Senior and Disability Services Acuity Rate Adjustment Final Report

PREPARED FOR THE ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

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CERTIFIED PUBLIC ACCOUNTANTS

MAY 20, 2014

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Senior and Disability Services Acuity Rate Adjustment Report

I. Background

Myers and Stauffer has been engaged by the Alaska Department of Health and Social Services (DHSS) to perform research of the reimbursement methodologies and recommend revisions to incorporate acuity adjustment strategies into the rate setting process for certain home and community based services. Acuity adjusted rates should produce a greater correlation between the cost of providing services and Medicaid reimbursement received.

Acuity adjustment for rates is most appropriate with services that are reimbursed with a broad unit of service. Myers and Stauffer suggested the home and community based services most appropriate for acuity adjustments are those reimbursed on a per diem basis. Accordingly, our discussions focus on-going acuity analysis on residential habilitation reimbursed on a per diem basis (procedure codes T2016 and T2016 TG) and assisted living home services (procedure code T2031 and T2031 TG).

To implement an acuity adjustment methodology for senior and disability services Myers and Stauffer recommended using the currently implemented Consumer Assessment Tool (CAT) and the Inventory for Client and Agency Planning (ICAP) assessments as the basis of the acuity adjustment.

The CAT, used in the waiver programs for seniors and individuals with physical disabilities, was designed to be objective and easy to administer. The CAT has language, definitions and a format similar to that used in the Minimum Data Set (MDS 2.0) previously used in nursing facilities in the United States that participate in Medicare or Medicaid (a new version of the MDS, MDS 3.0, is currently used). Accordingly, the use of the CAT as the basis for acuity adjustment for the reimbursement of assisted living home or other services for seniors and individuals with physical disabilities has reasonable precedent.

The ICAP is the current assessment tool used by DHSS for its waiver program for individuals with intellectual and developmental disabilities. It is a comprehensive, structured instrument designed to assess the status, adaptive functioning and service needs of clients. The ICAP is useful for determining a client's service needs and for monitoring behavioral changes. The types of information collected by the ICAP include:

- Diagnostic status and functional limitations.
- Adaptive behavior skills.
- Problem behaviors.
- Service status and needs.

Similarly, the use of the ICAP as a means of acuity adjustment for group home habilitation for individuals with intellectual or development disabilities has a reasonable basis. The ICAP service levels were developed through a series of analyses to determine an objective manner of combining assessment responses to accurately reflect appropriate service intensity (level of care or supervision and training) needed.

Myers and Stauffer also recommended that DHSS use a tiered rate approach for home and community based services using provider cost data already gathered or in the process of being gathered through current cost reporting processes.

Tiered rate systems divide the population into separately defined groups, with typically from three to five payment levels. The number of tiers should be small enough to be managed effectively yet large enough to sufficiently differentiate varying needs. Levels are defined based on the type, number and severity of activities of daily living (ADL) limitations, medical needs, cognition impairments and challenging behaviors. Tiered rates should create incentives for providers to serve residents with higher service needs.

II. Residential Habilitation

A. Data Gathering

The data needed to continue the analysis of a potential acuity rate system included claims data, ICAP assessments and as filed cost report data. The claims data file Myers and Stauffer used was for service dates between January 1, 2011 and December 31, 2011. The ICAP data used was from the period January 1, 2010 through December 31, 2011. We received cost reports in two batches with the first batch including 61 files with December 31, 2011 year end dates. The second batch included 67 files with both December 31, 2011 and June 30, 2012 year ends.

Data items available for use in the analysis required a claim for the service and a completed ICAP assessment that could be linked to a provider with a submitted cost report. The following steps were necessary to obtain that linkage.

In the ICAP data file each recipient is identified by a Client ID which is not included in the claims file. The claims file used the recipient's Medicaid number. To link the data additional tables had to be built which increased the difficulty in obtaining useable files. This process identified 379 ICAP assessments for individuals that had a claim for residential habilitation services. There were 35 individual Medicaid provider numbers represented in these claims.

The next step was to link these providers to a filed cost report. Myers and Stauffer received the cost reports from the Office of Rate Review in a PDF format. In order to perform any analysis, the data was keyed into an individual Excel template for each facility, aggregated into a single spreadsheet and then imported into an Access database file. The Medicaid provider numbers were included on the Building Tab within the spreadsheet and providers could have multiple provider numbers included on one cost report. Some cost reports did not include any Medicaid provider numbers which created some limits on the ability to link cost data to the analysis.

From the 35 providers with ICAP data linked to the claims, 25 providers had cost data that could be used in the analysis. Providers without cost data included those with partial years, year ends that were not yet due, those that submitted cost reports with errors needing correction or those with cost reports not currently submitted.

B. Analysis

The ICAP service level combines the broad adaptive (70%) and the general maladaptive behavior (30%) scores to assist in determining level of care, supervision, support or habilitation needed. The ICAP service scores are designed to identify individuals of various levels of need.

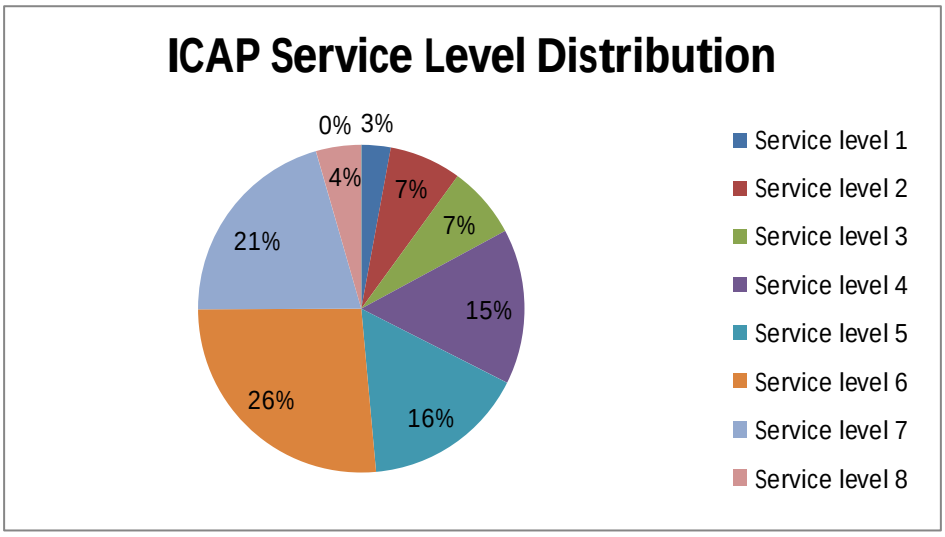
In preparation for an earlier report, Myers and Stauffer performed a preliminary analysis of ICAP service scores that were matched to Alaska Medicaid claims data for calendar year 2011. The distribution of individuals included 28% in Levels 1 through 4, 47% in Levels 5 and 6, 24% in Levels 7 and 8 and no individuals in Level 9. When ICAP scores were linked through the claims information to specific Medicaid

providers, the service scores of the clients averaged by provider were within the range of 4.0 to 7.0 for the majority of providers.

For the analysis Myers and Stauffer linked 379 ICAP assessments with claims data for residential habilitation procedure codes T2016 and T2016 TG. For these individuals, analysis of the ICAP scores yielded the following distribution across the nine service levels.

Service Level	Per Cent
1	3%
2	7%
3	7%
4	15%
5	16%
6	26%
7	21%
8	4%
9	0%

The majority of ICAP assessments have service levels in the range of 4 to 7. The percentage of individuals within the lower need service levels was similar but more varied in the higher need levels.



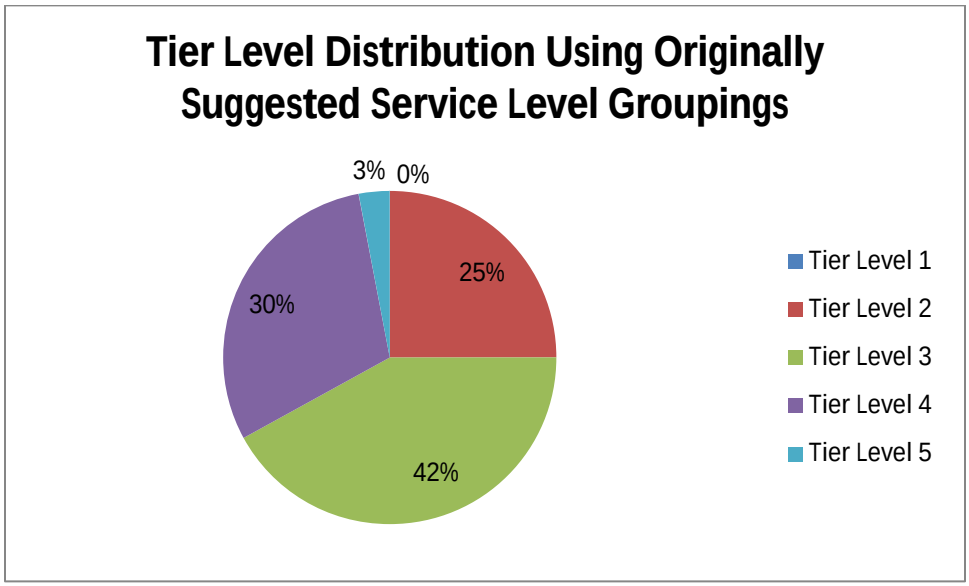
Myers and Stauffer offers three options for the development of acuity-based tiers for the reimbursement of group home habilitation services based on analysis of the ICAP data. Although the ICAP service levels are identified with the highest number being the less acute or needing the least assistance and the smaller numbers the most, it seems easier to understand if tiers are defined having the lowest tier number corresponding to individuals needing the least amount of assistance and the highest tier number the most. For consistency, all tier level discussions will use this same format.

Methodology 1: Tiers Based on ICAP Service Level Scores Only

Myers and Stauffer's first recommendation for group home habilitation service tier levels is based solely on the ICAP calculated service levels and is defined as follows:

- Tier 1: Service level 9 – Infrequent or no assistance for daily living
- Tier 2: Service levels 7 or 8 – Limited personal care and or regular supervision
- Tier 3: Service levels 5 or 6 - Regular personal care and or close supervision
- Tier 4: Service levels 2,3 or 4 - Extensive personal care and or constant supervision
- Tier 5: Service level 1 - Total personal care and intense supervision

Using that definition, the distribution of clients would be 0% in Tier 1, 25% in Tier 2, 42% in Tier 3, 30% in Tier 4 and 3% in Tier 5.



There has been concern expressed that the ICAP service level score alone did not adequately address problems relating to an individual's need for medical care or an individual's behavioral issues. To determine if additional information to address these concerns can be utilized from currently collected information, Myers and Stauffer obtained detailed ICAP data.

Methodology 2: Tiers Based on ICAP Service Level Scores and Measures for Safety, Mobility and Self Care

The detailed data includes sections relating to functional limitations, need for assistance including care by a nurse or physician and problem behavior including frequency of occurrence and severity. To evaluate the ICAP detail Myers and Stauffer first determined the distribution of responses across the various ICAP sections, particularly within Section B, Diagnostic Status; Section C, Functional Limitations and Needed Assistance and Section E, Problem Behavior. Using that information we determined three measures to use as additions to the ICAP service level. These include measures for Safety, Mobility and Self Care. Safety looks at responses to the questions on vision, hearing, frequency of seizures and behavior problems, including the frequency and severity rating on the questions hurtful to self, hurtful to others, destructive to property and disruptive behavior. Mobility encompasses the two mobility questions including assistance needed and self-care considers dressing and toileting. Thresholds for each item within the three measures were established. Points were assigned for each ICAP response at the

threshold and the points were totaled for each measure and then aggregated into an overall Threshold Total.

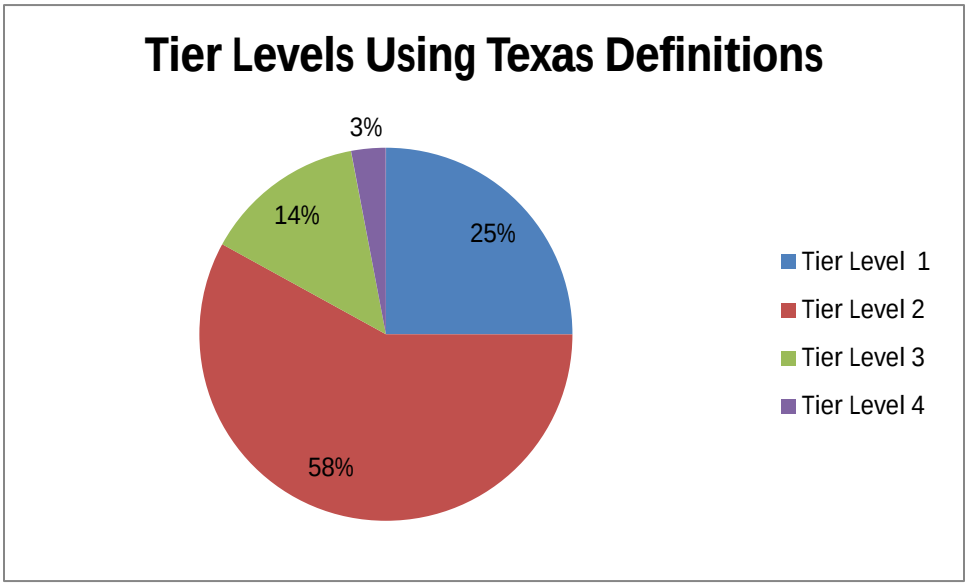
The Tier Levels described in Methodology 1 are also used in Methodology 2. These are then adjusted for each individual exceeding an established threshold level.

Methodology 3: Tiers Based on ICAP Service Level Scores and Measures for Behavior and Medical Issues (Texas Methodology)

The Texas Department of Aging and Disability Services (DADS) is currently using a tiered system in their IDD Waiver Program based on the ICAP service level. They have grouped the service levels into four tiers:

- Tier 1(Texas Level of Need 1 – Intermittent): Service level 7, 8 or 9 – Infrequent assistance or limited personal care and or regular supervision
- Tier 2 (Texas Level of Need 5 – Limited):Service levels 4, 5 or 6 - Regular personal care and or close supervision
- Tier 3 (Texas Level of Need 8 – Extensive): Service levels 2 or 3 - Extensive personal care and or constant supervision
- Tier 4(Texas Level of Need 6 – Pervasive): Service level 1 - Total personal care and intense supervision

Texas has an additional level, Level of Need 9 Pervasive Plus, for individuals requiring one-on-one staffing 24 hours a day and requires approval by DADS. Individuals in LON 1, 5, or 8 may also be assigned to the next higher tier if they have behavior issues requiring a behavioral support plan or medical needs requiring a certain level of care.



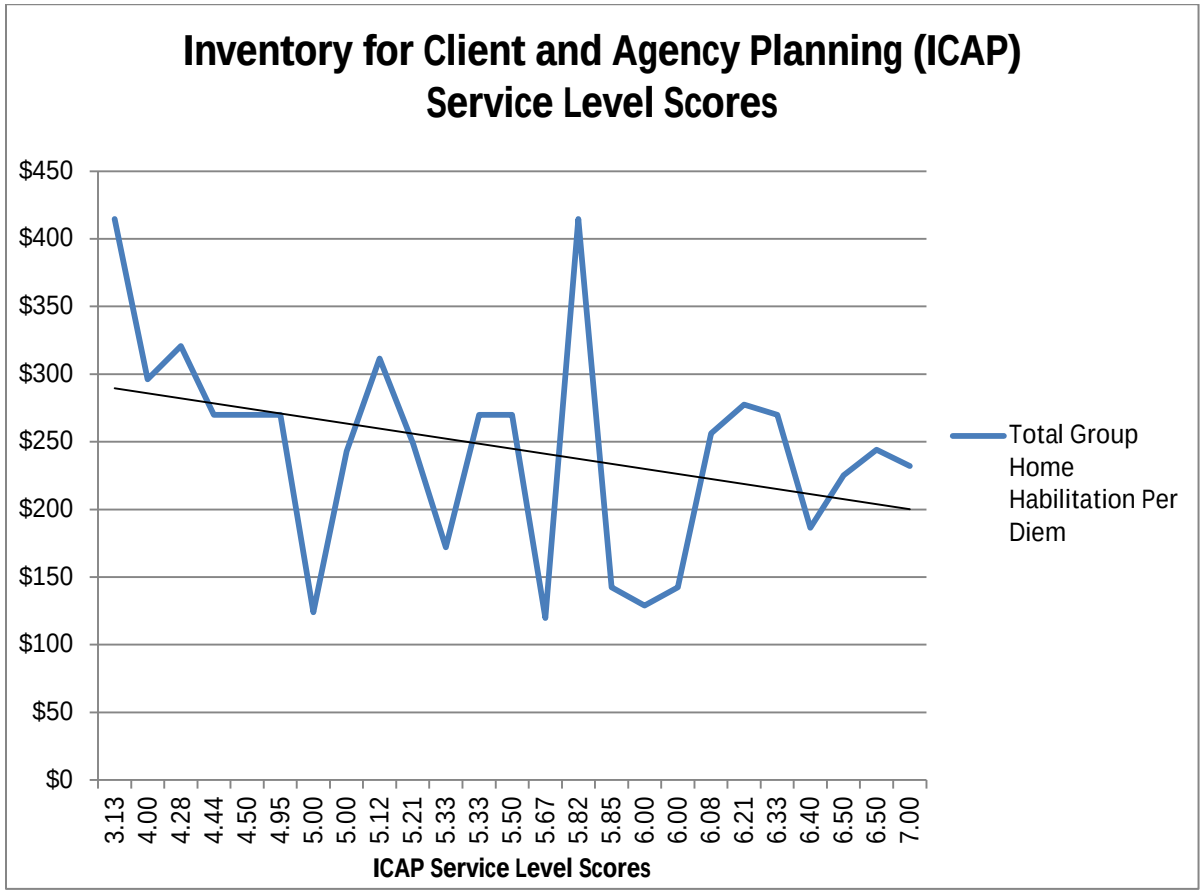
Using the frequency and severity for each of the problem behavior questions on the ICAP and anyone requiring medical care at least monthly, Myers and Stauffer developed a proxy of this methodology. Each behavioral item answered with a frequency of one to six times a week or more was assigned a

point and each item with a severity of serious or higher received a point. The points were then summed for each individual. Total points ranged from 0 to 4 with an average of 0.65 points and a standard deviation of 0.82. Tier levels were then assigned based on the ICAP service level scores. The assigned scores were increased to the next tier level if the behavior proxy was greater than two standard deviations from the mean score or if medical care by a nurse or physician was required at least monthly.

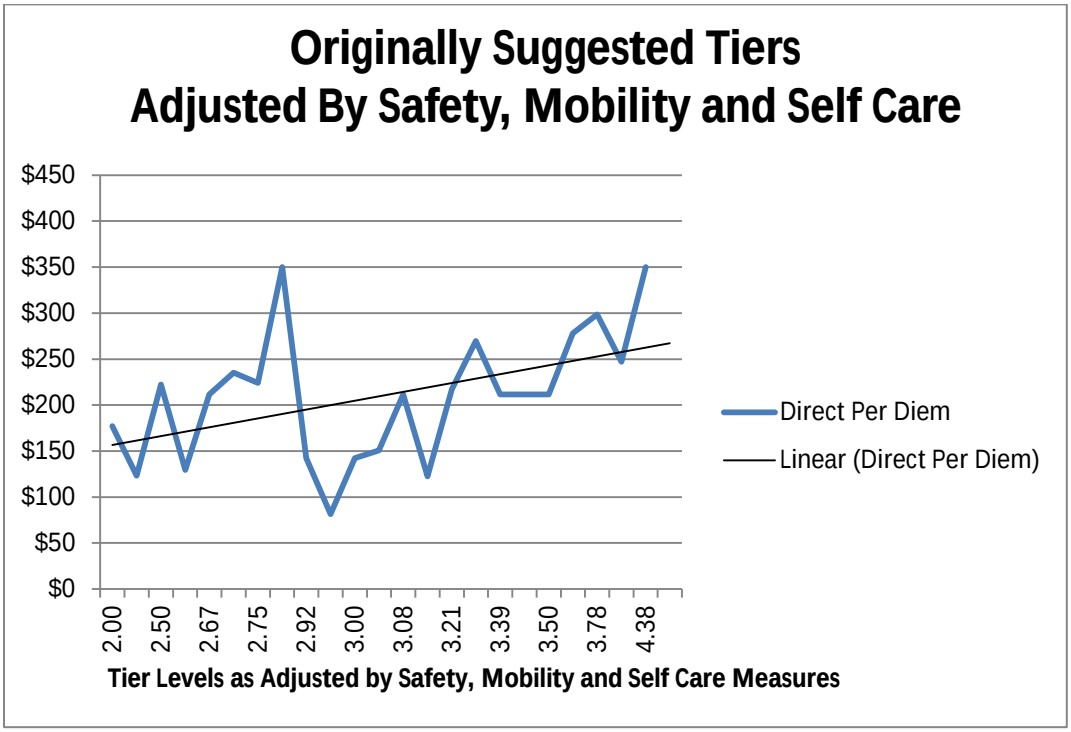
C. Findings

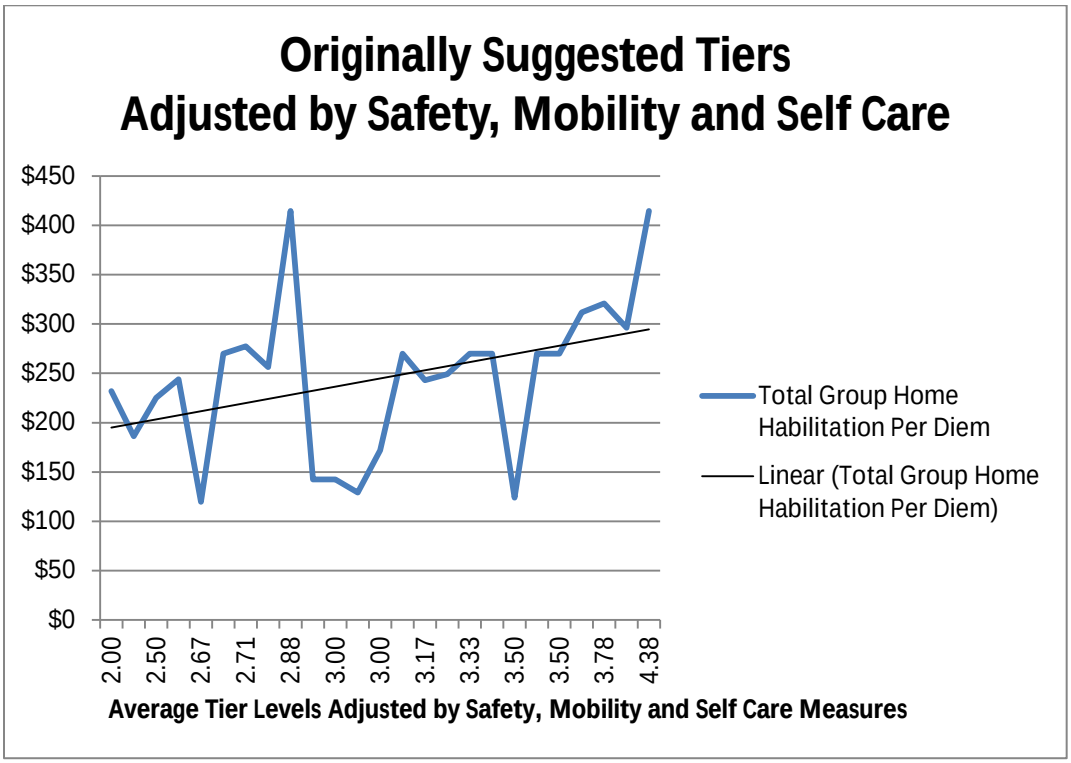
The average ICAP service level score for the 379 assessments that could be matched to all data sources was 5.18. That compared to an average of 5.45 for those providers for which cost data is available. The average per diem cost of salary, wages and fringe benefits reported on line 31 of the cost report was $207.01 (this average excludes two providers who reported all group home habilitation costs on line 33 of the cost report) and the median was $211.44. The average total group home habilitation per diem cost reported on lines 31, 32 and 33 was $244.82 and the median was $256.31.

A graph of the average ICAP service level scores compared to the average total group home habilitation per diem costs was developed. The graph indicates that the costs are quite variable and when a trend line is added, there is a slight inverse relationship which is counterintuitive to the purpose of an acuity adjustment methodology.



Myers and Stauffer then evaluated the impact of using the originally suggested tier groupings plus the tier increase linked to the additional measures for Safety, Mobility and Self Care. We graphed both the per diem costs for salary, wage and fringe benefits reported on Line 31 of the cost report and the total group home habilitation per diem costs.





Again the per diem costs are quite varied but the trend line shows a positive relationship.

D. Myers and Stauffer's Recommendation

Myers and Stauffer recommends using tiers as based on ICAP service level scores and also utilizing the measures of Safety, Mobility and Self Care to increase the assigned tier level when an ICAP assessment meets the threshold requirement. Additional analysis should be performed with the threshold criteria to evaluate whether all items should be included, whether all items should be weighted the same or if additional items should be added. We recommend a five-tiered system:

- Tier 1: Service level 9 – Infrequent or no assistance for daily living
- Tier 2: Service levels 7 or 8 – Limited personal care and or regular supervision
- Tier 3: Service levels 5 or 6 - Regular personal care and or close supervision
- Tier 4: Service levels 2, 3 or 4 - Extensive personal care and or constant supervision
- Tier 5: Service level 1 - Total personal care and intense supervision

The tier based system could be applied to rates in two ways. An average tier level or tier mix could be determined for each provider number or provider (cost reporting) group. A provider tier mix rate could then be calculated. This tier mix rate would be paid for all group home residents. Alternatively a tier specific rate could be established for each Tier and reimbursement would be linked to the number of days claimed at each tier level. Although the individual tier rate may more closely match DHSS goals, it may require additional data collection efforts during rate development and implementation.

Since not all costs reports have been submitted or evaluated and final rates have not been calculated, Myers and Stauffer is currently limiting our recommendation to only the differential reimbursement associated with the tier mix methodology. In the data available currently, there are average tier scores (i.e., the average value of the tier numbers for all clients receiving group home habilitation services on a per diem basis at the facility) ranging from 2.0 to 4.38. There are no facilities with an average tier level below 2 and none as high as 5. Given that the cost category most impacted by increases in acuity is the cost of staffing, we recommend basing the differentials on the direct salary costs. The average difference of costs from levels 2 and 3 is approximately 12% and the average difference of costs between levels 3 and 4 is 32%.

The overall average of the recommended tier groupings is 3.25. So, Myers and Stauffer recommends setting Level 3 at the base tier mix rate (i.e., the average rate determined from the rate calculation process to be undertaken by the Office of Rate Review.) Since currently available cost data should be considered to be preliminary, for simplicity we recommend setting Level 2 at 90% of the base rate, and Level 4 at 130% of the base rate. There are no providers that average in the highest and lowest tier levels. For evaluation purposes, we would propose setting Level 1 at 80% of the base rate and Level 5 at 150% of base. These rate differentials would also be used to establish the tier specific rates. There are individuals in all levels and the fiscal impact analysis of the tier specific rates would help in establishing the rate differentials for Levels 1 and 5 in the tier mix methodology.

For this preliminary analysis, Myers and Stauffer used multiple entries of a provider's cost if they had multiple provider numbers reported on the same cost report. Also the total cost did not include any

allocation of general and administrative costs. Once the rate setting is completed, a future analysis should be adjusted to use the same cost treatments as used by the Office of Rate Review in the rate calculation process.

E. Post Draft Data Gathering - Waiver Rate Calculation Documentation

On August 29, 2013 Myers and Stauffer received copies of the materials DHSS released to demonstrate the payment rate calculations for the proposed regulation changes governing payment rates for Medicaid home and community-based waiver services and personal care attendant services.

F. Additional Information on the Texas Tier Level System

Following the initial distribution of a draft report on June 28, 2013, DHSS asked for further information on the rate methodology used in Texas. We held a phone conversation with state staff and also researched available written documentation. Rates for 3-bed supervised living and 4-bed residential support services are built from fully weighted direct service staff hourly wage rates; staffing ratios; a full-time equivalent ratio to account for absences including vacation, sick leave, holidays and training; a supervision cost calculation. A component for indirect costs is added to the direct service costs and the sum is adjusted by an occupancy factor.

The following are the Texas rates effective September 1, 2013 for 3-bed supervised living and 4-bed residential support services.

Level of Need	Rates Effective 9/1/2013
Intermittent – LON 1	132.47
Limited – LON 5	140.81
Extensive – LON 8	152.97
Pervasive LON 6	173.31
Pervasive + - LON 9	254.97

Setting Level 8 as the base tier level with a percentage value of 100%, the other tier levels were evaluated on their relationship to the base. Using this assumption, the percentage adjustments for the other LON rates for Texas would be as follows.

Level of Need	Comparison to Tier Level 3 (LON 8) Total Rate	Comparison to Tier Level 3 (LON 8) Direct Care Only
Intermittent – LON 1	87%	78%
Limited – LON 5	92%	87%
Extensive – LON 8	100%	100%
Pervasive LON 6	113%	122%
Pervasive + - LON 9	167%	211%

Staff from the state felt the tier level system using the ICAP data was a good start on an acuity-based system. They are now in the planning stages of converting to a case mix rather than a tier system, using the Minimum Data Set Home Care for the assessment document.

G. DHSS Recommendation

After review of the information provided in the report draft of June 28, 2013, DHSS indicated its preference to implement a four tier system linked to the ICAP service scores. As discussed earlier, the higher the tier number the more acute the need. The selected tier system would be defined as follows:

Tier 1: Service level 7, 8 or 9 – Limited personal care and or regular supervision

Tier 2: Service levels 4, 5 or 6 - Regular personal care and or close supervision

Tier 3: Service levels 2 or 3- Extensive personal care and or constant supervision

Tier 4: Service level 1 - Total personal care and intense supervision

The initial assignment to Tier Levels 1, 2, or 3 would be adjusted to the next level if the individual exceeds an established threshold level for safety or security or if the medical needs meet the established criteria. An additional level could be established, as in the Texas system, for individuals with exceptional behavioral problems.

The selected system includes a tier specific rate, established for each tier with reimbursement linked to the number of days claimed at each tier level. The use of these individual tier rates will more closely match DHSS goals for an acuity adjustment, but will require additional data collection efforts during rate development and implementation.

Although all costs reports have been submitted, evaluated and payment rates established. Myers and Stauffer is currently limiting our recommendation to the differential reimbursement associated with the tier mix methodology and not specific rates. For evaluation purposes, we would propose setting Level 1 at 80% of the base rate and Level 5 at 160% of base.

Once more complete ICAP data is obtained, it should be linked to the payment rate calculations information to finalize the differentials and establish specific tier rates. This rate information would then be modeled to determine fiscal impacts on both providers and DHSS.

III. Assisted Living Home Services

A. Data Gathering

The data needed to continue the analysis of a potential acuity rate system for assisted living services are the same as for residential habilitation except the assessment data for this service category is based on the CAT. The CAT data made available to Myers and Stauffer was for the period January 1, 2010 through December 31, 2011.

The CAT data for each recipient is identified by the recipients' Medicaid number which could be easily linked to the claims file. This process identified 1,160 CAT assessments for individuals that had a claim for assisted living services. There were 72 individual Medicaid provider numbers represented in these claims.

Linking the provider numbers to a filed cost report required the same methodology used for the ICAP data. Three of the 72 providers did not report units of service and their cost data could not be included in the analysis which left 69 providers with 49 usable cost reports.

B. Analysis

The CAT form was designed to be an objective tool that is easily coded. The language, definitions, and format of the CAT form are similar to that used in the MDS 2.0 (Minimum Data Set) system, which is used in most long-term care nursing facilities. Definitions and time frames had to be modified in some areas of the CAT form in order to utilize the form in a community setting.

Using existing definitions from the CAT assessment, Myers and Stauffer defined various tier level groupings based on nursing facility level of care criteria. After analysis of the CAT data, Myers and Stauffer offers three options for tier group definitions for reimbursement of assisted living services:

Definition 1: A Six Level Tier System

Tier 6: An individual meeting presumed NF level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 ADL requiring extensive assistance or total dependence in CAT Section E.

And at least one of the following:

- An ADL need including bed mobility, transfer, locomotion, eating and toilet use.
- Professional nursing needs below the level of presumed eligibility.
- Impaired cognition.
- Behavior problems.

Tier 5: An individual meeting presumed NF level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 ADL requiring extensive assistance or total dependence in CAT Section E.

Tier4: An individual meeting NF level of care with professional nursing needs below the level of presumed eligibility without identified cognition or behavior problems.

Tier 3: An individual meeting NF level of care with either:

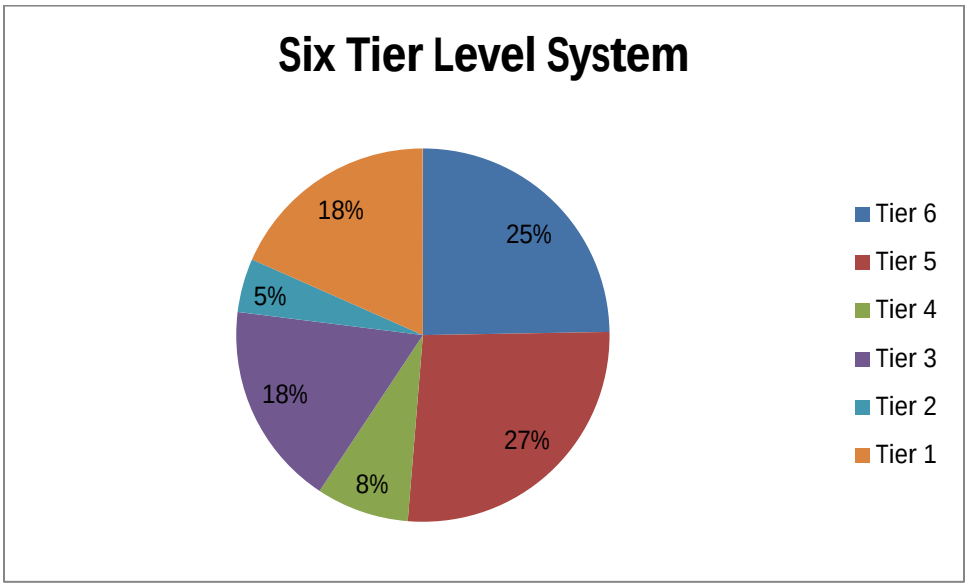
- Impaired cognition.
- Behavior problems.

And an ADL need in at least one of the areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier 2: An individual with ADL needs below the extensive assistance level in at least three of the areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier 1: An individual not meeting the definitions for any of the above defined tiers.

The six tier levels result in the following distribution with an overall average tier score of 3.94.



Definition 2: A Five Level Tier System

Tier 5: An individual meeting presumed NF level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 ADL requiring extensive assistance or total dependence in CAT Section E.

Tier4: An individual meeting NF level of care with professional nursing needs below the level of presumed eligibility without identified cognition or behavior problems.

Tier 3: An individual meeting NF level of care with either:

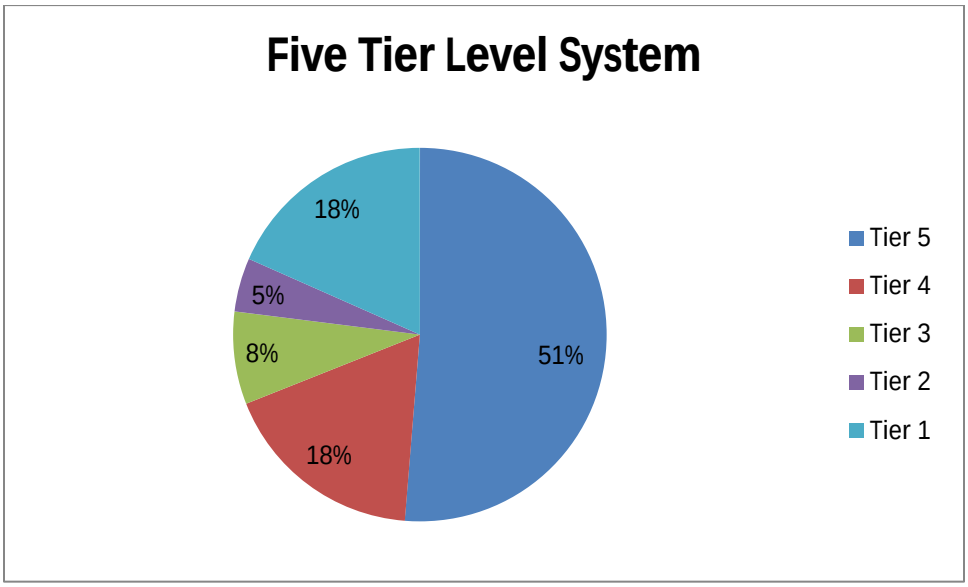
- Impaired cognition.
- Behavior problems.

And an ADL need in at least one of the areas including bed mobility, transfer, locomotion, eating and toilet use. .

Tier 2: An individual with ADL needs below the extensive assistance level in at least three of the areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier 1: An individual not meeting the definitions for any of the above defined tiers.

The five tier level system resulted in the following distribution with an overall average of 3.79.



Definition 3: The Five Level Tier System Reversing Tiers 3 and 4

Tier 5: An individual meeting presumed NF level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 ADL requiring extensive assistance or total dependence in CAT Section E.

Tier 4: An individual meeting NF level of care with either:

- Impaired cognition.
- Behavior problems.

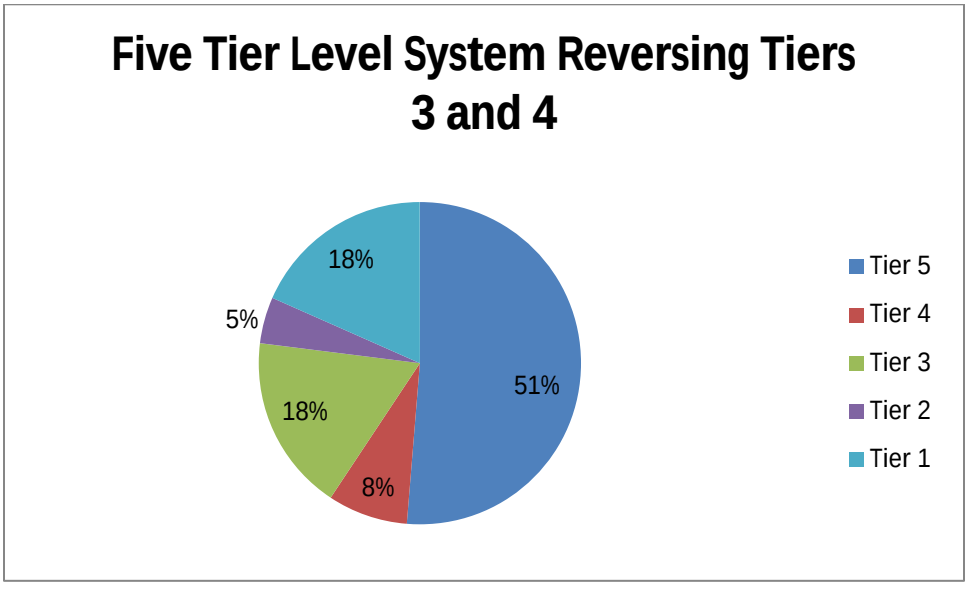
And an ADL need in at least one of the areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier3: An individual meeting NF level of care with professional nursing needs below the level of presumed eligibility without identified cognition or behavior problems.

Tier 2: An individual with ADL needs below the extensive assistance level in at least three of the areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier 1: An individual not meeting the definitions for any of the above defined tiers.

The last recommended tier level definitions did not change the distribution across the tiers but did change assignment of tier scores when doing the averaging.



As in the ICAP tier based system, rates could be applied in two ways. An average tier level or tier mix could be determined for each provider number or provider (cost reporting) group. A provider tier mix rate could then be calculated. This tier mix rate would be paid for all adult residential services. Alternatively a tier specific rate could be established for each tier and reimbursement would be linked to the number of days claimed at each tier level. This methodology could also require additional data collection efforts.

For each of the above recommended definitions, there was an evaluation averaging CAT scores for all provider numbers reported on one cost report and an evaluation in which multiple entries of a providers cost was used if they had multiple provider numbers reporting on the same cost report. For both evaluation methods Myers and Stauffer was not able to allocate the general and administrative costs across services. Once the rate setting is completed, a future analysis should be adjusted to use the same cost treatments as used by the Office of Rate Review in the rate calculating process.

C. Findings

Definition 1: A Six Tier Level System

	Combined Provider Numbers				Each Provider Number Separate		
	Avg. Score	Avg. Salary per Day (lines 76,79,82)	Avg. Total Cost per Day (lines 76 – 84)		Avg. Score	Avg. Salary per Day (lines 76,79,82)	Avg. Total Cost per Day (lines 76 – 84)
Tier 1	1.00	$41.84	$104.45		1.00	$41.84	$104.45
Tier 2	2.50	$41.54	$115.42		2.45	$53.21	$109.58
Tier 3	3.55	$73.80	$124.96		3.44	$78.14	$124.22
Tier 4	4.35	$78.46	$126.85		4.34	$76.07	$124.08
Tier 5	5.16	$67.30	$127.64		5.18	$72.43	$129.32
Tier 6	0.00				6.00	$68.79	$112.69

Definition 2: A Five Tier Level System

	Combined Provider Numbers					Each Provider Number Separate		
	Avg. Score	Avg. Salary per Day (lines 76,79,82)	Avg. Total Cost per Day (lines 76 – 84)			Avg. Score	Avg. Salary per Day (lines 76,79,82)	Avg. Total Cost per Day (lines 76 – 84)
Tier 1	1.00	$41.84	$104.45	58%		1.00	$41.84	$104.45
Tier 2	2.50	$49.87	$156.57	70%		2.48	$64.13	$123.37
Tier 3	3.49	$71.54	$126.12	Base		3.46	$75.68	$126.53
Tier 4	4.31	$73.25	$120.57	102%		4.30	$72.69	$118.10
Tier 5	5.00	$83.53	$142.20	117%		5.00	$78.32	$132.78

Definition 3: The Five Tier Level System Reversing Tier Levels 3 and 4

	Combined Provider Numbers					Each Provider Number Separate		
	Avg. Score	Avg. Salary per Day (lines 76,79,82)	Avg. Total Cost per Day (lines 76 – 84)			Avg. Score	Avg. Salary per Day (lines 76,79,82)	Avg. Total Cost per Day (lines 76 – 84)
Tier 1	1.00	$41.84	$104.45	59%		1.00	$41.84	$104.45
Tier 2	2.59	$60.91	$155.98	85%		2.41	$65.25	$127.95
Tier 3	3.49	$71.51	$123.87	Base		3.46	$76.21	$122.41
Tier 4	4.31	$73.25	$120.57	102%		4.29	$72.67	$119.26
Tier 5	5.00	$83.53	$142.20	114%		5.00	$78.32	$132.78

D. Myers and Stauffer's Recommendation

Myers and Stauffer recommends using the five level tier system with categories 3 and 4 reversed:

Tier 5: An individual meeting presumed NF level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 ADL requiring extensive assistance or total dependence in CAT Section E.

Tier 4: An individual meeting NF level of care with either:

- Impaired cognition.
- Behavior problems.

And at least one ADL need in areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier3: An individual meeting NF level of care with professional nursing needs below the level of presumed eligibility without identified cognition or behavior problems.

Tier 2: An individual with ADL needs below the extensive assistance level in at least three of the areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier 1: An individual not meeting the definitions for any of the above defined tiers.

Since not all costs reports have been submitted or evaluated and final rates have not been calculated, Myers and Stauffer is currently limiting our recommendation to the differential reimbursement associated with the tiers only. In the data available currently, there are average tier scores arranging

from 1.0 to 5.00. Given that the cost category most impacted by increases in acuity is the cost of staffing, we recommend basing the differentials on the direct salary costs. We recommend that the base rate be set at Tier Level 3 (i.e., the average rate determined from the rate calculation process to be undertaken by the Office of Rate Review), that Tier Level 1 be set at 50% of base, Tier Level 2 at 85% of base, Tier Level 4 set at 105% of base and Tier 5 at 115% of base. These rate differentials would also be used to establish the tier specific rates. As with the ICAP data, this analysis should be considered preliminary. The recommended differentials and cost treatments may need to be adjusted as the Office of Rate Review completes the rate calculation process.

E. Post Draft Data Gathering - Waiver Rate Calculation Documentation

On August 29, 2013 Myers and Stauffer received copies of the materials the Department of Health and Social Services released to demonstrate the payment rate calculations for the proposed regulation changes governing payment rates for Medicaid home and community-based waiver services and Personal Care Attendant services.

F. DHSS Recommendation Selection

DHSS has indicated its preference to adopt a four level tier system that would be defined as follows:

Tier 4: An individual meeting presumed NF level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in CAT Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 ADL requiring extensive assistance or total dependence in CAT Section E.

Tier 3: An individual meeting NF level of care with either:

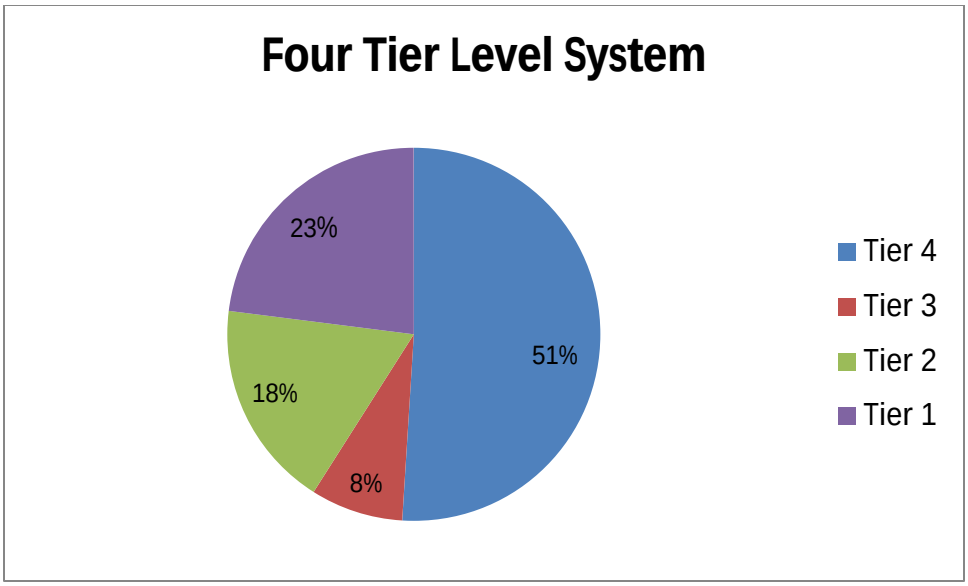
- Impaired cognition.
- Behavior problems.

And at least one ADL need in areas including bed mobility, transfer, locomotion, eating and toilet use.

Tier2: An individual meeting NF level of care with professional nursing needs below the level of presumed eligibility without identified cognition or behavior problems.

Tier 1: An individual with ADL needs below the extensive assistance level in at least three of the areas including bed mobility, transfer, locomotion, eating and toilet use OR not meeting the definitions for any of the above defined tiers.

The following chart shows the distribution across the tiers using the currently available and linked information.



Using a four tier level system, there are average tier scores arranging from 1.0 to 4.00. For further analysis, Myers and Stauffer recommends that the base rate be set at Tier Level 2 (i.e., the average rate determined from the rate calculation process to be undertaken by the Office of Rate Review or $124.81.) The other tiers would be adjusted according to the relationship of average costs. As a recommended starting place for further analysis, we recommend that Tier Level 1 could be set at 85% of base, Tier Level 3 set at 105% of base and Tier4 at 115% of base. Preliminary rates using the suggested differentials are as follows

Global Rate Analysis			
	Avg. Score	Average Cost	
Tier 1	1.59	$106.09	85%
Tier 2	2.49	$124.81	Base
Tier 3	3.31	$131.05	105%
Tier 4	4.00	$143.53	115%

Once more complete CAT data is obtained and linked to provider's reported costs, the tier rate differentials can be tested and refined and rates could be established to use in fiscal models to determine impacts on both providers and DHSS.

IV. Next Steps

The next steps in the process to establish an acuity adjustment methodology for providers of residential habilitation and assisted living home services include the following points:

- Decisions from DHSS on conducting further analysis evaluating the measures used and thresholds for the safety, mobility and self care items.
- Ensure information system capabilities
- Given the difficulty in linking information, it will be necessary to strongly consider refinements to the current approaches being used to collect maintain and analyze assessment data from the ICAP and cost data from the cost report. More robust data warehousing and analytical capabilities will promote better decision support and cost prediction capabilities.
- Obtain additional data potentially including the following:
    - New and resubmitted cost reports
    - Resident rosters
    - Additional ICAP and CAT data
    - Tier specific data
- Develop and model acuity adjusted rates
    - Rates developed for the tiers can be applied individually or at the provider level. Many states opt to apply rates at the provider level for the sake of administrative simplicity. To calculate a specific rate for each provider, the tiers for each individual will need to be calculated and averaged for each facility. Those averages would then be used to calculate facility specific rates. Whether individual rates or provider rates are established they need to be incorporated into the working model that will be used to evaluate the impact of the proposed tier rates on both DHSS and individual providers. This impact will be modeled using the established rates and historical claims volume. This evaluation will include administrative cost, system changes, implementation timing and claims payment.
- Implementation Strategy

Myers and Stauffer will work with DHSS to design and facilitate implementation of the new rate methodology. Myers and Stauffer will develop an assessment of staffing needs to implement the rate setting process and develop an implementation time line. Any other necessary infrastructure that will be needed to implement the new rate setting methodology will be assessed.