ESTABLISHMENT
OF A RATE-SETTING METHODOLOGY
FOR HOME AND COMMUNITY-BASED SERVICES
IN ALASKA

Recommendations for a Rate Methodology

Prepared for the
Alaska Department of Health and Social Services
Division of Senior and Disabilities Services

Prepared by
Myers and Stauffer LC
Certified Public Accountants
4123 SW Gage Center Dr., Suite 200
Topeka, Kansas 66604

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I. Table of Contents

II. Executive Summary

Background and Project Overview

The Alaska Department of Health and Social Services (DHSS) is in the process of reviewing the reimbursement methodology for home and community based (HCB) services provided under Medicaid waiver programs. Myers and Stauffer has been engaged by DHSS to perform research of HCB reimbursement methodologies and provide recommendations for revisions to the current HCB rate setting process. In a previous report, Myers and Stauffer presented preliminary research on methods used by DHSS to calculate rates for all providers reimbursed for services funded through the Medicaid program and other public assistance programs. The report also reviewed findings and recommendations presented by other consultants previously hired by DHSS and compared the HCB reimbursement methodologies in six other states. The current report is intended to build upon the preliminary research as well as information obtained during meetings with DHSS staff and provider organizations. This report presents an overview of possible rate methodologies and proposes three recommendations for the reimbursement of HCB services. A future report from Myers and Stauffer will present a transition and implementation plan for the reimbursement methodology selected by DHSS.

Overview of Rate Methodologies

There are a wide variety of strategies that state Medicaid programs can use to design their rate setting methodologies. Some rates are provider-independent and are not directly linked to the costs incurred by a specific provider to render services. Perhaps the simplest form of provider-independent rates are flat rates, based on a simple budget-driven approach of dividing available funding by expected service utilization to calculate a rate. Another form of provider independent rates are prices, which may be loosely linked to provider costs via analysis of actual provider cost data or through the process of modeling the cost inputs for a hypothetical provider. Provider-dependent rates are linked to the historical or projected costs of the specific provider for which a rate is being set. Provider-dependent rates can be retrospective, in which an interim rate is paid based on cost estimates, but is later settled to actual historical costs incurred by the provider. Alternately provider-dependent rates can be prospective, in which rates are established and paid without a subsequent settlement to the provider's actual cost experience. Prospective rates are typically established using past costs trended forward.

Each of these reimbursement methodologies comes with its own set of advantages and disadvantages. Provider independent price-based systems potentially can encourage provider efficiency, but tend not to reward providers for the provision of specialized services. Retrospective provider dependent systems tend to be highly inflationary and are currently falling out of favor with governmental payers. For most reimbursement methodologies, cycles of rate-rebasing and inflation adjustments should be established to occur at appropriate, regular and consistent intervals in order to best maintain a proper balance between rates and provider cost while maintaining incentives for provider efficiency.

The current reimbursement methodologies used by DHSS for HCB services include both provider-independent rates and provider-dependent rates. Services provided by HCB agencies are reimbursed according to rates that have a basis in projected agency costs and are provider-dependent. Rates for personal care agencies, assisted living homes and care coordinators are a combination of flat rate and price systems, but are primarily provider-independent.

All HCB providers have been subject to a "rate freeze" since 2004. In addition to restricting escalation of HCB rates, aggregation of historical state expenditure data to determine the freeze rates has blurred the historical origins and cost basis that the rates once had. Both DHSS staff and provider stakeholders have expressed concerns with the current HCB rate structure and the rate freeze.

Recommendations for an HCB Rate Methodology

After reviewing the current rate methodologies used by DHSS and evaluating stakeholder concerns regarding reimbursement methodologies, Myers and Stauffer has opted to provide three recommendations in the form of a primary recommendation with two additional variations that supplement the primary recommendation. The primary recommendation includes components that are essential to all three recommendations; the second and third recommendations, though independent of each other, are both predicated on the primary recommendation.

The primary recommendation is a pricing methodology implemented statewide with prices derived from a periodic survey of historical costs incurred by providers of HCB services. The second recommendation is to differentiate the pricing methodology by provider peer groups that accommodate valid and predictable cost differentials. The third recommendation adds regionalization of prices.

Myers and Stauffer's recommendation is coupled with recognition of the need for DHSS to have data on the cost of providing HCB services. Recent and accurate cost data should be available before final decisions can be made regarding the precise methodology for determining prices. Accordingly, the key decision presently before DHSS is whether to proceed with the implementation of an HCB cost survey. Many of the details relating to rate setting would be decided after cost data has been collected and analyzed. This includes the decision of whether or not the use of peer groups or regionalized rates are feasible. After completion of the initial HCB cost survey, DHSS will have access to the cost data needed to develop the rate calculation algorithms and to formalize the processes that will be used in future cost surveys to set rates.

Although a price-based system is relatively straightforward, implementation of a periodic survey will require several important implementation steps. These include developing a survey instrument, completion standards, cost finding methodologies, survey distribution procedures, review procedures and analytical procedures. The interval for future survey cycles will need to be set and appropriate inflation factors determined to escalate rates between surveys for interim years.

Myers and Stauffer has also considered two additional potential components of a rate-setting methodology and determined them to be admirable long-term goals for DHSS to consider as part of a reimbursement methodology. These components are rate adjustments based on acuity and quality. However, due to the complexity of incorporating these components into the proposed pricing methodology, it is recommended that these components be deferred as potential future enhancements. These components, although discussed in the report, are not formally part of Myers and Stauffer's recommendations for an HCB rate-setting methodology.

The process to implement an HCB cost survey, analyze the data from the first survey and subsequently finalize the rate-setting methodology will require a transition period of one or more years. For the interim period, however HCB providers have requested relief from the current rate freeze. There have been some indications that DHSS may be seeking legislative appropriations that may be able to provide some additional funding.

Although it would be ideal to apportion any additional funds received according to an improved HCB reimbursement methodology, it would be prudent to take advantage of available appropriations to address immediate rate needs. Additional funds available for HCB providers could be apportioned according to simple methodologies during the interim period while plans for a new HCB reimbursement methodology are implemented. Funds can be apportioned according to several possible strategies, including an across the board percentage increase to the current "freeze" rates (with the percentage determined by an analysis of utilization rates and available funding), or strategies that increase funding the most for providers whose rates have been "frozen" the longest or establish benchmarks for current provider rates (e.g., the median rate for each service code) that give the greatest amount of increase to those providers with reimbursement rates below an established benchmark.

Future Steps

The HCB rate-setting methodology recommendations in this report are being presented to DHSS for further review and discussion. As needed, the Myers and Stauffer project team will be available to answer DHSS' questions regarding the recommendations or to discuss any rate-setting concepts that were not recommended. Myers and Stauffer will continue to advise and assist DHSS as it considers the adoption of a recommendation, including specific components and potential refinements or clarifications necessary to reflect the needs of DHSS. We will also participate in additional provider meetings, should DHSS wish to involve stakeholders further in the deliberation process.

Following DHSS determination on a new rate-setting approach, Myers and Stauffer will assist in the development of a transition plan. The transition plan will include a discussion of implementation issues such as recommendations for changes to regulations and applicable timelines. We will also advise DHSS on next steps relating to any interim rate changes that may be considered prior to obtaining the results from the first HCB cost survey.

III. Introduction

1. Overview of the project

DHSS has expressed concerns regarding its current rate methodology for HCB services. These concerns led DHSS to engage Myers and Stauffer to review the current HCB rate methodology, to recommend alternative reimbursement methodologies and to develop a transition plan to implement a new reimbursement methodology.

In a previous report to DHSS, Myers and Stauffer presented preliminary research relating to the HCB reimbursement methodologies. The report included discussion of methodologies used by DHSS for rate determination for the wide variety of provider types that receive reimbursement under the Medicaid program or other public assistance programs administered by DHSS. The report also presented an analysis of findings and recommendations presented to DHSS by other consultants in recent years. Finally, the report included a comparison of HCB reimbursement methodologies in six other states.

There are several concerns regarding the current rate methodology for HCB services that prompted this rate methodology development project. In many ways, the current HCB rate methodology is a legacy of the state grant funding mechanisms that once accounted for nearly all financing for HCB services. This system has become outdated as the majority of funding for HCB services has been shifted to Medicaid waiver programs. Furthermore, HCB services have operated under a "rate freeze" since 2004. The rate freeze has effectively aggregated historical claims expenditure data to set rates that continue the average per-unit levels of reimbursement at each HCB provider.

Where appropriate, DHSS wishes to develop a more uniform approach to reimbursement of HCB services. A major objective of the project is to develop at least three different methodologies that would enable DHSS staff to set rates for HCB agencies, assisted living homes, personal care agencies and other related provider types.

2. Overview of rate setting methodologies

States have considerable latitude in the methods used to reimburse for HCB services and may use different methods for different services. To better understand the variety of rate-setting methodologies that are available, Myers and Stauffer's recommendations for an HCB rate methodology will be prefaced by a high-level overview of potential rate setting methodologies. It may prove helpful to place the current Alaska Medicaid HCB reimbursement methodology within that context of potential rate-setting methodologies. It will then become more clear how the methodologies proposed by Myers and Stauffer differ from the current methodology.

Definition of terms

In early discussions with DHSS and provider associations, it became evident to Myers and Stauffer that certain terms were being used to describe differing reimbursement concepts. To assist in reading

this report and evaluating the recommendations, it may be helpful to establish definitions for several key terms that will be used throughout the report.

Retrospective reimbursement: Payment of an interim rate that is settled to actual costs at the end of a set period.

Prospective reimbursement: Payment of rates based on historical data or budget projections with no subsequent settlement to actual costs.

Flat rates: Rates established by dividing available budget dollars by case load projections or anticipated units of service.

Price-based: A standard price established for all providers within the state or peer group. The price determination may be linked to the actual cost experience of the effected provider group.

Cost-based: A provider-specific rate determined using the provider's own cost experience or budget projections.

Historical cost: Actual cost experience determined from a completed fiscal period.

Budgeted cost: Projected cost experience for a future fiscal period.

Peer groups: Providers with similar characteristics such as size, specialty, ownership (e.g., public or private) or location (rural or urban).

Projected Inflation factors: A factor used to project inflation that providers will experience during the rate period.

Rate setting Methodologies for Medicaid programs

One significant feature that determines prices in the health care services market is the presence of third-party payers such as insurance companies or government programs (e.g., Medicare or Medicaid) which pay part or all of the cost of services. Without the third party payers, consumers and providers would interact directly with each other to determine rates. Prices would be set where the demand curve of consumers' willingness and ability to purchase goods and services intersects the supply curve of providers' willingness to sell those goods and services.

For HCB services, Medicaid basically controls the market, making the rate methodology extremely important. As a result, the methodologies recommended for Alaska must take into consideration the issues of access to services, the native populations, the diverse needs of populations served, provider availability, the grouping of similar services, consistency and accountability. The methodologies should create incentives for cost containment and efficient delivery of quality services.

The process of developing a new reimbursement methodology is complex. It should be based on knowledge of the factors that affect reimbursement, a detailed analysis of current conditions, and a clear understanding of the state's goals and objectives.

Reimbursement system design is an accumulation of decisions regarding a number of policy options. Some of the choices are basic. For example, should the rates be provider-independent or provider-dependent? If independent, how should prices be established? If dependent, should they be retrospective with an interim rate or prospective based on a provider's prior costs trended forward? Other choices are more detailed. For example, if cost data is incorporated into the rate methodology, how should it be collected, aggregated and evaluated?

Provider-independent rates

Rates that are not based on a particular provider's costs are *provider-independent rates*. Both flat rate and pricing systems are provider-independent rates. In these systems, providers are reimbursed according to a set flat rate or an established price regardless of their individual cost experience.

Flat rate systems were fairly common in the early years of the Medicaid program. In this type of system, reimbursement rates are established by determining available dollars within the state budget for a particular service and dividing by a projection of case load or anticipated units of service.

Prices may be established in a variety of ways. Prices may be developed through the creation of a hypothetical provider and determining necessary inputs and market prices for those inputs. Prices can also be developed based on benchmarks, such as means, medians or percentiles of the cost experience of the provider group.

An advantage of these provider-independent methodologies is that they create incentives for providers to control costs. States are also better able to forecast future expenditures. However, these systems tend not to create incentives for providers to provide services beyond the industry norm. To ensure the delivery of quality care, prices must be set at levels that allow most providers to cover their costs, but not so high as to provide excessive profit. The State must be willing to permit providers flexibility in spending and the ability to keep a reasonable profit without excessive reporting requirements and controls.

Provider-dependent rates

A common feature of a *provider-dependent* rate system is that the reimbursement to each provider is linked in some way to its particular costs, whether projected or historical. There is considerable variability in the design of provider-dependent rates. Provider-dependent rates can either be retrospective or prospective in nature.

Retrospective systems establish an interim rate, using cost estimates, which will be used to make payments during the rate period. After the rate period ends and actual cost experience is determined, there is an adjustment made from interim rates to actual cost experience. Given the need to settle to

actual cost, it is important to closely estimate the actual cost experience in order to minimize the settlement amount. Interim rates can be established using either budget projections or historical costs of a prior period.

In calculating the settlement to actual costs, upper limits or ceilings may be imposed, requiring a settlement to the lower of the actual cost experience or the calculated upper limit. If limits are set too low, this system more closely resembles a pricing system. However, if limits are set reasonably, it should compensate providers for the provision of services beyond the industry norm.

One disadvantage is that these systems lack incentives to control costs and tend to be inflationary. This decreases the state agency's ability to control expenditures and predict future costs. In recent years, there has been a trend by both state and federal governments to move away from retrospective reimbursement systems.

Prospective systems typically use past costs trended forward to establish reimbursement rates. Budget projections or some combination of budgeted and historical costs can also be used. Whatever the basis for establishing rates, they are not settled to actual costs at the end of the rate period.

Prospective systems can also incorporate various upper limits or ceilings. For providers with costs below the upper limits, there may be efficiency incentives. Efficiency incentives generally involve the payment of some portion of the difference between an upper limit and actual costs below the limit. In addition to upper limits, these systems may incorporate lower limits or floors. If there is a floor, the provider would be paid its cost or the floor, whichever is greater.

The rates for most of these systems are based on cost reports submitted by the providers. The rate calculation uses allowable costs, as defined by the state, frequently divided into cost centers or cost components. Examples of typical cost centers include direct service costs, indirect costs and general and administrative costs.

Inflation and rebasing

Once set, rates are normally in place for a specified period of time. Following this pre-determined payment period, rates should be evaluated and potentially adjusted for inflation. Without rate increases to account for the impact of inflation, providers would need to reduce costs by the amount of inflation in order to maintain an even status. Some of the more widely used indices to determine the inflation adjustment include the Consumer Price Index or various "market basket" indices designed to measure changes in prices paid for a fixed bundle of goods and services that are cost inputs to a given segment of the health care industry.

Not only are there inflationary increases that impact the cost of providing services, but also methods of service delivery may change. It is important to periodically evaluate the reasonableness of rates and rebase rates as indicated. Several states have established a set rebasing schedule for specific

services, such as annually or every three years. Other states have set the maximum amount of time that can pass before rates are rebased, such as no less often than once every five years.

3. Overview of Alaska HCB program and current reimbursement methodology

The current reimbursement methodologies in Alaska vary based on provider type for the HCB services under the jurisdiction of DHSS. Providers have been significantly impacted by a "rate freeze" which is currently set to continue until July 1, 2008 per regulations at 7 AAC 43.1058(l).

In general, Alaska's current reimbursement methodology for HCB agencies would be categorized as provider-dependent, prospective rate setting. For other provider types such as assisted living homes, personal care agencies and care coordinators, the rates are provider-independent.

A wide variety of HCB services are provided by HCB agency provider types. These services include:

- Chore services
- Adult day services
- Day habilitation services
- Residential habilitation services
- Supported employment services
- Intensive active treatment services
- Respite care services
- Transportation services
- Meal services

Prior to the current rate freeze, a cost-based reimbursement methodology was used for these services. Regulations at 7 AAC 43.1058 define a cost-based reimbursement methodology based on allowable direct service costs and allowable administrative and general costs. Providers submitted proposed budgets for each fiscal year that calculated cost rates. Rates for specific services to recipients were negotiated by agencies, case managers and DHSS on a per-recipient and per-procedure code basis for each agency.

Although a cost reporting system had been established for HCB agencies, the collection of cost data has effectively ceased with the advent of the rate freeze. Prior to the rate freeze, cost data was collected from providers to set initial rates for a provider and to rebase rates at subsequent intervals.

Under the current rate freeze, providers have had the option to participate in an aggregate rate agreement. The aggregate rate is set at the average cost-based rate for all recipients as derived from historical claims data. The aggregate rates for an agency are calculated on a per procedure code basis

and are the same for all recipients. If providers do not participate in the aggregate rate agreement, they receive the lesser of the aggregate rates or the rates derived from the individual budget amount approved for a specific recipient.

With the rate freeze, procedures are also in place to set rates for new providers or existent providers that begin to operate in a new region of the state. Additional policies set reimbursement rates in the case that a recipient transfers from one agency to another. Under the rate freeze, these rates are still based on aggregated historical expenditure data derived from an analysis of claims history, but there are limitations to allow for the lesser of multiple applicable rates to be used. Procedures are also in place to make exceptions to the rate freeze based on documentation of extraordinary circumstances meeting the criteria at 7 AAC 43.1058(r).

Rates for specialized private duty nursing services and specialized medical equipment regulations are also in place for persons receiving HCB waiver services.

Another significant provider type in the HCB system is assisted living homes providing residential supported living (RSL) services. Similar to HCB agencies, these RSL providers received cost-based reimbursement prior to the implementation of the current rate freeze. Prior to the rate freeze, RSL providers submitted cost reports for the determination of initial rates and at subsequent intervals. Cost data was reviewed and new cost-based facility rates were set periodically. Under the current rate freeze, provider cost data has not been regularly collected from most providers.

Under the rate freeze, rates for RSL services are based on daily service rates established at 7 AAC 43.1058(h). The base rates vary depending on the number of residents in the facility and whether 24-hour awake staff is provided (the base rate categories are commonly referenced as "Adult Foster Care", "Adult Residential I" and "Adult Residential II"). The rates are adjusted for several factors including:

1) A decrease to the rate if the recipient also receives adult day care services.

2) An increase to the rate if the recipient's needs warrant hiring additional staff.

3) An adjustment based on the region in which the provider is located to reflect regional differences in the cost of doing business defined at 7 AAC 43.1058(h)(6).

4) An increase to the rate of $8.65 per day as defined at 7 AAC 43.1058(h)(7).

5) An adjustment for a cost of living percentage increase (subject to the availability of appropriations).

Environmental modification (EM) services are reimbursed at billed charges with a per recipient limit of $10,000 for a 36-month period. EM services are contracted via a procurement process.

Care coordinators perform screenings, assessments, plan of care development and on-going care coordination. Reimbursement for these services is currently defined in a fee schedule included in the care coordination section of the Alaska Medicaid Provider Billing Manual.

Personal care agencies provide personal care services through either an agency or consumer-directed model. Regardless of the service delivery model used, services are reimbursed at the maximum allowable rate of $21 per hour set directly by regulation (7 AAC 43.790). The personal care agency section of the Alaska Medicaid Provider Billing Manual also defines a daily rate of $200 per day.

There are also certain non-Medicaid services funded through DHSS including assisted living homes general relief and grant services. Although these services are distinct from their Medicaid counterparts (due to the nature of the services, Medicaid eligibility requirements or the waiting list for the MR/DD waiver), it is important to understand their interaction with HCB services reimbursed through Medicaid funding. In many cases, there is a significant overlap between the providers and recipients involved with both the Medicaid and non-Medicaid funding sources.

4. Overview of general concerns and provider meetings

In addition to meetings with DHSS staff, Myers and Stauffer participated in meetings with several provider groups, including the Alaska Association on Developmental Disabilities, the PCA Provider's Association, the Assisted Living Association of Alaska and AgeNet. Several concerns regarding the current HCB reimbursement methodology were discussed in these meetings as well as expectations for a revised reimbursement methodology. The current rate-freeze and the prolonged period of time during which the freeze has been in effect was universally considered to be detrimental to HCB providers. Furthermore, providers are concerned that certain rate differentials that developed in the past may not be justified by actual differences in the cost of providing services.

Providers overwhelmingly endorsed a rate methodology in which providers' actual costs were a factor in the determination of rates. Ideal models for setting rates included a system with rates determined from provider cost which were then adjusted annually by an inflation factor. Methods to adjust rates for acuity and geographic location were generally considered positive refinements for a rate methodology. However, there was also a significant desire expressed by both DHSS staff and provider stakeholders that a rate system be simple and not excessively burdensome to providers or DHSS staff.

IV. Recommendations

Myers and Stauffer has been tasked with providing DHSS with three recommendations relating to the establishment of a rate-setting methodology for home and community based (HCB) services. After reviewing the current rate methodology used by DHSS and evaluating stakeholder concerns regarding reimbursement methodologies, Myers and Stauffer has opted to provide a primary recommendation with two additional variations that supplement the primary recommendation. The primary recommendation includes components that are essential to all three recommendations; the second and third recommendations, though independent of each other, are both predicated on the primary recommendation.

The primary recommendation is a pricing methodology implemented statewide with prices derived from a periodic survey of historical costs incurred by providers of HCB services. The second recommendation is to differentiate the pricing methodology by provider peer groups that accommodate valid and predictable cost differentials. The third recommendation adds regionalization of prices.

Myers and Stauffer has also considered two additional rate components, whose inclusion in the reimbursement methodology may become long term goals for DHSS These components are rate adjustments based on acuity and quality. Due to the complexity of incorporating these components into the proposed price-based rate methodology, it is recommended that they be deferred as potential future enhancements. Accordingly, these components, although discussed in the report, are not formally part of Myers and Stauffer's recommendations for an HCB rate-setting methodology.

1. Recommendation 1 - Statewide pricing methodology

The primary recommendation that Myers and Stauffer presents to DHSS is implementation of a statewide pricing methodology that is derived from historical costs incurred by HCB providers as determined from a periodic cost survey. "Statewide pricing" implies that uniform rates are set for all providers; rates would not be provider-dependent or provider-specific. "Derived from historical costs" implies that prices have a basis in actual costs incurred in the past by providers. Prices would be set at benchmarks derived from measures of central tendency such as means or medians or from other comparisons such as percentile rankings.

Need for historical cost data for reimbursement decision making

One of the primary obstacles currently facing DHSS as it considers alternative methods for the reimbursement of HCB services is the lack of detailed information regarding the actual costs incurred by providers. Perhaps the most common theme presented during meetings with DHSS staff and other stakeholders is that reimbursement rates should be based on the actual cost to render services to clients.

DHSS currently does not have comprehensive data on actual costs incurred by providers and also does not have in place a mechanism to obtain that data. Although there have been some past data collection efforts involving providers of HCB services, there are several limitations to using that data for future rate setting activities. Since 2004, a rate "freeze" has been in effect that has significantly reduced the level of cost data collected from providers. The cost data collection that does occur may have limited value due to a lack of precisely defined reporting standards. Furthermore, previous cost data collection has been in the form of cost budgeting or forecasting, as opposed to the reporting of historically incurred costs.

Historical cost reporting versus budgeting

The difference between historical cost reporting and budgeting is a key distinction that needs to be made. "Historical cost reporting" refers to the collection of costs that have already been incurred by a provider. This is typically accomplished via a standardized reporting tool that collects expense, statistical and other relevant information from a defined fiscal cycle that has already concluded. In contrast, "budgeting" refers to the forecasting of expenses a provider expects to incur in order to provide care to a specified client or a group of clients.

While there are some advantages to the use of budgeting, there are significant limitations to this practice. Budgeting has the advantage of being customized to specific clients and is highly flexible in the ability to anticipate expenses that will arise in the future even if certain expenses have not occurred in the past. However, this flexibility is also a serious limitation of budgeting because it introduces highly subjective and non-standardized accounting practices that often result in inaccurate cost projections and inequity in reimbursement among providers.

For HCB programs, DHSS has been using a budgeting process, particularly for services provided by HCB agencies and assisted living homes. Providers have anticipated their expenses for specific clients; DHSS has evaluated providers' forecasts and made modifications deemed necessary to set rates considered to be reasonable. From a state government perspective, one of the shortfalls of this approach is the limited requirement of providers to verify that anticipated expenses, included in rate determinations, were actually incurred. From the providers' perspective, there is some concern that adjustments made by DHSS staff during the budget negotiation process are not consistent and reasonable. Furthermore, there is a perception within the provider community that some providers have proven to be more successful in the past during budget negotiations with DHSS and have been able to achieve higher reimbursement rates, not necessarily because their costs actually incurred were higher, but because they were more successful negotiators in the budgeting process.

Historical cost reporting is based upon expenses incurred by providers in the past and has significant advantages over a budgeting process because it can be accomplished using highly standardized methods. In historical cost reporting, providers are required to report financial data that has been maintained in accordance with established and generally accepted accounting procedures. Historical cost reporting requires a high level of accountability from providers because reported cost data must be supported by financial records and other documentation, which can be verified via a desk review

or field audit. Cost finding techniques are also highly standardized, significantly limiting subjective decisions on the part of providers and rate-setting staff. One disadvantage of historical cost reporting is that it is less responsive to anticipating future expenses.

Due to the limitations of the budgeting approach to rate setting, Myers and Stauffer recommends the use of historical costs. As the recommendation for a statewide pricing methodology is further explained, it should be understood that the cost survey approach implies the use of a historical cost reporting approach and not a budgeting approach.

It should also be understood that the recommendation being offered by Myers and Stauffer refers to the process used to determine payment rates to providers for each unit of service rendered. This recommendation would not impact the current procedures relating to assessing client needs and the determination of the appropriate level of services to be authorized for that client.

Overview of the cost survey approach

To address the current lack of reliable cost data, a comprehensive survey of costs incurred by HCB providers is recommended. The performance of a cost survey is a critical aspect of the recommendation and is actually a precursor to further refinement of a specific algorithm for determining rates. Myers and Stauffer is aware that there is some desire on the part of DHSS and the provider community to have a well-defined rate methodology as soon as possible. However, it would be inadvisable to fully develop a specific algorithm for deriving rates from cost data when there is currently no ability to model potential outcomes. The recommendation to perform a cost study is not simply for the purpose of applying pre-determined formulas to develop rates, but rather the cost survey is for the purpose of determining which formulas for rate derivation are the most appropriate.

A simplified outline of the cost survey approach is as follows:

- A cost survey methodology is developed and implemented.
- Cost data is submitted by providers and reviewed by DHSS.
- Cost finding algorithms are applied to develop provider-specific cost per unit of service.
- The distribution of cost per unit of service from all providers is reviewed and various approaches to deriving rates from the data are modeled.
- The most appropriate rate calculation algorithm is selected and steps are taken to formalize the approach as the official rate-setting method (i.e., regulations changes, etc.).
- Rates are set based on the first cost survey.
- Going forward, rates could be adjusted annually on the basis of an inflation factor.
- After a specified period (e.g., two to four years), another cost survey is performed and rates are rebased according to the specific rate calculation algorithm established during the first cost survey cycle.

- The rate-setting cycle continues with periodic rebasing of rates derived from a cost survey and inflation adjustments for interim years.

Development of a cost survey methodology

In order to perform a survey of provider cost that meets the rate-setting objectives of DHSS, it will be necessary to develop a survey methodology. The process to develop an effective cost survey will be labor intensive and ideally should include interaction between DHSS and the provider and stakeholder community. Issues to consider in the development of a survey methodology include development of a survey instrument, instructions, cost reporting guidelines, completion format or medium, standards for allowable cost and cost-finding procedures. Additionally it will be necessary to determine the timing of the initial survey and periodicity for future surveys.

Development of survey instrument

A key component of the cost survey methodology will be the process of developing an appropriate cost reporting tool. The survey instrument should be customized to be relevant to HCB providers in Alaska, but should also be general enough to allow for differences in organizational structure, scope of services offered and level of accounting sophistication that occurs within the Alaska HCB provider community.

Differences in provider size are particularly relevant in developing an appropriate survey instrument. For example, there is a significant difference in the size, organizational structure and level of accounting sophistication between large HCB agencies providing services across all or much of the State of Alaska and small owner-operated assisted living homes, personal care agencies and care coordination practices. Due to this variability, Myers and Stauffer recommends that consideration be given to the possibility that at least two versions of a cost survey instrument be developed. A standard cost survey instrument would be more appropriate for larger agencies and assisted living homes. The standard form assumes that the provider maintains a robust level of accounting information and that there are complicated accounting issues that need to be considered in the derivation of an average cost per unit of service rendered. Complicating issues could include the need to isolate costs not associated with Medicaid waiver services or the presence of multiple provider entities under common ownership or control (i.e., multiple provider types and multiple provider locations). Alternatively, a "short form" of the survey instrument would be more appropriate for smaller providers. The precise standard to determine how providers would be classified as "large" or "small" would need to be determined, but could be based on the number of clients served (e.g., those serving under five recipients under all associated Medicaid providers numbers could be classified as "small"). Despite being more concise, the "short form" would collect sufficient information to determine an average cost per unit of service provided, but would assume a minimal number of issues complicating the financial cost structure.

Typically, the information collected by a cost reporting tool would include:

- Provider ownership structure, fiscal year cycle and demographical information including disclosure of entities under common ownership or control.
- Detail of expenses incurred during the fiscal year, separated into applicable cost reporting categories. Typically, special attention is given to capturing salary and wage expenses into applicable categories.
- Adjustments and/or reclassifications of expenses necessary to accommodate cost reporting standards.
- Statistical information necessary to perform applicable cost allocations and other cost finding algorithms. This may include square footage statistics for the allocation of certain building costs, utilization statistics by payer source and service category, revenues by payer source and service category, and other measures that may provide a reasonable basis for the allocation of overhead expenses.
- A declaration by the owner and/or preparer that all information reported is accurate and complete.
- Any other information that may be relevant to develop accurate calculations of the cost of providing services.

During the development of the survey instrument, it will be important to consider the final cost finding objectives to ensure that the survey instrument is capable of providing sufficient data to meet those goals. It may be desirable to isolate specific components of the total cost of providing services. Examples of components of cost that may be of interest include direct support labor, administrative and general, training and travel. The survey instrument must be designed to capture sufficient information to isolate those components of cost so that reported expenses do not become commingled to the point that isolation of a specific component of interest is not possible.

The survey instrument will also require a comprehensive set of instructions to help ensure proper completion. To the extent possible, the instructions should try to anticipate a wide variety of potential complicating circumstances that providers will encounter as they complete the cost reporting tool. Instructions must also set forth clear definitions for services, cost centers and expense categories. Draft instructions should be field-tested and refined based on provider feedback. Since it is impossible to anticipate all complicating circumstances and create instruction language that works in all situations, it will also be important to prepare for questions from the provider community by giving providers access to trained staff that can respond to provider inquiries during the survey process.

Development of Cost Finding Methodologies

In conjunction with the process of developing a survey instrument, the manner in which cost data will be used and the objectives for that cost data should be considered. The primary objective for the cost data is to calculate the average cost of providing services on a per unit basis for each provider. The standards and algorithms that will be applied to the cost data to accomplish that objective can be collectively referred to as the cost finding methodology.

Many HCB providers provide multiple types of client services. Some of these services are covered by Medicaid waivers and others are not. In a cost finding exercise, it is typical to establish "cost centers" associated with the major categories of services and to isolate the costs associated with those cost centers. The cost centers of primary interest to the rate-setting exercise are those associated with Medicaid waiver services for which rates need to be set. However, the process of cost finding may also require establishing cost centers for non-covered services in order to accurately isolate the costs within the cost centers for covered services.

Costs are captured within appropriate cost centers either through a process of direct assignment or via cost allocations. For some expenses, provider financial records may have sufficient detail to directly assign expenses to the appropriate cost center. For example, a provider may have records sufficient to definitively report the precise salaries associated with the provision of personal care services distinct from the provision of other agency services. For other expenses, the ability to directly assign expenses to a cost center may be more problematic. For example, the utility expenses associated with the operation of an agency home office have bearing on all lines of business in which that agency is engaged. For overhead expenses such as utilities, allocation of the expense across all applicable cost centers is necessary. The use of cost allocations requires a reasonable statistic on which to base the allocation. This means that the statistics to be used to allocate cost must be anticipated and collected via the survey instrument.

Cost finding methodologies need to account for the complexities that will be presented by some providers. For example, many agencies receive Medicaid reimbursement via multiple provider numbers. These multiple provider numbers may represent the existence of a variety of provider types under the current Medicaid classifications within an agency (e.g., an agency that has an "HC" home and community based agency number, a "PCG" personal care agency provider number and a "CMG" care coordinator provider number). In some cases, a provider may have Medicaid provider numbers that are not associated with waiver services (e.g., some HCB agencies in Alaska also provide community mental health clinic services under an "MH" provider number). Multiple provider numbers may also be associated with provider offices in multiple locations in the state. All of the complications associated with the presence of multiple entities under common control and/or ownership will need to be addressed in the cost finding methodology.

Cost finding guidelines must also address costs incurred by providers that are not directly related to the provision of Medicaid services to clients. In some cases, a category of expenses by their nature might be considered non-allowable and not related to client services. Examples of non-allowable expenses include certain forms of advertising, fund-raising and bad debt expenses. Other examples of non-allowable cost may arise in situations in which related party transactions occur. Expenses incurred between related parties often require additional levels of scrutiny to ensure that transactions are reduced to actual costs incurred. In the case of salaries received by facility owners, it is typical to consider reasonable limits to allowable cost.

Developing a cost finding process can become very complicated. The Medicare program and many state Medicaid agencies use hundreds of pages of policies to describe cost finding methodologies and guidelines for hospitals, nursing facilities and certain other provider types. Although well defined policies are important, for the cost survey process to be successful for HCB providers in Alaska, the benefits gained from complex policies should be balanced with the administrative burden that would be imposed on DHSS and providers. Where possible, Myers and Stauffer recommends that the cost survey for HCB providers use simple cost reporting standards and cost finding techniques.

One example of how cost finding methods can be simplified relates to the determination of costs associated with room and board for residents of assisted living homes and group homes. Under Medicaid waiver guidelines, payments cannot be made for room and board. However, it is also reasonable that certain physical facility expenses in an assisted living home or group home are associated with the covered waiver services of residential supported living and residential habilitation. Rather than perform complex cost allocation algorithms to try to differentiate between physical facility costs associated with room and board and the physical facility costs associated with covered services, it is possible to use the standard allowances for room and board included in the Social Security Supplemental Security Income (SSI) payments as a proxy to estimate facility cost for room and board, and then remove that standard allowance from the cost allocated to a Medicaid-covered service.

Cost survey distribution, review and analysis procedures

After a survey instrument is developed and a cost-finding methodology is determined, plans should be made to implement the cost survey process. Unlike typical cost reporting in hospitals and nursing facilities which occurs in a continuous cycle based on the providers' fiscal year ends, the HCB cost survey would be performed on a periodic basis (e.g., every two, three or four years). The cost survey process of survey distribution, data collection and data analysis would occur on a scheduled basis for all providers over a period of approximately six to twelve months. Providers would report cost data from their most recently completed fiscal year. The cost reporting tool, its accompanying instructions and cost reporting guidelines would be distributed to providers with a specified due date for survey completion.

Completed surveys would be submitted to DHSS and subjected to review and potentially audit procedures. Since the cost survey approach will set rates based on central tendencies, percentiles or other trends observed from the provider population at large, the risks associated with inaccurate cost reporting due to errors or intentional fraud are somewhat mitigated. In contrast, for a reimbursement methodology that sets provider-specific rates based on reported cost, the risk associated with inaccurate cost reporting is substantially higher. Regardless, some level of review of submitted cost data is reasonable to maintain the integrity of the cost survey process.

A basic review strategy can include multiple levels of cost survey scrutiny, with surveys progressing to higher levels of review based on an assessment of risk. A first line of review that could be applied to all incoming surveys would be standard checks for reasonableness. These standard checks could be

based on the internal consistency of the survey data or they could also be based on comparison of the survey data with basic financial documentation that the provider was required to submit. Requirements for the submission of additional documentation should be considered in conjunction with review and audit procedures. Formal cost reporting processes for larger institutional providers often require the submission of audited financial statements and working trial balances with each cost report. For the HCB cost survey, it may be reasonable to have similar requirements for larger providers. For smaller providers, documentation submission requirements may need to be modified to reflect the types of documentation actually available, including un-audited financial statements and various forms used for tax reporting purposes. Beyond the performance of standard checks for reasonableness, selected cost surveys could be subjected to additional desk review procedures that require a provider to submit additional supporting documentation. As a final level of review, some cost surveys could be subjected to on-site field examinations.

Data from reviewed and or audited surveys would be subjected to cost-finding algorithms. The resulting cost per unit of service data would be analyzed. There are a wide variety of methods available to transform unit costs into provider rates. Typically, rates are tied to some benchmark of the cost data such as a mean, median, percentile ranking or other measure of central tendency. In addition to measures of central tendency, it will be important to analyze the variation in provider costs and potential causes of that variation. As will be more fully explored in the second and third reimbursement methodology recommendations, an understanding of how provider costs vary will determine whether various ways of differentiating provider rates, such as through peer groups or geographic regions, are feasible.

Analysis of the cost data can also result in decomposition of costs into components of interest to DHSS, including labor for direct support staff, administrative and general, training and travel costs. Based on the variation observed in those categories, there may be some interest in modeling rates that place limits on certain components of cost. For example, rates could be constructed that allow for all of the observed labor cost attributed to direct support staff, but place reasonable limits on certain aspects of administrative costs.

During the first cycle of the HCB cost survey, the analysis of the cost data will take on special significance. During this analysis period, DHSS will get its first comparison of the current reimbursement rates to various benchmarks of the cost data. Myers and Stauffer recommends that a rate calculation algorithm not be established until after data from the first HCB cost survey has been analyzed and *pro forma* rates have been modeled. After the cost data has been extensively analyzed and rates modeled, the process for deriving provider rates from cost data could then be formalized via regulation promulgation. In subsequent iterations of the HCB cost survey process, the process for determining rates from provider cost data would be based on the process established during the first survey.

Additional issues related to a cost survey

The process of developing a survey instrument, refining cost-finding methodologies and determining review and analysis strategies are the primary tasks associated with adoption of the recommendation of prices based on a cost survey. In addition to these main tasks, there will also be several other smaller issues that need to be considered.

Regulations to authorize a cost survey should consider the manner in which the obligations to participate in the cost survey will be imposed on providers. Generally, it is a reasonable approach to develop policies that make participation in a cost survey mandatory with some exceptions for special circumstances. However, policies that require participation in the cost survey process would ideally be diplomatic with regards to any penalties associated with non-participation. Ideally, the primary motivation for providers to participate in the survey process is to assure that their costs are adequately represented in the cost survey and subsequent rate-setting process.

It is likely that there will be a limited number of providers that will be unable to participate in a cost survey due to limitations of financial information available. Providers that have recently opened or have had a recent change of ownership may not have access to a completed fiscal cycle consisting of a full twelve month year. It is typical in a cost survey process to set a minimum standard for the length of a financial reporting period for which data is collected. For example, the standard might be that only fiscal periods of six months or greater will be used. If a provider recently opened or changed ownership and had a transitional fiscal cycle of less than six months, the provider may be precluded from participating in the survey due to its irregular fiscal cycle.

The frequency at which the cost survey would be repeated will need to be determined. Myers and Stauffer recommends a survey interval of two to four years. It is realistic to expect that implementation of a survey cycle from beginning to end could take six months or longer for survey distribution, data collection, review and data analysis. Although a survey interval of one year would conceivably create an ideal dataset for trend analysis, the interval is most likely too frequent since one cost survey will begin as the previous one is in its final stages. Additionally, an annual survey would create a significant increase in the administrative burden on both providers and DHSS. Cost surveys and rebasing of rates on a four year cycle would be consistent with the interval currently used by the Office of Rate Review for rebasing hospital and nursing facility rates.

For interim years in which a cost survey is not performed, an escalating factor could be used to adjust the base rates established by the cost survey. Escalating factors are typically tied to inflation indices that are considered appropriate for the industry. Given the relative importance of labor costs for the HCB provider industry, an appropriate wage index could also serve as a reasonable escalating factor. The Alaska Department of Labor and Workforce Development currently tracks wage data for several categories of health care services including one for “personal and home care aides”.

Short-term inflation adjustments may also need to be incorporated in the cost analysis phase of the survey process. The cost survey is ideally based on the most recently completed fiscal year period of

a provider. Since the fiscal year cycles of providers will likely vary, it may be appropriate to apply short-term inflation adjustments during the analysis of the cost data to compensate for the differences in the fiscal years represented in the survey data.

Special concerns

Although rates based on a survey of HCB provider cost could be used to set rates for the majority of HCB services, there are a limited number of services covered under Medicaid waiver programs that are not ideally suited for prices based on a cost survey. In general, services that are highly specific or provided on an intermittent basis are not ideal subjects for a rate based on average cost.

Environmental modification providers make physical adaptations to the homes of recipients that are necessary for the health and safety of the recipient. Currently, environmental modification projects are negotiated through a bid process. Given the unique nature of each environmental modification project, and the wide variety of providers involved in the construction of environmental modification jobs, these projects would not be ideally suited to a pricing methodology. Myers and Stauffer recommends that DHSS continue the current practice of negotiated bids for environmental modification services.

Specialized medical supplies are currently reimbursed using a durable medical equipment (DME) fee schedule. This approach is comparable to the manner in which DME services are reimbursed outside of the waiver program. A fee schedule is an ideal basis for the reimbursement of specialized medical supplies, and Myers and Stauffer recommends that DHSS continue with the current reimbursement methodology for specialized medical supplies.

Intensive active treatment services are provided when a recipient needs immediate intervention to decelerate a condition or behavior that, if left untreated, would place the recipient at risk of institutionalization. Since this service is intermittent and highly specialized, using cost data to set average per diem rates may be inappropriate. Myers and Stauffer recommends that DHSS continue to determine reimbursement for intensive active treatment services using a budgeting approach specific to each client and the incident of service.

It is also likely that extraordinary situations will arise in which clients legitimately require services that are clearly beyond the “average” service being reimbursed through statewide, peer group or regional prices. Criteria for clinical exceptions should be clearly defined and require specific documentation. Policies for clinical exceptions should be designed to limit the number of extraordinary cases to a manageable level, and should set reasonable bounds for rate exceptions.

As DHSS chooses the appropriate parameters to include in a reimbursement methodology for Medicaid services from HCB providers, it is reasonable to give some consideration to incorporating certain elements of a new HCB rate-setting methodology into policies for a broader category of DHSS services. In meetings with DHSS staff, Myers and Stauffer has listened to discussion regarding similarities and overlap of HCB services with grant-funded HCB services, general relief assisted

living services, child care assistance and foster care services. For some of these services, such as grant-funded HCB services and general relief assisted living services, the application of the cost survey process could be applied to develop reasonable rates for those services in conjunction with the calculation of rates for Medicaid waiver services. For child care assistance and foster care, the direct application of the cost survey process is likely inappropriate, although some concepts from the HCB rate methodology may be applicable. This includes, for example, the concept of rates set via a periodic rebasing and escalated in interim years with an inflation factor. The use of peer groups or regional differentiations is also potentially feasible for child care assistance and foster care.

Reimbursement opportunities for public providers

Special circumstances and opportunities also exist for public HCB providers (e.g., Pioneer Homes) and tribal-sponsored providers. Federal regulatory changes described in the final rule at Federal Register Vol. 21, No. 102, May 29, 2007 would limit Medicaid reimbursement to public providers (including tribal-sponsored providers) to the actual cost of providing services. Congress has granted a one-year moratorium to these changes, but without further federal action, these standards will be enforced effective May 2008. If this occurs, states will have to demonstrate compliance with the cost limit. This requirement would need to be met regardless of the rate methodology used for public providers.

Given that this cost limit would require that some form of special cost findings be calculated for public providers, it may make sense to include an element of retrospective cost settlement for public providers. If a retrospective cost settlement were added to the reimbursement methodology for public providers, it is still possible to use the recommendation to set prices derived from cost data. However, for public providers, the price would become, in effect, an interim rate with retrospective settlement occurring later. Under the federal requirements, the settlement would have to include a recovery of interim payments made in excess of cost. It would be the option of DHSS to make additional payments to public providers for the case that the payments under the interim rates were less than actual cost.

There are some advantages to DHSS to use cost settlements for public and tribal-sponsored providers. Reimbursement at cost for Pioneer Homes ensures that the amount of Federal Financial Participation (FFP) is optimized for Medicaid-eligible residents. Cost reimbursement for tribal-sponsored providers may encourage tribal entities to sponsor the provision of HCB services since cost reimbursement would reduce financial risk to the tribal sponsor. This would benefit DHSS since the Medicaid federal match rate for services provided by a tribal-sponsored health care provider when providing services to an eligible Alaska Native recipient is 100%.

During meetings with HCB provider groups, Myers and Stauffer was aware of comments suggesting that an HCB rate-setting methodology should be fair and consistent for both private and public providers. It is possible that the suggestion that Pioneer Homes and tribal-sponsored providers receive cost reimbursement be perceived as unfair since Myers and Stauffer is also recommending prices for private providers that do not guarantee full cost reimbursement. However, full cost

reimbursement for public providers presents the state with opportunities to take advantage of federal funding in lieu of spending from state general funds. Maximizing those funding mechanisms could ultimately result in additional state general funds being available for the funding of reimbursements to private providers.

2. Recommendation 2 - Pricing methodology with peer groups

Myers and Stauffer's second recommendation for an HCB rate-setting methodology expands on the primary recommendation of prices based on a cost survey, but adds the concept that prices are differentiated based on provider peer groups. The need and feasibility for price differentials tied to provider peer groups will not become apparent until after an initial HCB provider cost survey has been performed and the cost data is analyzed. The use of peer groups would be indicated if the analysis of the cost data shows that there are meaningful differences in provider cost based on clearly defined groups of providers.

Peer groups can be defined based on a variety of criteria. The goal of defining peer groups is to determine if certain clearly defined attributes of a provider have a statistically significant relationship to costs incurred by the provider. Examples of peer groups include public or private provider ownership, provider size (i.e., number of clients served) and provider location (e.g., in an "urban", "rural" or "remote" location).

Peer groups can also be potentially tied to provider specialization if it is possible to clearly define the criteria for the specialization. Ideally, peer grouping by specialization would utilize pre-existing licensing requirements to determine whether a provider would be included in a "specialty" peer group. If it is possible to define peer groups that differentiate providers that typically service high needs clients, then a peer group methodology could effectively produce rates that are adjusted for acuity at the provider level.

Myers and Stauffer recommends that HCB cost survey data be analyzed to develop peer groups that are reasonable, clearly defined and not counterproductive to goals for cost efficiency (i.e., the definition of a peer group would ideally not be designed to encourage inefficient provision of care). The cost data should be analyzed to determine if differences in cost between various peer groups are statistically significant and substantial enough to warrant differentiation of rates.

Whether or not peer grouping should be used cannot realistically be determined at the present time due to the lack of robust cost data. If the analysis of cost data from the initial HCB cost survey indicates that a peer group rate structure is viable, the precise methodology for defining the peer groups and calculation of the rates could be developed. Peer grouped rates could be indexed annually using an inflation factor until they are rebased by a subsequent iteration of the HCB cost survey. Subsequent rebasing of the peer group rates would use the predetermined methodology.

3. Recommendation 3 - Pricing methodology with regionalization of prices

Myers and Stauffer's third recommendation for an HCB rate-setting methodology is also an expansion on the primary recommendation to set prices based on a cost survey. The third recommendation is to add differentiation of prices based on geographical regions. The need and feasibility for price differentials tied to regions will not become apparent until after an initial HCB provider cost survey has been performed and the cost data analyzed. The use of regional rates would be indicated if the analysis of the cost data shows that there are meaningful differences in provider cost based on region.

When discussing regionalization of rates, one of the issues that should be addressed is whether regional location refers to the location of the provider's facility, regional office, home office or the location of the client being served. Under ideal circumstances, it would be preferable to tie regional rates to the actual location of the client being served to recognize the fact that many HCB providers in Alaska have a client base that is geographically spread across the state.

Unfortunately, it is highly unlikely that a cost survey instrument and typical analysis methods will be able to calculate the cost of providing services to specific clients. Typically, a cost survey yields average costs of providing services to all clients of the provider reporting cost data. In the case of providers that are located primarily in proximity to the clients they serve, regionalization of cost would be possible with a standard cost survey instrument. If a provider with a widespread client base operates "field offices" in various cities across the state, it may be possible to establish cost centers that segregate costs according to the field offices thereby producing some level of cost regionalization. However, for practical purposes, regionalization of cost will realistically have to be tied to the primary location of the provider or the locations of field offices operated by the provider. Regionalization of cost to the location of the client is not likely to be attainable without extraordinarily complex cost reporting.

An important issue to determine the viability of regionally differentiated HCB rates is the establishment of standard regions and definitions for those regions. Currently there are several home and community related services that are reimbursed by DHSS with regional differences in rates. Examples include rates to assisted living homes for residential supported living services under Medicaid waivers and general relief payments of state-only funds. Rates under the Child Care Assistance Program include regional differentiation. Foster care reimbursement under the Office of Children's Services includes location adjustments that are specific to a given town or village. There is currently a lack of consistency in the regions defined for these purposes as demonstrated in the table below.

Regional Differentiation of Rates for Certain DHSS Services

Service	Division of DHSS	Brief Description of Regions Used
Residential supported living and general relief payments to assisted living homes	Senior and Disabilities Services	Anchorage South central Southeast Interior Southwest Northwest
Child Care Assistance Program	Public Assistance	Anchorage/Mat-Su Southeast Interior Gulf Coast Northern Southwest
Foster care rates	Office of Children's Services	Rates are differentiated by town or village

There are several options available to determine how regions would be developed for an HCB reimbursement system. The simplest method would be to choose one of the pre-existing regional definitions and continue with those definitions. A more complex option would be for DHSS to use the creation of regions for an HCB rate system as an opportunity to define standard regions that would be used uniformly for DHSS programs. However, this approach would involve coordination of several divisions within DHSS and there is the potential that ideal regions for one purpose would not be ideal for another purpose. For example, the current methodology for foster care reimbursement differentiates rates down to the level of towns and villages. This level of differentiation appears to be overly complex for the purposes of an HCB reimbursement methodology. However for the purposes of the foster care program, there may be valid reasons for the level of sophistication used in regional rate adjustments. A final option would be to define an entirely new set of regions for the purpose of an HCB rate-setting, and use the regions that make the most sense in the context of the HCB program regardless of whether they are consistent with regions used under other DHSS programs.

Regions can also be conceptualized in ways other than broad geographic categories. Regions could be linked to community size and/or relative isolation of a community. This approach somewhat overlaps with the notion of peer groups linked to the urban, rural or remote location of the provider.

Regardless of the method used to determine regions, there would need to be observable differences in provider costs from region to region in order to justify the creation of a regional price system. As with peer groups, Myers and Stauffer recommends that the decision to use regional rates be reserved until after an initial HCB provider cost survey has been performed. The cost data from the initial cost

survey should be analyzed to determine if differences in cost between regions are statistically significant and substantial enough to warrant differentiation of rates.

There are some indications that regional differentiations of cost may be justifiable. In addition to anecdotal accounts from providers relating to regional cost differentials, cost data used by the Alaska Department of Education and Early Development to determine District Cost Factors for public school funding purposes show wide variations in the level of cost across the state. District Cost Factors standardized at 1.000 for the Anchorage school district range up to factors higher than 2.000 for certain remote school districts. Of course, these cost differentials are specific to the provision of educational services and school administration; whether similar differentials occur within HCB services should be verified through analysis of the HCB cost survey data.

After the analysis of cost data from the initial HCB cost survey, if a regional rate structure is viable, the precise methodology for calculation of the regional rates could be developed. DHSS would need to determine if procedures for regional rates would be left to the discretion of internal policy or if they would be more formally promulgated into regulation. Regional rates could be indexed annually using an inflation factor until they are rebased by a subsequent iteration of the HCB cost survey. Subsequent rebasing of the regional rates would use the predetermined methodology.

Clearly, the recommendation for the development of regional rates is additive to Myers and Stauffer's primary recommendation for statewide prices based on a survey of HCB provider cost. It is also possible that regional rates could be used in conjunction with peer group rates. However, adding multiple permutations to a single statewide price causes the rate methodology to become increasingly complex. The benefits that may be gained from additional rate categories must be balanced against the complexity and additional administrative burden that multiple permutations of rates would create.

4. Contrast the recommendation for a pricing methodology based on cost surveys with current rate-setting for hospitals and nursing facilities in Alaska

During discussions with DHSS and provider groups regarding potential methodologies for the reimbursement of HCB services, the desire for a reimbursement methodology based on actual cost was discussed frequently. It was often the case that comparisons were made between a potential HCB reimbursement methodology based on cost and the current methodology used by DHSS to reimburse hospitals and nursing facilities. Due to the frequent use of current DHSS reimbursement of hospitals and nursing facilities as an example of cost-based reimbursement, it may be helpful to compare and contrast Myers and Stauffer's recommendation for an HCB reimbursement methodology and the current methodology for hospitals and nursing facilities.

Use of cost reports

Similar to hospitals and nursing facilities, Myers and Stauffer is proposing that an HCB provider cost reporting tool be used to collect provider expenses, statistics and other data relevant for determining

cost on a per unit of service basis. Although both methodologies are based upon cost data collection, it is anticipated that there would be some differences in the level of sophistication of an HCB provider cost survey and the current cost reporting forms in use for hospitals and nursing facilities.

Hospital and nursing facility cost reports are highly structured forms that were initially designed to be used by the Medicare program though the cost reports have been adapted for use by Medicaid programs as well. In contrast, there is not a Medicare version of an HCB provider cost reporting tool; therefore, a cost survey instrument must be designed specifically for use within the Medicaid program. There are several other states that currently use cost reporting tools within their HCB programs. The forms used by those states can help provide ideas for a cost survey tool in Alaska. However, due to differences in the HCB programs from state to state, and the uniqueness of the provider community in Alaska, a cost survey tool would have to be custom tailored for use in the Alaska Medicaid program. While development of a survey tool requires some effort, it is anticipated that an HCB cost survey form could be designed that is less complex than typical hospital and nursing facility cost reporting forms.

Cost reporting for hospitals and nursing facilities is an annual requirement. In contrast, Myers and Stauffer recommends that HCB cost surveys be conducted on a regular cycle every two to four years.

Cycles of rebasing and inflation updates

Currently, the Alaska Office of Rate Review rebases rates for hospitals and nursing facilities every four years. For interim years, an inflation factor is used to update rates. This methodology of rebasing rates on a regular cycle with inflation adjustments for interim years is comparable to Myers and Stauffer's recommendation for HCB providers.

Statutory basis for reimbursement

For hospitals and nursing facilities, there is currently a statutory basis that "health facilities" (defined at AS 47.07.900(11)) shall have rates that are based on "reasonable costs related to patient care" (see AS 47.07.070). Alternately, the statutory basis for HCB reimbursement is general (see AS 47.05.10); cost-based reimbursement is not required nor is it precluded.

Use of provider-specific rates

Rates for hospitals and nursing facilities are set on a provider-specific level. Accordingly, rates are determined primarily by the cost data reported by the facility; cost data from other facilities has little or no impact on a given provider's rate. Hospital and nursing facility rates are designed to fully reimburse, within certain limits, the costs incurred by a specific provider.

Myers and Stauffer's recommendation for an HCB rate-setting system would not be provider-specific. Cost data collected from all providers or a group of providers would be analyzed in the aggregate to determine prices to be applied to all providers or a group of providers. Prices are not designed to fully reimburse any specific provider. Providers with costs below the price will be

reimbursed in excess of their actual costs; providers with costs above the price will not be fully reimbursed for costs incurred.

Although there are some advantages to fully reimbursing provider-specific costs, it is likely that the disadvantages of such a system outweigh the benefits. Cost reporting that results in provider-specific rates inherently has higher risks (from an auditing perspective) than cost reporting that results in prices derived from aggregate cost data. Furthermore, provider-specific rates could reduce incentives for a provider to be cost efficient. Prices set from aggregated cost data may create incentives for efficiency since there is a potential for a cost-efficient provider to realize revenues in excess of cost (i.e., "profits", although it is understood that many HCB providers are not-for-profit entities).

5. Future enhancements

Acuity adjustments

One potential issue with price-based reimbursement systems is that they may not accommodate valid differences in the resources needed to provide a unit of services. The severity of this issue depends on the number and the definition of groups used for aggregating costs and establishing prices. Potentially, the lack of acuity adjustment may create disincentives for access to care and quality. During meetings with DHSS and HCB provider associations, the concept of incorporating an acuity adjustment into the HCB reimbursement system was discussed.

As a general principle, providing additional reimbursement for a unit of service for clients with greater needs and therefore greater costs to provide that service is an admirable goal for the HCB reimbursement methodology. While Myers and Stauffer agrees that acuity adjusted payments may be appropriate for certain services, we have not included acuity adjustment as a primary component of our recommendation for an HCB rate-setting methodology. Instead, Myers and Stauffer recommends that the incorporation of an acuity adjustment to the price-based methodology be deferred as a future enhancement.

Though there are certainly benefits to an acuity-based reimbursement methodology, there are also substantial challenges associated with the development and implementation of such a methodology. Long-term care researchers have been studying measures of client need and resource utilization for a number of years. Most of the work, however, has been completed in institutional settings, including hospitals and nursing facilities. A number of projects funded by the Federal government led to the development of several classification systems used in Medicare Prospective Payment: Diagnosis Related Groups (DRG), Resource Utilization Groups (RUG), and Ambulatory Payment Classifications (APC).

The purpose of a classification system is to provide a reliable and systematic method to account for the variation in resource needs. The various classification groups establish case mix indices or acuity payment levels. Case mix has become a familiar term in the health care field. The "case" refers to characteristics of individual clients. In DRG systems, cases are classified by diagnosis and length of

stay, APC systems are classified by procedures. RUG systems are based on functional status and clinical condition. The "mix" refers to the mixture of different clients receiving service. Case mix reimbursement is based on the principle that rates should take into account differences in needs or acuity and the resources necessary to provide appropriate services.

Ideally, an acuity adjustment should be objective. The factors that determine the acuity adjustment should be consistent regardless of the individuals involved in the acuity determination. However, such objectivity typically can only be attained through mechanisms developed in a relatively complex and sophisticated process. A significant level of effort is required for the research and development of an acuity adjustment methodology.

Services that are defined in units of time, 15 minutes or hourly, such as personal care services, are not suited for acuity adjustment. The cost differential for a timed unit of service is based on the experience and expertise of the individual providing the service rather than the acuity of the recipient. In such cases, the service planning function effectively adjusts for acuity when determining the time-defined units of services needed to meet client needs.

The HCB services that are the most appropriate for acuity adjustment are primarily those that are currently reimbursed via daily rates. Specific HCB services that could have an acuity adjustment mechanism include residential supported living, residential and day habilitation and supported employment. The resident acuity approach to reimbursement has gained widespread acceptance for nursing facilities. Currently 27 states have a case mix payment system in place for the Medicaid nursing home programs, but few states have developed case mix payment systems for assisted living and group homes. To date there has been little federal or state effort to develop case mix payment systems for home and community based programs.

There are several primary components to developing an acuity adjustment mechanism for reimbursement rates. First an appropriate assessment tool is needed to assign a quantitative value to the acuity level of recipients. Additionally, there needs to be a methodology and classification system for grouping recipients with similar levels of acuity. Finally, prices need to be set for each classification. The differential in those prices should have a reasonable relationship to the costs associated with providing services to clients in the respective acuity classification.

The Minimum Data Set (MDS) is an assessment and care planning instrument whose completion and electronic submission is mandated in all Medicaid and Medicare certified nursing homes. It took many years to develop and test the MDS before implementation. Determining an appropriate assessment tool to objectively quantify client acuity would be a significant component of developing an acuity-based reimbursement system.

Currently, the primary assessment tools used by DHSS to determine level of care for Medicaid waiver eligibility are the Consumer Assessment Tool (CAT) for the Older Alaskan (OA) and Adults with Physical Disabilities (APD) waivers. For the Mental Retardation and Developmentally Disabled

(MRDD) waiver program, the Inventory for Client and Agency Planning (ICAP) is used. The Children with Complex Medical Conditions (CCMC) waiver uses the Nursing Facility Assessment Form for Children.

Whether the current assessment tools used for level of care determination are suitable for an acuity-based reimbursement system would need to be further explored. The CAT assessment tool appears to have potential for use or adaptation within an acuity adjustment system. The language, definitions, and format of the CAT form are similar to that used in the MDS system. This similarity could make the data collection easier across long-term care programs and settings. Definitions and time frames were modified in some areas of the CAT form so it could be utilized in a community setting. The form was designed to be an objective tool that is easily coded. The design facilitates immediate eligibility determination by the assessor. Results of the CAT are maintained in a state database.

Although some state Medicaid programs have successfully incorporated the ICAP into acuity adjustment strategies, Myers and Stauffer is aware that there are some concerns regarding whether the ICAP would be an appropriate tool to use for acuity adjustment in the Alaska Medicaid waiver program. There are alternatives to the ICAP including the Supports Intensity Scale (SIS) and the Developmental Disabilities Profile (DDP). It is also possible for a state to independently develop its own assessment tool as did North Carolina with its Support Needs Assessment Profile (NC-SNAP).

However, the process of adopting or developing a new assessment tool to replace the current tool used for waiver eligibility or using an additional assessment tool exclusively for acuity adjustment, is likely to be complex and administratively burdensome for DHSS, providers and recipients.

Once an appropriate assessment tool has been developed, a system is needed to assign individuals of similar acuity into meaningful clusters. These groupings should have common characteristics that predict levels of resources required to provide services and the cost differences between groups should be significant enough to justify their existence. The classification systems developed for Medicare's prospective payment systems have all been developed using some measurement of actual experience. This process can be cumbersome and typically involves detailed time studies to measure the difference in costs attributed to persons of varying acuity.

The next step would be to link the classifications to reimbursement. This could be accomplished by developing separate prices for each group or tier or by a set of indices used to adjust a generic price. An alternative to classifying individuals into discrete clusters or tiers is to develop a continuous model of the relationship between an acuity measurement and a provider rate. A continuous model would be roughly equivalent to the DOORS model used in Wyoming for its MRDD adult and children waiver programs, which effectively produces an infinite number of possible rates based on the acuity values input into a complex formula.

Regardless of the assessment tool, the use of discrete tiers or a continuous rate model, there is a substantial level of complexity and cost involved in the development of an acuity-adjusted

reimbursement system. Even after an acuity adjustment system is developed, additional administrative cost will likely be incurred for on-going training of DHSS staff and providers to assure consistency and manage staff turnover. A review or audit program should be considered to continually monitor system accuracy.

As a long-term goal, the inclusion of an acuity adjustment is a reasonable refinement to the HCB reimbursement strategy. However, the transition from the current "freeze" rates to price-based rates with possible peer group and/or regional differentials represents a significant challenge without the added complexity of incorporating an acuity adjustment. Due to this complexity, Myers and Stauffer recommends that DHSS defer consideration of an acuity adjustment to the reimbursement methodology until the price-based rates are well established.

Quality Incentive

Quality is difficult to define, to say nothing of measuring. The term raises different associations and emphasis with different groups. Measuring service use, cost and outcomes has become standard practice for many health care services. Over the past 10 years, there has been growing consensus about quality measurements that are important to hospitals, nursing facilities, and managed care organizations. Other initiatives are underway between public and private entities to adopt and use measures as the basis for purchasing decisions, public reporting, incentive payments and performance improvement processes.

Historically, there has been only limited application of quality measurement to HCB services. In response to a letter from Senator Grassley and Senator Breaux in July of 2003 pertaining to the lack of oversight and monitoring of HCB waiver programs, the Centers for Medicare and Medicaid Services (CMS) developed a Quality Action Plan. In short, the plan details the goals, objectives and steps CMS implemented to improve quality, oversight and monitoring of HCB waiver programs.

The CMS Quality Framework describes quality outcomes for HCB services under seven focus areas:

1. Individuals have access to home and community-based services in their communities.

2. Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

3. There are sufficient HCB services providers and they possess and demonstrate the capability to effectively serve participants.

4. Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

5. Participants receive support to exercise their rights and in accepting personal responsibilities.

6. Participants are satisfied with their services and achieve desired outcomes.

7. The system supports participants efficiently and effectively and constantly strives to improve quality.

Taken together, these outcomes define quality for an HCB services program. Embedded within each of these outcomes are processes that, if implemented carefully, will yield the desired effect or quality. Indicators are used to measure how well a program is meeting its quality outcomes. States are at varying stages of developing indicators for determining how well each process is being implemented and if together these processes are achieving the above quality outcomes. Few states have fully organized and implemented quality management (QM) strategies. Many states, however, are developing work plans that show how, over time, they plan to fully assess the design and implementation of their wavier programs to improve overall system performance.

In 2003, CMS awarded grants to 19 states to enhance their QM programs for HCB services. CMS contracted with the Community Living Exchange Collaborative to assist states in their grant activities by promoting information exchange and facilitating discussions on topics of common interest. As part of its work with the Community Living Exchange Collaborative, the Muskie School of Public Service, together with grantee states, identified three initial priority topics and developed papers on: Quality Management Roles and Responsibilities, Discovery Methods for Remediation and Quality Improvement, and Managing and Using Data for Quality Improvement. The working papers provide additional resources for states as they seek to organize, analyze, and report data in a way that informs decision making and supports quality management and improvement.

Quality measurement is an essential feature of quality improvement. Valid, reliable and timely data about the care provided, consumer experience with care, and those providing care are fundamental to all strategies for monitoring and improving the quality of home and community-based care. This information is important to many constituencies including consumers, providers, program managers, and regulators.

While notable accomplishments have been made in recent years in the field of measuring and improving HCB quality, much of this work is still in preliminary stages. Significant effort, above and beyond the current efforts to define and collect quality indicators would be needed before it would be feasible to incorporate quality measures as an aspect of the HCB rate methodology. Although a quality adjustment is a reasonable long term goal for DHSS, Myers and Stauffer recommends that a quality component to the HCB rate be deferred for now.

6. Interim recommendation

An HCB cost survey offers DHSS the best opportunity to transition the current HCB reimbursement methodology to one in which rates are based on provider cost. However, it is apparent that the issues associated with implementation of an HCB cost survey, analysis of the data from the first survey and subsequently finalizing the rate-setting methodology will require a transition period of one or more years. For the interim period, HCB providers have indicated a desire for relief from the current rate

freeze. There have been some indications that DHSS may be seeking legislative appropriations that may be able to provide some additional funding.

Although it would be ideal to apportion any additional funds received according to an improved HCB reimbursement methodology, it would be prudent to take advantage of available appropriations to address immediate rate needs. Myers and Stauffer recommends that any additional funds available for HCB providers be apportioned according to simple methodologies during the interim period while on-going development of a new HCB reimbursement methodology is occurring. Funds can be apportioned according to several possible strategies:

1. An across the board percentage increase to the current "freeze" rates (with the percentage determined by an analysis of utilization rates and available funding).

2. A strategy that allocates the most funding to providers whose rates have been "frozen" the longest.

3. A strategy that establishes benchmarks for current provider rates (e.g., the median rate for each service code) and provides the greatest amount of increase to those providers with reimbursement rates below an established benchmark.

7. Overview

Recap of recommendations

Myers and Stauffer's recommendations for a reimbursement methodology for HCB providers is based on discussion with DHSS staff, meetings with provider associations, review of the current HCB reimbursement system and review of HCB reimbursement methodologies in other states. We have also carefully considered the requirements set forth in the Request for Proposal (RFP) issued by DHSS. In the table below, we have provided a reconciliation and comparison of the RFP requirements and our recommendations.

Reconciliation of Recommendations with RFP Requirements

Rate Methodology Criteria for Consideration per RFP	How addressed in Myers and Stauffer Recommendations
Auditable system for cost reporting and other additional data reporting required to evaluate and to maintain reasonable cost reimbursements in the proposed system. At least one proposed cost finding methodology must include defined standards for allowable costs and reporting formats similar to Medicare with identification of general services and revenue producing costs.	The primary recommendation offered by Myers and Stauffer is a statewide price for HCB services with prices determined by a periodic survey of HCB provider cost. The concept of a cost survey is a simplified variant of the cost reporting currently required for hospitals and nursing facilities. The cost survey will require the development of a survey instrument, survey instructions, standards for allowable cost and cost-finding methodologies. With defined cost standards in place, verification of cost survey data is

Rate Methodology Criteria for Consideration per RFP	How addressed in Myers and Stauffer Recommendations
	possible and recommended. Verification can include multiple levels of review including standard checks for reasonableness, desk reviews and on-site field audits.
System complies with federal Medicaid rate setting requirements and guidelines. State of Alaska Medicaid rates must be consistent with efficiency, economy and quality of care ensuring equal access to services for Medicaid beneficiaries.	Prices derived from historical costs are compatible with federal requirements. With an effective HCB cost survey methodology, DHSS will have substantially more information than is currently available to evaluate the cost coverage of the rates that are set. With this additional information, DHSS will have a greater ability to ensure that provider rates are reasonable and to ensure accessibility to services.
Reimbursement based on acuity of the consumer that links the cost of services to an assessment.	Myers and Stauffer has considered the option of acuity-based adjustment factors for a rate methodology. While acuity adjustment is an ideal long-term goal for DHSS, Myers and Stauffer recommends that DHSS defer potential inclusion of an acuity adjustment mechanism until a later date, after an HCB cost survey methodology has been developed and implemented.
System incorporates geographic differentials.	Myers and Stauffer has recommended two potential refinements to the primary recommendation of prices based on a cost survey of HCB providers. One of those options is for the differentiation of provider rates according to geographic regions. Determination of the feasibility of regional rates should be based on an analysis of the cost data derived from an initial survey of HCB cost.
System factors in agency size.	One of Myers and Stauffer's recommendations is to potentially use peer groups to differentiate prices determined from a cost survey of HCB providers. Peer groups can be based on several different criteria, including agency size. Determination of the feasibility of peer group rates should be based on an analysis of the cost data derived from an initial survey of HCB cost.
System utilizes an "escalating" mechanism allowing adjustment of rates under certain conditions established in the regulations.	Myers and Stauffer recommends provider rates based on an HCB cost survey which would be performed on a periodic basis of every two to four years. During interim years between surveys, inflation factors could be

Rate Methodology Criteria for Consideration per RFP	How addressed in Myers and Stauffer Recommendations
	used to adjust rates.
System factors in Program Quality Indicators that recognize and reward quality programs with "higher" rates and lower performing programs are held at "lower" rates.	Myers and Stauffer has considered the option of quality-based adjustment factors for a rate methodology. While adjustments based on quality are an ideal long-term goal for DHSS, Myers and Stauffer recommends that DHSS defer potential inclusion of a quality adjustment mechanism until a later date, after an HCB cost survey methodology has been developed and implemented. DHSS should continue to monitor on-going initiatives by CMS to promote quality through reimbursement incentive programs.
System suggests and includes program standard against which claims audit findings would be considered resulting in a "mitigation" profile inclusive of "hold harmless" periods during which higher scoring agency's claims would not be audited for some period of time as a result of their "high score"/"excellent" review.	Myers and Stauffer has reviewed this potential criteria from the RFP but does not recommend changes to the HCB reimbursement methodology tied to the outcome of claims audits. While "hold harmless" periods may be a viable strategy for DHSS to consider in its ongoing program integrity activities, this issue does not appear to be directly linked to rate-setting issues.
Methodology will define the "regulated" and "competitive" models for reimbursement.	During conversations with DHSS staff, Myers and Stauffer has determined that a "regulated" model of reimbursement, as intended by DHSS in the RFP, refers to one in which highly structured and regulated cost reporting lead to the creation of provider-specific, cost-based rates. Alternately, a "competitive" model refers to one in which all providers receive a common reimbursement rate (or "price") and must competitively manage their service delivery mechanisms to deliver services in a cost-efficient manner. According to these distinctions, Myers and Stauffer's recommendations primarily fall into the "competitive" category. Although the recommendations include elements of cost reporting, the recommended approach is to use a cost survey to set rates for all providers (or groups of providers) at cost benchmarks that will promote and reward efficient care and service delivery. Rates would not be provider-specific.
Discuss rate incentives for cost containment to the Medicaid program, as well as incentives	Myers and Stauffer's recommendations would set common rates, or prices, for all providers

Rate Methodology Criteria for Consideration per RFP	How addressed in Myers and Stauffer Recommendations
for improved quality care and efficient utilization of providers' capacity.	(or groups of providers). Prices set from aggregated cost data may create incentives for efficiency since there is a potential for a cost-efficient provider to realize revenues in excess of cost.
The rate-setting methodology addresses the uniqueness of Alaskan values, cultural heritages, budget realities and service principles.	The cost survey methodology proposed by Myers and Stauffer would collect data on the actual costs incurred by HCB providers in Alaska. Cost data relating specifically to the provision of HCB services in Alaska will provide DHSS with the information needed to set rates that reflect actual provider costs.

V. Plans for Future Work and Final Deliverable

1. DHSS evaluation of recommendations

Myers and Stauffer has developed these recommendations after careful consideration of discussions with DHSS staff, attendance at meetings with provider associations, and review of current rate-setting and program policies and three previous reports from consultants hired by DHSS.

The HCB rate-setting methodology recommendations are being presented to DHSS for further review and discussion. As needed, the Myers and Stauffer project team will be available to answer DHSS' questions regarding the recommendations or to discuss rate-setting concepts that were not recommended. Discussions will include the potential for meeting DHSS short and long-term program objectives.

Myers and Stauffer will continue to advise and assist DHSS as it considers the adoption of a recommendation, including specific components and potential refinements or clarifications necessary to reflect the needs of DHSS. We will also participate in additional provider meetings, should DHSS wish to involve stakeholders further in the deliberation process.

Transition Plan

Once DHSS has selected its preferred rate-setting approach, Myers and Stauffer will assist in the development of a transition plan. The transition plan will include a discussion of implementation issues, such as recommendations for changes to regulations and applicable timelines. We will also advise DHSS on next steps relating to any interim rate changes they may wish to adopt prior to obtaining the results from the first HCB cost survey.

Depending upon the methodology selected, the transition plan may include the following:

- Brief description of each step in the implementation process.
- Recommended dates for initiation and completion of each step.
- Identification and timing of provider communications.
- Recommendations for obtaining provider buy-in and support.
- Evaluation of regulatory changes.
- Recommendations for provider training.
- Development of training materials.
- Submission to CMS of waiver amendment(s).
- Submission to CMS of state plan amendment(s) .
- Development of provider manual updates.
- Preparation of fiscal impact analyses.

- Determination of a phase-in vs. full implementation of the new methodology.
- Evaluation and development of any authorization and claims system changes.
- Development of management reports.

As directed by DHSS, for any or all of the above, it may be useful to continue to solicit provider feedback via meetings, teleconferences, and other communications.

Timeline

As required by the RFP, this report of potential reimbursement methodologies is being presented by Myers and Stauffer to DHSS for further deliberation. A final report, which will present the transition plan for a new HCB services rate-setting methodology, will be provided to DHSS on or before June 30, 2008.