



Overview: Cost-Based Medicaid Payment Rates for HCB Waiver Services and PCA Services

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 (HCB) Waiver services and Personal Care Attendant (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.

The Department of Health and Social Services released its proposed changes to regulations dealing with service payment rates for HCB Waiver services and PCA services on August 23, 2013. In conjunction with its proposed changes, the Department has now released transparency materials to show the actual calculations of the cost-based payment rates that will go into effect on July 1, 2014.

Overview

Approximately 180 provider Annual Reports were used in setting the rates that will take effect on July 1, 2014. Understandably, a wide variety of provider sizes, accounting complexities, and reporting issues were present in these Annual Reports. Since this system is new for both providers and the Department, the Office of Rate Review (ORR) used 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 the *global spreadsheet* after transferring expenses and statistics (i.e. calculations) from the individual 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 the 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. Audited Financial Statement Cost Credit
 - For many providers, the 2011 annual report is the first time an Audited Financial Statement (AFS) has been completed. Since the AFS was completed after the close of the 2011 reporting year, the costs associated with obtaining an AFS were not reported in the annual report for first-time financial audits.
 - Additionally, "small" providers who received \$200,000 or less in annual Medicaid receipts had the option of receiving a reduction in payment rates instead of obtaining an AFS. Therefore, the costs associated with obtaining an AFS, which are later offset by rate reductions, were not reported in the annual reports of small providers that chose not to obtain an AFS.
 - In order to ensure that the costs associated with an AFS are properly reflected in the payment rates, ORR added \$7,000 in costs to each provider that obtained an AFS for the first time. ORR made the same addition in costs to small providers that chose not to obtain an AFS in return for a 10% rate reduction. This adjustment is to the benefit of providers as it results in higher payment rates.

Analysis and Calculations

The cost survey worksheets from a provider's Annual Report that directly affect rate calculations are the Expense Worksheet and Revenue and Statistics 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 this *individual 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.
 - 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 provides 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 the proposed changes to 7 AAC 145.520(j), the amount removed as the expenses associated with Room & Board was determined by multiplying total utilized bed days by the current (at the time of rebasing) maximum monthly Federal Supplemental Security Income benefit amount for individuals divided by 30 days.
 - This equates to $\$710/30 = \23.67 . This amount replaces \$40, which was the old amount that was associated with Room & Board expenses.
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 of total costs divided by total units; or
- 2) Entered into a calculation process designed to address unique circumstances related to that service code prior to the simple division of total costs divided by total units.

Transparency Materials

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

- Global Rate Calculations**
- Individual Provider Group 1**
- Individual Provider Group 2**
- Individual Provider Group 3**
- Individual Provider Group 4**
- Individual Provider Group 5**
- Individual Provider Group 6**
- Special Calculation Sheets**