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Ensuring Rate Sufficiency: Rate Review and Revision Strategies

Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

Training Objectives

- Recognize the importance of reviewing current 1915(c) Home and Community Based Services (HCBS) waiver service rates.
- Identify various approaches to determine if existing rates are sufficient to meet Social Security Act §1902(a)(30)(A) requirements.
- Review state options for updating waiver service payment rates upon determining rate insufficiency.

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Legislative Environment

Social Security Act §1902(a)(30)(A)

- Per page 252 of the 1915(c) Technical Guide, "while rate determination methods may vary, payments for waiver services (like other Medicaid services) must be consistent with the provisions of §1902(a)(30)(A) of the Act…**The state should have a monitoring process to ensure that these requirements are met**."

- "A state plan for medical assistance must—provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that **payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers** so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area…"

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Judicial Environment

Armstrong v. Exceptional Child

- On March 15, 2015, the Supreme Court issued a decision affirming the administrative responsibility of the United States Department of Health and Human Services (US-HHS) in monitoring the sufficiency of Medicaid provider rates and disallowed providers from taking legal action against the state to increase rates.
- The Armstrong decision bolstered CMS' responsibility for ensuring rates are consistent with efficiency, economy and quality of care, and that states adhere to approved rate methodologies. As a result, CMS will only approve transparent and defensible rates.

Importance of Rate Sufficiency and Rate Review

- Setting sufficient HCBS rates is key to ensuring individuals receive quality care and have access to an adequate pool of providers.
- CMS depends on information provided in HCBS waiver applications to help determine the sufficiency of rates and compliance with Social Security Act 1902(a)(30)(A), which includes evaluating whether rates are meeting efficiency and economy standards (e.g., examining whether rates are too high or too low).
- Revisions, when warranted by the results of a rate review, can help address elements of rate setting that were not considered when rates were first set and can allow for adjustments based on current data and experience.
  - United States Department of Health and Human Services, Office of Inspector General (HHS-OIG) is focusing on whether non-reimbursable room and board costs are part of the Medicaid payments. States should review existing rates to ensure non-reimbursable costs under 1915(c) waivers are excluded from the rate.

Rate Sufficiency Approaches - Overview

- Five main rate sufficiency review approaches
  - Approach 1: Analyze and incorporate feedback from stakeholders.
  - Approach 2: Benchmark waiver rates to rates for comparable services.
  - Approach 3: Collect evidence from *QIS D, Sub-assurance d*.
  - Approach 4: Measure changes in provider capacity.
  - Approach 5: Benchmark rate assumptions to available data.
- States are encouraged to think creatively and use multiple approaches.
- States must describe both the rate sufficiency review approach(es) and results in Appendix I-2-a.

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Approach 1: Analyze and Incorporate Feedback from Stakeholders

Overview of the State's Approach

- Evaluate feedback from individuals, families, independent case managers, advocacy groups, and providers about the adequacy of direct service providers.
  - Collect data on Fair Hearings, grievances or complaints related to lack of providers.
  - Complement Fair Hearing and grievance/complaint information with data from individual and provider surveys.

How does this approach relate to rate sufficiency?

- All states are required to operate a Fair Hearing system, which captures feedback on individuals' access to services.
- States may also have existing systems for grievances and complaints that can capture information related to provider shortages.

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Approach 1: Analyze and Incorporate Feedback from Stakeholders

How does this approach relate to rate sufficiency? (continued)

- Individuals, families, independent case managers, advocacy groups, and providers give states a frontline perspective on the sufficiency of rates.
  - Individuals know whether they have access to enough qualified providers to receive the services required by their person-centered service plan (PCSP).
  - Independent case managers have a broad overview of the services available in the area and should be able to assess whether there is a sufficient number of providers to ensure access to services.
  - While this approach does not necessarily provide a complete representation regarding rate sufficiency and access to care, it could indicate areas that require additional review.

Approach 1: Analyze and Incorporate Feedback from Stakeholders

Methods and Considerations

- Use existing Fair Hearing and grievance/complaint systems as a valuable data source.
  - Fair Hearing and grievance/complaint systems should be a state's primary mechanism for capturing feedback on provider access and rate sufficiency issues.*
- Provider shortages are grounds for a Fair Hearing when a participant is denied services.
  - Service plans must address **all** of an individual's assessed needs.
  - If an individual cannot receive services in the type, scope, amount, duration and frequency specified in their service plan due to a lack of providers, the individual has the right to a Fair Hearing.
  - States should educate waiver participants and case managers regarding this right.

***Note:** Although all states are Federally mandated to offer opportunities to request a Fair Hearing, states are **not** mandated to have a grievance and complaint system.

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Approach 1: Analyze and Incorporate Feedback from Stakeholders

Methods and Considerations - Continued

- Consider using individual, advocacy group, and provider surveys to complement data from Fair Hearing and grievance/complaint systems.
- For example, states can use existing and tested survey questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to establish a survey instrument.
  - A new CAHPS survey was issued by CMS in October 2016, which includes a number of questions directly addressing the individuals' experience with providers.
  - Responses indicating that individuals are not receiving all services in a timely manner may warrant further investigation

Note: The survey is available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/cahps-home-and-community-based-services-survey.html

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Approach 1: Analyze and Incorporate Feedback from Stakeholders

Methods and Considerations - Continued

- Conducting a survey requires consideration of the following:
  - Develop distinct surveys for individuals, advocacy groups, and providers customized for the services and population(s) in the waiver. The quality of the questions will dictate the quality of the responses.
  - Gather accurate survey participant contact information.
  - Consider how broad of a distribution pool is needed to receive a statistically valid random sample of responses (e.g., 95 percent confidence level and 5 percent margin of error), or distribute to all stakeholders.
  - Decide how to distribute the survey – web, paper, telephone, etc. (consider your audience).
  - Identify resources to compile and analyze the data.
  - Consider whether the survey results address all levels of need in the sample. Rate sufficiency in one level of care might not be the same for another.

Approach 1: Analyze and Incorporate Feedback from Stakeholders

Methods and Considerations - Continued

- Track individual and provider feedback from year-to-year to assess the impact of the rate.
  - When evaluating feedback, consider geographic variations of the individuals and providers.
  - If there are differences between provider and individual feedback, it is important the state understands the causes of those differences.
- Outside factors, such as macroeconomic issues, not related to quality and access of care, could distort assessment feedback.
- It may be difficult to mandate survey responses in which case the response rate may not be large enough to capture representative data.

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Approach 2: Benchmark Waiver Rates to Rates for Comparable Services

Overview of the State's Approach

- When submitting new or renewal applications, compare HCBS waiver rates with:
  - Rates for similar services within your programs (e.g., other HCBS waivers, Medicaid State Plan services, or other similar state programs).
  - Rates for similar services paid by public or private payers.
  - Rates for similar HCBS waiver services from bordering states and/or states with demographically similar programs.

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Approach 2: Benchmark Waiver Rates to Rates for Comparable Services

How does this approach relate to rate sufficiency?

- Demonstrates to CMS that the state has assessed the market for related or similar services.
- Allows comparison to the broader provider market.
- Possible indicator of acceptance of HCBS waiver rates by providers if rates are comparable to rates for similar services.
- Promotes equity and prevents unbalancing.

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Approach 2: Benchmark Waiver Rates to Rates for Comparable Services

Methods and Considerations

- To perform these comparisons:
  - Identify sources for the rate data.
  - Conduct surveys or interviews to collect the information.
  - Analyze the information and draw accurate conclusions.
- Direct service provider payment data for private payers is difficult to collect. Very few states have price transparency initiatives and those that do typically do not include HCBS.
  - For example, one state's Department of Insurance received a grant to collect and present health care price information, but it only covers medical specialties.

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Approach 2: Benchmark Waiver Rates to Rates for Comparable Services

Methods and Considerations - Continued

- HCBS populations not covered by commercial payers may not have sufficient data available in the private marketplace (e.g., I/DD population).
  - CMS recommends states compare Medicaid rates:
    - Between states with similar programs, or
    - Within the state's similar services.
  - Example: Rates provided in state A are higher than neighboring state B for personal care services for the I/DD population. Providers in state B decided to relocate to state A for the higher rate, causing a provider pool imbalance for similar services in two neighboring geographical areas.
- Depending on the service, rate information for other payers can be difficult to obtain or might not exist.*

***Note:** These considerations are mostly limited to comparisons with private payers

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Approach 3: Collect Evidence from Appendix D QIS, Sub-Assurance d

Overview of the State's Approach

- Review evidence related to performance measures outlined in *QIS D, sub-assurance d*, which reviews whether services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.
  - Evidence may include specific performance measures that assess whether services are delivered in a timely manner by qualified individuals.

How does this approach relate to rate sufficiency?

- If individuals are not receiving services in accordance with the service plan, it could indicate that there are insufficient providers to meet individuals' needs.
- At the same time, if individuals are receiving services in accordance with the service plan, it may be that the service plan was developed with an understanding of what services were available, possibly masking provider adequacy issues. This highlights the need to take multiple approaches for evaluating rate sufficiency.

Approach 3: Collect Evidence from Appendix D QIS, Sub-Assurance D

Methods and Considerations

- This approach builds on the existing sub-assurance.
- Evidence can show if individuals are receiving services from qualified providers.
  - A performance measure below 86 percent *could* indicate systemic problems related to availability of qualified providers, however a performance measure above 86 percent does not guarantee an adequate provider pool.
- Insufficient rates might not be the primary influence on the availability of qualified providers.
  - States would need to investigate further to determine whether any noncompliance with this sub-assurance is due to provider shortages and insufficient rates.
- In most cases, sub-assurance (d) does not take into account the quality or timeliness of care.

Approach 4: Measure Changes in Provider Capacity

Overview of the State's Approach

- Measure the change in the number of new providers and those providers' capacity following a change in waiver service rates.
  - Request provider capacity information (e.g., staff turnover, retention, etc.) approximately a year after the rate change.
  - Compare provider capacity information to the percentage change in enrollment for the previous two years or more.

How does this approach relate to rate sufficiency?

- An increase in provider capacity may be indicative that the change in rates was sufficient to attract new providers into the market.
- Conversely, a decrease in provider capacity may indicate that a change in rates was insufficient to attract new providers.

Approach 4: Measure Changes in Provider Capacity

Methods and Considerations

- Many states already collect provider capacity data. (e.g., new enrollment, disenrollment, service utilization, etc.)
- Low provider capacity does not necessarily mean that the change in rates was not sufficient. The state would need to investigate further if low provider capacity were identified.
- States may also consider continuously monitoring the providers' capacity using billing data or a provider survey. Examples include:
  - Review units of service rendered per provider
  - Review the number of individuals served.
  - Review amount of overtime used per direct service worker.
  - Review staff attrition rate.
  - Review waiver waiting lists.

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Approach 4: Measure Changes in Provider Capacity

Methods and Considerations - Continued

- An increase in provider enrollment in the affected provider category may, but does not necessarily, indicate rate sufficiency.
- States may have to stratify the provider capacity by county or other geographical area, particularly if the rates vary by geographical area.

Approach 5: Benchmark Rate Assumptions to Available Data

Overview of the State's Approach

- Review rate assumptions including direct service worker wages, benefits, and administration and program support costs used in fee schedule rate setting and compare this with a market data analysis.

How does this approach relate to rate sufficiency?

- Many states already use the direct service worker wage as the basis of their final rate and then apply various factors and adjustments, such as benefits, administration and program support factors.
- Documenting this information for each renewal and applicable amendment would demonstrate transparency and accountability for setting appropriate rates.
- Comparing the base wage to the wage paid in the market for similar services would help states understand if rates are being set to attract a quality workforce, in addition to a sufficient number of providers.
- Comparing the percentage of the rate assumed for benefits, administration and program support to other fee-for-service rates developed within the state provides a benchmark for the efficiency and economy of the rates.

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Approach 5: Benchmark Direct Service Rate Assumptions to Available Data

Methods and Considerations

- States can compare the base wage from the rate model to wage data from state run facilities, or publicly available data from the Bureau of Labor Statistics.
- This type of review requires the state to use a rate setting methodology with a direct service worker wage as the basis. If the state used a rate setting methodology that did not use wages, then this method would not be possible.
- If the state does not use a rate setting methodology with a direct service worker wage as the basis, the state would need to devise another way to determine the direct service worker wage (e.g., querying providers to determine the base wage).
- States can compare benefit, administration and program support assumptions to similar assumptions in other state program rates, such as assumptions from state employees or at state-operated facilities, costs within nursing facilities (removing room and board-related costs) or among other HCBS waivers.
- CMS strongly encourages states to continuously monitor the Medicaid direct service worker wage in the state to ensure that the providers are paying the comparable wage used for rate setting.

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Rate Revision - Overview

- Results of the rate sufficiency review might lead the state to perform one or more of the following rate revision methods:*
  - **Rate Adjustment:** The state revises the rates based on budgetary, programmatic and/or other legislative changes.
  - **Rate Rebase:** The state maintains both the existing waiver service definitions and methodology but adjusts the individual inputs that comprise the rate with new data.
  - **Bundled Rate Recalibration:** In the case of bundled service rates, recalculate the bundled rate when the services and/or mix of services changes.
  - **Rate Methodology Redesign:** The state develops a new rate setting methodology or completely reevaluates the existing methodology.

Note: Rate revision requires a waiver amendment, which will also require public notice.

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Rate Adjustments

Under what circumstances would states perform rate adjustments?

- Rate adjustments typically occur due to legislative changes, budget changes and/or cost of living adjustments.
- States include in their approved rate methodologies a trend or growth rate that allows for states to update rates periodically.
  - For example, if the state has a provision in its approved rate methodology that allows for rates to trend annually in line with consumer price index changes, this would require an adjustment.
- A rate adjustment is not a substitute for performing a rate sufficiency review, and states must document their rate sufficiency review methods, in addition to detailing the basis of the rate adjustment.

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Rate Adjustments - Considerations

State Considerations for Rate Adjustment

- Are rate adjustments sufficient to maintain an adequate rate?
- Does the state have the budget to implement continuous rate adjustments?
  - States also must ensure that fee schedule rates match the documented methodology. *QIS I, sub-assurance (a)* captures whether service claims are coded and paid for in accordance with the payment methodology specified in the approved waiver.
- Is the growth rate still relevant in the current healthcare market?

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Rate Rebasing

Under what circumstances would states perform a rate rebase?

- States would perform a rate rebase when it keeps both its existing services and rate setting methodologies.
- Rate rebasing allows the state to update its existing rate methodology with new data.
- A state may be legislatively required to perform a rebase at a predetermined frequency.

State Considerations for Rate Rebasing

- Examine existing inputs to determine if these inputs are still relevant for today's service delivery environment.
  - An update of wage assumptions may be necessary due to changes in the cost of living or the minimum wage.
- Review all parts of the existing rate model.
  - States should, at a minimum, consider provider costs, provider feedback, and individual feedback to determine whether a rate input needs to be adjusted.

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Rate Rebasing - Considerations

State Considerations for Rate Rebasing - continued.

- Consider whether a rate setting methodology redesign is necessary in lieu of rate rebasing
  - A rate methodology redesign may be more appropriate than a rate rebase in instances in which providers submit feedback that highlights additional costs that were not previously considered or if there are programmatic changes that the state did not consider when setting the previous rates.
- Examine the existing cost report/cost survey and determine if it adequately captures allowable and non-allowable costs for methodologies that rely on a provider cost report or cost survey.*
  - Adjusting the cost report to more accurately and adequately capture allowable costs would also be an example of rate rebasing.

***Note:** For additional information regarding cost reports/surveys, see the "HCBS Waiver Rate Setting Data Validation" training available here: https://www.medicaid.gov/medicaid/hcbs/training/index.html.

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Rate Methodology Redesign and Rate Recalibration

Under what circumstances would states perform a rate methodology redesign or recalibration?

- States would only perform a rate methodology redesign/recalibration in instances when a new rate setting methodology is needed or desired. Occurs when:
  - The existing methodology is no longer sufficient;
  - The initial methodology was performed so long ago that the state no longer has a documented methodology;
  - When the state determines the calculation of component services in a bundled service is no longer accurate;
  - When the state wishes to change the rate methodology and/or;
  - When the state wishes to align multiple state methodologies.
- States would perform a recalibration when dealing with bundled service payments.
  - A recalibration process involves changing or updating the service mix and accompanying rate methodology of a bundled service.

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Rate Redesign and Rate Recalibration - Considerations

State Considerations for Rate Redesign and Rate Recalibration

- Conduct a rate study to develop an independent rate methodology.
  - A rate study could involve collecting wage and cost data from service providers, developing and researching new input sources and factoring in considerations for the cost of living adjustments.
- Determine whether the current bundle service mix is meeting the state's goals for the service. Update the rate model inputs based on the changes in service definitions to meet individual needs and goals.
  - For instance, assume that existing service bundle encompasses adult day care, non-medical transportation, and employment services.
  - If the new bundled service removes the non-medical transportation, then the rate input assumptions would need to be reexamined for this change.

Rate Redesign and Rate Recalibration - Considerations

State Considerations for Rate Redesign and Rate Recalibration - Continued

- Examine whether a retrospective or prospective approach is best suited for the particular waiver program or service.
  - A retrospective approach will involve paying providers an interim rate and then reconciling payments to costs at the end of the period to pay actual provider costs.
  - A prospective approach involves setting payment rates established in advance of the service provision, i.e., a fee schedule.

Rate Redesign and Rate Recalibration - Considerations

State Considerations for Rate Redesign and Rate Recalibration - Continued

- Evaluate whether a cost-based or price-based approach is best suited to meet the state's goals for service delivery.
  - A cost-based approach establishes provider-specific rates based on provider cost data.
    - Example: Rate setting with interim rate and retrospective cost settlement.
  - A price-based approach establishes a standardized, prospective fee schedule that could be based on a variety of data sources, including the median costs of a provider group, market rates, or rates adopted from another program. Price-based rates are not directly based on cost.
    - Example: A prospective fee schedule established using rate assumptions.

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Summary

- States must consider various approaches that would allow them to review current service payment rates and evaluate if these rates are sufficient.
- There are multiple review methods and approaches states can adopt when evaluating rate sufficiency. Each approach may warrant changes in data collection and reporting processes that states need to consider.
- States have several options for updating their rate methodology. These options range in complexity and may require state legislative or programmatic changes.

Additional Resources

- Direct link to the site with the webinar is:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html

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Questions & Answers

For Further Information

For questions contact:

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Thank you for attending our session!