

HEALTH WEALTH CAREER

HCBS PROVIDER FEE DEVELOPMENT MARKET-BASED APPROACH

August 30, 2016

Presenters

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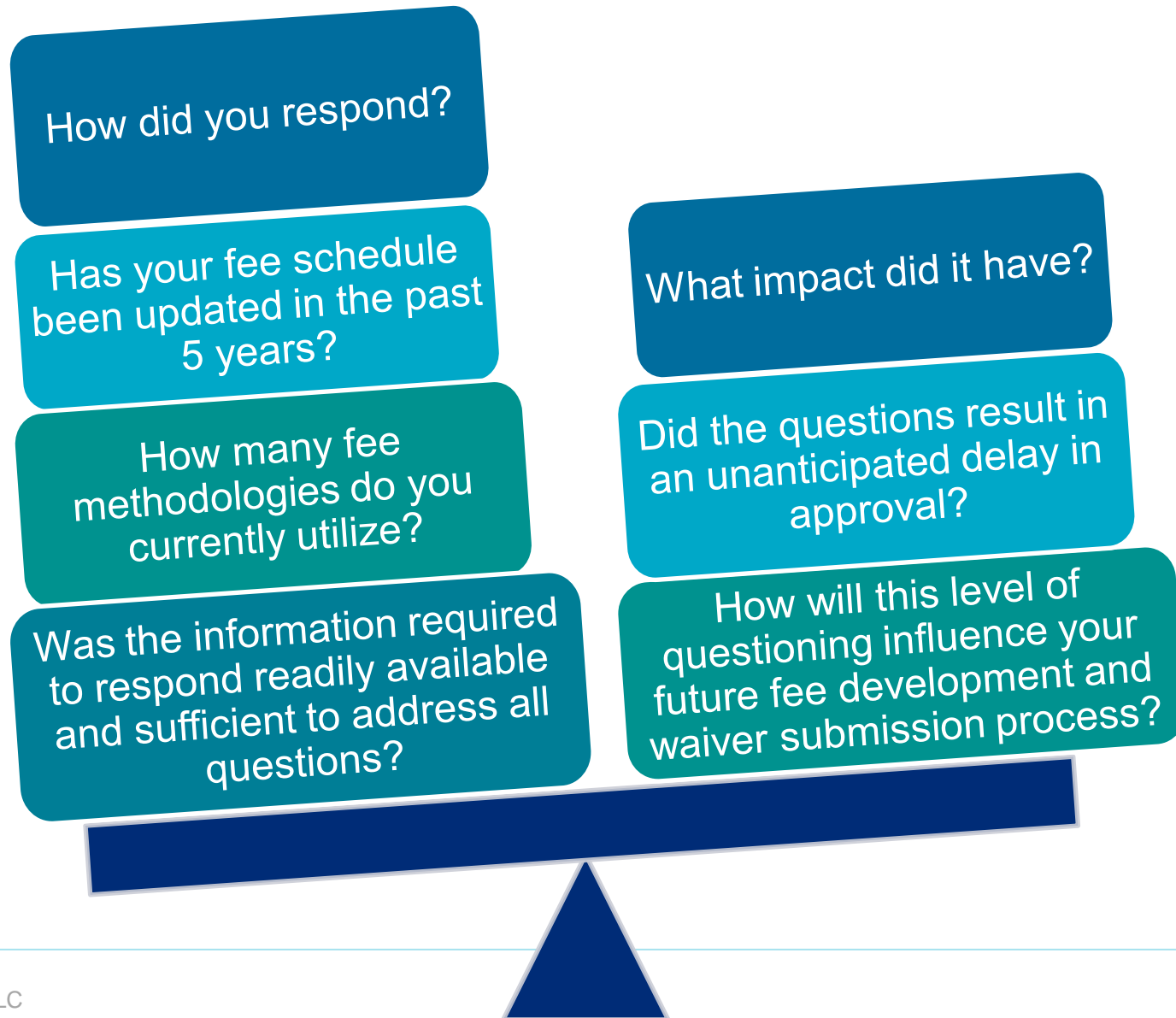


1915(C) HCBS WAIVER SUBMISSION AND REVIEW

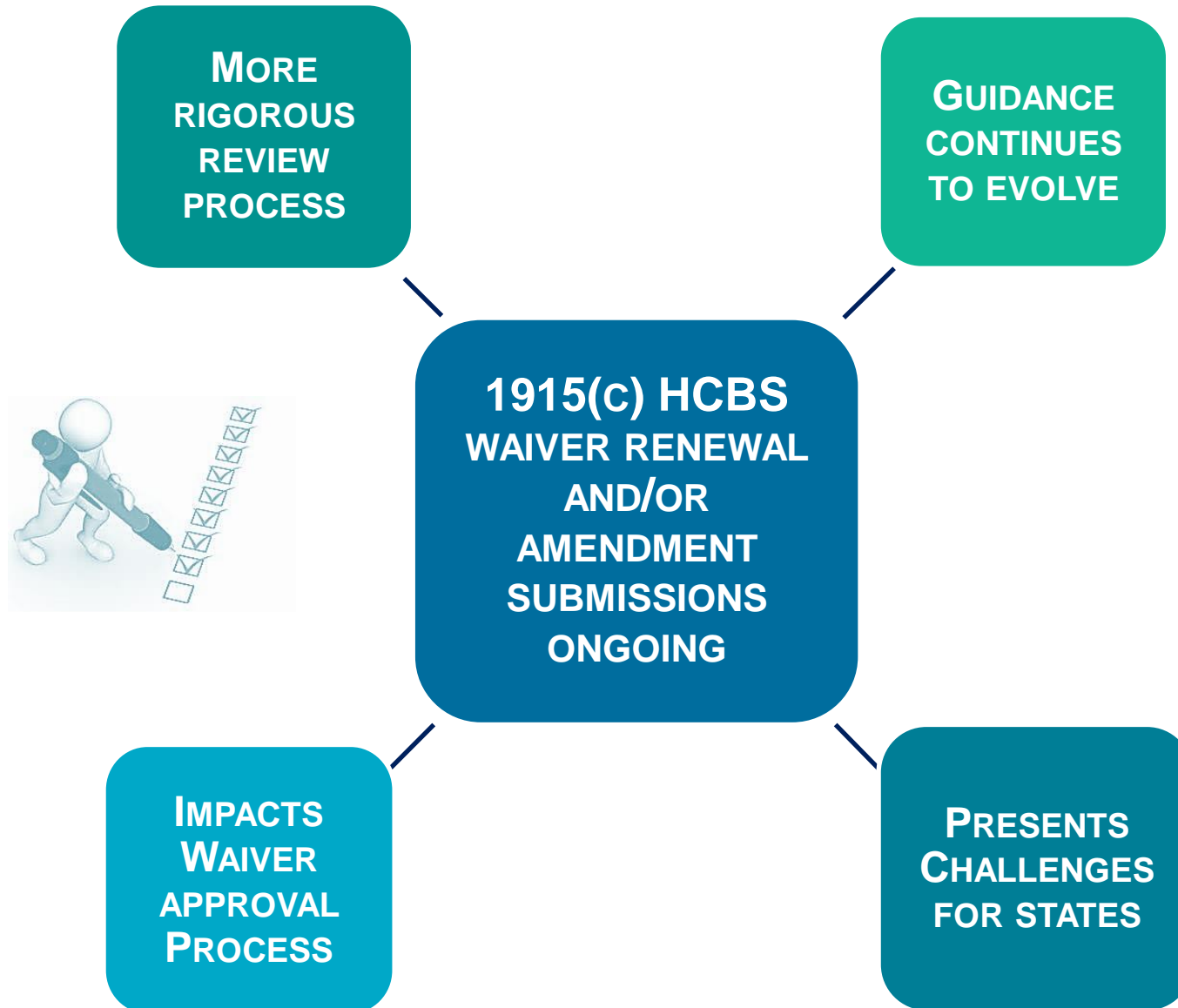
Specific to Appendix I-2a, have you been faced with these questions in response to your 1915(c) waiver amendment or renewal?

- 
- Describe the fee/rate methodologies used for each service
 - Describe additional factors considered in arriving at the final rate, such as cost of living, inflation factor, difficulty of care, acuity determination, etc.
 - Indicate the basis of variation when rates vary for different providers
 - Describe how geographical fees are developed and what factors are considered to account for wage differences across the state
 - If there is a schedule for annual cost of living increase for the rates, describe how it is determined and provide it
 - Describe how comments from providers participating in forums are used in the rate-setting process

1915(C) HCBS WAIVER SUBMISSION AND REVIEW



1915(C) HCBS WAIVER SUBMISSION AND REVIEW



SESSION OBJECTIVES

**OVERVIEW MARKET-
BASED HCBS FEE
SCHEDULE
DEVELOPMENT
PROCESS**

**COVER WHO, WHAT,
WHEN, WHERE, WHY
AND HOW**

**HOW WE WILL
GET THERE**



RECOGNIZE CURRENT ENVIRONMENT
IDENTIFY AND CLARIFY TERMINOLOGY
**DISCUSS ALLOWABLE FEE DEVELOPMENT
METHODS**
IDENTIFY KEY COMPONENTS OF PROCESS
DISCUSS DATA SOURCES
SHARE LESSONS LEARNED

YOUR SPEAKERS



Deidra Abbott, MPH
Principal

- Deidra has been with Mercer for almost five years, working on a wide range of issues including program design and implementation, health plan readiness reviews, program monitoring, health plan contracting and stakeholder engagement.
- Over 28 years of experience in MLTSS and HCBS initiatives,
- Former CMS Technical Director for Home and Community-Based Services Waivers.



Misti Beckman
Partner

- Misti has been with Mercer for more than fifteen years, assisting states in program design and implementation, fee-for-service and capitated managed care rate development processes, administrative design, program monitoring and stakeholder engagement.
- Almost 20 years of health care experience focused on HCBS and MH/BH initiatives.
- Directs consulting teams on a variety of state Medicaid programs, working with the state to develop options and models that best meets their needs.



Robert Karsten, ASA, MAAA
Senior Associate

- Bob has been with Mercer for almost five years, assisting states in program design and implementation, fee-for-service and capitated managed care rate development processes and stakeholder engagement.
- Provides actuarial consulting for a variety of state Medicaid programs and partners with the state in developing payment solutions that best meets their needs.
- Specializes in MLTSS and HCBS initiatives.

MERCER GHSC SOLUTIONS

CLINICAL / BEHAVIORAL HEALTH

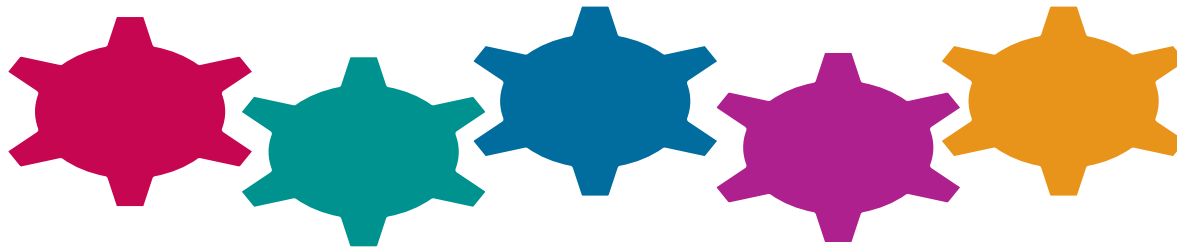
PROGRAM DESIGN, POLICY
PROCUREMENT,
IMPLEMENTATION AND
EVALUATION

PHARMACY

DESIGNING AND
IMPLEMENTING EFFECTIVE
PHARMACY MANAGEMENT
PROGRAMS

ACTUARIAL

DEVELOPING, REVIEWING AND
SETTING RATES, FINANCIAL
AND ACTUARIAL ANALYSES



INFORMATICS

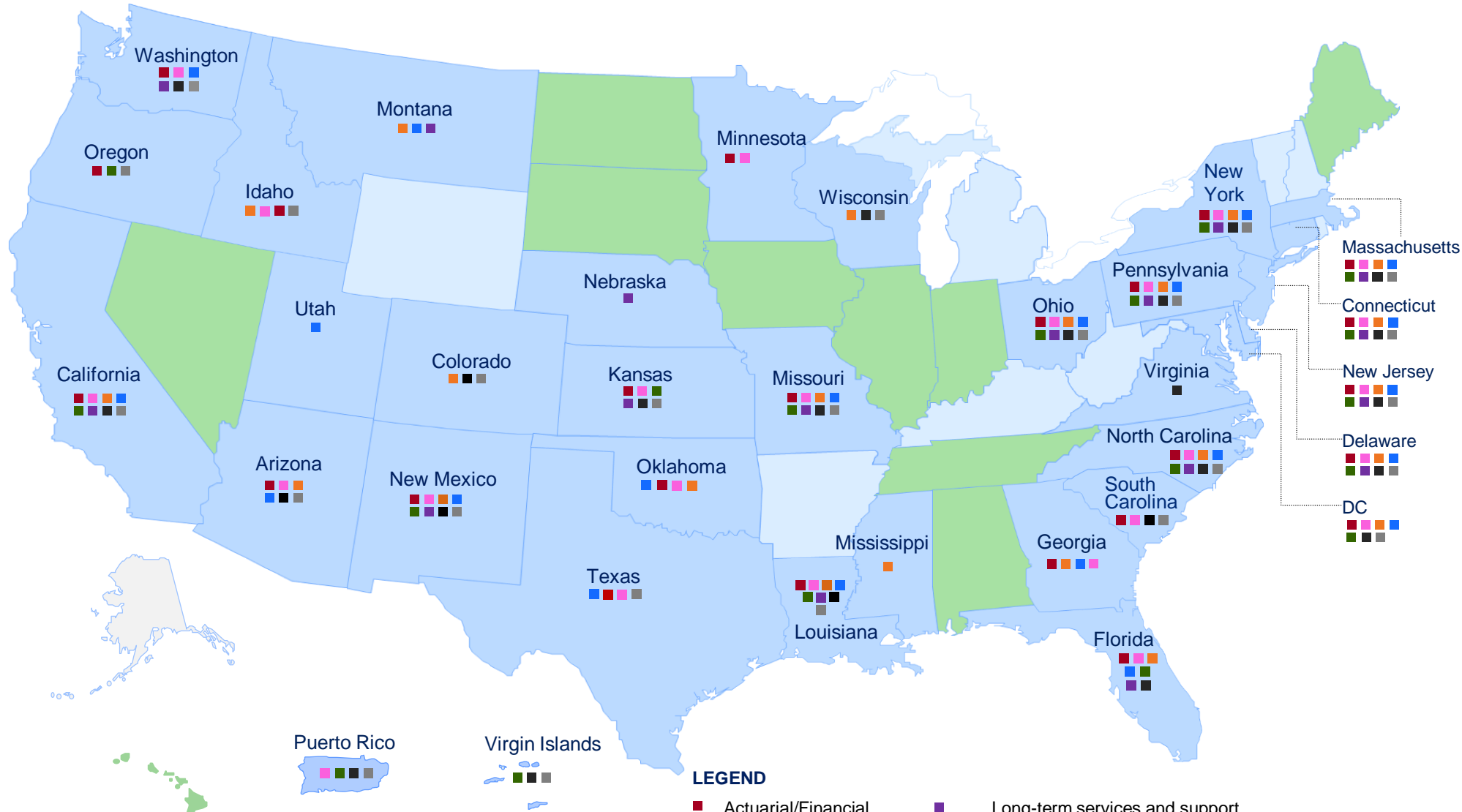
INTERPRETATION AND EVALUATION
CLAIMS AND ENCOUNTER DATA, ANALYSIS
AND ENHANCEMENT

POLICY & OPERATIONS

STRATEGIZE AND NAVIGATE FEDERAL
RULES TO ACCOMPLISH POLICY,
FINANCIAL AND OPERATIONAL GOALS

Our holistic approach provides a unique perspective and creative solutions for our clients

MERCER GHSC CLIENTS



LEGEND

- Actuarial/Financial
- Long-term services and support
- Clinical/Behavioral
- Policy
- Pharmacy
- Other
- Informatics
- Blue States — Current client
- HR/Uninsured
- Green States — Past client

INTERESTED IN THIS TOPIC — WHO? WHY?

STATES LOOKING TO
NAVIGATE 1915(C)
HCBS WAIVER
SUBMISSION PROCESS

PROVIDERS LOOKING
TO GROW, EXPAND,
EVOLVE THEIR
BUSINESS

STATES LOOKING TO
ALIGN PAYMENT WITH
PROGRAMMATIC
OUTCOMES

INDIVIDUALS AND
FAMILIES DESIRING
FLEXIBILITY AND
ACCESS TO NEEDED
SERVICES

CMS COMMUNICATIONS AND TRAINING

HCBS RATE SETTING IS EVOLVING IN 2016

*“RATE METHODOLOGY IN A
FFS HCBS STRUCTURE,
FEBRUARY 2016”*
PRESENTED IN MARCH 2016

*“FEE SCHEDULE HCBS
RATE SETTING”*
PRESENTED IN JULY 2016



KEY TAKEAWAYS

ALLOWABLE RATE SETTING
METHODOLOGIES PRESENTED

EXPECTATIONS OUTLINED FOR
1915(C) APPENDIX I-2A

EXPECTATION THAT FEE SCHEDULES
BE UPDATED EACH WAIVER RENEWAL

EXPECTATION THAT CRITERIA BE
DEVELOPED THAT ALLOWS FOR AN
ANNUAL REVIEW OF THE FEES

TERMINOLOGY

FEE SCHEDULE

NEGOTIATED MARKET PRICE

TIERED RATES

BUNDLED RATES

COST RECONCILIATION

OUTCOMES-BASED PAYMENTS

MILESTONE-BASED PAYMENTS

SALARY/WAGES

EMPLOYEE RELATED EXPENSE/BENEFITS

PRODUCT COSTS

GEOGRAPHIC CONSIDERATIONS

FULL-TIME VERSUS PART-TIME STAFF



EFFICIENCY, ECONOMY & QUALITY OF CARE

PROSPECTIVE

RETROSPECTIVE

ACUITY AND LEVEL OF CARE

BASE DATA

DIRECT CARE STAFF, DIRECT CARE HOURS

NON-DIRECT (INDIRECT) CARE STAFF, HOURS

ADMINISTRATIVE, OVERHEAD AND OPERATIONAL EXPENSES

STAFFING RATIOS

COST OF LIVING

ASSESSMENT TOOLS

CMS RATE-SETTING METHODS



- Fee Schedule



- Tiered Rates



- Cost Reconciliation



- Negotiated Market Price



- Bundled Rates



- Outcomes/Milestone – Based Payments

FEE SCHEDULE DEVELOPMENT MARKET-BASED METHODOLOGY

AN INTRODUCTION

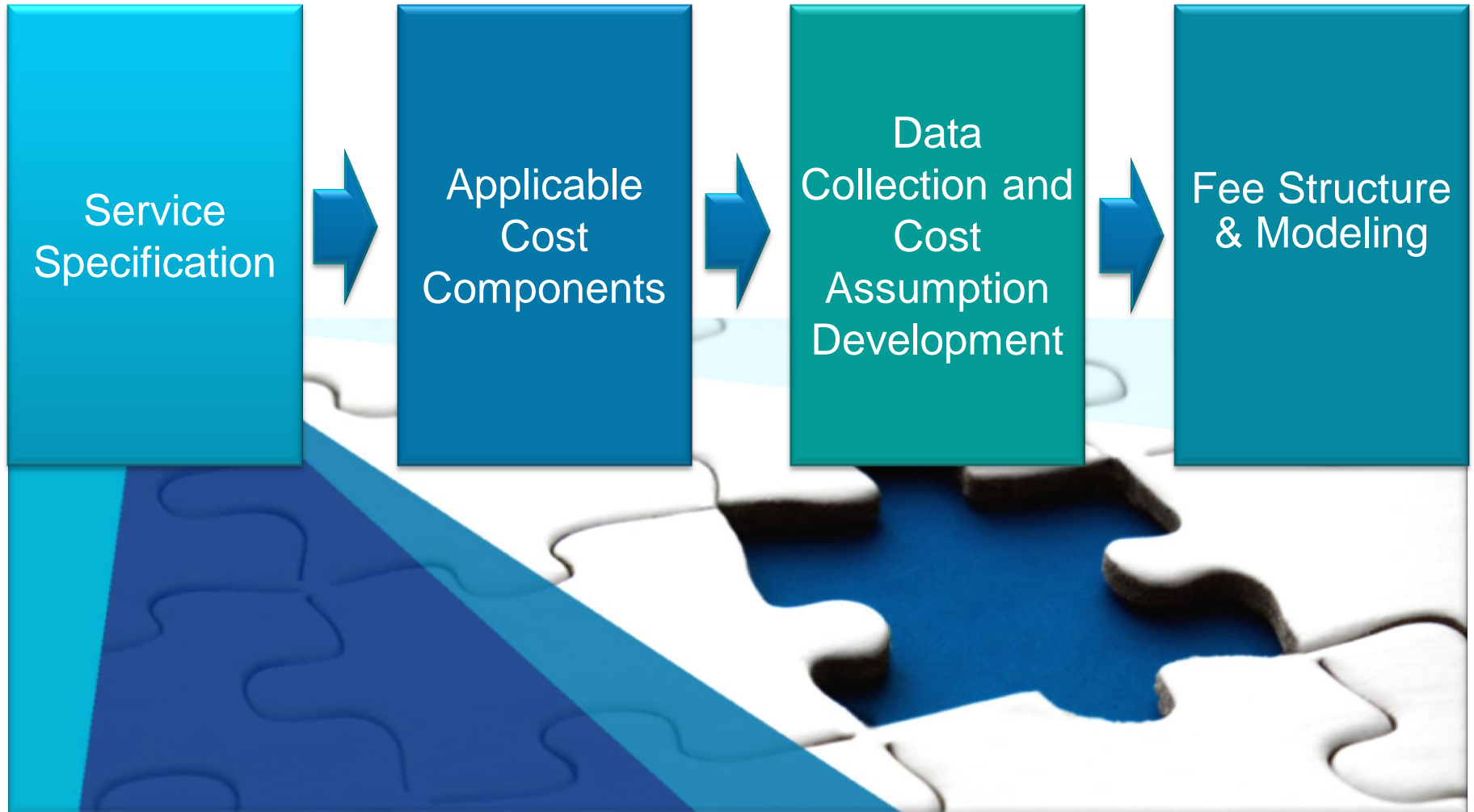
FEES ARE BUILT
USING
ASSUMPTIONS THAT
ARE REASONABLE
AND NECESSARY
TO DELIVER A
SERVICE

FEES VARY BY
INDIVIDUAL
CHARACTERISTICS
SUCH AS
GEOGRAPHY

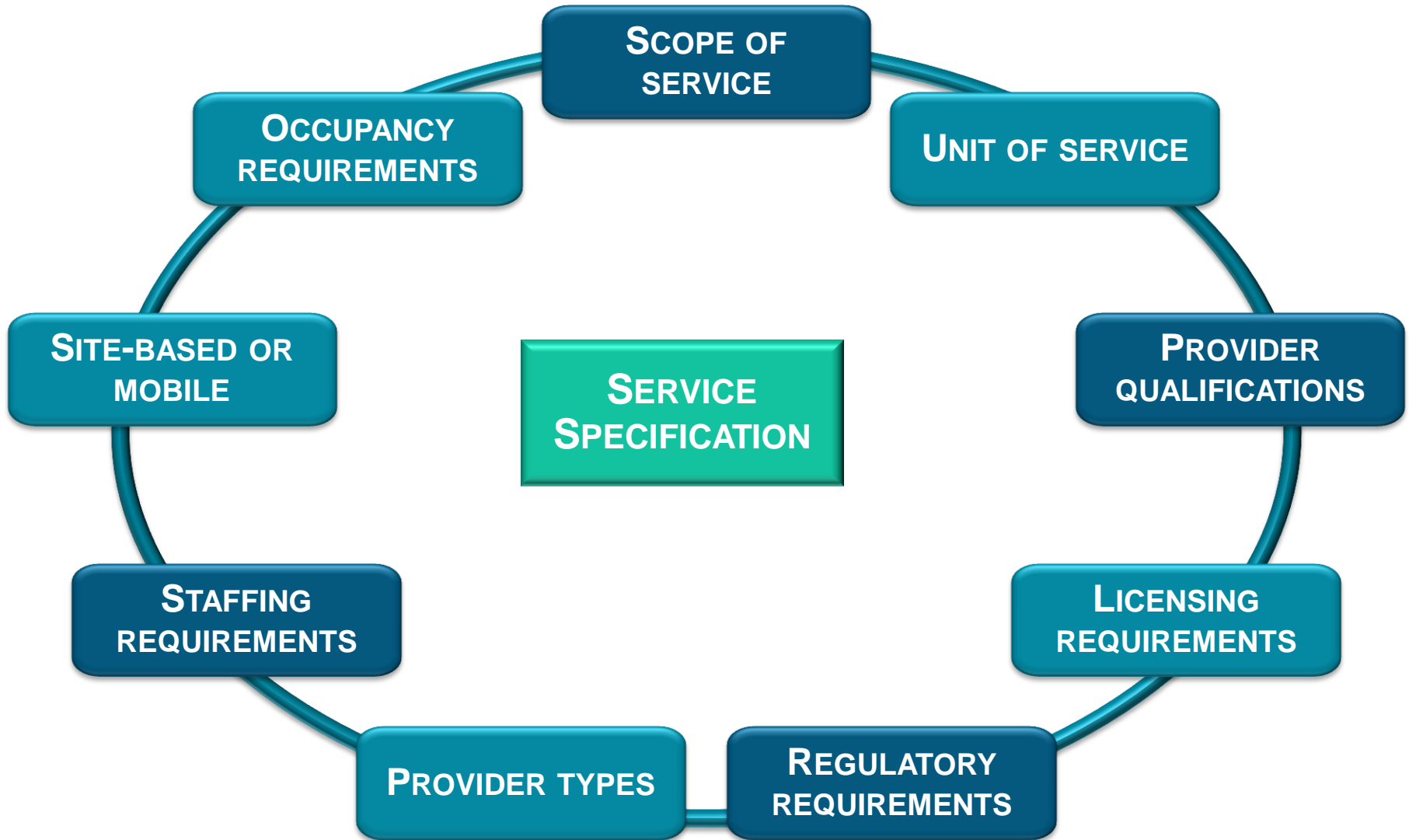
FEE SCHEDULE
MUST SUPPORT
AND ALIGN
MULTIPLE GOALS
ACROSS ALL
STAKEHOLDERS

FEES UNDER A
TIERED METHOD
MAY ALSO VARY BY
A PERSON'S
SUPPORT NEEDS

FEE SCHEDULE DEVELOPMENT MARKET-BASED METHODOLOGY



FEE SCHEDULE DEVELOPMENT MARKET-BASED METHODOLOGY



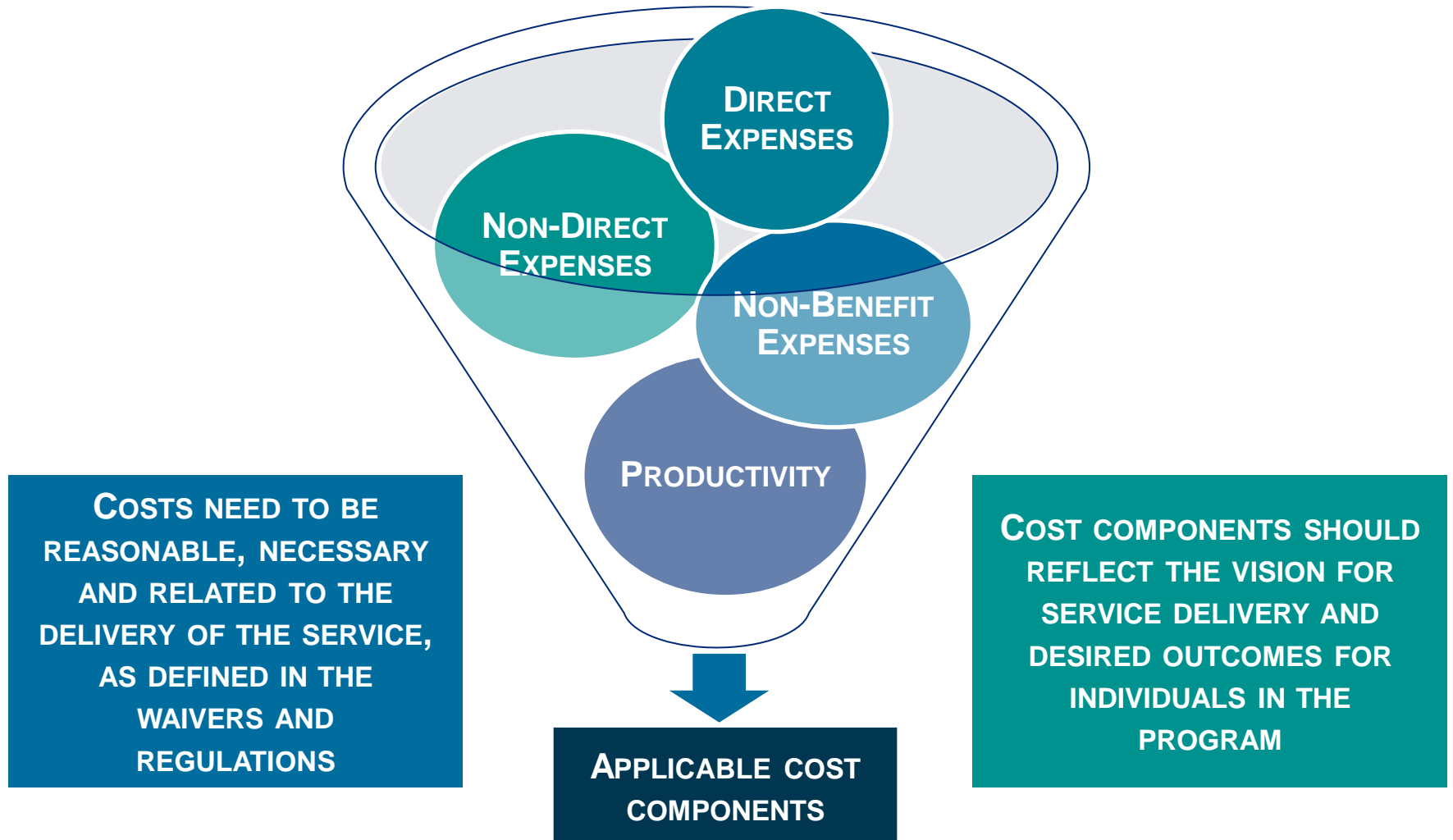
FEE SCHEDULE DEVELOPMENT MARKET-BASED METHODOLOGY

Service Specification	
Service Title:	Day Habilitation
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Day Habilitation assists participants in acquiring, retaining and improving self help, domestic, socialization, communication, self care, fine and gross motor skills, mobility, personal adjustment, relationship development and use of community resources and adaptive skills necessary to reside successfully in home and community-based settings, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. This service includes activities to improve the participant's capacity to perform activities of daily living (e.g., bathing, dressing, eating, mobility and using the toilet) and instrumental activities of daily living (e.g., communication, survival skills, cooking, housework, shopping, money management, time management and use of Transportation). Day Habilitation takes place in a licensed, non-residential setting separate from the participant's private residence or other residential living arrangement. This service is not provided in the participant's private home...</p> <p>Day Habilitation services provide waiver participants comprehensive day programming to acquire more independent functioning and improved cognition, communication and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice, as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the participant's service plan. The frequency and duration of this service are based upon the participant's needs as identified through an assessment and documented in the service plan.</p>	

FEE SCHEDULE DEVELOPMENT MARKET-BASED METHODOLOGY

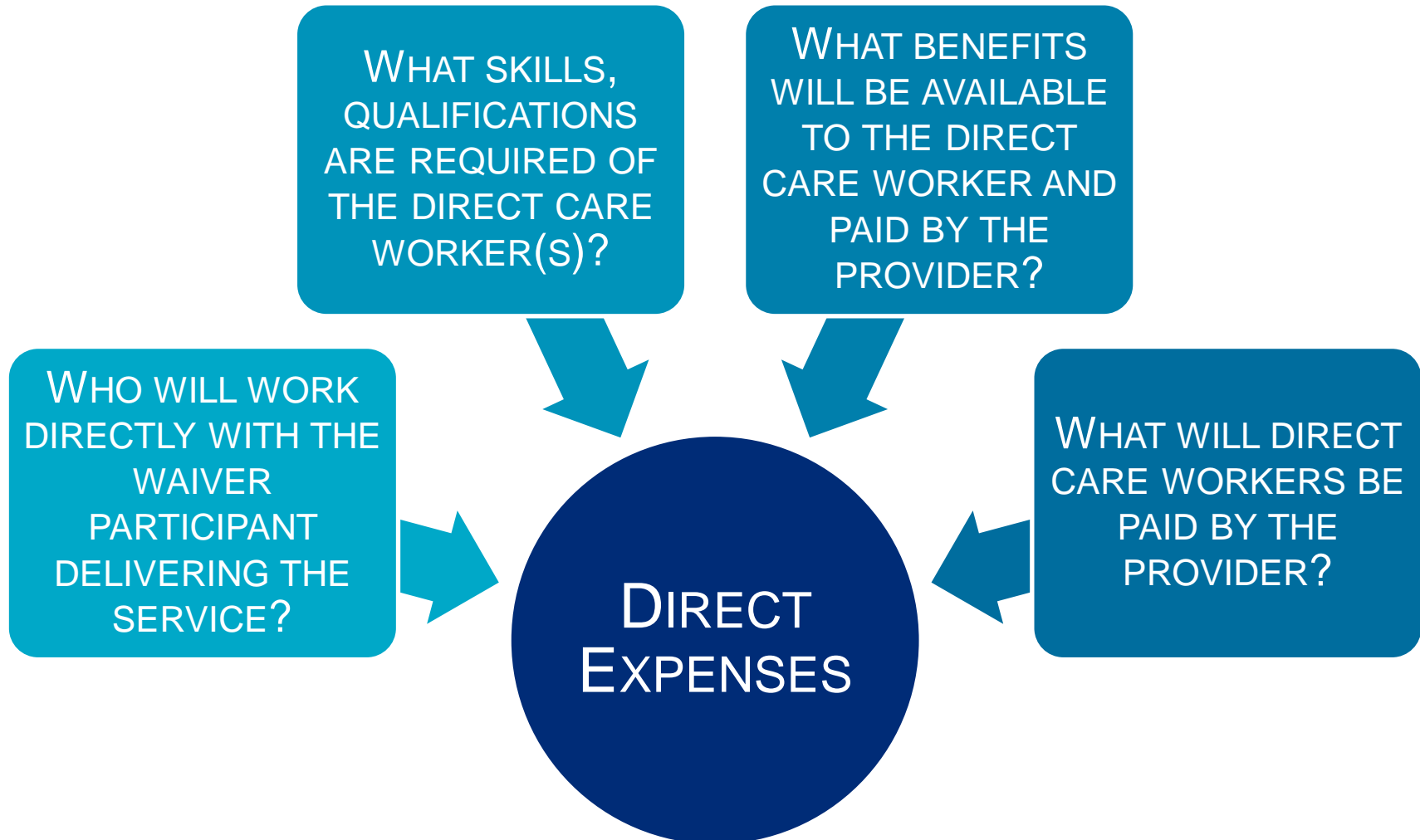
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Adult Training Facilities (Specific facility types)
			Structured Day Habilitation Provider
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Structured Day Habilitation Provider		By July 1, those providing structured day services must achieve CARF Brain Injury Home and Community Services (Adult) accreditation	<ul style="list-style-type: none"> • Agencies must have: <ul style="list-style-type: none"> — A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency, per Code, Chapter — Commercial General Liability insurance — Professional Liability Errors and Omissions insurance — Worker's Compensation insurance, when required by statute — Necessary staff, to include independent education instructors, speech therapists, physical therapists, occupational therapists, behavior therapists or other staff to meet participant needs as outlined in the participant's service plan

FEE SCHEDULE DEVELOPMENT MARKET-BASED METHODOLOGY



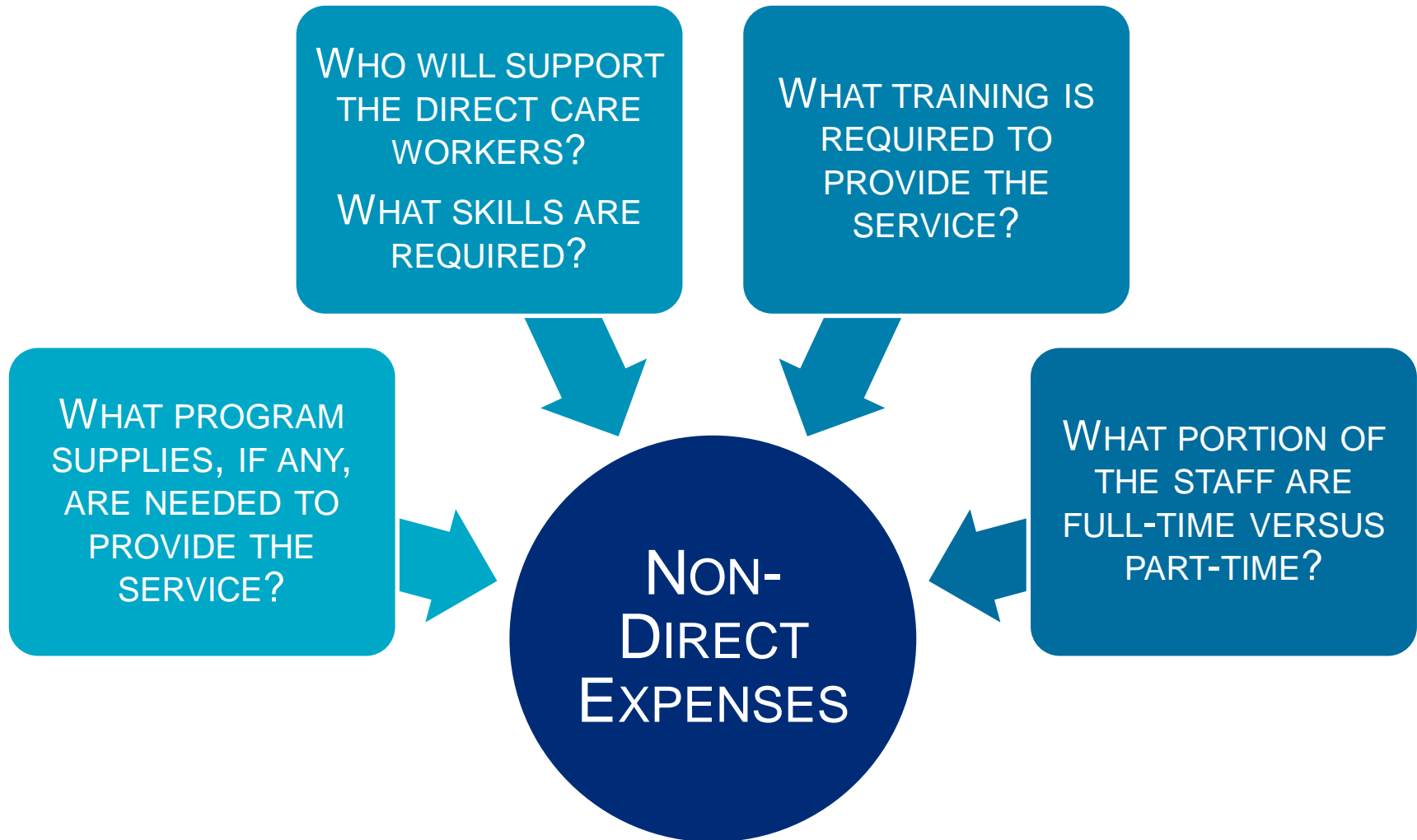
APPLICABLE COST COMPONENTS

DIRECT EXPENSES



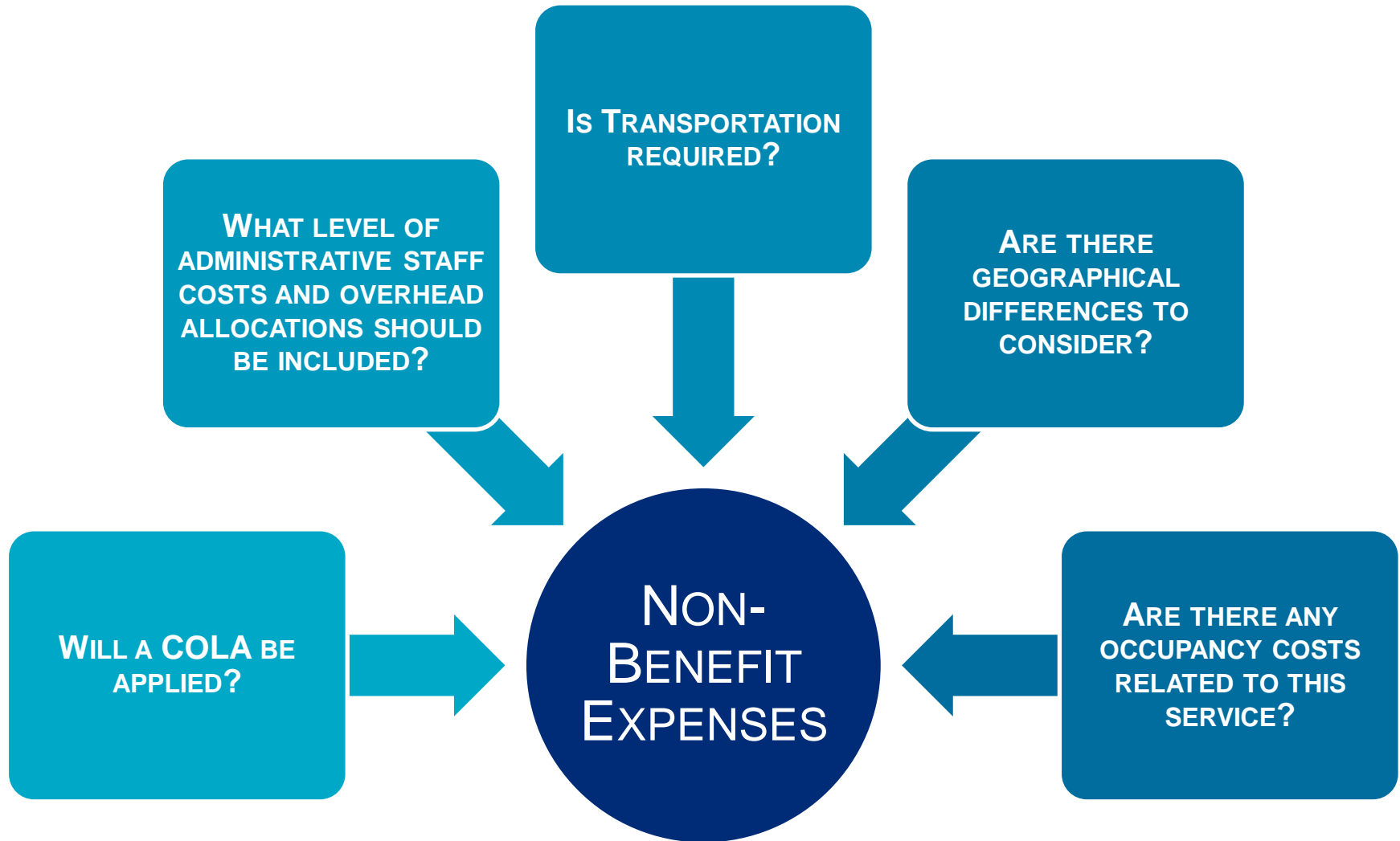
APPLICABLE COST COMPONENTS

NON-DIRECT EXPENSES & PRODUCTIVITY



APPLICABLE COST COMPONENTS

NON-BENEFIT EXPENSES



DATA COLLECTION AND COST ASSUMPTION DEVELOPMENT

ASSUMPTIONS NEED TO BE DEVELOPED TO “PRICE” EACH COST COMPONENT

MARKET-BASED RESEARCH IS COMPILED AND DATA ANALYSIS PERFORMED TO DETERMINE REASONABLE EXPENSES FOR EACH COST COMPONENT

MARKET-BASED RESEARCH AND ANALYSIS MAY ALSO BE USED TO DEVELOP ASSUMPTIONS FOR OTHER COST COMPONENTS SUCH AS STAFF TRAINING AND COST OF LIVING CONSIDERATIONS



EXAMPLES

STATE-SPECIFIC WAGE DATA FROM THE US BUREAU OF LABOR STATISTICS MAY BE USED TO DEVELOP WAGE RANGES FOR DIRECT CARE AND OTHER PROGRAM STAFF BY SERVICE

MARKET RESEARCH DATA, ALONG WITH STATE AND FEDERAL REQUIREMENTS, MAY BE USED TO ESTABLISH ASSUMPTIONS FOR EMPLOYER-PAID BENEFITS AND TAXES

DATA COLLECTION AND COST ASSUMPTION DEVELOPMENT

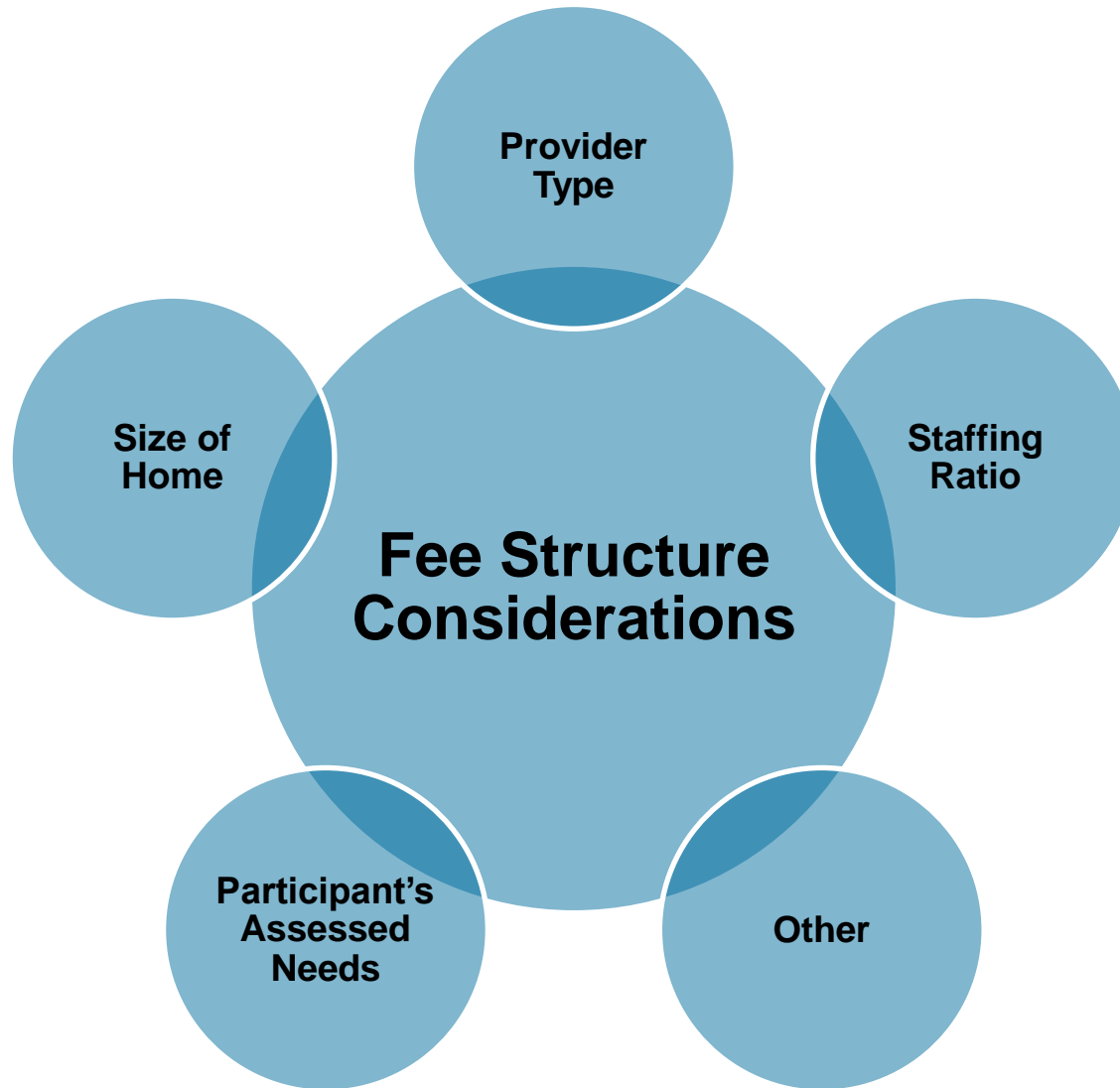
Market data may not be available for other components

- State experience may be utilized to establish assumptions in these instances
- Provider surveys may be conducted to inform cost assumptions

Federal considerations of regulatory and policy changes on the development of the fees may be necessary

- DOL ruling on application of FLSA to domestic care workers
- DOL proposed Threshold rule regarding exempt employee salary requirements
- Recent CMS guidance and training regarding the fee development process

FEE STRUCTURE & MODELING



SERVICE COMPONENT COMPARISON

SERVICE



Where is it delivered?

What is the unit(s) of service?

Who delivers the service?

When is it available?

Occupancy costs

COMPANION



In-home or community

15 min., hour

Direct care worker (DC)
(1:1)

8 hours/day or weekly
limit

None/limited

DAY ACTIVITY



Facility or community

15 min., half day

DC (staffing ratios) and
non-DC

4–8 hours/day or weekly
limit

Facility-based/ licensure
requirements

RESIDENTIAL HABILITATION



Provider-owned setting

Per diem (24 hours)

DC and non-DC (staff
time and staffing ratios)

24 hours, on call

Licensing requirements,
but room and board
must be excluded

LESSONS LEARNED

Fee schedule development is more than a financial exercise; involves state program, policy and fiscal staff

Fee schedule development may lead to service specification revisions

The state will select the assumptions they believe are most reflective of service delivery expectations

A fee schedule should reflect a reasonable total cost of service delivery. Every assumption used to develop the fee will not align exactly for any one provider

States will need to consider engagement with CMS and other stakeholders throughout the process

QUESTIONS



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