Personal Care Services, Community First Choice, Long-Term Services and Supports Targeted Case Management, and Waiver Rate-Setting Methodology

Office of Rate Review
Alaska Department of Health

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Target Rate Setting

Services and regulatory authority

Personal care services under 7 AAC 125.010 - 7 AAC 125.199, community first choice personal care services under 7 AAC 127.010 – 7 AAC 127.990, community first choice chore services under 7 AAC 130.245, adult day services under 7 AAC 130.250, day habilitation services under 7 AAC 130.260, residential habilitation services under 7 AAC 130.265, supported-employment services under 7 AAC 130.270, intensive active treatment services under 7 AAC 130.275, respite care services under 7 AAC 130.280, and meal services under 7 AAC 130.295.

Methodology

The Office of Rate Review ("ORR") will set Medicaid reimbursement rates for the services listed above using a target rate-setting methodology. This methodology consists of five key components: (1) collecting annual reports from a narrow list of target providers; (2) producing allowable cost pools for each service from the annual reports; (3) adjusting the allowable cost pools for each service to establish total allowable costs; (4) developing a raw Medicaid reimbursement rate for each service from the total allowable costs; and, (5) converting the raw Medicaid reimbursement rates for each service into final rates.

(1) Collecting Annual Reports from Target Providers

Given the large number of providers of home and community-based Waiver services, community first choice services, and personal care services, and the variety in financial and operational sophistication, ORR will collect cost reports from a narrow group of "target" providers. Target providers will be designated by ORR on an annual basis.

- *Target Provider Criteria*: For each service category listed above (see "Services and regulatory authority")—=total Medicaid units of service will be identified and organized by provider Tax ID over the most recent state fiscal year for which timely filing has passed. Starting with providers who provided the highest number of Medicaid service units and working down to providers who provided the lowest number of Medicaid service units, ORR will rank the providers (highest unit providers to lowest unit providers) until either 80% of the Medicaid service units are represented or 5 providers are identified, whichever occurs first. Each service category is defined as the procedure codes and modifiers that are reported together in a cost center on the expense worksheet of the cost survey. For example, Day Habilitation-Individual and Day Habilitation-Group are reported together in a cost center on the expense worksheet and will be analyzed together to determine the highest providers of day habilitation services. For services that are reported together in which the units of service are different, such as Adult Day Care – 15 minutes and Adult Day Care – Half Day, the half day units will be recalculated into 15 minute units using 3.5 hours as the standard half-day time.

- *Publishing Target List*: Once ORR identifies the target providers for each service category, a target list consisting of the identified providers and their corresponding fiscal years will be generated. If a provider is a target provider for multiple services, the target provider will be listed once on the list. On August 1st of each year, the department will publish the most recent target provider list on the Alaska Online Public Notice System, ORR will coordinate with SDS to publish the information on their website, and notify providers through the SDS E- Alert System.

  As stated above, the target provider list is based on Medicaid service units provided during dates of service in the most recent state fiscal year for which timely filing has passed. For example, the target provider list published on August 1, 2022 will be based on dates of service between July 1, 2020 and June 30, 2021.

- *Collecting Cost Reports from Target Providers:* For each provider on the target provider list, ORR will indicate whether it is a rebase year for which a full annual report is required or whether it is a non-rebase year for which a reduced annual report is required. This description will also specify the fiscal year that must be covered in the annual report. For example, if Target Provider A's fiscal year ends 12/31, Target Provider B's fiscal year ends 6/30, and Target Provider C's fiscal year ends 9/30, ORR would indicate for Target Provider A that it is a rebase year for which a full annual report is required, but for Target Provider B and Target Provider C, ORR would indicate that it is not a rebase year, so a reduced annual report is required. Since ORR rebases rates using cost information from three different fiscal years, in this example, the target provider list published the following year would indicate that Target Provider B and Target Provider C must submit full annual reports, but Target Provider A would only submit a reduced annual report. Eventually, ORR would rebase all of the rates using the costs from the full annual reports submitted by all three providers. Regardless of whether a full or reduced annual report is required, the annual report is due to ORR no later than 8 months after the end of the fiscal year specified in the description.

  - Full Annual Report
    - Cover sheet or letter signed by the chief executive officer indicating that the submitted information is complete and accurate to the best of the officer's knowledge;
    - Audited financial statements completed in accordance with generally accepted auditing standards ("GAAS") or generally accepted government auditing standards ("GAGAS");
    - Post-audit working trial balance that ties to the audited financial statements;
    - Statistics worksheet from the department's *Cost Survey*, adopted by reference in 7 AAC 160.900;
    - Reconciliation of the post-audit working trial balance to the Expense Worksheet of the Cost Survey;
    - Cost Survey, as adopted by reference in 7 AAC 160.900; and

  - Reduced Annual Report
    - Cover sheet or letter signed by the chief executive officer indicating that the submitted information is complete and accurate to the best of the officer's knowledge;

    - Audited financial statements completed in accordance with generally accepted auditing standards ("GAAS") or generally accepted government auditing standards ("GAGAS");

    - Per 7 AAC 145.531(b)(1), a provider with less than $750,000 in Medicaid revenue to personal care services, community first choice services, and home and community based waiver services may choose to substitute a reviewed audited financial statement by a CPA instead of audited financial statements when a reduced report is required,

- Post-audit working trial balance that ties to the audited financial statements;

    - Per 7 AAC 145.531(b)(1), a provider with less than $750,000 in Medicaid revenue to personal care services, community first choice services, and home and community based waiver services may choose to substitute a reviewed working trial balance by a CPA instead of post-audit working trial balance when a reduced report is required,

- Statistics worksheet from the department's *Cost Survey*, adopted by reference in 7 AAC 160.900

(2) Producing Allowable Cost Pools for Each Service from Full Annual Reports

Conceptually, a Medicaid reimbursement rate is calculated for each service using a simple formula: total allowable costs divided by total units of service. Full annual reports from target providers consist of cost data that is used to determine total allowable costs. To determine total allowable costs, ORR first needs to create allowable cost pools for each service category. Once it creates the cost pools for each service category, ORR can adjust those cost pools into total allowable costs for each service category. The total allowable costs for each service category are then computed into a raw Medicaid reimbursement rate, which ultimately is converted into a final Medicaid reimbursement rate.

Full annual reports include cost surveys. The worksheets in the cost surveys that are used to produce the allowable cost pools for each service category are the Expense Worksheet, Revenue and Statistics Worksheet, Home Office Worksheet, and Building Worksheet. The following steps are taken to derive allowable cost pools for each service category from cost surveys submitted by target providers.

- *Completeness and Accuracy:* To arrive at allowable cost pools for each service category, the cost reports submitted by the target providers are first reviewed for completeness and accuracy. Cost reports determined to be incomplete or inaccurate are returned to the target provider for correction. Cost reports that are determined complete and accurate are analyzed to ensure that non-allowable expenses, as listed in 7 AAC 145.533, are appropriately listed in the non-covered section of the cost report.

- *Geographic Adjustment:* Since target providers operate in different regions of the state, reported costs must be adjusted to a neutral base so that costs from different providers can be combined into allowable cost pools. Target providers with Medicaid reimbursement rates that receive a single geographic factor will have reported costs adjusted back by that factor. Target provides with Medicaid reimbursement rates that receive multiple geographic factors will have reported costs adjusted back by a weighted average of those geographic factors.

- *Allocation of General Service Costs:* These costs are allocated to each cost center based on a percentage that is determined by the following formula: [cost center's costs - building & maintenance costs] / [total costs - building & maintenance costs]. Note, this formula uses costs that have been geographically neutralized (see above). General Service costs are allocated to all cost centers including Waiver direct-care cost centers, non-covered costs centers, and non-waiver cost centers.

- *Room & Board Exclusion:* To ensure that Medicaid is not reimbursing room and board costs for residential habilitation services listed in the "Services" section (see page 1), an amount equal to the amount the federal government and State of Alaska pay for living expenses for adults on public assistance, which is derived from Social Security Income standards, will be adjusted off the Expense Worksheet. Specifically, the room and board exclusion shall equal the maximum federal Supplemental Security Income payment amount that is in effect on the June 30 that precedes the date on which rates are to be publicly noticed plus the Alaska State Supplementation amount to that maximum federal Supplemental Security Income payment amount for an individual residing in an residential supported living facility who is eligible for federal Supplemental Security Income minus the incidental personal needs amount in 7 AAC 40.395(a)(1). Shown in formula terms, the exclusion is as follows:

Room & Board Exclusion =

Maximum Federal Supplemental Security Income Payment
Amount in effect on the June 30 that precedes the date on
which rates are publicly noticed

+

Alaska State Supplementation Amount to that maximum
Federal Supplemental Security Income payment amount for an
individual residing in a residential supported living facility
who is
eligible for federal Supplemental Security Income

–

Incidental personal needs amount in 7 AAC 40.395(a)(1)

If Medicaid rates were to be rebased on July 1, 2023 and the public notice for those rates went out December 15, 2022, the Room & Board Exclusion would be
$844 [Room & Board Exclusion = $844 + $100 – $100 = $844].

- *Acuity Adjustment*: Some target providers receive enhanced Medicaid reimbursement for high-acuity group home habilitation services. For purposes of neutralizing costs so that costs from different providers can be combined into allowable cost pools, total units dedicated to high-acuity group home habilitation services are multiplied by the acuity add-on rate that is in effect on July 1 of the target provider's reported fiscal year. This dollar amount is then removed from the group home habilitation cost center.

- *Inflation*: After performing the aforementioned adjustments, each allowable cost pool is inflated to the mid-point of the time period in which the rate will be effective using the CMS Home Health Agency Market Basket in the most recent quarterly publication of Global Insight's *Healthcare Cost Review*, available 60 days prior to July 1.

<u>(3) Adjusting Allowable Cost Pools for Each Service to Establish Total Allowable Costs</u>

The allowable cost pools do not represent total allowable costs because they only represent costs of the target providers themselves. Although the target providers deliver a majority of the units of service, there are still other providers—many of which are small, intensely hands-on, and located in other geographic areas—with cost and operational structures that do not align with the target providers. For example, not all providers are capable of realizing economies of scale or other cost efficiencies that are often available to target providers. While cost data from target providers is the most efficient, sound starting point for establishing Medicaid reimbursement rates for services, adjustment is necessary to "assure that payments are consistent with efficiency, economy, and quality of care and services are available . . . to the extent that such care and services are available to the general population in the geographic area[.]" See *§ 1902 of the Social Security Act*.

Recipients can only access services if there are providers available to render the services. To ensure that an adequate number of providers can operate under Medicaid reimbursement rates that are derived from target provider cost data, the allowable cost pools for each service are increased by 5% to generate the total allowable costs. This is efficient because the allowable cost pools are created from providers who deliver a majority of the Medicaid service units for home and community-based Waiver services, community first choice services, and personal care services. It is economical because any growth in program costs from rate rebasing is controlled and contained through the stop-loss procedure described in (5) (see below). Finally, this adjustment ensures access to care and quality of services in a manner that is consistent with § 1902 of the Social Security Act.

<u>(4)</u> <u>Developing Raw Medicaid Reimbursement Rates from Total Allowable Costs</u>

With total allowable costs identified, a raw Medicaid reimbursement rate for each service can be generated by dividing total allowable costs by total units of services.

- *Validating Medicaid Units of Service*: Target providers report Medicaid units of service and total units of service on the Revenue Worksheet of the cost report. ORR pulls Medicaid claims data from the Medicaid Management Information System ("MMIS") to test the validity of the reported Medicaid units of service. If there is a variance greater than 2% between the target provider's Medicaid units of service and the MMIS Medicaid units of service, ORR will formally inquire about the discrepancy. If the variance cannot be adequately explained or supported, the target provider's Medicaid units of service will be adjusted to match the MMIS Medicaid units of service, and a corresponding adjustment will be made to total units of service.

- *Special Calculations*: Certain services have combined total allowable costs. In the absence of valid cost based reporting, these services require special calculations to generate separate Medicaid reimbursement rates from the same pool of total allowable costs. Using actual expenditures from providers to calculate the total allowable costs, the categories of service and special calculations are as follows:

    - <u>Individual and Group Codes</u>: Several services have codes for an individual setting and a group setting, but the total allowable costs for the codes are reported together in a single cost center or pool. These services include day habilitation, supported employment and pre-employment. To generate separate Medicaid reimbursement rates for group codes and individual codes within the same category of service, the rate for the group code is calculated as 60% of the rate for the individual code for the first rebase and will be stepped down in 10% increments over the next rebasing periods until the group rate is 40% of the individual rate. The rate for the individual code is set at an

amount that is consistent with the following formula: [unknown rate for individual codes X units of service for the individual code] + [unknown rate for group code X units of service for the group code] = [Total Allowable Costs after Application of Stop-Loss Adjustment]. Note, the stop loss adjustment is described in (5) below.

- Pre-employment: The rates for these services are calculated as noted in the individual and group codes section above. If no or insufficient pre-employment costs are submitted, the pre-employment rate will be set at the rate for supported employment.

- Respite Services: Respite services include respite and family-directed respite. These services are reimbursed using both daily units and 15-minute units. Reported daily units are converted to and combined with the 15-minutes units using an assumption that a daily unit equals 56 units of 15-minute units. Total allowable costs after application of the stop-loss adjustment (see (5) below) are then divided by total 15-minute units to generate the rate for 15-minute respite. The rate for daily respite is set by multiplying the rate for the 15-minute respite by 56 units of 15- minute units originally used to convert the daily units into 15-minute units.

- Adult Day Care: Adult day care services are reimbursed using both half-day units and 15-minute units. Reported half-day units are converted to and combined with the 15-minute units using an assumption that a half-day unit equals 14 units of 15-minute units. Total allowable costs after application of the stop-loss adjustment (see (5) below) are then divided by total 15-minute units to generate the rate for 15- minute adult day care. The rate for half-day adult day care is set by multiplying the rate for 15-minute adult day care by 14 units of 15-minute units originally used to convert the half-day units into 15-minute units.

- In Home Habilitation and Supported Living Habilitation: Costs and units of service for in-home habilitation and for supported living habilitation will be calculated together to set a rate that is the same for both services.

- Family Habilitation: Costs are units of service for adult and child family habilitation will be calculated together to set a rate that is the same for both services.

(5) Converting Raw Medicaid Reimbursement Rates into Final Rates

Rate systems are vulnerable to dramatic swings in reimbursement rates during rebasing. To avoid system shock from dramatic swings, a stop-loss procedure is deployed to convert the raw rates into final form.

The stop-loss procedure is a means of allowing Medicaid reimbursement rates to change in a predictable and controllable manner. The procedure compares the raw Medicaid reimbursement rates developed in (4) with the Medicaid reimbursement rates that are in effect during the state fiscal year preceding the effective date of the new, rebased rates ("benchmark rate"). If a raw rate is more than 5% higher than the benchmark rate, then Final Rate = [benchmark rate X 1.05]. Similarly, if a raw rate is more than 5% lower than the benchmark rate, then Final Rate = [benchmark rate X 0.95]. Finally, if the difference between a raw rate and the benchmark rate is less than or equal to + or - 5%, then Final Rate = [raw rate].

An aggregate stop-loss procedure is used for services that are subject to "special calculations" in (4) (see above). An aggregate approach is necessary because rates for these services are generated

from total allowable costs that are reported together in a single cost center or pool. Therefore, the stop-loss procedure for these services compares benchmark costs to the total allowable costs. If total allowable costs are more than 5% higher than the benchmark costs, then the Final Total Allowable Costs = [benchmark costs X 1.05]. Similarly, if total allowable costs are more than 5% lower than the benchmark costs, then Final Total Allowable Costs = [benchmark costs X 0.95]. Finally, if the difference between total allowable costs and the benchmark costs is less than or equal to + or - 5%, then Final Total Allowable Costs = [total allowable costs]. Note, benchmark costs are the Medicaid reimbursement rates that are in effect during the state fiscal year preceding the effective date of the new, rebased rates multiplied by the aggregated total units of service reported in the target provider cost surveys.

The stop-loss procedure ensures that the Medicaid reimbursement rates for home and community-based Waiver services, community first choice services, and personal care services, or the total allowable costs for services subject to special calculations, will never increase or decrease more than 5% during a rebasing. This creates fiscal predictability and more effective budget planning for both providers and the State. It also controls growth and contractions in the system by allowing changes to occur gradually over time.

Residential Supported Living Acuity Rate Setting

Services and authority

Residential supported-living services under 7 AAC 130.255.

Methodology

The Office of Rate Review ("ORR") will set Medicaid reimbursement rates for the services listed above using Medicare Cost Reports from the nursing facilities operating in Anchorage, Alaska that are not predominately dedicated to providing transitional care services. This methodology consists of four key components—(1) direct service wages; (2) direct service fringe benefits; (3) overhead; (4) rate calculation—and a single rate for Supported Living services: T2031.

To ensure that Medicaid is not reimbursing room and board for residential supported-living services provided under 7 AAC 130.255, this methodology specifically excludes room and board expenses in its calculation of overhead under (3) (see below).

(1) Direct Service Wages

Direct service wages are reported on Worksheet S-3, Part V of the Medicare Cost Report. Salaries and hours worked are reported for Registered Nurses ("RNs"), Licensed Practical Nurses ("LPNs") and Certified Nursing Aides ("CNAs"). Hourly wage can be computed by dividing salaries by hours worked. Inpatient Days from the Department's MR-O-14 report from the Medicaid Management Information System, and other credible sources, are utilized to arrive at hours per patient day.

The sum of all calculated direct salary amounts is called allowable direct service wages.

Direct Service Salaries

Direct service salaries are computed by multiplying the reported wage rate for CNAs by percentage of the reported hours for RNs, LPNs and CNAs.

(2) Direct Service Fringe Benefits

Direct Service fringe benefits are reported on Worksheet S-3, Part V of the Medicare Cost Report. Fringe benefits and wages are reported for Registered Nurses ("RNs"), Licensed Practical Nurses ("LPNs") and Certified Nursing Aides ("CNAs"). Fringe benefits are calculated by multiplying the calculated direct salaries by the average fringe benefit percentage.

(3) Overhead

Overhead Costs for Employee Benefits

Employee benefits must be first calculated separately from "all other" overhead costs because of reporting on the Medicare Cost Report. The figure reported on the Medicare Cost Report includes all fringe benefits, even those already calculated from the Worksheet S-3 series for direct service workers fringe benefits under (2) (see above).

Allowable salaries for overhead cost centers are aggregated to determine total allowable overhead wages. The overhead cost centers include column 1 (wages) of Admin & General, Laundry & Linen, Housekeeping, Dietary, Central Services & Supply, and Social Service.

Total allowable overhead wages are divided by total salaries from Column 1 of Worksheet A of the Medicare Cost Report to arrive at allowable overhead salaries as a percentage of total salaries.

Allowable overhead salaries as a percentage of total salaries is multiplied by employee benefits as reported in Column 7 of Worksheet A of the Medicare Cost Report to arrive at allowable overhead fringe benefits. Allowable overhead fringe benefits are then included in the "all other" overhead costs (see below).

Overhead Costs "All Other"

Allowable overhead costs include allowable overhead wages, allowable overhead other, and allowable employee benefits. Amounts are reported on the Medicare Cost Report as Wages (Col. 1), Other (Col. 2), Total (Col. 3 calculated as Col. 1 + Col. 2), Reclassifications (Col. 4), Reclassified Trial Balance (Col. 5 calculated as Col. 3 + Col. 4), Adjustments for Expenses (Col. 6), and Net Expenses for Allocation (Col 7).

First, the allowable overhead wage portion is calculated by adding the wage portions (Col. 1) for Admin & General, Laundry & Linen, Housekeeping, Dietary, Central Services & Supply, and Social Services. Plant Operation & Maintenance is excluded because it constitutes "room and board."

To calculate the allowable overhead other portion, the other portion of the Medicare Cost Report (Col. 2) cannot be used because it may include expense amounts that are not Medicaid allowable expenses, such as Bad Debt and certain types of advertising. The Net Expenses for Allocation (Col. 7) cannot be used because while it excludes the non-allowable Medicaid expenses, it includes salary expenses. Therefore, the allowable overhead other portion is calculated as Net

Expenses for Allocation (Col. 7) minus wages (Col 1.) for Admin & General, Laundry & Linen, Housekeeping, Central Services & Supply, and Social Services. The other portion of Dietary, Buildings & Fixtures, Moveable Equipment, Plant Operation, and Maintenance & Repairs are non-allowable because they constitute "room and board."

To determine the percentage of allowable overhead that is allocated to direct service costs for each rate tier, first non-general service costs are calculated by subtracting all general service cost report lines from total expenses reported in column 7 of Worksheet A. The percentage of allowable overhead is calculated by adding direct service wages calculated for each tier divided by the calculated non-general service costs. The percentage of allowable overhead for each tier is then multiplied by allowable overhead to determine the amount of allowable overhead that is allocated to the calculated direct service costs for purposes of arriving at overhead costs.

(4) Raw Rate Calculation

The direct service wages, direct service fringe benefits, and overhead are added together to arrive at total allowable Residential Supported Living costs. The total allowable Residential Supported Living costs are then divided by the total reported nursing home expenses reported in Column 7 of Worksheet A of the cost reports to arrive at a percentage.

The percentage is multiplied by the "average Anchorage nursing facility Medicaid rate" to generate a raw rate before inflation. The "average Anchorage nursing facility Medicaid rate" is calculated by taking a weighted average of the long term care Medicaid rates in effect during the time period covered in the Medicare Cost Reports used by this methodology for each nursing facility operating in Anchorage, Alaska that is not predominately dedicated to providing transitional care services.

The raw rates before inflation are next inflated to the midpoint of the effective year using the most recent 1st quarter Global Insight's Home Health market basket index to arrive at raw rates after inflation.

(5) Converting Raw Medicaid Reimbursement Rates into Final Rate

The stop-loss procedure is a means of allowing Medicaid reimbursement rates to change in a predictable and controllable manner. The procedure compares the raw Medicaid reimbursement rate after inflation developed through the methodology above with the average Medicaid reimbursement rate for residential supported living services ("aggregate benchmark rate"). The aggregate benchmark rate will be calculated by multiplying the rates in effect during the state fiscal year preceding the effective date of the new, rebased rates by the residential supported living units of service for the dates of service in the most recent state fiscal year for which timely filing has passed. For example, an aggregate benchmark rate for a rebased rate effective July 1, 2016 would be= [[(SFY15 T2031 rate x SFY15 units of service) + (SFY15 T2031 UR rate x SFY15 T2031 UR units of service) + (SFY15 T2031 US rate x SFY15 T2031 US units of service)] / (T2031 units of service + T2031 UR units of service + T2031 US units of service)].

If a raw rate after inflation is more than 5% higher than the aggregate benchmark rate, then Final Rate = [aggregate benchmark rate X 1.05]. Similarly, if a raw rate after inflation is more than 5% lower than the aggregated benchmark rate, then Final Rate = [benchmark rate X 0.95]. Finally, if the difference between a raw rate and the benchmark rate is less than or equal to + or - 5%, then Final Rate = [raw rate after inflation].

Care Coordination Services and Long-Term Services and Supports Targeted Case Management Rate Setting

Services

Care coordination services under 7 AAC 130.240 and long-term services and supports targeted case management under 7 AAC 128.010..

Methodology

Rates will be set using a modeled rate methodology that includes components for salaries, fringe benefits, administrative/general, and case load size.

Transportation Rate Setting

Services

Transportation services under 7 AAC 130.290(a).

Methodology

The rates for transportation per trip up to 20 miles – receipient and for transportation per trip attendant or escort will be set using a modeled rate methodology that includes components for salaries, fringe benefits, administrative/general, time, and mileage.

The paratransit rate and the transportation per trip greater than 20 miles will be set at double the rate for transportation per trip up to 20 miles – recipient.

Exceptional Rate changes

The department may increase the Medicaid reimbursement rate or rates if it finds by clear and convincing evidence that the rate or rates established under the regional-based nursing facility Medicare Cost Report rate model do not allow for reasonable access to quality recipient care provided by efficiently and economically managed providers of services, that that increasing the reimbursement rate is in the public interest.