



## **Annual Report Intake and Rate Calculation Processes**

### **Introduction**

In March of 2011, the Department of Health and Social Services adopted regulations to change the rate-setting system for Home and Community Based waiver services (HCB waiver services) and Personal Care Attendant services (PCA services) from a budget-based system to a more accurate cost-based system. The new system is designed to periodically link the actual cost of providing a service to the reimbursement rate for that service. Given the magnitude of this change, a gradual transition to the cost-based rate system has been ongoing since 2011. This transition will largely be complete January 1, 2014 when new, cost-based rates will go into effect that were derived from the Annual Report requirements adopted in the 2011 regulation change.

Under 7 AAC 145.531(e), HCB waiver services providers and PCA services providers are required to submit to the Office of Rate Review (ORR) an Annual Report no later than nine months after the end of the provider's fiscal year. The provider community has expressed questions as to how ORR intends to use the Annual Reports to calculate the rates that will go into effect on January 1, 2014 and beyond. The Department recognizes the importance of working together with the provider community as partners, so in the spirit of cooperation and transparency, ORR is using this opportunity to share its procedures and methodology for calculating cost-based rates. This release will be followed up with public stakeholder meetings in July so that interested parties can offer input on these processes.

### **Overview**

Approximately 180 provider Annual Reports will be utilized in setting the rates that will go into effect on January 1, 2014. Understandably so, a wide variety of provider sizes, accounting complexities, and reporting issues are present in these Annual Reports. Since this system is new for both providers and the Department, ORR is using a focused review and adjustment process to appropriately deal with these varying complexities and issues. The focused review and adjustment process can be broken down into four components:

1. ***Intake and Initial Review*** of newly submitted Annual Reports
2. ***Focused Review and Adjustment*** of targeted areas
3. ***Analysis and Calculations*** using individual provider worksheets
4. ***Final Rate Calculation in Global Spreadsheet*** after transferring expenses and statistics (i.e. calculations) from provider worksheets

### **Intake and Initial Review**

The intake and initial review of newly submitted Annual Reports is intended to assure that a valid Annual Report is received and that it is usable for calculating rates. The intake and initial review steps consist of:

1. Determine completeness of submitted report
2. Assess compliance to account for any required rate reductions or penalties
3. Return deficient Annual Reports with explanation for deficiency or communicate with provider to resolve deficiency
4. For valid Annual Reports, finalize intake documentation and forward for focused review

### **Focused Review and Adjustment**

Since a full-scale audit of the Annual Reports is impractical, especially given existing resources in terms of time and staff, ORR developed a focused review for certain critical areas. The focused review includes:

1. Units of Service (UOS) review and adjustment
  - Due to significant variances between the UOS reported by providers and the UOS shown in the Department's claims data, a uniform method of review and adjustment was applied to each provider's reported UOS.
  - Specifically, a 2% variance was implemented for Medicaid UOS.
  - Additional evaluation was necessary if Medicaid was less than 100% of the reported revenue for the specific service. These adjustments are calculated on a separate worksheet.
2. Certified and Licensed Beds review and adjustment
  - The number of certified beds drives the calculation of Room & Board expenses that need to be removed from allowable costs. An error of 1 certified bed would result in the removal or non-removal of \$14,600 (365 x \$40) from reimbursable costs. Although these errors occurred infrequently, the adjustments are necessary.
  - The Department's licensing and certification information is the basis for these adjustments.

### **Analysis and Calculations**

The cost survey worksheets from a provider's Annual Report that directly affect rate calculations are the Expense Worksheet, Revenue and Statistics Worksheet, and Building Worksheet. At this point in the process, staff imports this data and generates a single worksheet for each provider. Once the worksheet is generated, a variety of calculations are applied in the provider worksheet so that the data can ultimately be transferred to and used in a global spreadsheet for the final calculation of rates.

The following components were imported and adjusted through calculations to generate the individual provider worksheet:

1. Reclassification of Unique Categories
  - It was necessary to reclassify and adjust certain categories of service due to recent changes to regulations concerning HCB waiver services and PCA services. These adjustments are the result of ORR staff identification of a reporting issue and the provider's agreement with the adjustment.
    - Nurse Oversight and Care Management (NOCM) and Intensive Active Treatment (IAT) expenses required review because of the need to separate the NOCM service from the IAT services.
      - Transition difficulties created UOS that were reported for the year that were part quarterly units and part 15 minute units. These adjustments are calculated on a separate worksheet.
    - Shared Care (Adult and Child) are combined with Family Habilitation (Adult and Child). This adjustment will provide for a single service category to cover the need.
2. Geographic Factor
  - Expenses were brought to a neutral 1.00 geographic amount by adjusting expenses down by the provider's geographic factor that is in excess of 1.00. An additional spreadsheet calculating an average geographic factor is necessary for those larger organizations with service providers in multiple geographic areas. The average geographic factor is per service and is based on Medicaid charges.
3. Allocation of Administration and General Expenses to Service Areas
  - Administrative and General Expenses are allocated to service areas based on percentage of total cost.
4. Removal of Room & Board Expenses
  - Per 7 AAC 145.520(j), \$40 is removed as the expenses associated with Room & Board.
5. Removal of Acuity Service Costs
  - This adjustment removes \$320 per each unit of service for acuity. This number is the same as the acuity rate that was set prior to inflation in 2011.
6. Inflation of Expense to the Rate Year
  - Since expenses are reported by providers who operate on different fiscal year calendars, the expenses need to be inflated (using the appropriate inflation factors) to a common point in time for purposes of comparison. Here, the expenses are first inflated to a common date of 12/31/2012 before being inflated together to the new rate year.
  - The inflation factors used by ORR are from Global Insights

## **Final Rate Calculation in Global Spreadsheet**

At this stage in the process, the costs and statistics for each specific HCB waiver service and PCA service are transferred from the individual provider worksheets to the Global spreadsheet for the final calculation of rates. Costs and statistics are accumulated at the bottom of the Global Spreadsheet. These accumulated costs and statistics are either:

- 1) Factored into rates by simple division; or
- 2) Entered into a calculation process designed to address unique circumstances related to that service code prior to simple division.

## **Sample Methodology**

In order to be as transparent as possible and to provide interested parties the capability of reviewing and evaluating ORR's rate calculation process, four other documents are being released with this overview document.

1. Individual Provider Worksheet A: this document is an example of data from a provider who offers multiple billable HCB waiver services and PCA services across the state. This document not only shows what an Individual Provider Worksheet consists of, but it also includes examples of UOS adjustments (see UOS adjustment tab) and of Room & Board adjustments (see expense worksheet).
2. Individual Provider Worksheet B: this document is an example of data from a provider who offers residential supported living HCB waiver services (i.e. an assisted living home billing under T2031 UR). This document not only shows what an Individual Provider Worksheet consists of, but it also includes examples of UOS adjustments (see UOS adjustment tab) and of Room & Board adjustments (see expense worksheet).
3. Global Spreadsheet: this document is an example of ORR's global spreadsheet. This document includes examples of the costs and statistics that are imported from individual provider worksheets and used for the final rate calculations. This particular example document uses sample costs and statistics from Individual Provider Worksheet A and Individual Provider Worksheet B. It also uses other sample costs and statistics that were made up outside of the sample individual provider worksheets that are included.
4. Eight Unique Demonstration Calculations: as indicated above, some costs and statistics from the individual provider worksheets do not go straight into the Global Spreadsheet. Rather, they are entered into a calculation process designed to address unique circumstances related to that service code prior to simple division in the Global Spreadsheet. Two of these demonstration calculations will be the only place to review the rate calculations because they will not be part of the Global Spreadsheet. These are Pre-employment, a new service, and Adult Day, which has had a change in its unit structure. The other six unique demonstration calculations are for:
  - Care Coordination, T2022, T2024U2, and T1023 – Demonstration
  - Group Home, T2016 and T2016TG – Demonstration
  - Daily Respite, S5151 and S5151U2 – Demonstration

- Transportation, T2001, T2003, and T2003TN – Demonstration
- Day Habilitation, T2021 and T2021HQ - Demonstration
- Supported Employment, T2019 and T2019HQ – Demonstration

The individual provider spreadsheets are not actual providers but have been developed using real provider circumstances and information. The global spreadsheet is intended to show the calculation processes being utilized and does not necessarily demonstrate rates that will be calculated and adopted in the future.