HCBS PROVIDER FEE DEVELOPMENT
MARKET-BASED APPROACH

August 30, 2016

Presenters
Deidra Abbott, MPA
Misti Beckman
Robert Karsten, ASA, MAAA

Mercer Government Human Services Consulting
Atlanta, Minneapolis, Phoenix and Washington, DC
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

How did you respond?

Has your fee schedule been updated in the past 5 years?

How many fee methodologies do you currently utilize?

Was the information required to respond readily available and sufficient to address all questions?

What impact did it have?

Did the questions result in an unanticipated delay in approval?

How will this level of questioning influence your future fee development and waiver submission process?
1915(c) HCBS Waiver Submission and Review

More Rigorous Review Process

Guidance continues to evolve

1915(c) HCBS Waiver Renewal and/or Amendment Submissions Ongoing

Impacts Waiver Approval Process

Presents Challenges for States
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

© 2016 MERCER LLC
**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.
MERGER 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
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**
### 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**

### 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
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

1. Service Specification
2. Applicable Cost Components
3. Data Collection and Cost Assumption Development
4. Fee Structure & Modeling
**Fee Schedule Development Market-Based Methodology**

- **Scope of Service**
- **Unit of Service**
- **Provider Qualifications**
- **Licensing Requirements**
- **Provider Types**
- **Regulatory Requirements**
- **Staffing Requirements**
- **Occupancy Requirements**

**Service Specification**

**Site-based or Mobile**

© 2016 MERCER LLC
Fee Schedule Development
Market-Based Methodology

Service Specification

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Day Habilitation</th>
</tr>
</thead>
</table>

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- [ ] Service is included in approved waiver. There is no change in service specifications.
- [ ] Service is included in approved waiver. The service specifications have been modified.
- [ ] Service is not included in the approved waiver.

Service Definition (Scope):

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...

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.
# Fee Schedule Development

## Market-Based Methodology

### Provider Specifications

<table>
<thead>
<tr>
<th>Provider Category(s) (check one or both):</th>
<th>Individual. List types:</th>
<th>Agency. List the types of agencies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>X</td>
</tr>
<tr>
<td>Adult Training Facilities (Specific facility types)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured Day Habilitation Provider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify whether the service may be provided by (check each that applies):

- □ Legally Responsible Person
- □ Relative/Legal Guardian

### Provider Qualifications (provide the following information for each type of provider):

<table>
<thead>
<tr>
<th>Provider Type:</th>
<th>License (specify)</th>
<th>Certificate (specify)</th>
<th>Other Standard (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured Day Habilitation Provider</td>
<td>By July 1, those providing structured day services must achieve CARF Brain Injury Home and Community Services (Adult) accreditation</td>
<td></td>
<td>• Agencies must have:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency, per Code, Chapter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Commercial General Liability insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Professional Liability Errors and Omissions insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Worker’s Compensation insurance, when required by statute</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– 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</td>
</tr>
</tbody>
</table>
Costs need to be reasonable, necessary and related to the delivery of the service, as defined in the waivers and regulations.

Cost components should reflect the vision for service delivery and desired outcomes for individuals in the program.

Applicable cost components:

- Direct expenses
- Non-direct expenses
- Non-benefit expenses
- Productivity
**A P P L I C A B L E  C O S T  C O M P O N E N T S**

**D I R E C T  E X P E N S E S**

- **What skills, qualifications are required of the direct care worker(s)?**
- **What benefits will be available to the direct care worker and paid by the provider?**
- **Who will work directly with the waiver participant delivering the service?**
- **What will direct care workers be paid by the provider?**

**Direct Expenses**
APPLICABLE COST COMPONENTS
NON-DIRECT EXPENSES & PRODUCTIVITY

- Who will support the direct care workers?
- What skills are required?
- What program supplies, if any, are needed to provide the service?
- What training is required to provide the service?
- What portion of the staff are full-time versus part-time?

NON-DIRECT EXPENSES
APPLICABLE COST COMPONENTS
NON-BENEFIT EXPENSES

- Will a COLA be applied?
- What level of administrative staff costs and overhead allocations should be included?
- Is transportation required?
- Are there geographical differences to consider?
- Are there any occupancy costs related to this service?
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.
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

## Fee Structure Considerations

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Staffing Ratio</th>
<th>Size of Home</th>
<th>Participant’s Assessed Needs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
CONTACTS

• Deidra Abbott, Principal
deidra.abbott@mercer.com

• Misti Beckman, Partner
misti.beckman@mercer.com

• Bob Karsten, Senior Associate
robert.karsten@mercer.com