HOME AND COMMUNITY-BASED SERVICES

Use of Cost Information as the Basis for Rate Setting

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INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) affords states flexibility in designing their approach to pay for home and community-based services (HCBS).[1] The only requirement is that states establish their rates for HCBS services in compliance with §1902(a)(30)(A) of the Social Security Act, which states, in part:

> *Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.*

States are required to review their HCBS rate setting methodologies, at a minimum, every five years with their HCBS waiver renewal.[2] The role of the State Medicaid Agency in developing rates is described in 42 CFR §447.201: "The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program."[3]

There is no uniform approach that states use to pay for HCBS services, but many states develop their methodologies using an approach based on costs. Based on our review of states' 1915(c) waiver applications, more than 80 percent of all waiver programs use cost reports or cost surveys to develop or otherwise guide service rates.[4] Cost-based rate setting for HCBS is an approach that pays for services based on the reported historical costs of providing a service. The state obtains cost information through some type of state-specific cost survey or cost report. States use this cost information and then pay HCBS providers based on those reported costs, through either a prospective or a retrospective methodology.[5]

HCBS RATE SETTING

There is no uniform approach that states use to pay for HCBS services, but many states develop their methodologies using an approach based on costs.

Based on our review of states' 1915(c) waiver applications, approximately 80 percent of all waiver programs use cost reports or cost surveys to develop or otherwise guide service rates.

This paper explores the use of costs by states:

- The reasons this is a frequent source of information.
- The use of cost surveys to obtain information.
- The general process for using cost information.
- The approaches that can make the cost survey process more efficient and effective.
- The development of methodologies for rate determination.

We conclude with a discussion of potential considerations in the implementation of a rate model based on costs.

[1] Centers for Medicare & Medicaid Services, Home-and Community-Based Services (last updated September 30, 2020), https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs.

[2] *Home & Community Based Services Training Series* (last visited November 18, 2021), https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series/index.html#ratesfiscal. These regulations apply to HCBS rate setting for waiver services. However, states often use a cost-based approach for the development of fee for service rates for state plan services, so many points raised here are relevant.

[3] 42 C.F.R. § 447.201.

[4] Myers and Stauffer reviewed active **1915**(C) waivers as of July 18, 2022, to determine waiver rate methodologies. See: https://www.medicaid.gov/medicaid/section-

[5] We focus on the use of cost data to develop prospective payment rates in this paper.

USE OF COST INFORMATION AS THE BASIS FOR RATE SETTING

There are benefits associated with collecting and using cost data and challenges for providers and states. Most of the challenges result from the processes used to collect cost information.

BENEFITS OF USING COST INFORMATION

There are several reasons why states use cost-based approaches to pay for HCBS services:

- **Consistency.** A cost-based approach is consistent with the approach states use for certain other services. For example, states have traditionally used providers' reported costs to develop payment rates for services such as inpatient and outpatient hospitals, nursing facilities, federally qualified health centers (FQHCs), rural health clinics (RHCs), and others.
- **Compliance.** Collection and review of cost data allows states to ensure the payment methodology and rates comply with the federal requirement that they document their approaches to preventing unallowable costs, such as room, board, and food in 1915(c) waiver applications.
- **Payments and Access.** Understanding the costs of services helps states establish appropriate reimbursement and ensure access to care.
- **Evaluations.** Collecting cost data enables states to evaluate the percentage of the providers' costs covered by reimbursement. The ability to evaluate cost coverage allows states to assess the adequacy of rates and provides information about Medicaid spending for HCBS services.

Providers also often support using costs as a basis for HCBS rate determination. Providers regularly reference their own costs in delivering services when they seek to demonstrate that rates are insufficient to adequately support the delivery of impactful care.

CHALLENGES IN USING COST INFORMATION

Although cost data information is useful, the process for collecting it requires significant investment from both the state and providers. Many providers lack the resources or knowledge to complete the data request timely and correctly. Some providers do not maintain the accounting or business records to provide accurate cost data in the format requested, and providers may also incur additional costs for a consultant to complete the cost survey due to lack of staff availability. In particular, smaller providers are unable to submit cost survey information. Consequently, the percent of providers who submit cost survey information may be lower than desired.

PROVIDER CHALLENGES IN RESPONDING TO A COST SUVEY

- Ability to report cost data that aligns with cost survey requirements.
- Recordkeeping that yields inadequate detail as required in cost survey.
- Missing or incomplete cost data.
- Lack of resources to finish survey.

Survey results that indicate costs significantly higher or lower than current rates can raise questions about the efficacy, accuracy, and completeness of data. States should consider the lack of data from providers or groups of providers and develop a realistic view of the costs of service delivery.

Additionally, providers may view the cost collection process as intrusive. Providers could be reluctant to provide details of cost and service information to the state for fear of how this data will be used. For example, in the absence of historical information, providers are concerned cost survey information may reflect that, for certain services, the reimbursement rates are higher than actual costs. Without recognition of

[6] States must provide documentation of the data, process, assumptions, and research that informed how costs were factored into the proposed rates and that they addressed requirements stipulated in the 1915(c) Technical Guidance. They must illustrate that payments are consistent with 1902(a)(30(A) of the Social Security Act Appendix 1-2-a: Rate Determination Methods; Appendix 1-5, Exclusion of Medicaid Payment for Room and board, Appendix 1-6, Payment for Rent and Food Expenses of an Unrelated Live-in Caregiver.

additional funding needed to pay for future costs — such as increases in salaries and benefits, capital acquisitions and improvements, or quality initiatives — providers fear that historical cost experience is not sufficient to quantify their resource requirements in future years. Legislators are often not able to fund rate changes commensurate with reported costs.

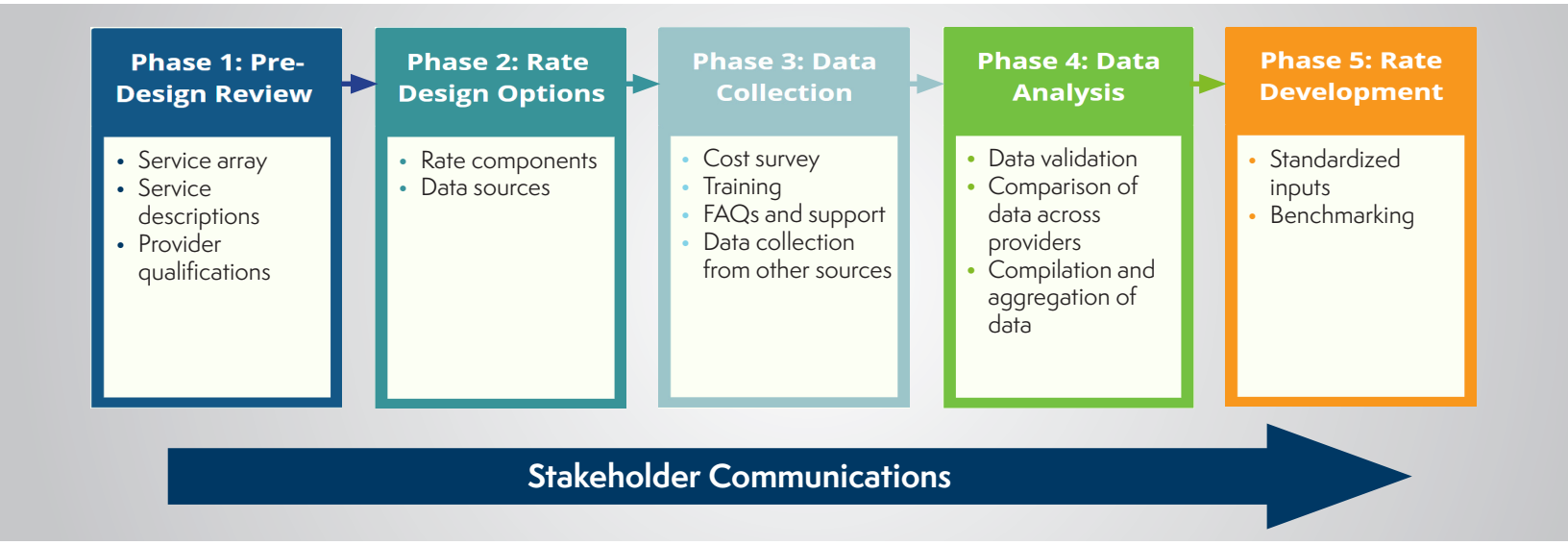
Given the desire to use cost data, but being mindful of the issues associated with collection of complete and accurate data, states should balance obtaining detailed-level data against securing provider buy-in to submit that data. In the remainder of this paper, we discuss opportunities to make the cost survey process more efficient and effective and how to collaborate with providers to achieve the desired results.

PROCESS FOR OBTAINING AND USING PROVIDER DATA FOR RATE DEVELOPMENT

States undertake cost surveys to evaluate their rate structures and payment levels, develop new methodologies and rates, or both. States use cost surveys to collect not only cost data, but also other information that supports the calculation of rates for each unit of service. The cost survey captures wages and benefits costs for staff (direct care, program operations, and administration), facilities expense (rents, maintenance, utilities, etc.), and transportation (vehicles, mileage). Additionally, states may elect to capture other important information such as staffing ratios, staff turnover rates, productivity, the amount of time direct care workers spend providing direct care versus other activities, such as training and recordkeeping.

Cost reports for non-HCBS services are generally standardized. For example, Medicare and state Medicaid agencies uniformly use the Medicare cost reports to collect information for services such as inpatient and outpatient hospital services, FQHCs, RHCs, etc. However, there is no standard HCBS cost survey format used by states, even though cost survey elements are comparable from state to state. States have an opportunity to develop cost surveys that take into account the particular nuances of the state's own HCBS program.

To be most efficient in development and execution of cost surveys we encourage states to plan carefully, obtain information that will satisfy state objectives, and refine that data as necessary. For example, if undertaking a new cost survey process, states may determine the primary objective is to obtain a high response rate using a more simple approach to retrieve cost information. A simplified method may be sufficient to encourage provider participation, increase understanding that cost surveys will be required periodically, and require providers to maintain records in ways that facilitate survey completion. As cost surveys become an accepted norm, states can refine the surveys or request information to address specific questions and issues. Generally, we suggest the activities in the graphic below related to rate setting for HCBS.



ENGAGING IN MEANINGFUL COMMUNICATION WITH PROVIDERS AND OTHER STAKEHOLDERS

Stakeholder communications are the underpinnings of each phase. There are numerous opportunities to engage providers and other stakeholders in the cost survey and rate development process. Stakeholder participants may include Medicaid and other agency representatives, provider associations, advocacy groups, and others. Stakeholder engagement promotes a transparent process, which facilitates informed decisions. Stakeholders can also provide valuable insight into the delivery of services and the best way to obtain cost information. Providers are in the best position to describe exactly how services are delivered. Agency staff is not always aware of the nuances of services delivery. Discussions between agency staff and providers can clarify these specifics. Work groups can be a sounding board in the design of cost surveys that are most reflective of provider needs and can be implemented effectively and efficiently.

THE VALUE OF STAKEHOLDER GROUPS

We have found convening a small work group of stakeholders during the design of the cost survey to be of great value. These stakeholders collaborate to develop a cost survey that provides adequate cost information, is easily understood, and allows for reporting costs for a wide array of services.

This targeted work group often includes representation from the state policy and budget teams, provider associations, and providers who represent entities of various sizes. If a state already has a cost survey tool established, it might want to consider soliciting feedback from the provider community for suggested modifications prior to its next use.

After the state obtains and summarizes cost data, a potentially different group of stakeholders, sometimes referred to as an advisory group, may review that data and provide comments about analyses and findings. States may rely on stakeholders who are knowledgeable about the finances and operations at a provider site to offer advice on the cost report design. States may also then rely other stakeholders who have a perspective on state policy and reimbursement as well as consumers or their representatives to comment on findings and recommendations for rate development.

CASE STUDY: PURPOSE AND FUNCTION OF WORK GROUPS

Work groups can be a sounding board in the design of cost surveys that are most reflective of provider needs and can be implemented effectively and efficiently.

One state convened an HCBS rate-setting work group that included representatives from the state, provider community, and Myers and Stauffer. This effort included establishing a preliminary prescribed methodology to calculate rates for the services and identifying the information to be collected during a cost survey. The work group reached consensus on the types of information needed to calculate rates.

This group and its proceedings made providers aware of the type of information to be collected and the importance of that information in calculating rates. Convening this work group allowed for a transparent and streamlined process for surveying costs. The work group also helped establish a relationship with Myers and Stauffer that helped providers feel more comfortable about asking questions and giving additional insight helpful to the project. The result was a survey tailored to the services provided and an efficient implementation.

States vary on their approaches to the design of their stakeholder processes, but no matter how they are designed, the stakeholder input is important to help state policymakers understand why cost data differs for some providers, or provide input regarding data that appears to be incorrect or misreported. This process can also help to fulfill the CMS requirement for provider input.[7]

PHASE 1: PRE-DESIGN REVIEW

The pre-design review is a critical first step in the development and execution of cost surveys for rate development. Careful execution of this phase can reduce the level of effort throughout the process. Before embarking on cost survey design and execution, it is imperative states have a clear understanding of HCBS definitions and delivery. The cost collection and rate development process provides an opportunity for states to review the services in the waiver and determine:

- Are services as they are described in the waiver meeting the needs of the participants?
- Do the service descriptions accurately depict the services that providers are delivering to participants?
- Are staffing ratios and provider qualifications an accurate depiction of the services? Are staffing ratios adequate to meet the goals and needs of the individual?
- Are there any "workarounds" or supplemental costs, fees, or rate enhancements that the state has implemented to accommodate participant needs that it should consider for permanent change or inclusion in the rate design?

Service definitions detail provider specifications, service exclusions, and limits, which serve as guardrails to the type of services covered under a waiver and who can deliver those services.[8] Waiver participants' needs change over time, however, and providers may adjust their service delivery to meet those evolving needs. Providers are in the best position to help the state understand service delivery and cost reporting for those services. When developing the new rate design, it is important to consider changes in service definitions that may have occurred since the last rate development. These changes may have a significant impact on costs of providing the service and should be captured in the data collection process for consideration in rate development.

CASE STUDY: DELIVERY APPROACH AND COST SURVEY DESIGN

Different delivery approachers can be significantly influential designing surveys

One state recently developed a cost survey to obtain detailed cost information about services provided through multiple waivers. Upon receipt and analysis of cost data, and through working with stakeholders, we noted that providers of daily live-in caregiver services use one of two models: the participant has one individual living with them full-time, or the participant has two individuals who are each providing services half of the week.

In the first case, the provider would be paying overtime to the worker and experience different costs than the provider who staffs the service with two people. The state had to determine if both models were appropriate (they determined that they are), and how to create different rates for those services. In this case, the different delivery approaches were not discussed in designing the survey.

[7] 42 C.F.R. § 447.204(a)(2).

[8] States establish specifications for their waiver services and describe any limitations that may apply to these services in Appendix C of their 1915(c) waiver application. CMS requires states to complete a service specification template in Appendix C-3, which states use to outline the scope of waiver services, including limitations in amount and duration, as well as qualifications of providers delivering these services.

An attempt to collect cost information based on how the service is described in the waiver, rather than on how the service is actually delivered, is a disconnect that will create significantly more work for both providers and the state during the data collection, data analyses, and rate development phases of the project. Sometimes, however, the different delivery approaches are not known until after cost data is collected. It may not occur to either providers or the state that such circumstances exist. In these instances, it will be necessary to adjust the cost data after the survey information is received. It may also be necessary to redefine billing codes to allow for different rates.

THE IMPACT OF SERVICE DEFINITIONS

When developing the new rate design, it is important to consider changes in service definitions that may have occurred since the last rate development. These changes may have a significant impact on costs of providing the service and should be captured in the data collection process for consideration in rate development.

In our experience, states may hesitate to change their waivers to reflect more current service delivery as it becomes known, because of limitations in the budget and administrative challenges in identifying and formalizing service definitions. However, the cost survey process and findings discussions could point to a need to do so for future cost collection, rate setting, and effective program administration.

PHASE 2: PRELIMINARY RATE DESIGN OPTIONS

Phase 2 is identifying the preliminary rate design options available to states for use in their rate methodology and data sources to develop those options. The process for collecting cost data can be time consuming and costly for all parties, so limiting the data collection effort to essential elements is important to create an efficient cost collection plan. States should make decisions about how they will use costs in the rate model and the preliminary design of that rate model. This will help identify potential sources of information (e.g., cost survey, nationally published data, or other state information) and the best way to obtain that data.

States should also consider the level of complexity of the cost survey. It may be difficult for providers to identify the exact costs of providing a particular service within the spectrum of all the services it provides. For example, instead of asking the provider to allocate costs across all of its services on the cost survey, the cost survey can be designed in a way to make those allocations and ease the burden on providers. Further, the rate model design, and the definition of cost components during this phase, should be viewed as preliminary. The preliminary identification helps determine what needs to be collected and from where and helps to make sure costs are reported in a manner that supports rate determination. Defining this information in advance will also help providers understand how the state will use the information collected and the importance of complete and accurate information.

Table 1 shows a sample of rate component options, possible sources of data to determine those components, and potential rate calculation options. This table provides guidance related to the information needed to calculate those cost components. For example, referring to direct support worker wages, the table indicates that the methodology will consider cost-per-hour and then inflate the data under consideration, provided through the survey or through Bureau of Labor Statistics (BLS) published information.

Table 1: Data Sources and Rate Methodology Options for Cost Components

Data Sources and Rate Methodology Options for Cost Components

Potential Component	Possible Data Sources	Rate Methodoloy Calculation Options
Direct Support Worker Wages	• Collect from providers through a cost or wage survey. • Reference publicly available wage data, such as BLS. • State licensure limits on hours of service delivery. • Negotiated.	• Cost-per-hour. • Total hours of service delivery. • Inflation.
Employee Benefit Expense	• Collect from providers through a cost survey. • Reference publicly available wage data, such as the BLS. • Negotiated.	• Total costs of benefits provided to direct support workers. • Percent of direct wages that are benefit costs. • Cost-per-hour.
Productivity – Non-billable hours, training hours, and paid time off	• Collect from providers through a cost or wage survey. • Use data obtained from a similar service.	• Percent of direct wages. • Cost-per-hour. • Separate cost components for transparency.
Program Support Costs	• Collect from providers through a cost or wage survey. • Use data obtained for a similar service or other comparable program. • State licensure limits on hours of service delivery. • Negotiated.	• Total program support costs. • Percent of direct care wages that are program support costs. • Cost-per-hour or unit of service. • Calculated at the median, mean, or set percentile of all collected cost data. • Separate cost components for transparency, e.g. separate food expense component for adult day services.
Administrative Costs	• Collect from providers through a cost or wage survey. • Use data obtained for a similar service. • State licensure limits on hours of service delivery. • Negotiated.	• Total administrative costs. • Total hours or units of service. • Percent of direct care wages that are administrative costs. • Cost per hour or unit of service. • Calculated at the median, mean, or set percentile of all collected cost data.
Staffing Ratio	• Collect from providers through a cost or wage survey. • Service descriptions.	• Number of staff needed. • Group services.
Unit of Service	• Service descriptions. • Fee schedule.	• Hours of service provided, i.e., how many hours of service are actually provided in a service with a daily rate.

HYBRID APPROACH

While there is interest in using cost as the basis for rates, there are tradeoffs states could consider to make the cost survey process more efficient, as shown in the **Table 2**. Many states take a hybrid approach, using surveys to collect cost and other information, such as the number of employees, and then relying on national and other data to supplement.

Table 2: Hybrid Approach Pros and Cons

Hybrid Approach Pros and Cons	
Pros	**Cons**
Reduces the amount of data requested from providers.	National data may not be reflective of all areas in the state where there are factors that create significant differences.
Creates standardized data that can be updated more frequently.	State may have made policy or legislative decisions that impact the rate and would not be comparable to other states or national data.
Creates equitable standards between providers paid using a fee schedule outside of the waiver and who also provide waiver services.	Providers may express concern the actual costs were not considered.
Using a combination of external data sources and requesting data from providers allows providers to have some voice, but does not rely entirely upon provider submitted data.	Providers still have to provide some data and may not have the capacity to provide it.

Identifying information that may not be readily available or retrievable by providers during the planning phase allows for consideration of viable hybrid approaches. In these cases, using a hybrid approach can make the survey process more efficient, avoid provider frustration, and lead to greater provider participation.

DATA COLLECTION

While many states' methodologies describe the development of HCBS rates as cost-based, these methodologies often include the use of data sources in addition to cost reports or cost surveys during the rate-setting process. **Table 3** describes other data sources.

CASE STUDY: SAMPLING PROVIDERS. One state that relies on cost surveys has written into regulations that providers must submit a completed cost survey, and establish base line costs for rate development. Now, the state collects new survey data on a rotating basis, so each provider is required to submit cost data only once during a defined period of time. The state surveys 20 percent of the providers each year. Collecting data using this approach allows the state to continuously, rather than periodically, monitor cost information, allowing it to timely identify anomalies between cost and service delivery.

Table 3: Data Sources in Addition to Cost Data

Additional Data Sources			
Data Source	**Description**	**Benefits**	**Limitations**

Nationally Published Data Reports and Indices	• United States BLS and the Agency for Healthcare Research and Quality, Medical Expenditure Survey – Insurance Component (MEPS-IC), capture data that inform various cost factors, such as median wage rates for a range of occupations as well as their employee related expenses, such as annual vacation/ personal, sick, holiday, and training hours.
	• IRS mileage rate to determine transportation costs.
	• Inflation Indices:
	  • BLS releases the Provider Price Index (PPI), which includes an index of inflation for multiple industries.
	  • CMS releases the Medicare Economic Index, which estimates annual changes in operating costs and earning levels.
	  • Others, depending on the state, for example, from Workers Compensation Insurance Rating Bureau for workers compensation costs, U.S. Census Bureau for population information.
		These data rely on a stringent collection process, which includes data reliability testing. Also, these reports capture data annually allowing for comparative analysis across years.	Certain defined occupations may not accurately reflect responsibilities of staff delivering services, however, and states may need to match services to BLS categories, potentially creating some level of subjectivity.

State-Specific Data	• Available reports or information that are developed by and are specific to the state, such as fee schedules for state plan services, cost reports for skilled nursing facilities, licensing requirements stipulated by state law, and annual billing data. • Other waiver rates.	Provides state-specific information that can be leveraged to calculate costs.	Reliability of data depends on state-specific methodologies. In addition, the state-specific data may not be available for all services (e.g., state licensing requirements. may only be defined for certain providers).
Other States' Data	• Other states may release additional information via state reports or their 1915(c) waiver applications that help inform some cost components (e.g., employee-related expenses, administration or program factors). • States also often refer to payment rates of select other states (e.g., with similarly sized programs, or states that are geographically adjacent to compare their own rates).	Data can be used to benchmark costs and/or prices.	• Availability of data is dependent on what states choose to release. • Also, service definitions may not be completely aligned. • State rates often reflect policy goals and objectives of the individual states, making a one-to-one comparison of rates difficult.
Commercial or Market Research	Data that details what commercial payers pay in the private market. This information is particularly useful when rates are determined via a negotiated market price.	Data can be used to benchmark costs and/or prices.	This analysis depends on availability of data released by commercial payers, which is often limited.

As another example, states may choose to use a cost survey to request information about wages, but also use BLS data as a benchmark to the wages reported by the providers. Alternatively, they may opt to use only BLS information, instead of collecting wage data, as this significantly reduces the reporting needed by providers. Federal indices can validate data collected from providers and highlight variances between provider-reported data and national standards.

An important consideration for data collection is determining if all providers, or only a sample of providers, should submit a survey. Given that survey response rates may be relatively lower than desired, most states require (or request) that all providers submit information to have as full a picture as possible of the cost structures of the various entities. Once base data is established, it may be appropriate to collect data from a sample of providers. The sample should include various size organizations, from various geographic locations, so there is representation of the full provider community.

PHASE 3: DESIGNING THE COST SURVEY

In working with states to promote the efficient design of cost surveys, and in addition to the information we discuss in Phases 1 and 2, we recommend a number of overarching principles to consider in the design of the cost survey:

- **Design a cost survey that is simple yet effective to capture the needed data.** As discussed above, states may consider the possibilities of collecting certain information from national or state data sources. In addition, they should consider the organization and format of the cost survey (e.g., Excel-based versus web-based survey tools) so that providers can easily and accurately submit data, and collect only the data that will be used as described in the preliminary rate model. The level of complexity can vary because of the type or number of services included in cost collection efforts as well as the availability of information from other data sources. For example, we know that detailed cost allocations for each service type can be difficult and time consuming for providers to determine. To streamline the process, one solution states have adopted is to collect aggregated cost data, and request that the provider simply identify if that cost is related to a particular service. This approach is a simpler one to identify which costs are related to the service without the complexity of in-depth manual calculations.
- **Set a reasonable timetable to develop the cost survey and review the cost information.** Allowing ample time for development and testing of a survey, training for providers, periodic help sessions for providers, and cost survey completion can increase participation and reduce the need for extensions. States should be prepared to consider a less rigorous approach than planned if providers simply cannot provide the requested cost survey information. The state may want to consider providing additional training or holding additional Question & Answer sessions (one-on-one should be considered) if needed. As the state evaluates response rates, it should identify if there are any underrepresented provider populations. In those situations, outreach efforts can help obtain cost information from a representative sample of the aggregate provider population.
- **Allow service providers to review and provide input on the design of the cost survey and the instructions for completion, through work groups and other external stakeholder opportunities.** If time allows, the state should consider requesting that a small group of providers complete the survey prior to issuing it to all providers. Doing so allows for provider input on challenges in completing the survey, and proactive implementation of revisions in an effort to collect better data. Based on our experience, if providers tell us that the cost report is too complex or onerous, then states will not obtain the information they are looking for. It is important to engage providers, understand what they can and cannot provide, and make adjustments to expectations before disseminating the cost survey.

- **Prior to distribution of the cost survey, states should communicate with providers to notify them about the survey and its purpose.** States should also provide other details about completing the cost survey. States should be prepared to address providers' concerns if they say they are not capable of producing survey information within the times specified.
- **Schedule and hold cost survey completion training and follow-up provider Q&A sessions.** States should consider how they could provide technical assistance to support those providers who encounter challenges completing the cost survey.
- **Consider implementing regulations to require the submission of cost surveys.** If states desire to collect cost information from providers, they may want to consider how administrative rules support compliance with requests.

PHASE 4: DATA ANALYSIS

The data analysis phase of work consists of two steps, which often occur concurrently: first, validating the cost data submitted by providers; and second, conducting various analyses of that data to prepare for rate setting. The state should have a data analysis plan that includes reviewing data for completeness, consistency, and accuracy. If necessary, where there are discrepancies, the provider should be contacted to clarify the information submitted. The analysis should also include comparing data across providers to understand anomalies and if these result from reporting errors or from actual cost experience. If other data sources are to be used, the data from those sources should also be combined with the survey data to create a file that can support the evaluation of costs and for rate setting activities.

THE IMPACT OF SERVICE DEFINITIONS

The data analysis phase of work consists of two steps, which often occur concurrently: first, validating the cost data submitted by providers; and second, conducting various analyses of that data to prepare for rate setting. The state should have a data analysis plan that includes reviewing data for completeness, consistency, and accuracy.

Typically, after cost information is validated, we then extract data points to identify specific costs and other information, such as staffing ratios, that are necessary elements of rate setting. This process ensures that calculated HCBS service rates use only allowable costs, as defined by applicable regulatory authority. This is significant, as states must demonstrate to CMS that rates only include allowable costs when obtaining waiver approval. For example, some providers may incur room and board costs for specific HCBS services. Federal Medicaid law generally prohibits the inclusion of room and board payments for non-institutional (HCBS) beneficiaries and as such, these expenditures are excluded from established rate methodologies.[9]

The cost data can be evaluated by component to calculate cost medians, means, or values at a certain percentile. This information may be used in the rate setting efforts to model calculated rates that fit within budgetary limitations but are also sustainable and provide for quality service delivery.

PHASE 5: RATE MODEL DEVELOPMENT

After the state has a complete database, including information from surveys and other data sources, it can move on to development of the final rate model, and rates. At this point, the state can finalize rate components, determine ceilings or other limits, and determine if any adjustments are needed. All of these design elements will lead to the development of final rates, generally an iterative process that includes not only cost data but also policy and financial decisions.

A solid rate model is one that is dynamic, allowing various inputs, weights, assumptions, etc., to be adjusted to develop rates. A flexible and adaptive model can be a key tool for states to model cost and rates quickly as they

[9] *Home & Community-Based Services* 1915 (c) (last visited November 16, 2021), https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html. C.F.R. § 447.204(a)(2).

make program and policy changes to respond to participant needs, while also managing a program that already has services and providers operating within it. This flexibility can help a state make financial decisions as well as work with providers to understand the financial impact they may experience.

Rate setting for HCBS services is designed to be flexible to meet the needs of a state's program, and the collection of cost data creates a strong foundation for doing so. Most states design their HCBS rate models with the objective to account for costs of the direct care service worker, employee benefits, program support, and administrative services. The following are additional considerations in the cost-based rate-model development process:

- **Staffing Ratios and Required Staffing Levels.** Rate models should consider services provided in a group setting and any required staffing levels. Often times, state licensure requirements or service definitions define these ratios, which are then used in the rate model and in the calculation of base rates. Changes in the service delivery and group/staffing requirements are easy to address in reimbursement rates because the base rates are built on the hourly cost of one staff providing the service to one individual.
- **Geographical Considerations.** Many times, the cost of providing the service may vary because of the geographic location. The rate model can address geographic differences in costs by adjusting the direct staffing cost component of the base rate to account for the regional pay differential.
- **Tier-Based Rates.** The rate model can include considerations for participant acuity levels by applying adjustments to the "base" hourly calculated rates. This flexibility allows for rate modifications that account for the participants' specific needs, while promoting access to quality care. In addition to using the base hourly rates, a system to classify participants by individual care needs has to be considered. States may already be using these tools, or one may need to be designed in tandem with the cost survey.
- **Performance-Based Payments.** States are now more frequently having discussions on how to implement performance measures into HCBS payment models. While these considerations may still be in the infancy stages, states can design a system of measures to evaluate the service delivery. Based on the outcomes of the service, the base rates can be modified to pay for desired outcomes. One example includes paying high-performing providers an additional premium to a rate.

CONSIDERATIONS

Development of a rate methodology based on costs provides states with an excellent tool to understand HCBS delivery, to update service definitions, and to develop a rate methodology that addresses those equitably. There is no question, however, that cost surveys, data collection, data analysis, and rate modeling require significant resources from all parties involved. States that embark on a cost survey process should demonstrate they recognize the level of effort needed, and make use of the information collected. One of the most significant sources of dissatisfaction with the cost survey process is the perception that information collected from providers was not considered in determining final rates. There are a number of reasons, however, where states take into consideration the information they collect, but they may not act on specific cost information. For example:

- **Cost data may provide unexpected information such as current rates that exceed costs.** This may be the case for one or several of a single provider's services, or for a majority of services across multiple providers. The state will have to determine how to address those circumstances. If the state is allocating a fixed budget, then any increase in rates to providers will likely be offset by the additional payment to providers whose rates are too high based on the new model. A single provider will have underpayments and overpayments, so the net impact is neutral, but states generally do not reduce payment levels. States should discuss this potential occurrence in the planning phase, if possible, and consider how rate changes will be implemented in an equitable fashion across providers.

- **There may not be sufficient funding to immediately support a new fee schedule that includes significant rate increases.** States may need to provide background information to legislators to help them understand the components of costs and how those costs were considered in rate proposals. States may also want to discuss a plan for implementing a rate phase-in, where possible.
- **States should also be prepared to release information about the results of the cost survey.** The information can be used by providers and their representatives in discussions with legislators, and can also provide insight into service delivery, and perhaps suggest needed changes in how providers record and report costs for future surveys.
- **Cost data may indicate significant differences in costs across geographic areas.** States will also want to consider how the rate methodology should take those differences into account.
- **New waiver rates may appear out of line with state plan fee-for-service rates or with the same services covered by another waiver.** Sometimes, waivers are managed by different agencies within a state, and these agencies have developed their rate models independently of one another. Providers, however, may provide services connected with several waiver programs. States should consider how a cost-based rate model could apply across all services and waivers, and to other fee-for-service state plan services, if they are the same.

HCBS RATE DEVELOPMENT

States should consider approaches to collect cost data that minimize the administrative burdens on providers and state agency resources, but also capture the necessary information that helps inform a reliable rate model.

These are only some of the considerations states will make in the implementation of a new methodology and rates. Frequent and open communications, and balancing information needs with expected outputs, will help build an understanding of the relationship between data collection and rate methodologies.

CONCLUSION

Collecting cost information for the development of HCBS rates is an important part of many state Medicaid agencies' activities to manage and finance their waiver programs. However, states should consider approaches to collect cost data that minimize the administrative burdens on providers and state agency resources, but also capture the necessary information that helps inform a reliable rate model. Careful analysis and planning prior to implementing a cost survey is an essential step in collecting useful cost information for rate setting.

MYERS AND STAUFFER: UNCOMMON SKILL

BACKGROUND

Established in 1977, Myers and Stauffer is a nationally based consulting and certified public accounting (CPA) firm. For more than four decades, we have worked exclusively with local, state, and federal government health and human service agencies to help them accomplish their most critical goals for the nation's most vulnerable people. Our exposure to state Medicaid programs around the nation enables us to draw upon a range of compliance, program integrity, auditing, and other experiences, as well as best practices, to address the requirements of important initiatives for clients with varying needs. Our experience affords us an uncommon perspective and granular understanding of the challenges related to designing, developing, and implementing the solutions our clients need most for their health care and social service programs. Together with our insight into state programs across the nation, we offer a constellation of value-added competencies our clients are unlikely to find elsewhere.

Just a important, diligence, rigor, and discipline define our approach, and we exercise care and caution to demonstrate proper stewardship of the trust our clients place in us. We are equally committed to helping them effect positive change in their public health care environments for the people who need these services most. We bring these same philosophies to every engagement we perform, and we think it sets us apart.

Ultimately, what defines us most as a firm is our people. Many of them have dedicated their careers to supporting health care and public services, and they share the deeply held conviction that what they do matters in the lives of the people our clients serve. Our executive and senior professionals have considerable academic training and specialized experience in health care audit, consulting, and reimbursement. These experienced individuals truly understand the needs and objectives of these programs, their sponsoring agencies, and the vulnerable populations they serve. We are proud of our professionals' talent and experience, and we are pleased to present this level of skill and knowledge to our clients. Simply put: they are the right people with the right experience.

Backed by disciplined professionals who meet the highest ethical and compliance standards, we continue to forge solid working relationships with our clients, built on foundations of trust we have strived to earn through our history of strong performance and exacting execution. We help our clients meet their goals, one engagement at a time, and each is a rewarding chapter in our effort to support government health care programs that increase access, enhance quality, and improve outcomes for beneficiaries across the United States. We build our entire professional practice around missions such as these, and the values that inspire them inform all we do on our clients' behalf.

BENEFITS

- **Demonstrated Health Care Policy, Delivery System, and Payment Transformation Success.** We have provided consulting for some of the nation's most innovative and effective health care delivery system and payment transformation initiatives. Throughout our experience, we have been involved in every phase of policy and program planning, implementation, operation, and evaluation. Often, our work involves the coordination of multiple concurrent reform efforts that we have successfully navigated in the past, which demonstrates our in-depth understanding of delivery system and payment transformation, quality programs and measures, and evaluation of health outcomes.
- **Leadership in HCBS Program Development.** Myers and Stauffer is well qualified to support state agencies in the development of rate methodologies, waiver programs, and state plan amendments (SPAs). We bring together skilled consulting professionals who have spent their careers working in public sector health care and who can work with you to quickly identify the best options for designing, developing, and implementing Medicaid rate methodologies, waivers, and SPAs. Our decades-long history of supporting HCBS programs across the country has afforded us invaluable opportunities to learn critical lessons and develop institutional knowledge, giving us the insight and expertise that can only be gained through direct, hands-on experience.
- **Independent National CPA and Consulting Firm.** Unlike most firms in our industry, we intentionally restrict our practice to government-sponsored health care and human service programs. We have never accepted providers, health plans, or individuals as clients, and therefore avoid any engagements that could create real or perceived conflict of interest. We also conduct ourselves according to rigorous professional and ethical standards designed to serve the public good, hallmarks of professional CPA standards that make us unique within our business community. We meet all independence standards and can provide unbiased consulting.
- **In-depth Knowledge of State and National Health Care Environment.** We maintain dialogues with CMS executives, state Medicaid officials, and industry leaders across the nation to provide clients with truly insightful guidance and assistance. We also closely monitor the activities of state and national health care regulatory environments regarding Medicaid policy, operations, and compliance matters to keep a current knowledge base of relevant legislative and regulatory issues.

MEET THE AUTHORS

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Catherine has more than 35 years of experience working with state health care payers, providers, and managed care organizations to transform health care delivery and financing systems. She has served as a senior advisor to health care providers, government and commercial payers, state legislators and the executive government, focusing on development of health insurance performance improvement strategies, government program financing and policies, Medicaid managed care programs, and business operations.

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Krista brings nearly 20 years of experience in audits, cost reports, and consulting for long-term care facilities, hospitals, intermediate-care facilities, disproportionate share hospitals, and federally qualified health centers. She manages the daily operations of the firm's Idaho long-term care contract. In that role, she schedules audit and consulting work, and reviews reports for accuracy. Krista reviews interim and final hospital cost settlements for Idaho hospitals, out-of-state hospitals, and home health agencies.

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Julia has more than 20 years of providing policy and analytic support to clients related to the delivery and financing of long-term care services and supports, behavioral health services, and public health services. Prior to joining Myers and Stauffer, she served as Administrator of the Nevada Division of Behavioral and Public Health, functioning as the State Health Official and the Mental Health Director. She also served as the Deputy Director of the Nevada Department of Health and Human Services, the Deputy Administrator and Chief of Disability Services in the Division of Aging and Disability Services where she oversaw the operations of all the Nevada home and community-based waiver services programs.

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With more than a decade of experience, Nancy directs projects and provides technical assistance support to various states' Medicaid managed care programs, which include training staff in monitoring key program metrics and performance issues related to managed care organizations. Prior to joining Myers and Stauffer, she was a Senior Research Analyst for NORC at the University of Chicago and a Public Health Analyst at the U.S. Department of Health and Human Services, Health Resources and Services Administration.

FOR MORE INFORMATION

Need some assistance?
Myers and Stauffer can help.

If you are interested in more information about HCBS programs, please contact one of our partners or senior managers to the right.

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