Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

December 31, 2012

Michael Marshall
Secretary of the Senate
State Capitol Building
L O C A L

Carmine Boal
Chief Clerk of the House
State Capitol Building
L O C A L

Dear Mr. Marshall and Ms. Boal:

Enclosed please find the Home Health and HCBS Rate Methodology Report.

This report was prepared pursuant to Senate File 2336, Division IV, Section 36.

This report is also available on the Department of Human Services website at http://www.dhs.iowa.gov/Partners/Reports/LegislativeReports/LegisReports.html.

Sincerely,

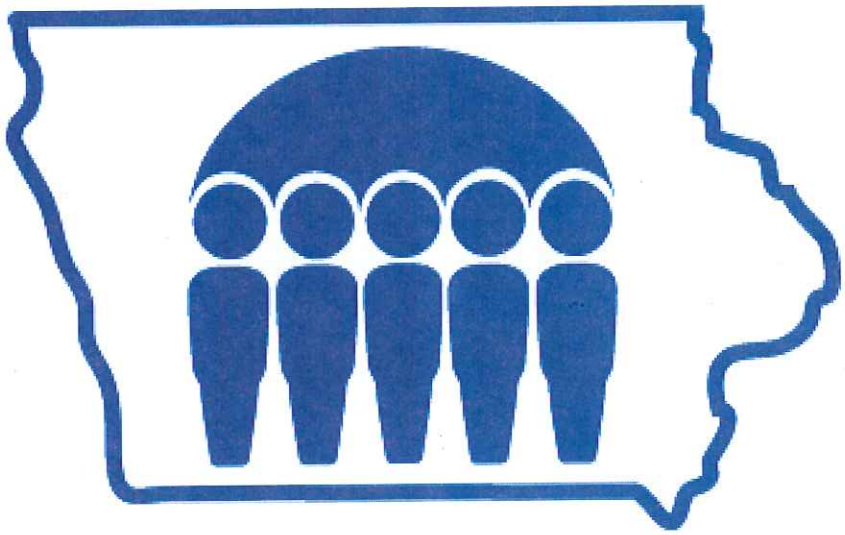
Jennifer Davis Harbison (dy)

Jennifer Davis Harbison
Policy Advisor

Enclosure

cc: Governor Terry E. Branstad
Senator Jack Hatch
Senator David Johnson
Representative David Heaton
Representative Lisa Heddens
Legislative Services Agency
Aaron Todd, Senate Majority Staff
Josh Bronsink, Senate Minority Staff
Carrie Kobrinetz, House Majority Staff
Zeke Furlong, House Minority Staff

Iowa Department of Human Services



Home Health and HCBS Rate Methodology Report

December 2012

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Executive Summary

This report was written to recommend a rate and rebasing methodology for home health agencies, to provide an analysis of the recommended methodology; and to discuss the advantages and disadvantages of adopting a Medicaid Low Utilization Payment Adjustment (LUPA) methodology.

Members of the Department of Human Services (DHS) and the Iowa Alliance in Home Care (IAHC) comprised the Home Health Methodology Workgroup. This workgroup recommends the implementation of a Medicaid LUPA visit methodology that includes wage adjustment for Iowa's differing geographic areas.

The Medicaid LUPA methodology would be utilized to establish reimbursement rates for home care services provided by Medicare-certified home health agencies. These specific home care services would be those medical services determined to be medically necessary through the professional assessment of a physician and written into physician-approved plans of care for Iowa Medicaid members.

Introduction

This report is written in direct response to Division IV, Section 36 of Senate File 2336. This reference states that the Department of Human Services (DHS), Iowa Medicaid Enterprise (IME) shall review reimbursement of home health agency providers. This legislation also directs DHS to review home and community-based services (HCBS) waiver providers and submit a recommendation for a rebasing methodology applicable to such providers to the individuals identified in this Act for receipt of reports by December 31, 2012.

Body of the Report

Per the noted Iowa Acts, this report requires the review and rebasing methodology recommendation of two separate programs:

- The Home Health Agency programs included in the Medicaid State Plan
- The Home and Community-Based Services Waiver programs

Although both of the above-noted programs must provide medically necessary services to Medicaid members, the programs differ in the classification of the services provided and the reimbursement methodologies for each. Each program is generally described as follows:

- The Home Health Agency programs' services provide medically-based services that are provided by Medicare-certified home health agencies. Its rates are primarily based on annual cost reports by which individualized agency rates are calculated.
- The Home and Community-Based Services (HCBS) Medicaid Waiver program's services provide primarily non-medically-based, informal supports to allow members to remain living in their communities as an alternative to facility services per the Centers for Medicare and Medicaid Services (CMS) regulations for State approval. Primarily, the reimbursement rates are based on fee schedules or limited cost reporting for a small number of waiver services.

Because of the differences in these programs, this report has been divided into two separate sections to avoid confusion. Section I addresses the Home Health Agency programs (pages 2- 9) and Section II addresses the Home and Community-Based Services waiver programs (pages 10 - 14).

SECTION I – HOME HEALTH AGENCY

Background
During the course of the last seven years, the IAHC and DHS have evaluated the merits and financial impact of several different methodology models for home health agency services. Through these periods of evaluation, the LUPA visit methodology consistently has arisen as a model bearing close consideration. LUPA visit methodology is based on the reliability of CMS national data and its equity is applied to all providers.

Medicaid Programs and Services Impacted
Implementation of a Medicaid LUPA methodology for Medicare-certified home health agencies would impact the following three programs:

- Home Health Services (HHS)
- Early Periodic Screening Diagnosis and Treatment (EPSDT) Private Duty Nursing (PDN)/Personal Cares (PC)
- HCBS Waiver (AIDS/HIV, Elderly, Intellectual Disability (ID) and Health and Disability (formally known as the III and Handicapped)

The Medicaid LUPA rate methodology would directly impact the reimbursement for the following services provided by Medicare certified home health agencies:

- HHS Services
  - Home Health Aide
  - Medical Social Services
  - Occupational Therapy
  - Physical Therapy
  - Skilled Nursing
  - Speech Language Pathology/Therapy
  - Medical Social Services
- EPSDT PDN/PC
  - Personal Cares
  - Private Duty Nursing (as provided by either Licensed Practical Nurses (LPN) or Registered Nurses (RN)
- HCBS Waiver (AIDS/HIV, Elderly, ID, Health and Disability)
  - Skilled Nursing
  - Home Health Aide

The two HCBS Waiver services noted above (Skilled Nursing and Home Health Aide) are an exception to the description of the HCBS waiver program as non-medically based, informal services with reimbursement based on fee schedules. With the implementation of the Medicaid LUPA methodology, Skilled Nursing and

Home Health Aide services under the three HCBS waiver programs would be reimbursed at the same rates as the Home Health Services (Medicaid State Plan benefit) program.

A visual chart illustrates how these separate programs and services interrelate to each other (Attachment A). On the right hand side of the chart, you will notice a program named, In Home Health Related Care. Although this is a program with services that are similar to the EPSDT PDN/PC program, its funding is not supported through Iowa Medicaid. The funding that supports the IHHRC program is State only revenue. The IHHRC program is not included for discussion in this report.

Home Health Methodology Workgroup

In order to develop a well-balanced and comprehensive report, the IME and the IAHC formed a Home Health Rate Methodology workgroup. The workgroup convened a series of three meetings with intervals of several weeks in between each meeting. The intervals were used for research, writing and review for presentation and discussion at upcoming meetings.

The objective of the workgroup's first meeting was to identify and discuss methodologies that could reasonably be implemented; and to come to a consensus on the methodology that would be recommended. The consensus of the workgroup was to further research the LUPA visit methodology.

For the second meeting, the IME Provider Cost Audit Unit (PCA) researched the Medicare LUPA methodology and calculated the Medicaid LUPA reimbursement methodology. The methodology, how the calculations were applied were applied to the data and the results of the LUPA calculations were explained to the Home Health Rate Methodology workgroup. The workgroup discussed questions regarding the Medicaid LUPA methodology and policy adjustments that would be needed. Workgroup members were given assignments for information needed by the IAHC for its district meetings with its members to discuss this methodology.

At the third meeting, the IAHC presented the response of its membership to a proposed implementation of the LUPA visit methodology for home health agency Medicaid reimbursement. The membership of the IAHC represents over 80% of the Medicare-certified home health agencies enrolled in Iowa Medicaid. The general IAHC membership support is aligned with reimbursement at the 100% level of the geographic and wage adjusted LUPA rates as a means to uniformly and fairly reimburse Iowa home health agencies. Adoption of this methodology will create a majority of home health agencies whose rates will increase and a limited number of home health agencies whose rates will decrease, even at reimbursement of 100% of the LUPA rates. Understandably, those agencies whose rates would decrease expressed concern

Overview - The Medicare LUPA Reimbursement Methodology

- The LUPA rates are national rates that Medicare uses to pay providers per visit by service discipline, instead of the 60 day Medicare episode rate, when a patient requires a limited amount (4 visits or less) of services. LUPA rates represent a fee for service model which

CMS calculates for each State annually, with consideration for each urban or metropolitan service area and rural areas with each State.

- The major components which Medicare uses to annually update LUPA rates are home health input price indexes and wage indexes.
  - **Home Health Input Price Index**
    This index is also known as the Home Health (HH) Market Basket. The yearly percentage change in the home health market basket reflects the average change in the price of goods and services purchased by HH agencies in providing an efficient level of home health care services across the nation. The price index is the -labor cost that home health agencies incur to provide home health services.
  - **Wage Index**
    The wage index is an adjustment to the proportion of the payment amount that accounts for area wage differences. The wage index is, simply, the labor cost to employ staff to provide home health services. A wage index is a percentage that is applied to LUPA rates for each urban (Metropolitan Statistical Area) and -urban areas. Wage indexes are unique to each State.

The Medicaid LUPA Reimbursement Methodology
Medicare LUPA rates would be utilized as the basis for Medicaid LUPA reimbursements and adjustments as applicable. The key components of the Iowa Medicaid LUPA rates are as follows:

- Frequency of LUPA Adjustments – CMS releases updates to both the HH Market Basket and the Wage Indexes on a yearly basis. It is recommended that Iowa Medicaid update the LUPA rates every two years to coincide with the governor's two-year budget cycle.
- Geographic Adjustment – It is recommended that LUPA reimbursement be adjusted by urban and rural areas within our state to more accurately reflect the local market basket and labor costs.
- Billed LUPA Units – Current billing units implemented for the three programs (HHS, EPSDT PDN/PC and HCBS waiver) affected in this report remain the same.
  - **HHS Program** - HHS home health agencies billing for services under the HHS program bill per visit. Based on claims paid from July 1, 2011 – June 30, 2012, calculated projected expenditures using the 2013 LUPA rates with wage index by where the provider was located. Assumptions made by the Workgroup in the LUPA calculations are that usage of medical supplies and administration of immunization remain as currently implemented.
  - **EPSDT PDN/PC Program** - Home health agencies billing for services under the PDN/PC program bill per hour. The LUPA methodology is based on a per visit basis; therefore, the per visit adjusted LUPA rates (Column 9 Attachment B) were converted to a per hour rate for this program. The current EPSDT PDN/PC fee schedule was calculated to pay EPSDT Personal Cares at 44% of the adjusted LUPA rate for revenue code 570-Home Health Aide. The EPSDT Private Duty Nursing (PDN) services was calculated at 44% of the adjusted LUPA rate for revenue code 550-Skilled Nursing. The hourly rate for PDN provided by a licensed practical nurse (LPN) is 67.7% of the EPSDT – PDN/RN hourly rate.

- **The HCBS Waiver Providers** - AIDS/HIV, Elderly and IH waivers bill per visit and the ID waiver providers bill per hour. The home health agencies providing skilled nursing and home health aide services under these waivers will bill the same rates as calculated for the HHS program. The ID Waiver bills per hour for skilled nursing and home health aide services. The home health agencies providing skilled nursing and home health aide services under this waiver will have the rates calculated for EPSDT PDN/PC. However, for the sake of consistency, the Workgroup recommends that the billing units for skilled nursing and home health aide under the ID Waiver be changed from per hour to per visit correspond with the visit rates for the AIDS/HIV, Elderly and IH Waivers.

- The Iowa Medicaid LUPA reimbursement rates will be determined by LUPA rate assigned to the geographic area in which the member resides. This practice will be consistent with the CMS Medicare LUPA methodology.
- Legislative Funding – DHS will compare the Medicare Adjusted LUPA rates with the legislative funding allocated for the three programs impacted and, working backwards, will adjust the Iowa LUPA rates to a percentage of the published LUPA rates, if necessary, to maintain budget neutrality; or in accordance with increased legislative funding for home health agency services, if appropriated .

Calculating the Medicaid LUPA Rates –
The Excel spreadsheet (Attachment B) illustrates how the LUPA methodology was applied to calculate the Medicaid LUPA rates utilizing current home health funding at 88.25% of Medicare unadjusted LUPA rates:

- **Column 1 – City/County**
  This column identifies Iowa's nine metropolitan statistical areas (MSA) is this statistical area or service areas or both. Page for says service. The last section of this column is titled, Non-urban. The Non-urban category includes all counties and areas of the State that are rural and not included in the nine MSA's.
- **Column 2 – Co. Code**
  This column identifies the county number assigned to each Iowa County identified in Column 1 – City/County.
- **Column 3 – Rev/Proc. Code**
  This column identifies the revenue code or the procedure code that a home health agency uses to bill for each home health service.
- **Column 4 – Procedure**
  This column names the nine home health services that would be included in the Medicaid LUPA methodology. Each MSA and the Nonurban sections include these same services in the same order: Home Health Aide, Medical Social Services, Occupational Therapy, Physical Therapy, Skilled Nursing, Speech-Language Pathology (Therapy), EPSDT–Personal Cares, EPSDT Private Duty Nursing/LPN, and Private Duty Nursing/RN.
- **Column 5 – Unadjusted LUPA Rate**
  This column identifies the home health service rates as calculated by Medicare. Medicare updates these rates using the Home Health (HH) Market Basket. The yearly percentage change in the HH Market basket reflects the average change in the price of goods and

services purchased by HH agencies in providing an efficient level of home health care services. This column is used as the basis to calculate adjustments that will determine the Medicaid LUPA rates.

- **Column 6 – Labor Portion**
  This column identifies what percentage of the Unadjusted LUPA Rate that Medicare considers the cost of labor. As you will note, this percentage is the same for all Iowa MSA's and Nonurban areas.
- **Column 7 – Labor Portion of LUPA**
  The amount identified in this column is calculated by multiplying the Unadjusted LUPA Rate (Column 5) by the Labor Portion percentage (Column 6.)
- **Column 8 – Wage Index**
  These percentages represent Iowa-specific MSA and urban sections of the State. The wage index is a percentage adjustment to the proportion of the payment that accounts for Iowa area wage differences. Medicare updates the wage indexes nationally on an annual basis.
- **Column 9 – Adjusted Wage Rate**
  The amount in this column is calculated by multiplying the Medicare LUPA Labor amount (Column 7) by Iowa's MSA and urban wage index percentages (Column 8). The appropriate wage index value would be applied to the labor portion of the LUPA rate based on the site of service for the member.
- **Column 10 – Non-labor Amount of LUPA**
  This is the amount that Medicare has determined as the non-labor cost of providing each home health service. The non-labor amount of LUPA is the difference between the unadjusted LUPA rates (Column 5) and the labor portion of LUPA (Column 6).
- **Column 11 – Adjusted LUPA Rate**
  This amount is the total of the Adjusted Wage Rate (Column 9) + the non-labor amount of LUPA (Column 10). This column reflects the Medicaid LUPA reimbursement rates if the LUPA rates were funded at a 100% level.
- **Column 12 – Budget Neutral % of LUPA**
  This is the 88.25% percentage that must be applied to the Adjusted LUPA Rates (Column 11) to reflect current legislative funding for home health services.
- **Column 13 – Budget Neutral Rate**
  This column identifies the Medicaid LUPA rates that home health agencies would be reimbursed to remain within the SFY 2014 budget. The budget neutral rates are calculated by multiplying the adjusted LUPA rates (Column 11) by the budget neutral percentage (88.25%)

Conclusion

Iowa is one of only five states nationally that still maintains a cost-settlement /fee-based reimbursement methodology. There are a number of reasons why the majority of states have moved to alternate home health reimbursement methodologies. There are many inequities in a cost-based reimbursement methodology:

- ***Reimbursement Inequity Among HH Agencies***
  In 1999, Iowa implemented the current methodology. For those home health providers enrolled in Iowa Medicaid in 1999, base rates were calculated on their then current cost reports. Rate increases or decreases from that point forward were based on those base rates. However, for home health agencies that enrolled after 1999, base rates were

calculated on current cost report data. This data, of course, reflected higher costs resulting in higher reimbursement rates. The methodology implemented in 1999 did not provide a mechanism for rebasing rates for established providers. As a result, an inequity of rate reimbursement was created among our state's home health providers with long-term providers being the most adversely affected. The LUPA methodology will provide a fair and equitable method to reimburse our home health agencies based on home health industry benchmarks and Iowa-specific wage and geographic indexes.

- ***Cost and Labor Intensity***
  The current fee based/cost settlement methodology is cost and labor intensive for both Medicaid and the home health agencies.

  As an annual requirement, home health agencies must be able to complete and document these fiscal reports with or without a financial specialist. The operating budgets of many smaller HH agencies are not able to incur the costs of a certified accountant. As a result, cost reports are often completed by nursing or administrative personnel. Lacking the accounting expertise to accurately capture and calculate costs, HH agency staff inadvertently miss legitimate costs and deductions that could increase their reimbursement.

  In State Fiscal Year (SFY) 2012, the Provider Cost Audit and Rate Setting unit (PCA) IME completed the review of approximately 400 home health agency cost reports. These 400-some reports require the accounting expertise of four (4) staff. The time savings from cost report analyses could be more effectively utilized to address rigorous oversight of current Medicaid programs and alternate health care models that are in various stages of development.

  The LUPA methodology offers an actuarially sound methodology that is calculated by CMS.

  Retroactive Reimbursement
  The cost-based methodology bases current home health agency reimbursement on the past year's business costs calculated as interim rates. This retrospective method requires HH agencies to "look back" to project their budgets on services instead of being able to project on identified rates for specific services. The retrospective process often results in HH agency overpayment which requires refund of reimbursement, that is, most likely already spent or allocated for expenses. Payback is not ideal for any business entity. For Medicaid, this means commitment of staff time chasing, tracking and reconciling HH agency payments. The LUPA methodology will allow HH agencies to budget and manage more effectively and for Medicaid to reduce the pay and chase process.

Iowa's HH Reimbursement Percentage Changes

Following is a chronological SFY schedule of home health agency rate reimbursement:

SFY 2001: Lower of Medicare limit or Medicaid cost
SFY 2002: 3% decrease
SFY 2003: No % change
SFY 2004: No % change
SFY 2005: 3% increase

SFY 2006: 3% increase
SFY 2007: No % change
SFY 2008: 1% increase
SFY 2009: 5% decrease
SFY 2010: No % change
SFY 2011: No % change
SFY 2012: 2% increase

You will note that over the course of eleven years, home health reimbursement rates decreased by 1 percentage point. The IAHC enlisted BKD, an accounting and cost reporting firm with extensive knowledge of Iowa Medicaid cost reporting to complete an analysis of the *"health"* status of home health in the state. On average, an Iowa home health agency is reimbursed $.71 for every $1.00 of expense. This inability to cover costs has led to the demise of home health agencies especially in rural areas where unmet home health needs are significant. Home health will play a role in the growing movement toward Health Homes, Affordable Care Organizations, Programs of All Inclusive Care (PACE) and other Home and Community Based Service programs. Home health will play a role in each of these programs and services which will deliver high quality and managed care for members who universally choose home care with limited facility and hospital care. The need for home health agencies will grow. It is important to level the home health agency playing field to curtail the state attrition of home health agencies.

Winners and Losers

Any reimbursement methodology change will result in winners and losers. The Medicaid LUPA methodology is no exception. There will be home health agencies that will receive an increase in reimbursement and those that will have a decrease with an implementation of the LUPA methodology. Fortunately, the analysis to identify winners and losers results in significantly more winners than losers. However, that will not diminish the disconcerting effect on those agencies whose rates will decrease. The IAHC will offer assistance to those member agencies in analyzing business practices which can result in efficiencies that can add to the bottom line and minimize reimbursement loss.

The Medicaid LUPA methodology would result in the impartial calculation of home health rates biennially. The workgroup recommends that legislative language directs that the rates are non-negotiable and not subject to the exception to policy process.

A Future Look

The HH Rate Methodology Workgroup regards the implementation of the Medicaid LUPA methodology as a necessary first step on the path to a payment for performance methodology which focuses on quality and improved care, which ultimately lowers the overall cost of care. The momentum for this kind of imperative change is continually increasing. Implementing the LUPA methodology will form a solid and fair reimbursement base.

Roster of Workgroup Members

Lin Christensen, Medicaid Program Manager, Home Health Services
Jhonna DeMarcky, IME Provider Cost Audit
Kim Foltz, Executive Director, Iowa Alliance in Home Care
Deborah Johnson, Bureau Chief, Long Term Care

Julie Lovelady, Assistant Medicaid Director
Jeff Marston, IME, Provider Cost Audit
Sally Nadolsky, Medicaid Program Manager, Early Periodic Screening, Diagnosis and Treatment, Private Duty Nursing and Personal Care
Anita Smith, Bureau Chief, Children and Adult Services

SECTION II – HOME AND COMMUNITY-BASED WAIVER

Executive Summary

This report was written to recommend a rate and rebasing methodology for Home and Community Based Services (HCBS) Waiver and Habilitation service providers to provide an analysis of the recommended rate rebasing methodology, and to identify the positive and negative aspects of the methodology.

For the purpose of gathering rebasing recommendations for HCBS Waiver and Habilitation service providers, the department brought together an ad hoc committee of eight (8) HCBS Waiver and Habilitation service providers, three (3) DHS policy personnel, and one (1) staff from the Iowa Medicaid Enterprise (IME) Provider Cost Audit unit (PCA) to discuss current rate setting process and make recommendations for improved methods for rate setting and rebasing. The HCBS Waiver and Habilitation service providers, ad hoc committee represented providers of HCBS Waiver services and Medicaid State Plan Habilitation services. The recommendations made were to assure that HCBS Waiver and Habilitation service providers, rate reimbursement methodologies capture all provider costs for providing direct services while recognizing the need for fiscal accountability and cost limitations.

Basis of Report

This report is written in direct response to Section 36 of the 2011 Iowa Acts, chapter 129, section 141, subsection 10A. This reference states that the Department of Human Services (DHS), Iowa Medicaid Enterprise (IME) shall review reimbursement of home health agency This legislation also directs DHS to review home and community-based services (HCBS) waiver providers and submit a recommendation for a rebasing methodology applicable to such providers to the individuals identified in this Act for receipt of reports by December 31, 2012.

Background

The HCBS Waiver and Habilitation service providers made numerous recommendations for changes within the current rate setting process. HCBS Waiver and Habilitation service providers, currently use numerous rate setting methodologies based on the Waiver or Habilitation services provided. HCBS Waiver and Habilitation rates methodologies include:

- Fee schedules,
- Retrospective cost related,
- Cost based rates,
- Retrospectively limited prospective rates, fee schedule with cost settlement, and
- Rates established through contracts with a local county/region Central Point of Coordination (CPC).

See Iowa Administrative Code 441-79.1(1) for definitions of rate processes (Attachment C)

Many HCBS Waiver and Habilitation providers serve both populations. While there are many similarities in the way services are provided within HCBS Waiver and Habilitation programs,

the rate setting and rate reporting processes are different. There are times when a provider may be providing services to members in the same home or service location that have different rates, rate setting processes, rate reimbursement and reporting mechanisms based on the program funding the service.

Medicaid Programs and Services Impacted

The HCBS Waiver and Habilitation rate recommendations made by this committee would impact all seven of the HCBS Waiver programs (AIDS/HIV, Brain Injury, Children's Mental Health, Elderly, Health and Disability (formally known as the Ill and Handicapped), Intellectual Disability, and Physical Disability) and the Habilitation program.

The HCBS ad hoc committee met two times. The first meeting was designed to identify, discuss, and make recommendations for changes to rate methodologies. The committee identified short term strategies that could be accomplished in 6-12 months and long term strategies requiring 12+ months to implement. The second meeting was held to review and finalize the recommendations for this report.

Rate Models and Discussion

HCBS Committee Recommendations

Several recommendations were made by the HCBS Waiver and Habilitation service providers' ad hoc committee to improve reimbursement to HCBS Waiver and Habilitation providers. Many of the recommendations revolve around the current retrospectively limited prospective rate setting process used with HCBS Waiver services. All providers were in agreement that the current retrospectively limited prospective rate setting process should be changed or eliminated. The retrospectively limited prospective rate setting process sets future rates based on actual cost that were incurred in the past, sometimes up to 18 months behind. The process adds an inflationary percentage increase to the approved cost reported rate based on the most current consumer price index. Currently there is no mechanism to account for unforeseen or uncontrollable future expenses, such as increases on workers' compensation or healthcare premiums until the cost have been incurred and paid in the previous year. The current provider rate will not reflect current direct or administrative costs until 12+ months of expenses have been paid out by the provider.

Another theme that was central to many of the rate rebasing recommendations is to have consistent reporting and rate setting processes for providers. The HCBS Waiver program uses retrospectively limited prospective rates for establishing and reporting of supported community living services (SCL), supported employment (SE) and some types of respite services. Day habilitation and prevocational service rates are established through fee schedule. The Habilitation program uses the retrospective cost-related process for home based habilitation (a service similar to SCL), supported employment, day habilitation, and prevocational services. Services may be provided to members receiving HCBS Waiver and Habilitation funding in the same environment. Thus providers may potentially have different rates setting, tracking, and reporting processes for the same service depending on who is being serviced at the time.

One recommendation to address both of these issues is to use the same rate setting and reporting methodology for the two programs. The committee recommended using the retrospective cost related process currently used in the Habilitation program for two reasons. First, the retrospective cost related process is a two way cost settled process. The two way cost settlement process allows a provider to be compensated for actual allowable costs that are above their reimbursement rate that was received. Currently HCBS Waiver uses a one way cost settlement process that will not allow actual allowable costs to exceed revenues. In other words, if a provider's annual costs are less than what they were reimbursed, they will pay back the overpayment to Medicaid, but if the costs are more than revenues, the provider is not compensated and is out those funds. There is no way for the provider to recoup any of these costs. Two way cost settlement will address the issues identified with the lag time of costs identified with the retrospectively limited prospective rate methodology.

Second, the retrospective cost related process does not limit indirect administrative costs to 20% of total costs of providing services. HCBS Waiver providers are limited to the indirect administrative costs at 20% of direct costs. Recommendations are to eliminate the 20% cap, like with Habilitation, or if that is not possible, redefine the definition of direct/indirect costs using generally accepted accounting principles. Currently indirect costs include staff training, supplies, agency expenses and fees for using space in a member's home, etc. which providers consider direct expenses. If there is a need to cap indirect costs, the group recommended capping indirect expenses at a lower percentage of total costs, in conjunction with redefining direct/indirect costs.

Other recommendations made by the committee for rate setting and rebasing include:

1. Allow the Consumer Price Index (CPI) increase applied to rates to begin on July 1 each year rather than applying the increase with the yearend cost reporting process in December or January. This would allow cost of living increases to be given to providers and coincide with the fiscal year funding reporting cycle. Currently the CPI is added to new provider rates that are approved after the completion of finalized cost reports which are typically issued in December and January, which is 5-6 months into the current fiscal year.

2. Raise service cap rate by the current CPI annually. Historically rate caps have been adjusted sporadically. An annual increase would assure that rate caps keep pace with inflation.

3. Remove the rate freeze currently in place for all fee scheduled rates. As part of Executive Order #19, fee schedule rates have not increased except by legislative action. Fee schedule rates have increased one time (2.5% on July 1, 2011) to restore the 2.5% reduction implemented on 12/1/09. A 2% rate increase is scheduled for January 1. 2013. This recommendation would allow providers to operate within the limits of the current fee scheduled rate methodology to cover costs.

4. Adjust the ID waiver respite cap of $7050 to reflect inflation. The $7050 cap has not been adjusted in 20 years. Respite service rates have increased over the years, but the cap has not increased.

5. Use a fee schedule with cost settlement process for all hourly and daily services. This would set an upper service rate cap for providers with fiscal year end cost settlement

6. Currently there is a benefit in the ID and BI waivers that allows a Medicaid member to access travel and transportation, consulting, instruction, and environmental modifications and repairs within the SCL service. The recommendation is to remove the $1570 limit in setting hourly and daily SCL rates in the ID and BI Waivers. Providers state this process limits getting members needed services and causes increased administrative costs of tracking the limited funds. Habilitation providers would recommend using funds from line 4320 for initial member start-up costs that is available in the ID waiver.

7. Raise all monthly caps for waivers annually according to the consumer price index.

8. Use acuity based funding with a fee schedule. This recommendation will take a longer period of time to implement and will need further study. Currently some case management units are experimenting with the Supports Intensity Scale (SIS) assessment that pairs a level of need with a tiered funding system. The higher the service need, the more funding available for services. The current SIS is for assessment purposes only and does not apply a tiered funding method.

Additional research needed:

Use of a tiered fees schedule to reimburse providers based on number of hours of service and members acuity level. This would coincide with use of the Supports Intensity Scale (SIS) standardized assessment tool to identify the level and intensity of services that a member requires.

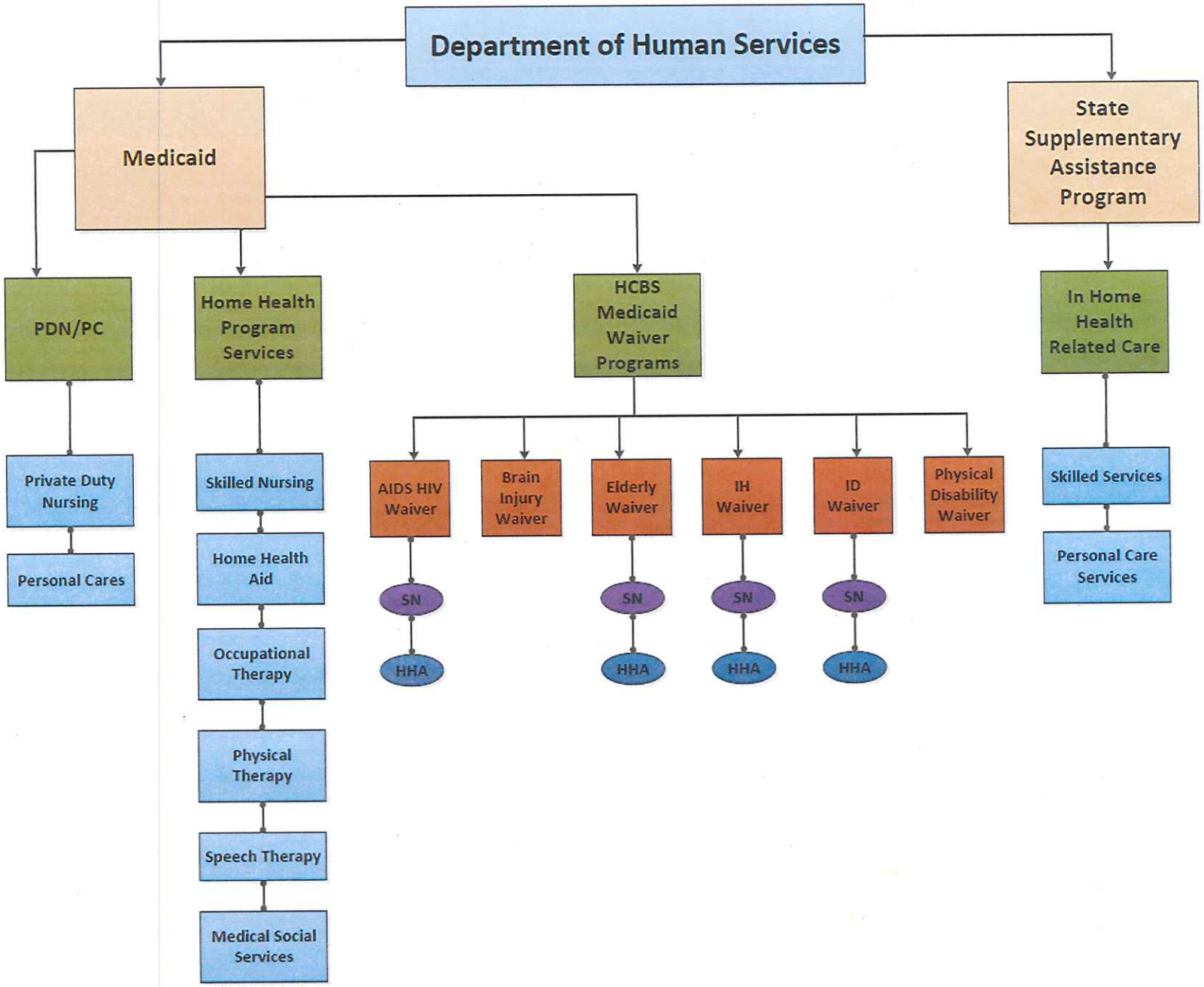
Conclusion/Recommendations

The ad hoc HCBS Rebasing committee made numerous recommendations to assist in streamlining the provider rebasing and rate setting process. All rebasing and rate setting recommendations were made to assure that providers are fairly and adequately reimbursed for service provision costs, while maintaining fiscal accountability and cost containment to Medicaid. Recommendations for consistency in rate setting processes across the HCBS Waiver and Habilitation service providers will allow for efficiencies and consistencies for provider personnel that will reduce administrative costs. Please note that the Department has not determined if the recommendations would be acceptable per CMS guidelines, what the financial impact would be or the steps needed to implement these recommendations. Further analysis would be needed to determine if any of these recommendations would be in the best interest of Iowa's service delivery system.

Roster of HCBS Ad Hoc Workgroup Members
Leslie Beerends, IME Provider Cost Audit
Jennifer Bauer, Candeo
Marcy Davis, Candeo
Colette Edmundson, First Resources
Don Gookin, IME Policy

Lori Ledger, First Resources
Leann Moskowitz, IME Policy
Duane Obbink, Hope Haven of Rock Valley
Susan Seehase, Exceptional Persons Inc.
Bob Swigert, Crest Services
Bob Williams, Williams and Associate, PLC.
Brian Wines, IME Policy
Matt Zima, Crossroads of Western Iowa

ATTACHMENT A



Calculation of Hospice Rates
FY: 10/1/12-9/30/13

CMS National Data

Iowa HHA LUPA Wage Indexes and Rates

City / County	Co. Code	Rev / Proc. Code	Procedure	Unadjusted LUPA Rate	Labor Portion	Labor Portion of LUPA [4]	Wage Index [5]	Adjusted Wage Rate	Non-labor amount of LUPA	Adjusted LUPA Rate	Budget Neutral % of LUPA	Budget Neutral Rate
11180 - Ames		HH570	Home Health Aide	$51.79	0.78535	$40.67		$39.03	$11.12	$50.14	88.25%	$44.25
Story Co.	85	HH560	Medical Social Service	$183.31	0.78535	$143.96		$138.13	$39.35	$177.48	88.25%	$156.63
		HH430	Occupational Therapy	$125.88	0.78535	$98.86		$94.86	$27.02	$121.88	88.25%	$107.56
		HH420	Physical Therapy	$125.03	0.78535	$98.19	0.9595	$94.22	$26.84	$121.05	88.25%	$106.83
		HH550	Skilled Nursing	$114.35	0.78535	$89.80		$86.17	$24.55	$110.71	88.25%	$97.70
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$102.38	$29.16	$131.54	88.25%	$116.08
		S9122	EPSDT - Personal Cares[1]							$22.06	88.25%	$19.47
		S9124	ESPDT - PDN[6]/LPN[2]							$32.49	88.25%	$28.67
		S9123	ESPDT - PDN[6]/RN[3]							$48.71	88.25%	$42.99
16300 - Cedar Rapids		HH570	Home Health Aide	$51.79	0.78535	$40.67		$36.38	$11.12	$47.49	88.25%	$41.91
Benton Co.	06	HH560	Medical Social Service	$183.31	0.78535	$143.96		$128.76	$39.35	$168.11	88.25%	$148.35
Jones Co.	53	HH430	Occupational Therapy	$125.88	0.78535	$98.86		$88.42	$27.02	$115.44	88.25%	$101.88
Linn Co.	57	HH420	Physical Therapy	$125.03	0.78535	$98.19		$87.82	$26.84	$114.66	88.25%	$101.19
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.8944	$80.32	$24.55	$104.87	88.25%	$92.54
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$95.43	$29.16	$124.59	88.25%	$109.95
		S9122	EPSDT - Personal Cares[1]							$20.90	88.25%	$18.44
		S9124	ESPDT - PDN[6]/LPN[2]							$30.78	88.25%	$27.16
		S9123	ESPDT - PDN[6]/RN[3]							$46.14	88.25%	$40.72
19340 - Davenport		HH570	Home Health Aide	$51.79	0.78535	$40.67		$37.20	$11.12	$48.31	88.25%	$42.64
Scott Co.	82	HH560	Medical Social Service	$183.31	0.78535	$143.96		$131.65	$39.35	$171.00	88.25%	$150.91
Moline		HH430	Occupational Therapy	$125.88	0.78535	$98.86		$90.41	$27.02	$117.43	88.25%	$103.63
Rock Island		HH420	Physical Therapy	$125.03	0.78535	$98.19		$89.80	$26.84	$116.63	88.25%	$102.93
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.9145	$82.13	$24.55	$106.67	88.25%	$94.14
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$97.58	$29.16	$126.74	88.25%	$111.85
		S9122	EPSDT - Personal Cares[1]							$21.26	88.25%	$18.76
		S9124	ESPDT - PDN[6]/LPN[2]							$31.31	88.25%	$27.63
		S9123	ESPDT - PDN[6]/RN[3]							$46.94	88.25%	$41.42
19780 - Des Moines		HH570	Home Health Aide	$51.79	0.78535	$40.67		$39.11	$11.12	$50.23	88.25%	$44.33
Dallas Co.	25	HH560	Medical Social Service	$183.31	0.78535	$143.96		$138.43	$39.35	$177.78	88.25%	$156.89
Guthrie Co.	39	HH430	Occupational Therapy	$125.88	0.78535	$98.86		$95.06	$27.02	$122.08	88.25%	$107.74
Madison Co.	61	HH420	Physical Therapy	$125.03	0.78535	$98.19		$94.42	$26.84	$121.26	88.25%	$107.01
Polk Co.	77	HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.9616	$86.36	$24.55	$110.90	88.25%	$97.87
Warren Co.	91	HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$102.60	$29.16	$131.76	88.25%	$116.28
		S9122	EPSDT - Personal Cares[1]							$22.10	88.25%	$19.50
		S9124	ESPDT - PDN[6]/LPN[2]							$32.55	88.25%	$28.72
		S9123	ESPDT - PDN[6]/RN[3]							$48.80	88.25%	$43.06
20220 - Dubuque		HH570	Home Health Aide	$51.79	0.78535	$40.67		$35.23	$11.12	$46.35	88.25%	$40.90
Dubuque Co.	31	HH560	Medical Social Service	$183.31	0.78535	$143.96		$124.70	$39.35	$164.05	88.25%	$144.77
		HH430	Occupational Therapy	$125.88	0.78535	$98.86		$85.63	$27.02	$112.65	88.25%	$99.42
		HH420	Physical Therapy	$125.03	0.78535	$98.19		$85.05	$26.84	$111.89	88.25%	$98.74
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.8662	$77.79	$24.55	$102.33	88.25%	$90.31
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$92.42	$29.16	$121.58	88.25%	$107.30
		S9122	EPSDT - Personal Cares[1]							$20.39	88.25%	$18.00
		S9124	ESPDT - PDN[6]/LPN[2]							$30.03	88.25%	$26.50
		S9123	ESPDT - PDN[6]/RN[3]							$45.03	88.25%	$39.74
26980 - Iowa City		HH570	Home Health Aide	$51.79	0.78535	$40.67		$41.16	$11.12	$52.28	88.25%	$46.14
Johnson Co.	52	HH560	Medical Social Service	$183.31	0.78535	$143.96		$145.69	$39.35	$185.04	88.25%	$163.30
Washington Co.	92	HH430	Occupational Therapy	$125.88	0.78535	$98.86		$100.05	$27.02	$127.07	88.25%	$112.14
		HH420	Physical Therapy	$125.03	0.78535	$98.19		$99.37	$26.84	$126.21	88.25%	$111.38
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	1.0120	$90.88	$24.55	$115.43	88.25%	$101.86
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$107.98	$29.16	$137.14	88.25%	$121.03
		S9122	EPSDT - Personal Cares[1]							$23.00	88.25%	$20.30
		S9124	ESPDT - PDN[6]/LPN[2]							$33.88	88.25%	$29.90
		S9123	ESPDT - PDN[6]/RN[3]							$50.79	88.25%	$44.82
36540 - Council Bluffs		HH570	Home Health Aide	$51.79	0.78535	$40.67		$40.82	$11.12	$51.94	88.25%	$45.84
Harrison Co.	43	HH560	Medical Social Service	$183.31	0.78535	$143.96		$144.50	$39.35	$183.84	88.25%	$162.24
Mills Co.	65	HH430	Occupational Therapy	$125.88	0.78535	$98.86		$99.23	$27.02	$126.25	88.25%	$111.41
Pottawattamie Co.	78	HH420	Physical Therapy	$125.03	0.78535	$98.19		$98.56	$26.84	$125.39	88.25%	$110.66
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	1.0037	$90.14	$24.55	$114.68	88.25%	$101.21
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$107.09	$29.16	$136.25	88.25%	$120.24
		S9122	EPSDT - Personal Cares[1]							$22.85	88.25%	$20.17
		S9124	ESPDT - PDN[6]/LPN[2]							$33.66	88.25%	$29.70
		S9123	ESPDT - PDN[6]/RN[3]							$50.46	88.25%	$44.53

Calculation of Hospice Rates
FY: 10/1/12-9/30/13

CMS National Data

Iowa HHA LUPA Wage Indexes and Rates

City / County	Co. Code	Rev / Proc. Code	Procedure	Unadjusted LUPA Rate	Labor Portion	Labor Portion of LUPA [4]	Wage Index [5]	Adjusted Wage Rate	Non-labor amount of LUPA	Adjusted LUPA Rate	Budget Neutral % of LUPA	Budget Neutral Rate
43580 - Sioux City		HH570	Home Health Aide	$51.79	0.78535	$40.67		$36.65	$11.12	$47.76	88.25%	$42.15
Woodbury Co.	97	HH560	Medical Social Service	$183.31	0.78535	$143.96		$129.71	$39.35	$169.06	88.25%	$149.19
		HH430	Occupational Therapy	$125.88	0.78535	$98.86		$89.07	$27.02	$116.09	88.25%	$102.45
		HH420	Physical Therapy	$125.03	0.78535	$98.19		$88.47	$26.84	$115.31	88.25%	$101.76
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.9010	$80.91	$24.55	$105.46	88.25%	$93.07
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$96.13	$29.16	$125.30	88.25%	$110.57
		S9122	EPSDT - Personal Cares [1]							$21.02	88.25%	$18.55
		S9124	ESPDT - PDN [6]/LPN [2]							$30.95	88.25%	$27.31
		S9123	ESPDT - PDN [6]/RN [3]							$46.40	88.25%	$40.95
47940 - Waterloo		HH570	Home Health Aide	$51.79	0.78535	$40.67		$34.26	$11.12	$45.37	88.25%	$40.04
Blackhawk Co.	07	HH560	Medical Social Service	$183.31	0.78535	$143.96		$121.25	$39.35	$160.59	88.25%	$141.72
Bremer Co.	09	HH430	Occupational Therapy	$125.88	0.78535	$98.86		$83.26	$27.02	$110.28	88.25%	$97.32
Grundy Co.	38	HH420	Physical Therapy	$125.03	0.78535	$98.19		$82.70	$26.84	$109.54	88.25%	$96.66
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.8422	$75.63	$24.55	$100.18	88.25%	$88.41
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$89.86	$29.16	$119.02	88.25%	$105.04
		S9122	EPSDT - Personal Cares [1]							$19.96	88.25%	$17.62
		S9124	ESPDT - PDN [6]/LPN [2]							$29.40	88.25%	$25.95
		S9123	ESPDT - PDN [6]/RN [3]							$44.08	88.25%	$38.90
Nonurban	Various	HH570	Home Health Aide	$51.79	0.78535	$40.67		$33.97	$11.12	$45.08	88.25%	$39.79
		HH560	Medical Social Service	$183.31	0.78535	$143.96		$120.22	$39.35	$159.57	88.25%	$140.82
		HH430	Occupational Therapy	$125.88	0.78535	$98.86		$82.56	$27.02	$109.58	88.25%	$96.70
		HH420	Physical Therapy	$125.03	0.78535	$98.19		$82.00	$26.84	$108.84	88.25%	$96.05
		HH550	Skilled Nursing	$114.35	0.78535	$89.80	0.8351	$75.00	$24.55	$99.54	88.25%	$87.85
		HH440	Speech-Language Patholog	$135.86	0.78535	$106.70		$89.10	$29.16	$118.27	88.25%	$104.37
		S9122	EPSDT - Personal Cares [1]							$19.84	88.25%	$17.51
		S9124	ESPDT - PDN [6]/LPN [2]							$29.21	88.25%	$25.78
		S9123	ESPDT - PDN [6]/RN [3]							$43.80	88.25%	$38.65

[1] is 44% of the HH570 Home Health Aide Rate
[2] LPN is 66.7% of the PDN/RN rate
[3] is 44% of the HH550 Skilled Nurse Rate
[4] CMS-1358-F Regulation
[5] Medicare Home Health CY 2013 Wage Index
[6] PDN - Private Duty Nurisng

Iowa Administrative Code 441 79.1 Rates

79.1(1) *Types of reimbursement.*
a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.
b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.
c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:
(1) The actual charge made by the provider of service.
(2) The maximum allowance under the fee schedule for the item of service in question.
Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988. There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15). Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at:
http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.
d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.
(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on

reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).
(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.
(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:
1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).
e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).
(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.
(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.
(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.
f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.
g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed
prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule
441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services
rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day. Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.