost data is needed to build the acuity adjusted rates, it may be the case that data obtained in an initial pilot cost data collection is the logical source to use for the purpose of developing acuity adjusted rates for new service packages. Normative data from other sources can also be used as needed to build these initial rates.

INCORPORATE PILOT STEPS

The inclusion of pilot steps throughout the process to develop acuity adjusted rates is recommended. Modifications to service packages and rates for target populations do not necessarily need to be implemented simultaneously but could be introduced initially with only one or two of the target populations. Additionally, the roll-out of level of care tools, new service packages and acuity adjusted rates may initially occur on pilot basis. Feedback received during pilot stages can assist to refine policies prior to full implementation.

CONCLUSIONS AND NEXT STEPS FOR BEHAVIORAL HEALTH SERVICES

With respect to behavioral health services, the logical next steps for the project include data collection and analysis relating to the cost of providing services and further evaluations and decisions regarding approaches to acuity adjustments for rates.

IMPLEMENTATION OF A COST REPORTING PROCESS

A primary component of the cost analysis of behavioral health services should include the development of a cost report instrument and methodology in collaboration with stakeholders. Part of the planning process should include a pilot cost data collection of a small number of behavioral health providers who volunteer for the project and are willing to provide feedback regarding the cost report instrument and process. Data collected in the pilot cost data collection will be used to refine the cost finding methodologies that would be employed to determine average cost per unit of service. Normative data can be used to supplement the cost data obtained from providers. While the pilot cost data collection does not necessarily need to be performed with the intention that the cost data obtained would be used to set actual rates, DHSS can evaluate if the data obtained has sufficient validity and if the need exists to implement rate changes based on the pilot cost data collection. Additionally, data from the pilot cost data collection can assist in the process of evaluating the feasibility of acuity-based rates.

Regardless of how the data from the pilot collection is eventually utilized, the process of performing the pilot cost data collection and the feedback obtained will help to provide the necessary experience to develop the methodology for the full cost reporting process, the approaches to be employed for cost finding procedures and the time intervals for future implementations of cost reporting cycles.

DEVELOPMENT OF ACUITY ADJUSTMENT METHODOLOGY

Simultaneous to the development of a cost reporting process, DHSS can make decisions regarding the approaches to be used to incorporate concepts of acuity adjustment into the rate process.

With respect to the services or target populations to be subject to an acuity adjustment, Myers and Stauffer recommends that the initial focus should be on children receiving rehabilitation services. Specifically, the services recommended for initial inclusion in an acuity adjustment mechanism are:

- Recipient support services
- Therapeutic behavioral health services for children

- Daily behavioral rehabilitation services

Case management also lends itself towards possible inclusion in an acuity model. However, the rehabilitation services of recipient support services, therapeutic behavioral health services for children and daily behavioral rehabilitation services constitute a large block of Medicaid spending and serve as an ideal starting point.

Rehabilitation services that are being reimbursed through per diem rates lend themselves naturally to an acuity model of tiered rates. However, inclusion of individuals receiving high levels of rehabilitation services through codes reimbursed with 15 minute units also could be incorporated into a per diem model of tiered rates that are adjusted for acuity. Effectively, this would incorporate the “bundled service reimbursement” option previously presented and represent an expansion of the number of individuals for which services are billed through per diem rates.

For an acuity tool, the CASII for children and adolescents and the LOCUS for adults are strong candidates for the role of an acuity tool to divide the population of behavioral health recipients into meaningful level of care categories. Such category assignments would not only be useful for differentiating reimbursement levels based on acuity, but the tools would provide other useful clinical benchmark data to DBH for the purpose of monitoring overall program effectiveness.

However, the time and cost to implement a new acuity tool in the behavioral health program is not insignificant and presents a substantial barrier to the implementation of an acuity adjustment methodology for behavioral health services in the near term. Implementation of the CASII and LOCUS would most likely require a time frame of several years and costs associated with survey tool licensing, training and a data collection infrastructure.

In order to bring about an acuity adjustment methodology for behavioral health services within a shorter timeline and at lesser cost, DHSS should consider resources that are more readily available. To gain further insights into the viability of the Alaska Screening Tool (AST) and/or Client Status Review (CSR) as an interim means of establishing an acuity adjustment mechanism for behavioral health services, Myers and Stauffer obtained an extract of accumulated AST and CSR data covering a two-year time period from the AKAIMs database.

Of the two datasets, the AST data shows the most promise for use as a basis for acuity adjustment. The AST is administered to individuals entering the behavioral health system which ideally makes data available for assigning appropriate reimbursement rates relatively quickly after entry into the behavioral health system. Additionally, the

questions of the AST measure several domains that are potentially relevant to a measurement of acuity.

The areas measured in the AST include:

- Depression
- Risk of harm
- Distress and trauma
- Anxiety
- Perception of reality (hallucination and paranoia)
- Substance abuse
- Co-occurring disorders
- Fetal Alcohol Spectrum Disorders (FASD)
- Traumatic Brain Injury (TBI)
- Major life change
- Adverse experiences
- Intimate partner violence

Several of these domains overlap with the areas measured by the CASII and LOCUS tools.

In contrast, the CSR is a measure of quality of life and is administered at intervals to individuals that are already established in the behavioral health system. Both in terms of timing of the administration of the CSR and the nature of the questions included, the CSR does not appear to be as ideally suited to be the basis of an acuity adjustment mechanism as does the AST.

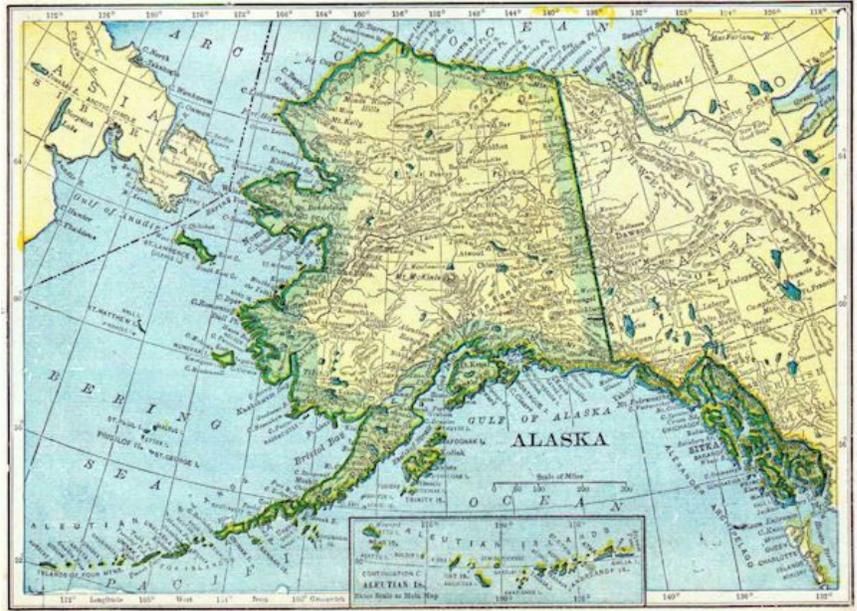
Myers and Stauffer summarized behavioral health claims data to produce a measure of service intensity for certain individuals receiving relatively high levels of rehabilitation services through time-based codes. These volume measures and AST scores were subjected to a multiple regression analysis to determine if any of the AST domains correlated with service intensity.

Though additional work with the AST data is still needed, Myers and Stauffer observed potential correlations for several of the AST domains including depression, risk of harm and substance abuse in the population of children and adolescents. This preliminary work suggests the possibility that AST scores could be used to develop a limited scope tiered reimbursement methodology for rehabilitation services for children and adolescents.

Despite positive indications that the AST could be used as a basis for an acuity adjustment mechanism, there are several important issues that would need to be resolved. These include the following:

- AST data does not appear to be as broadly available for all Medicaid eligible individuals in the behavioral health system. One key data limitation is the current lack of a valid Medicaid identifier for many of the records in the AST data set. This recipient identifier issue should be resolvable through implementation of data submission standards and software edits to ensure compliance. The overall completeness of the AST data within the AKAIMs database may still need to be addressed with certain providers.
- As currently structured, the AST is administered by the agency that is facilitating the intake of an individual into the behavioral health system. If AST data were to be used to determine reimbursement levels, an inherent conflict of interest would exist with the practice of providers continuing to perform the assessment. This issue would need to be addressed through reassignment of the screening roll to an outside party or enforcement of accurate screening through documentation requirements and reviews for compliance and accuracy of AST submissions.
- The AST is currently administered upon the intake of an individual into the behavioral health system and an infrastructure for repeated implementations of the AST are not currently in place. For meaningful use as a basis of acuity adjustment in a reimbursement methodology, a mechanism for repeated applications of the AST would need to be established.

Assuming a resolution of the above issues with the AST data, the use of the AST data for an acuity adjustment mechanism presents the option for DHSS to implement acuity adjusted rates on a considerably shorter timeframe than would be required for a methodology based on the CASII and LOCUS instruments. However, consideration of implementation of the CASII and LOCUS is an appropriate long-term goal. The CASII and LOCUS tools will conceivably allow for greater refinement of acuity adjustments which would have a more robust grounding in academic research than would an acuity adjustment mechanism that is based on the AST data.



PART 3

HOME AND

COMMUNITY BASED

SERVICES

PART 3 HOME AND COMMUNITY BASED SERVICES

OVERVIEW

Home and community based care and personal care services encompass an array of services designed to assist people who are limited in their abilities to function independently. The intensity of the need may vary over time but should be designed to help the individual and families:

- Perform basic life functions.
- Improve skills and capabilities to maximize independence and function.
- Maintain optimal health status.
- Establish and maintain social and personal relationships in the individual's neighborhood and community.
- Provide supervision and support to persons when needed.

These programs in Alaska provide a significant level of services for clients in several eligibility categories:

- Alaskans living independently (seniors and individuals with physical disabilities).
- Adults with physical and developmental disabilities.
- People with intellectual and developmental disabilities (IDD).
- Children with complex medical conditions (CCMC).

These categories provide clients with alternatives to institutional placement. Additional home care services are offered through the Personal Care Assistant Program to frail elderly individuals and functionally disabled and handicapped individuals of all ages.

Significant changes to the reimbursement methodologies for home and community based services and personal care assistant services were implemented beginning in 2010. Since then, DHSS has been transitioning to a newly adopted cost basis of reimbursement. Rates are set based on cost report data submitted by the providers. Calculated rates are adjusted for inflation and regional differences. The procedures and regulatory basis for ongoing cycles of cost report data collection and rate calculation are already established.

There is currently a mechanism to adjust for acuity in the system, but it only accounts for individuals with atypically high needs and requires submission of documentation to justify significantly higher levels of services with a subsequent review of that documentation by DHSS staff.

The goal of this project is to propose, model and evaluate an alternative method to adjust for acuity that recognizes functional, cognitive and health service differences in a more incremental manner than the current acuity adjustment.

The process that is necessary to develop an acuity process for home and community based services includes the following steps:

- Assess services to be subject to an acuity rate adjustment.
- Select and implement an assessment tool.
- Determine reimbursement options to use.

Properly planned and implemented, an acuity adjustment to rates for home and community based services will more properly correlate cost to provide services to high needs individuals with the associated Medicaid reimbursement and help to allay concerns expressed by DHSS and providers regarding this issue.

ASSESS SERVICES TO BE SUBJECT TO AN ACUITY ADJUSTMENT

The unit of service is extremely important in any reimbursement system. Units of service for Alaska's home and community based services waiver programs are defined in many ways including per project, per month, per diem or smaller time-based units (typically, 15-minute units). The incentive in the reimbursement system is for providers to increase the number of service units and the resulting payments while reducing the costs per unit.

Table 3.1 lists services provided under each waiver and includes the unit of service. All listed services could potentially include an acuity adjustment in the rate calculation although some may be more suited than others.

Table 3.1 Units of Service for Alaska Home and Community Based Services

Alaska 1915C Waivers				
	Adults with Physical and Developmental Disabilities	People with Intellectual and Developmental Disabilities	Alaskans Living Independently	Children with Complex Medical Conditions
	Units	Units	Units	Units
Adult Day Services	Half day	N/A	Half day	N/A
Care Coordination	Per month	Per month	Per month	Per month
Day Habilitation	15 minutes	15 minutes	N/A	15 minutes
Residential Habilitation	15 minutes / per diem	15 minutes / per diem	N/A	15 minutes / per diem
Respite	15 minutes / per diem	15 minutes / per diem	15 minutes	15 minutes / per diem
Supported Employment	15 minutes	15 minutes	N/A	15 minutes
Chore	15 minutes	15 minutes	15 minutes	15 minutes
Environmental Modifications	Per project	Per project	Per project	Per project
Intensive Active Treatment	15 minutes	15 minutes	N/A	15 minutes
Meals	Per meal	Per meal	Per meal	Per meal
Residential Supported Living Services (Assisted Living)	Per diem	Per diem	Per diem	N/A
Specialized Medical Equipment	Per unit	Per unit	Per unit	Per unit
Specialized Private Duty Nursing	15 minutes	15 minutes	15 minutes	N/A
Transportation	Per ride (one way)	Per ride (one way)	Per ride (one way)	Per ride (one way)
Nursing Oversight and Care Management	N/A	15 minutes	N/A	15 minutes

SERVICES APPROPRIATE FOR AN ACUITY ADJUSTMENT

The units of service associated with the various waiver services is a significant factor in determining which services are appropriate for an acuity adjustment for rates. The broader the unit of service, the more important an acuity adjustment becomes. An acuity adjustment incorporated into the reimbursement methodology should be objective and the factors that determine the adjustment should be consistent regardless of the individuals involved in the determination.

The home and community based services that are the most appropriate for acuity adjustment are those that are reimbursed on a per diem basis. These services include:

- Assisted living home services.²
- Adult day care.³
- Residential habilitation (on a per diem basis).⁴
- Respite (on a per diem basis).⁵

SERVICES LESS SUITED FOR AN ACUITY ADJUSTMENT

Services that are reimbursed on a time unit basis are less suited for an acuity rate adjustment. Rates that are based on discrete units of time can inherently provide for a form of “acuity adjustment” without the need for rate adjustment. During periods of higher need or “acuity”, medical necessity justifies the provision of a longer duration of service thereby intensifying the service. A provider will continue to be appropriately reimbursed during this period of more intense consumer need since their payment continues to reflect the time and cost of the service activity.

For some services that are reimbursed on a time unit basis, the ratio of direct service providers to clients can be variable. Some states have used these client ratios as a basis to refine service definitions to essentially create multiple tiers that capture differing levels of service intensity with an appropriate differential reflected in the corresponding rates. Client ratios could be used to establish rate tiers for the following services:

- Day habilitation.⁶
- Supported employment.⁷

² Assisted living home services are reimbursed using procedure code T2031. Applicable modifiers are:

- No modifier: 17 or more beds.
- US: 6 to 16 beds.
- UR: 5 or fewer beds.
- TG: Acuity add-on.

³ Adult day care is reimbursed using procedure code S5101.

⁴ Residential habilitation is reimbursed on a per diem basis using the following procedure codes:

- S5140: Family habilitation, adult.
- S5140-U2: Shared care, adult.
- S5145: Family habilitation, child.
- S5145-U2: Shared care, child.
- T2016: Group home habilitation.
- T2016-TG: Group home habilitation, acuity add-on.

⁵ Respite is reimbursed on a per diem basis using the following procedure codes:

- S5151: Respite.
- S5151-U2: Respite, family directed.

⁶ Day habilitation is reimbursed using procedure code T2021.

⁷ Supported employment is reimbursed using procedure code T2019.

Services that are typically associated with one-to-one staff to client ratios are essentially adjusted during the service planning function when units of services needed to meet client needs are determined. While the potential for acuity adjustment for these services exists as part of the service planning function, adjustments to the rates of service are not necessary to reflect differing levels of acuity. Such services with one-to-one staff to client ratios include:

- Supported living habilitation.⁸
- In-home habilitation.⁹
- Respite (on a time basis).¹⁰
- Personal care assistant services.¹¹
- Chore.¹²
- Meals.¹³
- Transportation.¹⁴
- Nurse oversight and care management.¹⁵

Notably, the service of supported living habilitation has generated recent discussion regarding the number of units of service that should be authorized during the plan of care development process. During one meeting with DHSS staff, there was discussion regarding a comparison of supported living for developmentally disabled clients that was billed under the per diem code for group home habilitation (T2016) versus the time-based code for supported living habilitation (T2017). To review the difference in service intensity between these service types, Myers and Stauffer analyzed Alaska Medicaid claims data from calendar year 2011 to compare the distribution of average

⁸ Supported living habilitation is reimbursed using procedure code T2017.

⁹ In-home habilitation is reimbursed using procedure code T2017-U4.

¹⁰ Respite on a time basis is reimbursed using the following procedure codes:

- S5150: Respite.
- S5150-U2: Respite, family directed.

¹¹ Personal care assistant service is reimbursed using the following procedure codes:

- T1019: Personal care, agency.
- T1019-U3: Personal care, consumer directed.

¹² Chore service is reimbursed using procedure code S5120.

¹³ Meals are reimbursed using the following procedure codes:

- S5170: Home delivered meal.
- T2025: Congregant meal.

¹⁴ Transportation is reimbursed using the following procedure codes:

- T2001: Per trip, attendant or escort.
- T2003: Per trip, recipient, up to 20 miles.
- T2003-TN: Per trip, recipient, greater than 20 miles.
- T2003-CG: Paratransit provider, per trip, recipient.

¹⁵ Nurse oversight and care management is reimbursed using the following procedure codes:

- T1016-U2: Local (within 200 miles of provider).
- T1016-U4: Non-local (greater than 200 miles from provider).

payments per day for developmentally disabled clients billed using the per diem code with those billed using the time based code. The majority of recipients for which the services are being billed on time-based codes have daily average payments less than the average payments for recipients billed using the per diem codes. It appears the use of the time based code provides a method to bill for lesser levels of support than would be included in a full per diem rate.

Personal care assistant services have been listed among those services that are less ideally suited for inclusion in the process to establish acuity adjusted rates. Since reimbursement for personal care assistant services are based on 15 minute units, the service is not ideally suited for acuity adjustment of rates. DHSS is currently in the process of evaluating the opportunity to establish a Community Choice First Option program under section 1915(k) of the Social Security Act for personal care assistant services.

Care coordination services were also discussed in meetings with stakeholders. Some providers suggested that rates for these services should also be subject to an acuity adjustment. The rationale presented to support this premise related to the activities necessary to compile supporting documentation that is required to support an application for the current high acuity payment rate provided under 7 AAC 130.267. This reason alone does not appear to be a compelling factor to develop an acuity adjustment for care coordinator rates. The number of applications for a high acuity rate under the current system is low, and even if reimbursement for these activities were to be implemented, the best approach would be to develop a new service definition with an associated rate. Regardless, these activities may not be an issue under a new acuity model adopted by DHSS. However, a broader implementation of an acuity adjustment process to rates will conceivably have implications for the workload of care coordinators, particularly if any assessment processes involving care coordinators are revised. Accordingly, the potential impact to care coordination rates would need to be considered.

SELECT AND IMPLEMENT AN ASSESSMENT TOOL

USE OF CURRENT PROCESS FOR ACUITY ADJUSTMENT

Medicaid clients receiving services through the waiver programs enter the home and community based system through referrals initiated by clients, family members, community agencies, hospitals, nursing facilities or other caregivers. Specific pathways into the care system vary depending on the client's specific needs and other eligibility factors. A care coordinator typically performs an initial screening to determine financial eligibility and candidacy for the waiver programs (as described in

7 AAC 130.230). The type of assessment used varies with the specific waiver program being accessed. For the Alaskans living independently waiver (seniors and individuals with physical disabilities) and adults with physical and developmental disabilities waiver, the Consumer Assessment Tool (CAT) is used. For the intellectual and developmental disabilities (IDD) waiver, the Inventory for Client and Agency Planning (ICAP) is used. Finally for the children with complex medical conditions (CCMC) waiver, the assessment tool used is the Nursing Facility Level of Care Assessment Form for Children.

The applicable assessments are completed by Division of Senior and Disability Services (DSDS) staff or a care coordinator subject to DSDS review and approval.

Implementation of an acuity adjustment to rates will require an assessment of the various levels of need presented by individuals receiving services. The assessment tools that are used currently determine eligibility and assist in service planning. During this project, an evaluation of the currently used assessment tools is needed to determine if the tools can provide the information necessary to support a proposed acuity system. Additionally, an evaluation is needed to determine if the current tools, if augmented by adding additional items or questions, could adequately serve as assessment tools to support an acuity payment system.

In addition to the waiver program, home care services are also offered through the Personal Care Assistant Program to frail elderly individuals and functionally disabled and handicapped individuals of all ages. Eligibility for personal care services is determined via the PCA Consumer Assessment Tool/Personal Care Assessment Tool (CAT/PCAT).

ASSESSMENT TOOLS AND METHODS

There are a variety of screening tools used in the assessment of individuals who might benefit from HCBS services. Many of these tools were developed specifically for use in a particular state and are used in the determination of eligibility. The following list describes the current tools used in the Alaska waiver programs as well as a few additional tools with broader implementation. These additional tools might be considered if DHSS has an interest in changing the current assessment process.

All of the assessment tools described were developed primarily for the purpose of eligibility determination and to assist with the service planning function. Although some state programs have incorporated these tools into their reimbursement methodologies, none of these tools were originally developed specifically for that purpose.

ASSESSMENT TOOLS FOR SENIORS, PHYSICAL DISABILITIES AND PERSONAL CARE ASSISTANTS

The Consumer Assessment Tool (CAT) is the assessment tool currently used by the state of Alaska for its waiver programs for seniors and individuals with physical disabilities. The CAT also is used for the personal care assistant program. The CAT was designed to be objective and easy to administer. The CAT has language, definitions and a format similar to that used in the Minimum Data Set (MDS 2.0) previously used in nursing facilities in the United States that participate in Medicare or Medicaid. (A new version of the MDS is currently used, MDS 3.0.)

The interRAI, Minimum Data Set Home Care (MDS-HC) is another assessment tool available for seniors and individuals with disabilities. It is a scientifically validated and reliability tested comprehensive and standardized instrument for evaluating the strengths and preferences of elderly persons and individuals with adult onset disabilities. The RAI, MDS-HC was designed to be compatible with other MDS tools including the MDS 3.0 used in nursing homes in the United States. This compatibility promotes continuity of care across multiple health care settings. It is used to assess function, health, social support and service use.

ASSESSMENT TOOLS FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DIABILITIES

The Inventory for Client and Agency Planning (ICAP) is the current assessment tool used by DHSS for its waiver program for individuals with intellectual and developmental disabilities. It is a comprehensive, structured instrument designed to assess the status, adaptive functioning and service needs of clients. The ICAP is useful for determining a client's service needs and for monitoring behavioral changes. The types of information collected by the ICAP include:

- Diagnostic status and functional limitations.
- Adaptive behavior skills.
- Problem behaviors.
- Service status and needs.

The ICAP service level combines the broad adaptive (70%) and the general maladaptive behavior (30%) scores to assist in determining level of care, supervision, support or habilitation needed. The ICAP service scores are designed to identify individuals of various levels of need. Categories include the following:

- Scores of 1 to 19 (Level 1) and 20 to 29 (Level 2) indentify individuals with total personal care needs or intense supervision.

- Scores of 30 to 39 (Level 3) and 40 to 49 (Level 4) identify individuals needing extensive personal care and/or constant supervision.
- Scores of 50 to 59 (Level 5) and 60 to 69 (Level 6) identify individuals needing regular personal care and/or close supervision.
- Scores of 70 to 79 (Level 7) and 80 to 89 (Level 8) identify individuals needing regular supervision.
- Individuals with scores of 90 or above (Level 9) would require infrequent or no assistance for daily living.

Myers and Stauffer performed a preliminary analysis of 735 ICAP service scores that were matched to Alaska Medicaid claims data for calendar year 2011. The analysis yielded the following results:

- 209 individuals (28%) were in Levels 1 through 4.
- 349 individuals (47%) were in Levels 5 and 6.
- 177 individuals (24%) were in Levels 7 and 8.
- No individuals were in Level 9.

Additionally, the ICAP scores were linked through the claims information to Medicaid providers. For each home and community based agency provider, the average ICAP score was calculated for individuals being served. The averages for the majority of providers were within the range of 40 to 79. Of the 55 providers identified, 3 had average ICAP service scores in between 20 and 39 and there were none with average scores between 1 and 19 or 80 and higher. This preliminary analysis gives some indications that the ICAP scores are broadly distributed among the total population of individuals with intellectual and developmental disabilities and also among providers. Further analysis is needed to fully evaluate the implications of the distribution of ICAP scores for an acuity adjustment model.

Several other assessment tools for individuals with intellectual and developmental disabilities are available. One of these is the Developmental Disabilities Profile (DDP). This tool was designed by the New York Office of Mental Retardation and Developmental Disabilities, this four-page assessment evaluates functional skills, challenging behaviors and health factors. It yields three index scores, adaptive, maladaptive and health that can be aggregated into an overall needs score.

The Supports Intensity Scale (SIS) is an assessment tool that evaluates support requirements of a person with an intellectual disability. The SIS measures support requirements in 57 life activities and 28 behavioral and medical areas. The assessment is completed by interview with the consumer and others who know the person well. The SIS measures support needs in the areas of home living, community living,

lifelong learning, employment, health and safety, social activities and protection and advocacy. Each activity is ranked according to the frequency, amount and type of support. A Support Intensity Level is determined based on the Total Support Needs Index, which is developed from scores on all items tested.

The interRAI Intellectual Disability Assessment (ID) is a comprehensive, standardized instrument developed and validated through research efforts of the interRAI Consortium. The assessment evaluates the needs, strengths and preferences of persons with intellectual or developmental disabilities and is intended for use with adults in multiple settings, including community, residential and institutional. A small inter-rater reliability study in Ontario revealed excellent agreement between raters.

CONCLUSIONS REGARDING ASSESSMENT TOOLS

Although there are multiple options for assessment tools that could be used in the acuity adjustment process for rates of selected home and community based services, it should be noted that none of the currently available assessments were developed specifically for setting acuity adjusted reimbursement rates. Myers and Stauffer understands that some interest has been expressed to explore potential changes in the current assessment tools. However, the time and cost associated with the implementation of new acuity tools are significant and would present a substantial barrier to the implementation of an acuity adjustment methodology in the near term.

Implementation of new assessment tools such as the Minimum Data Set Home Care (MDS-HC) for seniors and individuals with physical disabilities or the Supports Intensity Scale (SIS) for individuals with intellectual and developmental disabilities are potentially well-intentioned goals. However, such a change would most likely require a time frame of several years and require additional costs for purchasing or licensing the assessment, training and data collection.

To implement an acuity adjustment methodology for senior and disability services within a shorter timeline and at a lesser cost, Myers and Stauffer recommends using the currently implemented CAT and ICAP assessments as the basis of the acuity adjustment for home and community based services.

As mentioned earlier, the CAT format is similar to the Minimum Data Set which was used to develop the Resource Utilization Group (RUG) reimbursement system for Medicare and Medicaid nursing facility payment. Accordingly, the use of the CAT as the basis for acuity adjustment for the reimbursement of assisted living home or other services for seniors and individuals with physical disabilities has reasonable precedent.

Similarly, the use of the ICAP as a means of acuity adjustment for group home habilitation for individuals with intellectual or development disabilities has a reasonable basis. The ICAP service levels were developed through a series of analyses to determine an objective manner of combining assessment responses to accurately reflect appropriate service intensity (level of care or supervision and training) needed. The Broad Independence and General Maladaptive Index scores were the most predictive of service intensity.

The use of the CAT and ICAP assessment tools present the most ideal option as a basis for an acuity adjustment methodology for home and community based services. Although neither are currently used for acuity assignment, both the CAT and the ICAP provide DHSS with a valuable set of data which is readily available and could support an acuity adjustment system.

DETERMINE REIMBURSEMENT OPTIONS TO USE

There are several options available to implement adjustments to rates to make adjustments for acuity.

POTENTIAL SERVICES TO BE ADDED IN LIEU OF ACUITY ADJUSTMENTS

Acuity adjustments can be used to match reimbursement for a service to the cost of providing that service, when the difference in cost is based on the need of the individuals receiving the service. If however, the activities for the delivery of the service need to change to reflect higher need, it is generally viewed that a different service is being provided. In such instances, it may be simpler and more cost effective to define a new service with a different corresponding reimbursement rate. During discussions with representatives of home and community based providers, there were two examples provided that may fit this situation.

One concern related to costs attributed to behavioral management services that were provided to the HCBS recipients. This activity was perceived to add to the cost of providing other services defined in the various waivers. An acuity adjustment for challenging behaviors could be linked to the rate, but these challenging behaviors may be episodic. An assessment would need to be completed when the behaviors were manifested and again when the behaviors no longer impacted the cost of the service. This approach could create an administrative burden for providers and DHSS. A more efficient approach would be to add a behavioral management service to the existing home and community based waivers and set an appropriate rate. This approach would require that the eligibility for the service be carefully defined and monitored with

appropriate service limitations included in the waiver amendment to assure adequate cost controls.

Another issue discussed during meetings with providers was the various levels of transportation service described as “curb-to curb”, “door-to-door” and “hand-to-hand”. For “hand to hand” services, the transportation service needed to ensure a proper handoff from a caregiver at the transportation’s origin to another caregiver at the destination. According to providers, the staff time to provide the transportation increased significantly from the “curb-to-curb” level of service to the “hand-to-hand” level of service. Assuming the level of an individual’s need changed infrequently, an acuity adjustment would require defining the population groups, evaluating the additional cost and periodically assessing the recipient’s level of need. A less complicated approach may be to define and reimburse for different levels of transportation service.

ACUITY ADJUSTMENT OPTIONS

The amount of assistance an individual needs varies widely based on age, clinical diagnosis, functional ability and their home and family situations. Needs range from basic safety and security to skilled nursing and therapy services. This variation in need impacts the cost of care. To assist in matching payment levels to the cost of care, several states have adjusted rates paid for certain home and community based services by an evaluation of the acuity of the need served.

Based on a review of rate setting options used in several states, four primary categories for acuity adjustments to home and community based service rates were observed:

- Tiered rates.
- Case mix.
- Service plan.
- Base plus add-on rates.

The groups are not mutually exclusive and some states use combined approaches.

These approaches are used in multiple types of waivers including those for elders, individuals with physical disabilities and individuals with intellectual and developmental disabilities. The following discussions describe state systems that are currently using or have employed the various acuity rate adjustment options. The discussions include a brief description of the primary acuity category, information on the state’s methodology and the waivers and services to which it is applied.

TIERED RATES

Tiered rate systems divide the population in separately defined groups. There are typically three to five payment levels. The number of tiers should be small enough to be managed effectively yet large enough to sufficiently differentiate varying needs. Levels are defined based on the type, number and severity of activities of daily living (ADL) limitations, medical needs, cognition impairments and challenging behaviors. Tiered rates should create incentives for providers to serve residents with higher service needs.

In many states, the tiered rates are used for supported living or residential services. A rate study by Robert Mollica prepared for the National Center for Assisted Living American Health Care Association lists nineteen states that use some form of tiered rates in their home and community based services.

This tiered rate approach provides a reasonably simple method to set rates that create incentives for providers to serve residents with higher needs. Myers and Stauffer recommends that DHSS give strong consideration to a tiered rate approach for home and community based services to be developed using provider cost data already gathered or in the process of being gathered through current cost reporting processes.

KANSAS

In the Kansas Developmental Disabilities waiver, reimbursement rate tiers are assigned based on a required annual assessment of each individual's general level of disability. A modified version of the Developmental Disabilities Profile (DDP) is used as the assessment document and contained within a larger assessment process entitled BASIS. The resulting payment structure, on average, should reflect the demographics of the served population and provide adequate financial support to meet their population needs.

Services covered under the day program (supported employment, vocational, non-vocational and senior activity) and residential services (individual homes, shared apartments and group homes) are paid for according to the level of disability of the person receiving the service. As an individual's level of disability increases, the reimbursement rate for providing services to that person also increases.

People who apply for day and residential services are assessed and assigned to one of six "tiers." People in Tier 1 are considered the most severely disabled, while those assigned to Tier 5 are considered the least severely disabled. The sixth tier, called Tier 0, is for people whose disability is not so severe that they would be eligible for

funding under the Medicaid home and community bases services waiver program, but who may be eligible for some state moneys available outside the Medicaid program.

Each tier also includes a rate for an exceptional level of services or “super tier” which requires specific documentation of need. This approach is similar to the acuity adjustment mechanism that is currently used in Alaska.

Developmental disabilities rates paid for supportive home care, respite and night support were previously based on a flat hourly or daily rate. Recently these services were bundled into a service called in-home/individual supports. Using the tier structure, rates were established as an option for payment of the bundled service.

Although the tier system has been in place for many years, concerns have been expressed regarding the predictive ability of the DDP for cost drivers.

IDAHO

Tier levels have also been used to define or limit specific amounts of services. In Idaho, tier levels are used to set the number of hours of service for personal care assistant services provided under the state plan. This varies from the Kansas system of tiers in which the tier levels are used to establish actual rates and do not specifically define the level of service provided.

In the Idaho system, there are four tier levels. Each level is assigned a specific number of hours of personal care services that are available:

- Level 1: 1.25 hours per day or 8.75 hours per week.
- Level 2: 1.5 hours per day or 10.5 hours per week.
- Level 3: 2.25 hours per day or 15.75 hours per week.
- Level 4: 1.79 hours per day or 12.5 hours per week. This level is assigned based on a documented diagnosis of mental illness, intellectual disability or Alzheimer’s disease. It has a higher rate of provider reimbursement documented in the Idaho Administrative code.

Prevailing hourly wage rates are used for comparable positions in the nursing home industry. Providers also receive a supplemental percentage to cover travel, administration, training, payroll taxes and fringe benefits.

CASE MIX RATES

Several states have adopted case mix payment systems either based on the nursing home case mix methodology or a separate collection of functional and health data. Like tiered rate approaches, case mix approaches create incentives to serve more

impaired individuals by linking reimbursement to the level of care needed. Case mix approaches typically have more categories than tiered rates, are more frequently seen in waiver programs for seniors and are frequently tied to the Resource Utilization Group case mix systems used by many states in their nursing facility program.

In case mix systems, individuals are assessed, the assessments are grouped into support or need categories and then assigned a score that describes relative resource needs. Rates can be linked to the various case mix categories. More typically, the scores are averaged by providers and the average scores are used to adjust a base rate. The development of case mix systems is a more complicated process than the development of tiered systems. Case mix system development requires more extensive time studies to determine the time required to provide services for the individuals in each classification group. Data gathered in time studies must be augmented with an analysis of wage data to develop the scores.

MINNESOTA

In Minnesota's Elderly Waiver, services in residential settings are called "customized living". Rates are negotiated, but caps are based on the case mix classification table listed below. Waiver recipients of the elderly waiver or alternative care program are screened by county screening teams. They are assigned to one of the 11 case mix levels based on the severity of their service needs.

The case mix framework is used to establish individual service packages and has evolved over time to provide more accountability and consistency in developing an individual service package based on assessed needs. Rates for individuals change when a new assessment justifies a change in services. Payment rate parameters and service limits may change annually based on legislative actions that affect all provider rates.

Table 3.2 Minnesota Case Mix Categories

Minnesota Case Mix Categories	
Case Mix Level	Description
A	Up to 3 ADL dependencies
B	3 ADLs + behavior
C	3 ADL + special nursing care
D	4-6 ADLs
E	4-6 ADLs + Behaviors
F	4-6 ADLs + Special nursing care
G	7-8 ADLs
H	7-8 ADLs + Behaviors
I	7-8 ADLs + needs total or partial help eating (observation for choking, tube, or intravenous feeding and inappropriate behavior)
J	7-8 ADLs + total help eating (as above) or severe neuromuscular diagnosis or behavior problems
K	7-8 ADLs + Special nursing

LOUISIANA

In Louisiana per diem rates are grouped into three or more tiers. Adult residential care (ARC) services provided to waiver participants are based on a comprehensive assessment of need. Assessments are performed by service coordinators using the Minimum Data Set for Home Care (MDS-HC). The RUG-III/HC system has been derived from the RUG-III payment system now used by Louisiana to reimburse nursing facilities and support the integration of a common payment methodology into a new service setting. The per diem payment to Medicaid eligible individuals is determined as follows. The rate paid for ARC services are based on a percentage of the statewide average nursing facility case-mix rate after removing a provider fee component and patient liability amount. Removal of the patient liability amount accounts for the portion of the nursing facility rate that is for room and board. After establishing the statewide average nursing facility case mix rate, minus the provider fee and patient liability, the result is multiplied by an ARC percentage associated with the nursing services for each tier provided for waiver participants for services within the care plan.

SERVICE PLANS

In some states, rates are based on the number of units of service identified in a care plan or a point system based on an assessment.

MINNESOTA

The Minnesota Elderly Waiver is an example of a mix approach to acuity adjustment. In addition to the case mix system previously described, the Minnesota Elderly Waiver also uses the service plan approach. Although rates caps are determined by the various case mix levels, the rate paid for a specific individual is negotiated based on the care plan developed from an assessment completed by a case manager.

SOUTH DAKOTA

In the South Dakota Choices Waiver, providers serving developmentally disabled individuals in South Dakota periodically conduct time studies to estimate how much time is spent with individuals or groups of clients. Multiple regression techniques are then used to build models which best explain variation in time logged with each client. These models are turned into formulas used to generate “predictive” units for each client and rates are then determined prospectively. Most predictor variables come from the Inventory for Client and Agency Planning (ICAP.)

BASE RATE WITH ADD-ONS

These rate structures begin with a basic or base rate. As additional services or service levels are identified, additional reimbursement is added to the base rate. An example of such a system was recommended by Myers and Stauffer during the previous rate study commissioned by DHSS for home and community based services.

PRIOR PROPOSAL FOR ASSISTED LIVING SERVICES IN ALASKA

Myers and Stauffer was involved in a project beginning in 2007 to evaluate the rate methodologies for the home and community based service programs operated by DHSS. As part of that evaluation, Myers and Stauffer received completed Consumer Assessment Tools (CAT) for over 800 individuals. Information from those assessments were entered into a spreadsheet and aggregated as support for a possible acuity adjustment to the rates for assisted living homes.

At that time, Myers and Stauffer proposed a possible acuity adjustment methodology for rates for assisted living home providers. Add-on factors calculated from data fields on the CAT would be applied to a previously established base rate. The sum of these factors would be used to adjust the potential rate. Add-on factors were established for professional nursing services, impaired cognition or behavior problems and the need for physical assistance with the performance of activities of daily living. The factors were considered to be additive and not mutually exclusive. Under this methodology, a minimum acuity factor would have been 0.00 which would have resulted in payment

of the base rate. A maximum acuity factor would have been 2.17 and would have resulted in a rate of the base plus 2.17 times the adjustment rate.

MONTANA

In the Montana Big Sky waiver program, assisted living rates are based on two components. Providers receive a basic service payment, which covers meal service, homemaking, socialization and recreation, emergency response system, medical transportation and 24-hour availability of staff for safety and supervision. Additional payments are calculated based on ADL and other impairments. Points are calculated for impairments, including bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, cognitive functioning and other. Each function is rated as follows:

- “With aids/difficulty”: Needs consistent availability of mechanical assistance or expenditure of undue effort.
- “With help”: Requires consistent human assistance to complete the activity, but the individual participates actively in the completion of the activity.
- “Unable”: The individual cannot meaningfully contribute to the completion of the task.

Each point resulted in an additional amount added to the monthly rate.

WISCONSIN

In Wisconsin, the Family Care is authorized to serve people with physical disabilities, people with developmental disabilities and frail elders. Two major organizational components of Family Care are the aging and disability resource centers (ADRCs), and managed care organizations (MCOs). ADRCs are intended to be the single point of entry for information on available services, while the MCO manages and deliver the Family Care benefit.

In Family Care, rates are additive, with additional needs identified by the Long Term Care Functional Screen. Additional needs result in a higher payment rate for the individual. Using Family Care Services as an example, a base amount is set for each consumer. There are three disability levels and each of these levels receive a different add-on to the base rate. There is an additional add-on if the individual requires skilled nursing services and for self injurious behaviors. ADL dependencies progressively add to the rate beginning at a low of dependencies in 3 ADL to a high of dependencies in 6 ADL.

CONCLUSIONS REGARDING ACUITY ADJUSTMENT OPTIONS

During a previous engagement for DHSS, Myers and Stauffer performed preliminary development steps for a base rates plus add-on methodology for assisted living home providers. This option was not adopted at that time, but the preliminary development indicated that an acuity adjustment based on existing CAT assessment data could be viable.

Although a base rate plus add-on methodology was previously presented, we would now recommend that DHSS give strong consideration to a tiered rate approach for home and community based services using provider cost data already gathered or in the process of being gathered through current cost reporting processes. The base rate plus add-ons and the tiered rates methodology are both relatively simple approaches and are intuitive for providers.

There are a preponderance of states using a tiered rate system. The tiered rate approach provides a reasonably simple method to set rates that create incentives for providers to serve residents with higher needs. The use of tiered rates, unlike the base rate plus add-ons, allows for the development of a tier level with service needs and associate costs below the base rate level to better match rates to the cost of providing services.

To begin modeling and rate analysis, criteria for tiers will need to be established. There are several approaches that are traditionally used for development of tiered rates. These include linking assessment results with claims data to analyze patterns associated with variability in the intensity of services. Alternatively, one can develop tiers by developing new tier criteria from information regarding service intensity through time and motion studies and performing comparisons with assessment results. Based on Myers and Stauffer's experience, neither of these two options appear to be a workable solution for DHSS.

Myers and Stauffer has obtained both CAT and ICAP data for preliminary analysis. However, linking claims data with information from the assessments provides little insight for tier development. The variance in the intensity of services provided is not captured in claims data since the data under the current reimbursement methodology only reflects codes for a single day of residential care regardless of the level of services rendered. Furthermore, an attempt to link assessment results for the individuals with currently approved high acuity rates does not inform the development of tiers due to an insufficient number of individuals with approved high acuity rates.

Defining new criteria for tiers would require obtaining additional information including possible time and motion studies. Such an expansion of the project scope would extend the timeline for implementing an acuity adjustment mechanism and would also add to the cost of development.

This leaves a third option for development of tiered rates. Using existing definitions from the CAT assessment, tier levels could be based on nursing facility level of care criteria. The exact Nursing and ADL Needs scores used to differentiate the tier levels should be refined during the modeling phase. The following is an example of possible definitions:

Tier 1: An individual meeting NF level of care with a total nursing and ADL needs score of three (3) or the minimum criteria to be eligible for HCBS services not including the presumed eligibility for professional nursing.

Tier 2: An individual meeting presumed NF level of care with professional nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.

Tier 3: An individual meeting NF level of care with a total nursing and ADL needs score of 4 through 6 composed of at least two of the following categories:

- Some combination of needs in multiple ADLs, including bed mobility, transfer, locomotion, eating and toilet use.
- Professional nursing needs below the level of presumed eligibility.
- Impaired cognition
- Behavior problems.

Tier 4: An individual meeting NF level of care with a total nursing and ADL needs score of 7 or above composed of at least three of the categories referenced for Tier 3.

Tier levels for group home habilitation services based on the ICAP assessments could be defined based on the calculated service levels.

Tier 1: Service level 9 – Infrequent or no assistance for daily living

Tier 2: Service levels 7 or 8 – Limited personal care and or regular supervision

Tier 3: Service levels 5 or 6 - Regular personal care and or close supervision

Tier 4: Service levels 4, 3 or 2 - Extensive personal care and or constant supervision

Tier 5: Service level 1 - Total personal care and intense supervision

Currently, information relating to an individual’s physical health problems that require medical care is limited and is not a part of the ICAP data set currently available to DHSS. If tier definitions were to incorporate the need for professional nursing, this information would need to be made available. If physical health needs could not be obtained from current information collected or if currently available data is not sufficient to support further definitions of the tiers, an additional physical health assessment could be developed and performed at the time the ICAP is administered to provide the necessary information on medical needs.

CONCLUSIONS AND NEXT STEPS FOR SENIOR AND DISABILITIES SERVICES

DHSS has already transitioned providers of home and community based services to a cost-based rate methodology and ongoing cost report collection to periodically update those rates are in progress. Additionally, the program has already implemented assessment tools into the current eligibility screening process that provide baseline data that we recommend be used to drive the acuity adjustment process. This combination of factors has the potential to make the end goal of acuity adjustment of rates for home and community based services more easily achievable than the previously described process for behavioral health services.

The steps that need to be made as part of the acuity process for home and community based services are to:

- Clarify target services and refine objectives for acuity adjusted rates.
- Make final decisions on the assessment tool and reimbursement options to be used.
- Ensure information system capabilities.
- Develop and model acuity adjusted rates.
- Incorporate pilot steps as appropriate throughout the process.

Each of these steps is described with additional detail below.

CLARIFY TARGET SERVICES AND OBJECTIVES

For home and community based services, an initial step in the process to establish acuity adjustment for rates is identification of services for which an acuity adjustment is appropriate. Based on the nature of the various services offered in the waiver programs and the current units of measure associated with those services, Myers and Stauffer has identified several services as being the most conducive to an acuity adjustment to rates. These are services that are reimbursed according to daily (or per half day) rates including assisted living home, residential habilitation, respite and adult day care services. These services are the most impacted by individuals with high medical and behavior-related needs that were identified by DHSS and stakeholders as being the primary factors driving the need for an acuity adjustment mechanism. Final decisions will need to be made regarding the inclusion of these services in the acuity adjustment process.

Some services were identified as not being ideal for an acuity adjustment mechanism, but possibly would benefit from other refinements to help individuals with high levels of needs. Although not part of this acuity initiative, an evaluation could be made

regarding circumstances that justify the creation of new service definitions and whether the level of need for such services is sufficient to justify the time and effort for their creation. Additionally, for coverage under the current waiver programs, an evaluation of the necessary waiver and regulatory changes needed should be evaluated and the budgetary impact of the change calculated.

MAKE FINAL DECISIONS ON THE ASSESSMENT TOOL AND REIMBURSEMENT OPTIONS TO BE USED.

DHSS will need to make final decisions regarding the assessment tools to be utilized in the acuity adjustment process for home and community based services. While an interest has been expressed in changing assessment tools, Myers and Stauffer's recommendation would be to utilize the Consumer Assessment Tool (CAT) and Inventory for Client and Agency Planning (ICAP), with the possible addition of supplemental materials. Although these tools are currently used as the basis of determining eligibility for waiver programs and not specifically as a level of care or acuity adjustment tool, they present DHSS with a valuable set of data currently being collected which can be used to drive placement of individuals into a tiered reimbursement system.

Myers and Stauffer has performed preliminary analysis using currently available CAT and ICAP assessment data. This initial analysis will be refined and additional analysis performed as tiers are developed and the new acuity adjusted rates are modeled.

DHSS will also need to make final decisions regarding the rate options that will be utilized to implement the acuity adjustments. As previously discussed, many states are using tiered rate systems. This method provides a reasonably simple approach to setting rates that not only creates incentives for providers to serve individuals with higher needs but also allows for more appropriate matching of rates and costs for all levels of support needs.

ENSURE INFORMATION SYSTEM CAPABILITIES

In order to successfully implement a revision to the payment methodology for home and community based services to include adjustments for acuity, DHSS will need to consider the capabilities of its information system. Of critical importance, the payment methodology will need to be capable of being processed by the MMIS. DHSS is currently in the process of updating its aging MMIS. Accordingly, the evaluation of system capabilities potentially will need to include the current MMIS as well as the new MMIS which is under development. Additionally, DHSS may want to consider refinements to the current approaches being used to collect, maintain and analyze

assessment data from the CAT and ICAP. More robust data warehousing and analytical capabilities will promote better decision support and cost prediction capabilities.

DEVELOP ACUITY ADJUSTED RATES

Acuity adjusted rates for the tier levels that are developed in the previously described steps will be based on existing cost-based rates or will incorporate cost data currently being obtained from providers as part of the existing cost reporting process. This process will be supplemented through the use of normative data from other sources as needed to build initial rates.

INCORPORATE PILOT STEPS

The inclusion of pilot steps throughout the process to develop acuity adjusted rates is recommended. The roll-out of any new level of care tools or enhancements to the current assessment tools as well as the resulting acuity adjusted rates may initially occur on pilot basis. Feedback received during pilot stages can assist to refine policies prior to full implementation

WORKING MODEL, IMPLEMENTATION STRATEGY, AND MODELING OF FISCAL IMPACT

Myers and Stauffer will work with DHSS to design and facilitate implementation of the new rate methodology. This phase of the project will include developing the processes and data processing tools that state and provider staff will need to utilize to accomplish the rate setting process. Myers and Stauffer will develop an assessment of staffing needs to implement the rate setting process and develop an implementation time line. Any other necessary infrastructure that will be needed to implement the new rate setting methodology will be assessed.

Recommendations adopted by DHSS will be evaluated for their impact on the programs and services. This evaluation will include administrative cost, system changes, implementation timing and claims payment. The evaluation will consider fiscal impact from both the perspectives of DHSS as well as providers. Fiscal models will be built from available data including provider cost data, MMIS claims data and assessment tool scores.