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Documentation of Rate Setting Methodology

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

Training Objectives

- Understand rate setting instructions and guidelines related to completing Appendix I-2-a in the waiver application.
- Understand five different types of common rate setting methodologies and how to document these methods effectively in Appendix I-2-a.

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What is Rate Setting & Why Does it Matter?

Rate setting is the process for determining a payment amount that a payer reimburses to a provider for the provision of a service.

- When a state develops rates for services, they generally try to determine rates that are cost effective and affordable, while meeting the service delivery systems' needs.
- Rate setting determines what providers will receive for delivering services under the waiver authority.

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What is Rate Setting & Why Does it Matter?

Proper rate setting will assist the states with the following fiscal integrity issues.

- Establishing deliberate approaches for how each service is paid.
- Creating ways to develop methods to ensure proper post-payment control.
- Developing means for monitoring service utilization and payment trends over time.

For 1915(c) Home and Community-Based Services (HCBS) waiver applications, rate methodology must be described in the Appendix I-2-a.

- Details of the rate methodology must include inputs (e.g., wages, administrative costs, etc.), cost assumptions, and other projections that were used to establish the rate.

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Federal Guidance for Rate Setting

Social Security Act

- Overarching guidance for rate setting methodology for Medicaid services including HCBS is §1902(a)(30)(A) of the Social Security Act.
  - "Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population"

Code of Federal Regulations Related to HCBS Rate Setting

Code of Federal Regulations (CFR): 42 CFR 447.201-202 Highlights

- The state Medicaid Agency's responsibility in rate setting:
  - 42 CFR 447.201 - must describe the policy and the methods used in setting payment rates for each type of service.
  - 42 CFR 447.202 - must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.*

** Fee plus cost of materials: a common rate setting methodology for services such as Personal Emergency Response Systems (PERS) or environmental modifications.*

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Code of Federal Regulations Related to Rate Setting

42 CFR 447.203-204 Highlights

- **The state Medicaid Agency's responsibility in rate setting:**
  - 42 CFR 447.203 - must maintain documentation of payment rates and record the following for making increases in payment rates for individual practitioner services.
    - The state should be aware of service rates for similar or identical services in other geographical areas. The state should estimate and describe how the updated service rates compare with other areas and the methods used to make this comparative estimate.
    - The state should estimate the average percentage increase of updated rates over prior rates.
  - 42 CFR 447.204 - payments must be sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

Code of Federal Regulations Related to Rate Setting

42 CFR§ 447.302(f) Highlights

- Federal Financial Participation (FFP) is not available for a state's expenditures for services that are in excess of the amounts derived from the approved rate setting methodology.
- Third Party Liability
  - Medicaid is generally the payer of last resort.
  - FFP is not available if the state Medicaid Agency does not fulfill its requirement to establish liability and seek reimbursement from a third party.

CMS Review Criteria

- **Technical Guide pages 252 – 254 CMS Review Criteria requires that the states describe the following for rate setting in Appendix I-2-a:**
  - "Methods" that are employed to "establish provider payment rates" for "each" waiver service.
  - Entities that are responsible for rate determinations.
  - How public comments are solicited.
  - How payment rates are made available to individuals.
  - For 1915(b) and (c) concurrent waivers or any other managed care authority running concurrently with 1915(c):
    - Reference capitation rate methodology described in the specific section in the 1915(b), 1115, or any other managed care concurrent authority waiver application and associated materials.

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How to Document Rate Methodologies in Appendix I-2-a of the 1915(c) Waiver Applications

Four Basic Rules for Meeting Appendix I-2-a Requirements

No matter what your rate methodology is, Appendix I-2-a description should:

- **Rule 1:** Be Specific – Describe the method of rate setting for each service.
  - For each service, also include the rate setting methodology for different methods of service delivery, such as participant direction.
- **Rule 2:** Describe how and how often the rate methodology is reviewed and rates are updated.
- **Rule 3:** Describe the public comment process.
- **Rule 4:** Describe how the individual rates are available to the public.

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Rule 1: Rate Setting Methodology Description in Appendix I-2-a

Rule 1: Be Specific – Describe the method of rate setting for each service.

- The most common request for information in a review of Appendix I-2-a is for detail on the rate setting methodology.
- How can the state be more "specific" in describing its rate setting methodology?
  - Outline the different service types.
  - Detail the rate methodology specific to each service.
    - Services can be grouped when the methodology is uniform for those services.
- Specify the data sources and variables that comprise the rate (see following slide for examples).
- Explain which entity is responsible for *rate setting* and *oversight*.
- Clearly document the related state codes and regulations.
  - Caveat: Copying and pasting the state's provider reimbursement regulation will generally not describe the *method* of rate development.

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Rule 1: Rate Setting Methodology Description in Appendix I-2-a

Data Sources Example

- The following are examples of common data types used in FFS rate setting:
  - **Wages** (The hourly amount paid to direct support staff, excluding benefits and taxes. This information is often obtained from the Bureau of Labor Statistics website or from a survey of providers, etc.)
  - **Productivity Assumptions (**The amount of "billable" time spent during an 8-hour day or 40-hour week in which service was directly provided to an individual).
  - **Benefits Factor** (Employer-paid taxes: Federal Insurance Contributions Act, Social Security Administration, worker's compensation, benefits premiums, etc.)

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Rule 1: Rate Setting Methodology Description in Appendix I-2-a

Data Sources Example (continued)

- **Administrative Overhead** (Administrative staff, executive leadership, accounting, human resources, office supplies, office leases, etc.)
- **Program Support Costs (**program development, quality assurance, staff training and expenses associated with these staff, etc.)
- **Acuity Levels/ Assessment Results for Tiers** (Supplementary Security Income, Inventory for Client and Agency Planning, etc.)
- **Inflation / Cost-of-Living Adjustment Factors** (Cost-of-Living Adjustment, Consumer Price Index-All Urban Consumers/Urban wage Earner and Clerical Workers, Market Basket, etc.)
- **Other Rate Setting Formulas or Indices**

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Rule 1: Special Consideration – Participant-Directed Services

What should states consider for participant-directed service rate setting?

- Technical Guide, pg. 253 discusses specifics for participant-directed service rate setting.
- Participant-directed services can vary from individual to individual and may have different rates than agency-directed waiver services.
- If rate setting for participant-directed services differs in any way from rate setting for agency-directed services, then the state must fully explain **how** the two differ and methods used for formulating the participant-directed service rate, such as:
  - Are rates negotiated?
  - What is the process for setting an individual budget? (This should be included in Appendix E-2-b-ii and referenced in Appendix I-2-a.)
  - Can individuals allocate the expenses in their budgets? (This should be included in Appendix E-2-b-iv and referenced in Appendix I-2-a.)
  - Do states issue guidelines that include a cost range for services?

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Rule 2: Rate Methodology Update and Review

Rule 2: Describe *how* rates will be reviewed and updated.

- How does the state document and review the rate setting methodology?
  - If the rates are updated using a set of factors, these factors should be explained.
    - Explain why each factor is used to update the rate.
    - Factors for trending can be inflationary factors, or observed growth rate factors.
  - Stay consistent with the service limits in Appendix C-1/C-3 service definitions.
    - Appendices I-2-a and C-1/C-3 should not contain conflicting information
    - Example:
      - Under the "Specify applicable (if any) limits on the amount, frequency, or duration of service" section of the Appendix C-1/C-3 states that billed respite units must not exceed 240 hours per year. However the state reports in Appendix I-2-a that respite units are billed in hourly units and the cap is 40 units. Appendix I-2-a and Appendix C-1/C-3 in this case have conflicting information.
    - The state may cross reference C-1/C-3 in Appendix I-2-a
- **Reminder: CMS requires states to review rate setting methodologies, at minimum, every five years.**

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Rule 3: Public Comment Process Requirements

Rule 3: Describe public comment process.

What are public comment process requirements per federal regulations?

- Related Federal Regulations per Instructions - 42 CFR 447.205 and 42 CFR 441.304 (e):
  - The state Medicaid Agency must provide public notice of *any significant proposed change in its methods for setting payment rates* for services.
- Related Federal Regulations per Instructions - 42 CFR 441.304(f):
  - The state Medicaid Agency must establish and use a public input process, for any changes in the services or operations of the waiver.
    - The process must be described fully in the state's waiver application and ensure meaningful opportunities for input for individuals served, or eligible to be served, in the waiver.
    - This process must be completed a minimum of 30 days prior to implementation of the proposed change or submission of the proposed change to CMS, whichever comes first.

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Rule 3: Public Comment Process Requirements

What should be included in the public notification?

The notice must:

- Describe the proposed change in methods and standards.
- Give an estimate of any expected increase or decrease in annual aggregate expenditures.
- Explain why the agency is changing its methods and standards.
- Identify the electronic and non-electronic notification methods that will reach waiver program stakeholders.
- Provide an address, both electronic and physical, where written comments may be sent and reviewed by the public.
- Identify a time frame of no less than 30 days within which the public can give input.
- If there are public hearings, provide the location, date, and time for these hearings.
- This should be cross referenced to or internally consistent with the information listed in Main 6-I, Public Input: Process of public notification.

Rule 3: Public Comment Process Requirements

Where is the rate methodology notice required to be posted?

- The notice must appear as a public announcement in one of the following publications:
  - A state register similar to the Federal Register.
  - The newspaper of widest circulation in each city with a population of 50,000+ or, if there is no city with a population of 50,000+, the newspaper of widest circulation in the state.
  - A web site developed and maintained by the single state agency or other responsible state agency that is accessible to the general public.

Rule 3: Public Comment Process Requirements

The website must:

- Be clearly titled and easily accessible from a hyperlink included on websites that provide general information to beneficiaries and providers, and must be included on the state-specific page on the Federal Medicaid website.
- Be updated for bulletins on a regular and known basis (e.g., the first day of each month), and the public notice is issued as part of the regular update.
- Comply with national standards to ensure access to individuals with disabilities.
- Include protections to ensure that the content of the issued notice is not modified after the initial publication and is maintained on the website for no less than a 3-year period.

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Rule 4: Rate Information Availability

Rule 4: Describe how the individual rates are available to the public.

What should be included in the rate information available to individuals and families?

- Technical Guide, Page 254, CMS Review Criteria
  - Describe how information about payment rates are made available to individuals and families.
    - Explain how rates are communicated to individuals receiving services, including services that are participant-directed.
    - Specify the web address where rates are publicly available, and update this address as necessary.

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Examples of Rate Methodology Documentation in Appendix I-2-a

Common Rate Setting Methodologies

- Five common rate setting methods found in 1915(c) Waiver Applications:
  - Fee Schedule
  - Negotiated Market Rate
  - Tiered Rate
  - Bundled Rate
  - Cost Reconciliation Rate
- In the next section of the slides:
  - Each rate setting method is defined and demonstrated using a mock state example.

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Appendix I-2-a: Fee Schedule Documentation

- **<u>Definition</u>: Provider receives a fixed, pre-determined rate for a single service for a designated unit of time.**
  - Does not vary by client, acuity, or provider.
- **The following slides provide examples illustrating language that meets the requirements of the Technical Guide, pages 252-254.**
  - "Methods" that are employed to "establish provider payment rates" for "each" waiver service.
  - Entities that are responsible for rate determinations.

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Appendix I-2-a: Fee Schedule Example

- **Part 1 - Identify overall methodology and which service uses the methodology:**
  - Application Says: *Personal Care Services.* The state uses the Fee Schedule model of rate setting for its Personal Care Services. The initial rate methodology was set in 2008, rates were increased in 2013, and the last regularly scheduled review was performed in June 2015 where rates remained unchanged. The state's Medicaid Agency reviewed the methodology to ensure economy, efficiency, quality of care, and found it to be sufficient to meet these requirements and recruit enough providers.
- **Part 2 - Describe the methodology used, BLS Data & Info:**
  - Application Says: Rate model begins with an examination of the most relevant state-specific information available from the Bureau of Labor Statistics (BLS) as a means to identify a base employee wage for personal care aides (PCA).

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Appendix I-2-a: Fee Schedule Example

- **Part 3 - Base wage and employee benefits factor:**
  - Application Says: The state Medicaid Agency performed a cost survey of the state's 200 Personal Care Agencies in 2014 to determine the base PCA wage, employee benefits factor, productivity adjustment, administrative costs, program support costs and staffing ratio. Out of 200 agencies, 150 agencies responded.
  - Base wage: Base PCA wage per hour is $20.00 according to the 2014 cost survey conducted.
  - Employee benefits factor: Using the cost survey, the state was able to determine that, on average, employee benefit costs accounted for 15% of provider's total costs. Employee benefits include health insurance paid for PCAs and paid time off.

Appendix I-2-a: Fee Schedule Example

- **Part 4 - Productivity adjustment, administrative and program costs:**
  - Application Says: The state used the same cost survey to calculate the productivity adjustment, administrative and program expenses.
  - Productivity adjustment: The state defined the productivity adjustment as PCA time spent on duties that prevented them from providing direct services. These included service record keeping time, travel time between clients, time spent on program development, and time spent on other job duties (e.g., time spent on staff meetings). Overall, the cost survey showed that the PCA spent 8 hours per day and the billable on-site time on average was 6.8 hours per day. Total productivity adjustment time was therefore 1.18, i.e., 8 ÷ 6.8 = 1.18.

Appendix I-2-a: Fee Schedule Example

- **Part 4 - Productivity adjustment, administrative and program costs: (continued)**
  - Administrative and program expenses: The cost survey showed that on average, the administrative costs accounted for 6% and program support costs accounted for 4% of the provider's total costs.
  - Administrative expenses comprised of the costs incurred for human resources and accounting staff. The program support costs are comprised of annual in-service PCA training and quality assurance activities.
  - *As a result of the cost survey, administrative and program support represent 10% of the final personal care service rate.*

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Appendix I-2-a: Fee Schedule Example

- **Part 5 - Inflation Factors:**
  - Application Says: Estimated rate increases are determined by Cost of Living Adjustments (COLA) from the Social Security Administration. We will use the latest COLA adjustment percentage from www.ssa.gov/oact/cola/colasummary.html at the time of the next renewal application.
  - Rate increases are solely at the discretion of the state's legislative appropriation availability. SSA COLA is announced every October. At the state's annual legislative session, the state makes the determination of whether to adjust the rates by the SSA COLA percentage.

Appendix I-2-a: Fee Schedule Example

- **Part 6 - Composition of Final Rate:**
  - Application Says: The base wage for PCAs per cost survey from 2014 is $20.00 per hour. Employee, admin, and program expense factors were applied (0.10 for employee benefit expenses and 0.06 for admin and program expenses) to the $20.00 hourly base wage to come up with an $31.00 per hour total rate.
  - In 2012, the BLS COLA adjustment was 2% and the state Legislature approved these COLA rate increases. In 2013 the state was not able to adjust the rate per COLA as there was no funding available. The rate remains at $31.00 per hour for this renewal period. The state will submit an amendment application if the rates are updated.
    - **Note:** When the state does not incorporate a COLA, it is the state's responsibility to ensure that payments for waiver services are consistent with efficiency, economy, quality of care, and are sufficient to enlist enough providers in accordance to the §1902(a)(30)(A) of the Social Security Act.

Negotiated Market Rate Definition

- **<u>Definition</u>: Provider receives the market price of a service, with an expectation that some negotiation will take place to reach an agreed-upon market price.**
  - Typically involves the state creating a rate range for permissible rates.
  - Range is determined by reviewing prices of comparable services and negotiated prices for other providers of similar services.
  - Requires maintenance of clear documentation for the process.
  - Common services that use such rate setting methods are: Consumer-Directed Attendant Care Services, Assistive Technology, Home Modifications, and Personal Emergency Response Systems (PERS).
- **The following slides provide examples illustrating language that meets the requirements of the Technical Guide, pages 252-254.**
  - "Methods" that are employed to "establish provider payment rates" for "each" waiver service.
  - Entities that are responsible for rate determinations.

Appendix I-2-a: Negotiated Market Rate Example

- **Part 1- Describe which services require a negotiated market rate:**
  - Application Says: Consumer Directed Attendant Care Services are reimbursed based on the agreement of the individual and the provider.
- **Part 2 – Describe how the rate is negotiated:**
  - Application Says: The individual or the family member responsible for the individual's care negotiates a rate (within the permissible rate range) with the attendant at the time of hire. The state requires the individual and the family to re-negotiate the rate on the attendant's anniversary date. The case manager and the consultants are required to be present at the time of negotiation and this discussion must be documented in the individual's record.

Appendix I-2-a: Negotiated Market Rate Example

- **Part 3- Describe how the floor and ceiling (minimum and maximum rates) are set:**
  - Application Says: The state requires every provider be paid at no less than the state's posted minimum wage for all attendants. The current minimum wage is posted on the state's website (www.examplelink.state.gov/minwage) and it is $7.00 per hour. The maximum wage paid to the attendant is the hourly wage posted for agency-directed Personal Care Services and it is $8.28 per hour.

Tiered Rates Definition

- **Definition: Providers receive payment for one service in which the rate varies by identified characteristics of the individual, the provider, or some combination of both.**
  - Tiered individual characteristics are often determined by an assessment tool.
    - Assessment Tool: A tool used to collect and document ~~client~~ participant information in a uniform and consistent manner during a face-to-face interview.
    - Service tiers are set based on the average cost and service utilization of the core benefit.
    - Tiers are formed by matching individuals, stratified by assessment tool outcomes, with associated utilization cost brackets for a given service.
      - Individuals with more complex health concerns, such as health or behavioral issues, utilize more services and are thus authorized for a higher-cost tier.
  - Rates can be partially based off of average rates in a geographical region.

Tiered Rates Definition

- **The following slides provide examples illustrating language that meets the requirements of the Technical Guide, pages 252-254.**
  - "Methods" that are employed to "establish provider payment rates" for "each" waiver service.
  - Entities that are responsible for rate determinations.

Appendix I-2-a: Tiered Rates Example

- **Part 1 - Describe how tiers are part of the rate foundation:**
  - Application Says: Tiered rates are used in the Department's rate setting model to reimburse those services for which the level of provider effort and the intensity of the service are variable based upon the differing support needs of individuals. Difficulty of care factors have been incorporated into the rate-setting model for rates.
- **Part 2 - Describe how the assessment tool translates into tiers*:**
  - Application Says: Through an analysis of data compiled from the Supports Intensity Scales (SIS), historical utilization, and other sources, the state's contractor developed a methodology that groups individuals into six support levels. These support levels are reflective of similar adaptive skills, behavioral and medical support needs, and the presence of safety risk factors individuals present to themselves or to the community. Rates are reimbursed at a tiered, fee-for-service rate that varies by the individual's support level.

** Reference Appendix C-1/C-3 if tiers are explained as part of the service definition.*

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Appendix I-2-a: Tiered Rates Example

- **Part 3 - Explain implications of using assessment tool-based tiers:**
  - Application Says: Individuals may change support levels based upon changing needs and/or circumstances, and support level determinations may be disputed. Individuals may submit a request for support level re-determination at any time. A Department-convened review panel considers the request and may decide that the current support level is appropriate, re-assign the individual to another support level, or request the re-administration of the SIS Interview and/or safety risk factors.

Bundled Service Rate Definition

- **<u>Definition</u>: A waiver service that encompasses two or more discrete services with distinct purposes that are not closely related. The State must demonstrate that such bundling will result in more efficient and economical delivery of services and ensure that waiver participants have free choice of providers.**
  - Provider receives a fixed, pre-determined rate for a pre-determined amount of time that includes the delivery of multiple services for an episode of care.
  - The estimated cost of each of the various components of a service code (treatment, administration, direct labor, non-labor costs allocated to the service, etc.) are determined and added together to determine a payment rate.
  - Rates are set by inputting costs of all services under the bundle into a complex algorithm, factoring in acuity-related, administrative and resource costs.
  - Bundled payments are specific to individuals' need and associated episodes of care (services provided to address a specific need).
  - Bundled services are typically provided by a single service entity.

Bundled Service Rate Example

- **Part 1 - Describe the components of care included in the bundle:**
  - Application Says: Payment for Personal Care Services, as prescribed by the Medicaid Agency, also includes the provision of assistive technology and environmental modifications services as needed.
- **Part 2 - Describe how costs of each component are rolled into a single bundled rate:**
  - Application Says: The Agency's contractor takes reimbursed claims costs of each individual service within the bundle and, based on average utilization of each component for the given bundled condition, factors those costs into an algorithm. The algorithm produces an overall fee value that encompasses all services within the bundle for a given condition or service.

Cost Reconciliation Rate Definition

- **Definition: Type of rate setting where providers are filing cost reports or cost surveys created by the state, ultimately to be reimbursed at the true cost of service**
  - Involves interim rates set by the state
  - The state compares the interim rate against the final rate set by the state, and the provider is reimbursed at the actual expenditure of delivering the service.
  - Final rates can be set by using claims history, market rate research, or other methods determined by the state. Interim rates can be projected by using provider costs reports.
  - States must include the process for how final and interim rates are set.
  - In instances in which the interim rate is higher than the final rate, the State must recoup the difference. This recoupment process should be detailed in both Appendix I-1 and I-2-a.
- **The following slides provide examples illustrating language that meets the requirements of the Technical Guide, pages 252-254**
  - "Methods" that are employed to "establish provider payment rates" for "each" waiver service
  - Entities that are responsible for rate determinations

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Appendix I-2-a: Cost Reconciliation Rate Example

- **Part 1 - Describe the development of the interim rate used:**
  - Application Says: Personal Care interim rates were established based on the projected costs of the service to be provided, calculated based on existing market rates that are available through commercial insurance. We reviewed ten commercial providers operating in rural areas and another ten providers operating in metropolitan areas and determined the average of both areas for an existing market rate of $12.50 per hour.
- **Part 2 - Note any variations within the interim rate:**
  - Application Says: A preliminary interim statewide rate may be further refined by taking into consideration the geographical area. In those cases the geographical areas will reflect different final rates and therefore reflect different reconciliation processes.
    - Personal care interim statewide rate was set at $8.00 per hour for rural areas, the actual cost was $7.90 and for urban areas it was $9.50. For urban areas, the state will have to reimburse the additional $1.60 per hour. For rural areas, the state will need to recoup $.10 for each hour of service provided.

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Appendix I-2-a:Cost Reconciliation Rate Example

- **Part 3 – Explain the reconciliation process:**
  - Application Says: The Department reviews submitted claims for the past state fiscal year and determines the average cost of claims for that year. After state cost rates are established, claims are reconciled at the true cost of delivering the service. Costs are reimbursed if the final rate is higher than the interim rate or recouped if the final rate is lower than the interim rate. The State will then be responsible for reimbursing CMS for all federal financial participation (FFP) payments for all overpayments identified.
- **Part 4 – Describe methods for cost reimbursement/recoupment:**
  - Application Says: Each provider receives a letter outlining the determination of recoupment or reimbursement. If the provider is receiving reimbursement, the payment is made within 90 days from the reconciliation date. If the provider's payment is recouped, the invoice is sent with instructions on how to submit payment to the Department. An appeals process is available.

Conclusion

- We discussed common issues noted in Appendix I-2-a of the application and made suggestions that states can consider when completing 1915(c) waiver applications.
- We provided state waiver rate setting methodology that was both detailed and transparent and also fully demonstrated the rate basis for each service.

Additional Resources

- Additional rate setting resources are available in the below website. Topics include:
  - Rate Methodology in a FFS HCBS Structure
  - HCBS Rate Construction Illustration and Topical Discussion
  - Inflation
  - Data Validation
  - Cost Neutrality Demonstration
- https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html

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Questions

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