Provider Rate Setting Process

Provider Reimbursement Interim Study

June 27th 2016

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Expenditures by Provider Type

Majority of Expenses by Provider Type, SFY2015

Provider	SFY 2015 Expense (Millions)	% of Total
Hospital	$191.3	23.9%
Nursing Homes/Assisted Living Providers/Hospice	$150.5	18.8%
Community Support Providers	$120.1	15.0%
Physicians, Independent Practitioners and Clinics	$103.9	13.0%
Indian Health Services	$70.3	8.8%
Pharmacies	$35.1	4.4%
South Dakota Developmental Center and Human Services Center	$35.3	4.4%
Substance Abuse, Mental Health and Other Community Support Providers	$23.3	2.9%
Psychiatric Residential Youth Care Providers	$28.9	3.6%
Dentists	$20.9	2.6%
Durable Medical Equipment Providers	$10.4	1.3%
In-Home Service Providers for the Elderly and Skilled Home Health	$ 10.3	1.3%
Total for Majority of Expenses	**$800.3**	

Overview

- The goal of any effective rate setting methodology is to include all allowable and reasonable costs and allow the provider to cover the cost incurred for the provision of the service while incentivizing quality care.
- Not all programs and services for which rates are set are the same, therefore there is no one methodology, or formula to establish rates.
- Federally, not all costs are allowable for Medicaid or other federal fund reimbursement. Some examples include advertising, bad debt, fund raising as examples.
- Medicaid funded services cannot be reimbursed at rates greater than private pay.
- Federal Medicare Upper Payment Limits apply – i.e. comparison of Medicaid to Medicare.

Overview

- Based on the approach and service type, rates may be uniform for a specific service for all providers or may be unique to each provider for the same service.
- Federal requirements can be very specific, or provide a general framework and states have more flexibility in establishing reimbursement methods.
- For Medicaid and other grants, various federal regulations and guidance outline allowable costs and cost allocation methods used to report costs.

  - OMB Circular A-87
  - CMS Publications 15-1 & 15-2 Provider Reimbursement Manual
  - South Dakota's Medicaid State Plan

Overview

Reimbursement rates are set using two primary sources:

- Based on other payer fee schedules (private pay, Medicare, etc.)
- Costs reported through annual cost reports

- Rate setting cannot be done in isolation. A collaborative approach using financial workgroups is used when possible to develop rate setting models.

Basis of Reimbursement by Provider Type

Fee for service rates based on other payers (private pay/Medicare/other)

- Clinics/Independent Practitioners
  - Physicians, CNP/PA - fee schedule for most services
  - Clinics- including Federally Qualified Health Centers/ Rural Health Centers
  - Optometrists, Chiropractors, Dentists
  - Durable Medical Equipment and Ambulance Services
- Pharmacies
- Hospitals
- These provider groups are less reliant on state funding.

Basis of Reimbursement by Provider Type- Clinics/Independent Practioners

- Over 4,000 providers
- Annual FY15 expenditures: $135.2 Million (include physician, transportation, dental, chiro, DME, crossovers, etc.)
- Clinics/Independent Practitioners
  - Physicians, CNP/PA - fee schedule for most services
    - Primary Care Case Management (PCCM) program $3 per member per month
    - Total expenditures $1.7 million
  - Clinics- including Federally Qualified Health Centers/ Rural Health Centers
    - FQHC/RHC – rate methodology federally prescribed.
    - Encounter based rate vs variable fee for service (i.e. all services paid at the same rate per encounter)

Basis of Reimbursement by Provider Type- Clinics/Independent Practioners

- Optometrists
- Chiropractors
- Dentists
- Durable Medical Equipment and Ambulance Services

Actual fee schedules can be found on-line at:

https://dss.sd.gov/medicaid/providers/feeschedules/dss/

Payment Methodology
Pharmacies- Prescription Drugs

Over 300 Providers

Annual FY15 Expenditures: $35.1million (net expenditures after drug rebates)

Current reimbursement is the lesser of:

- Provider's Usual and Customary Charge
- Average Wholesale Price (AWP) less 13% +$4.40
- The payment amount established by the US Department of Health and Human Services for multi-source drugs + $4.40; or
- The payment established by the department for drugs listed on the state's Maximum Allowable Cost (MAC) list + $4.40.

Payment Methodology
Pharmacies- Prescription Drugs

- AWP is similar to a Suggested Retail Price; inflated and not accurate of actual pharmacy costs. AWP also makes it difficult to predict costs and ensure local pharmacies recover their costs.
- DSS has been exploring alternatives; in February 2016 CMS announced requirement for states to transition to Actual Acquisition Cost (AAC) plus dispensing fee or similar methodology.

  –DSS is transitioning to this new payment methodology in FY18

  – AAC is the actual cost of drug. CMS contracts with an accounting firm to survey invoices from independent and chain pharmacies.

  –Dispensing fee that accounts for the local pharmacy's cost to dispense.

  –Working with South Dakota Pharmacy Association and pharmacists to provide input and data to validate dispensing fee findings.

Payment Methodology
Hospitals

- 49 SD hospitals
- Annual FY15 expenditures: $191.3 million (include both inpatient, outpatient, crossovers and all types)

Inpatient Services

- Similar to Medicare and other private payers, Medicaid reimburses larger hospitals on a Diagnosis-Related Group basis.
- 37 states use this methodology or something similar.
- Reimbursement for episodes of care based on diagnosis, procedures, age, sex, discharge status, and presence of complications.
- Each DRG has a South Dakota specific weight to account for acuity and each hospital has a specific target amount used to calculate the reimbursement of the hospital stay.
- Similar to Medicare, smaller hospitals – referred to as Non - DRG on a percentage of total charges – includes Medicare Access Critical

Payment Methodology
Hospitals

Outpatient Services

- Larger hospitals were previously reimbursed a percentage of charges. Starting in 2017 – the 17 hospitals that current bill Medicare using an Ambulatory Payment Classification (APC) will also bill Medicaid the same way.
  - 12 states use this methodology
- Transition developed in collaboration with hospitals, recommendation of a financial workgroup formed in 2011.
- Will streamline billing processes for DRG hospitals so they bill Medicare and Medicaid the same way.

Payment Methodology
Hospitals- Specialized Units

- There are 10 Specialized Units (or DRG-exempt) in South Dakota. Specialized units are reimbursed using the cost settlement method.
- These include 3 neonatal, 4 rehab units, 3 psychiatric
- Providers are paid a per diem based on historical costs or based on Medicare fee schedules.
  - Inpatient psychiatric services prioritized in 2017 budget as part of Governor Daugaard's 3-year plan

Cost Reports

Rates based on reported costs from providers:

- Nursing Homes
- Community Based Providers
  - Assisted Living
  - In Home Services for the Elderly and Disabled (homemaker/nursing)
  - Senior Meals
  - Psychiatric Residential Treatment and Group Care
  - Behavioral Health Services
  - DHS Community Support Services
  - DHS Assistive Daily Living Services
- These groups are more heavily reliant on Medicaid/State funding.

Cost Reports

- Most providers submit cost reports on an annual basis. Cost reports are due four months after the provider's operational year ends.
- While the most common operational year runs July 1 – June 30, providers can have operational years that run on a calendar year, federal fiscal year, or other timeframe.
- Some providers – hospitals, other Medicare certified facilities submit cost reports to Medicare as well.
- Costs reports are used to identify the actual cost to provide services on a per unit basis (daily, hourly, etc. base on methodology).
- DSS and DHS use standardized cost report format.

Cost Reports

Not all costs are allowable for Medicaid reimbursement based on federal requirements. Some examples of non allowable costs include:

- Costs which have not been incurred by the agency, including the value of donated goods and services.
- Costs for idle facilities except when such facilities are necessary to meet caseload fluctuations.
- Costs of fines and penalties resulting from violations of, or failure to comply with Federal, State and local laws and regulations are unallowable.
- Cost of securing contributions or donations.
- Telephone costs attributable to personal use by employees and consumers.
- All costs associated with payment to registered lobbyists.
- Costs of membership to a country club, social or dining club or organization is unallowable.
- Finance, late charges and the following items of interest expense are not reimbursable:
  1. Funds borrowed for investment purposes;
  2. Funds borrowed to create working capital in excess of two months operating costs;
  3. Funds borrowed for the personal benefit of employees, officers, board of directors, members, or owners of the provider agency;

Cost Reports

- Includes expenses (Schedule A and Attachment 1/Schedule C) and revenue (Schedule B).
- The horizontal axis on Schedule A – Expenses contains the following columns:
- Column for each service provided by the organization.
  - If the provider provides one service- stand alone nursing home for example, there would typically be just one column.
  - Providers that provide multiple services – homemaker, nursing, and personal care for example would have multiple columns.
  - Adjustment columns to report non-allowable costs or other adjustments.
- The vertical axis outlines various cost components to include:
  - Salary and Benefit Costs
  - Operating Costs
    - Utilities
    - Supplies
    - Depreciation
- Total allowable costs for each service are calculated.
- Providers report total units of service provided and a per unit cost is calculated.

Cost Reports- Schedule A Expenses (Homemaker/Nursing Example)

SCHEDULE A EXPENSES

HOMEMAKER SERVICES

Account Number and Title	Trial Balance	Program Related Adjustments	Non-Program Related Adjustments	Total Trial Balance & Adjustments	Admin. & Support	Homemaker	Nursing	Total Adjusted Costs
2100 Personnel Salaries:								
2110 Administrative		6,522		6,522	6,522			6,522
2120 Homemaker Supervisor/Coordinator	6,285			6,285		5,414	871	6,285
2130 Direct Staff (Other)	100,902			100,902		86,912	13,990	100,902
2140 Clerical		2,977		2,977	2,977			2,977
TOTAL PERSONNEL SERVICES	107,187	9,499	0	116,686	9,499	92,326	14,861	116,686
2200 & 2300 Benefits & Taxes:								
2210 Health Benefits Plans	25,025			25,025		21,555	3,470	25,025
2220 Retirement Plans	4,684			4,684		4,035	649	4,684
2280 Vacation/Personal Paid Leave	0			0		0	0	0
2290 Other Benefits	2,470			2,470		2,127	343	2,470
2310 FICA Taxes	6,357			6,357		5,475	882	6,357
2320 Unemployment Insurance	0			0		0	0	0
2350 Worker's Compensation Insurance	1,242			1,242		1,070	172	1,242
TOTAL PERSONNEL BENEFITS & TAXES	39,778	0	0	39,778	0	34,262	5,516	39,778
2500 Professional Fees & Contract Services:								
2510 Accounting/Auditing		461		461	461			461
2520 Legal Services				0				0
2530 Maintenance/Professional Services	44	2,753		2,797	2,797			2,797
TOTAL PROFESSIONAL FEES & CONTRACTS	44	3,214	0	3,258	3,258	0	0	3,258
2600 Supplies:								
2620 Office Supplies	358			358	358			358
2640 Medical Supplies	843			843	843			843
2690 Other Supplies/Minor Equipment Purchases				0				0
TOTAL SUPPLIES	1,201	0	0	1,201	1,201	0	0	1,201

Cost Reports- Schedule A Expenses (Homemaker/Nursing Example)

SCHEDULE A EXPENSES

HOMEMAKER SERVICES

Account Number and Title	Trial Balance	Program Related Adjustments	Non-Program Related Adjustments	Total Trial Balance & Adjustments	Admin. & Support	Homemaker	Nursing	Total Adjusted Costs
3100 Occupancy:								
3110 Rent of Space				0				0
3130 Utilities				0				0
3140 Telephone	755			755			755	755
3160 Property Insurance & Taxes				0				0
3190 Other				0				0
TOTAL OCCUPANCY	755	0	0	755	0	0	755	755
3200 Other Agency Costs:								
3240 Advertising/Employee Recruiting				0				0
3250 Dues/Membership/Subscription/Training/Videos				0				0
3270 Bad Debt/Private Pay				0				0
3271 Bad Debt/Waiver Co-Pay				0				0
3275 Professional Liability Insurance				0				0
3290 Miscellaneous	104	165		269	269			269
TOTAL OTHER AGENCY COSTS	104	165	0	269	269	0	0	269
3300 Travel/Transportation								
3310 Rental/Mileage	10,914			10,914		9,402	1,512	10,914
3320 Other				0				0
TOTAL TRAVEL/TRANSPORTATION	10,914	0	0	10,914	0	9,402	1,512	10,914
4400 Depreciation								
4410 Vehicles				0				0
4420 Equipment				0				0
4480 Building				0				0
TOTAL DEPRECIATION	0	0	0	0	0	0	0	0
Total Prior to Admin Allocation	159,983	12,878	0	172,861	14,227	135,990	22,644	172,861
ALLOCATED ADMIN. & SUPPORT						12,196	2,031	
TOTAL EXPENDITURES	159,983	12,878	0	172,861		148,186	24,675	172,861
Total Units						5,220	444	
Cost per Unit						$28.39	$55.54	

Cost Reports – Expenses – Schedule C /Attachment 1 Personnel

(Homemaker/Nursing Example)

Position/ Job Title	Total Hours Paid	Total wages paid	Number of Employees	Benefits Cost	Salary/Hr. Ranges		
					Base	Mid-Point	High
	Column I	Column II	Column III	Column V	Column VI	Column VII	Column VIII
Administrator/Director	131	$6,522	1.00		$35.00	$49.70	$64.40
Managers/Supervisors	253	$6,285	1.00	$2,269	$24.84	$24.84	$24.84
Office Staff	149	$2,977	5.00	$1,075	$14.00	$19.41	$24.83
Coordinators							
RN	445	$13,991	1.00	$5,051	$31.44	$31.44	$31.44
LPN							
C.N.A.							
Home Health Aide	6,173	$86,912	4.00	$31,375	$10.32	$12.20	$14.08

Cost Reports- Schedule B Revenues

SCHEDULE B REVENUES

Please list a breakdown by the source of revenue and amount received by each service type.

Account Number & Title	Total
2000 Income:	
2010 Homemaker	170,209
State of South Dakota	
DSS Adult Services & Aging	53,197
Department of Human Services	
Private Pay	86,616
Medicare	5,303
Other	25,092
2020 Nursing	749,317
State of South Dakota	
DSS Adult Services & Aging	21,062
Department of Human Services	
Private Pay	59,564
Medicare	581,982
Other	86,708
TOTAL REVENUE	919,526

Cost Reports

- Provider Reimbursement staff validate cost report data through
  - Independent Audits
  - Trial Balance/Work Papers
- Desk review
- On-site reviews based on any desk audit findings
- Ongoing training/communication
- Provider Cost Report Instructions and Materials can be found at:

DSS:
http://dss.sd.gov/keyresources/financeoffice/reimbursementaudits

DHS:

http://dhs.sd.gov/bfi/provider.aspx

Rate Setting Methodologies/Process

- Once cost report data is validated, it can be used to develop prospective reimbursement rates.
- Various methodologies are used depending on provider type. Models can include ceilings or limits, or other mechanisms to minimize the impact that outliers could have on rates and offer a tool to manage costs.
- The annual cost report data can be used to measure how well the model performed and if adjustments need to be made.
- Periodic adjustments to recognize more recent cost report data may also be incorporated into the model.

Payment Methodology
Nursing Facility

Annual Expenditures: $136.2 million

Annual Number Served: 3,252

Number of Providers: 109
9 facilities designated as Medicaid Access Critical (SDCL 34-12-35.5)

- Prospective rate based on historical costs
- Medicaid pays for approximately 55% of nursing facility residents in South Dakota
- SFY 2016 Average facility rate $132.33

Payment Methodology
Nursing Facility

- South Dakota's reimbursement method pays a daily rate unique to each resident. Rates for residents with special or heavy care needs are higher while those with less needs are lower. This methodology is referred to as a "case mix methodology".
- The majority of states (38) utilize this type of methodology.
- A resident's care needs are identified through an assessment called the Minimum Data Set (MDS). The MDS is used to collect data regarding the individual's functional capacity including basic self care activities such as health, bathing, dressing, toileting, eating, and transferring. The assessments are completed by the nursing home staff and monitored by state staff.
- Each level of care from the MDS is assigned a Case Mix Weight.

Payment Methodology
Nursing Facility

- Case mix scores range anywhere from .59 for an individual with lower care needs to 2.67 for a resident that requires extensive care.
  - Statewide average case mix: 1.17
- In addition to the individual resident assessment, a cost report is submitted annually by the facility and subject to review annually. The cost report also includes the number of residents served during the year.
- Nursing facilities utilize a range of timeframes for cost reporting with fiscal year ends ranging from December 31 to March 31. This impacts the lag time between submission of the data and use for rate setting.

Payment Methodology
Nursing Facility

- "Ceilings" or limitations are applied to allowable costs based on a comparison of costs in each category among all facilities.
  - Administration
  - Direct Care
  - Non Direct Care
  - Capital
  - Occupancy
  - Overall
- Ceilings are applied to all allowable costs.
- A minimum occupancy level based on licensed beds is imputed for providers when actual occupancy falls below the statewide average. Incentive for providers to align licensed bed capacity closely to actual occupancy.
- A facility specific direct care and non direct care rate are established.

Payment Methodology
Nursing Facility

- When facilities are reimbursed for services, the direct care component of the rate is multiplied by the resident's case mix score resulting in an individualized rate for each resident based on their specific care needs.

  The total rate is calculated by:

  Facility Direct Care Rate X Resident Case Mix + Facility Non Direct Care Rate = Total Rate per day

Payment Methodology
Nursing Facility

Example 1: higher care needs

Sally's care requirements put her in the Extensive Category for reimbursement. Sally needs the assistance of 2 staff for multiple assistive daily living categories (bathing, dressing, assistance with feeding) along with a diagnosis of Multiple Sclerosis, IV Medication, and oxygen therapy.

Before Case Mix Adjustment:
DC rate $54.78
NDC rate $77.44
Total rate $132.22
Case Mix weight 2.67

After Case Mix Adjustment:
$54.78 * 2.67 = $146.26 + $77.44 = Total Daily Rate $223.70

Payment Methodology
Nursing Facility

Example 2: lower care needs

Sue requires minimal assistance with assistive daily living activities, has mild cognitive decline and requires restorative therapy 3 days per week.

Before Case Mix Adjustment
DC rate $54.78
NDC rate $77.44
Total rate $132.22
Case Mix weight .59

After Case Mix Adjustment
$54.78 * .59 = $32.32 + $77.44 = Total Daily Rate $109.76

- Specialized populations - wound care, challenging behaviors, traumatic brain injury include additional cost of providing specialized services not captured through the case mix methodology.

Community Based Services

Annual FY15 Expenditures:

Assisted Living	$9.0 million
Homemaker/Nursing (Medical Services & ASA)	$13.9 million
Senior Meals	$4.3 million
Community Mental Health	$25.2 million
Substance Abuse	$18.2 million
Psychiatric Residential Treatment for Youth (DSS and DOC)	$28.9 million

Annual Number Served:

Assisted Living	720
Homemaker/Nursing	5,458
Senior Meals (average monthly number of consumers served)	4,870
Community Mental Health	16,420
Substance Abuse	12,568
Psychiatric Residential Treatment for Youth	342

Community Based Services

Number of Providers:

Assisted Living	123
Homemaker/Nursing	37
Senior Meals	17
Community Mental Health	11
Substance Abuse	53
Psychiatric Residential Treatment for Youth	7

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Payment Methodology
Community Based Services

- Prospective rate based on historical cost
- Providers submit an annual cost report subject to audit. The cost report includes revenue, expense, and units of service provided during the reporting period.
- Because of the time lag between submission of the cost report and use of the information for rate setting, costs are typically inflated.
- Several categories of providers in this group have adopted a uniform timeframe for the cost report period so that all provider cost data is from the same time period.

Payment Methodologies
Community Based Services

- Input from providers is gathered and used in model development.
  - How the service is delivered, staffing patterns.
  - Documentation and other training or certification requirements.
- Review and analysis of the raw cost report data is completed to identify outliers and establish ranges and mean values for various components of the model.
  - per unit cost information by provider
  - average salary and benefits
  - relationship of personnel costs to operating
- If outliers do exist, they can be excluded from use in model development by use of standard deviation calculations.

Payment Methodology
Community Based Services

- In addition to cost report data, additional information may be collected through surveys or other tools for use in model development.
- Survey data could include time spent updating care plans, travel time for home based services, average leave days used, etc.

Payment Methodology
Community Based Services

Example of a model where service is paid on an hourly rate and typically delivered by a single staff person:

Average Salary and Benefits	$30,015
Average Operating	$ 7,125
Total Cost	$37,140

Billable Time 80% or 1664 hours annually

Total Cost divided by Billable Time = rate per hour

$37,140 ÷ 1664 = $22.32 per hour

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Payment Methodology
Community Based Services

- When modeling a service where direct service delivery involves a team of staff, multiple staff salaries and either billable time or daily census data is used.

- Once models are developed, annual cost report data – including per unit cost information used to validate model.

Current Methodology for Payment

DHS Community Based Providers – Direct Support

(Residential Habilitation, Day Habilitation, Prevocational, Supported Employment, Nursing, Other Medical)

FY15 Expenditures: $109,159,089 Providers: 19

Payment Methodology: Service Based Rates (SBR) System

- Statistical model used to fairly and equitably distribute existing resources within the system based upon the care level and mix of services of the person supported
- Establishes a daily rate for every person supported – those with higher needs receive a higher rate
- Sources of data used in SBR system
  - Provider cost reports
  - Activity logging (time study) data
  - Services received by individual supported
  - Adaptive behavior assessment tool
  - Economic measures

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Current Methodology for Payment

DHS Community Based Providers – Direct Support

	A	B	C	D	E	F	G
1							
2	***Name***	***CID***		***Agency***			
3	*Joe Average*	*AJ770707*		*CSP*			
4							
5	**Predictor Measures**	**Parameter**		**Variable**		**Column**	
6		**Estimate**		**Value**		**B x D**	
7	*Intercept ("Base")*	*13,219.64*		*1*		*13,219.64000*	
8							
9	**Economic Measures**						
10	2001 County Per-capita Income	0.30612		25,139		*7,695.55068*	
11	Special Child Program?	10,331.56		0		0.00000	
12							
13	**ICAP Measures**						
14	Service Score	-94.59654		63		*-5,959.58202*	
15	Swallows soft foods (D.3.1)	-1,689.63069		3		*-5,068.89207*	
16	Age	-310.82602		40		*-12,433.04080*	
17	Age Squared	2.28362		*1600*		*3,653.79200*	
18	Need for MD/Nursing Care (C6)	646.22257		1		*646.22257*	
19	No Current Medications (C7-1)?	-1,388.79301		0		*0.00000*	
20	Number of Rx Drugs (C7-2 - C7-4)	975.29342		1		*975.29342*	
21	Mobility Limits (C9)	1,730.81091		1		*1,730.81091*	
22	Occasional Mobility Assistance (C10-3)?	2,090.43457		0		*0.00000*	
23	Always Needs Mobility Assistance (C10-4)?	5,016.88429		0		*0.00000*	
24							
25	**Residential Services/Supports**						
26	Lives w. Family ?	1,773.74283		0		*0.00000*	
27	*Adult Foster Care ?*	*5,868.23727*		*0*		*0.00000*	
28	*Monitored Apartment ?*	*5,868.23727*		*0*		*0.00000*	
29	Supervised Apartment ?	22,837.67727		0		*0.00000*	
30	Group Residence ?	28,601.85727		1		*28,601.85727*	
31	Child Foster Care ?	31,288.81727		0		*0.00000*	
32	Home Size (Service Record)	-419.77488		7		*-2,938.42416*	

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Current Methodology for Payment

34	Daytime Hours (Service Record)			
36	Day/PreVoc Hours	180.96302	21	3,800.22342
38	Supported Employment Hours	200.00000	6	1,200.00000
40	*Subtotal*			$35,123
41				
43	*Medical Services*	Agency Rate		
44	Speech, Hearing & Language?	$0	1	$0
45	Medical Equipment & Drugs?	$272	1	$272
46	Other Medical Services (therapies, etc.)?	$292	1	$292
47				
49	*Individual Reimbursement Amount*			$35,688
51	*Inflation Adjustment*	1.311		$46,787
52	(+3%+2.2%+2.9%+2.4%+3%+2.4%+1.5%+0.8%+3.3%+2.5%+3.42%)			
53	*Agency Adjustment (± 0%) Gain/Loss*	0.95000	Annual Reimbursement:	$44,448
54			Daily Reimbursement:	$121.77
55	Update: 04/2016		FY17 Rate:	$119.38

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Current Methodology for Payment

DHS Community Based Providers – Direct Support

- 40 payment categories & enhanced rates
  - Low: $2.65
  - High: $529.39
  - Mode: $145.88
  - Median: $132.63
  - Mean: $128.99
- Payment categories can be located at the DSS website at:

http://dss.sd.gov/medicaid/providers/feeschedules/dhs/

Current Methodology for Payment

DHS Community Based Providers – Case Mgmt.

FY15 Expenditures: N/A Providers: 4

Payment Methodology: Fee-for-service delivery system

- Complies with CMS Final Rule regarding conflict-free case management
- 15-minute unit established for the delivery of case management services
- $12.08 per unit rate initially calculated
  - Base data used from CSP cost reports included salaries, benefits and taxes, operating overhead and staff time for existing case managers
  - Department of Labor wage statistics were reviewed to validate base data
- **$12.49** per unit rate after applying 3.42% inflation effective for services provided on or after June 1, 2016

Current Methodology for Payment

DHS Community Based Providers – Case Mgmt.

- Budget neutral
- Approximately 50% of CSP case management budget remained with CSP
- $1,550 reduced from each individual's SBR calculation –
  - Less than 5% reduced from total CSP budget

Current Methodology for Payment

DHS Community Based Providers – Family Support

(Case Mgmt., Companion Care, Respite, Personal Care, Home/Vehicle Modification, Supported Employment)

FY15 Expenditures: $4,727,701 Providers: 29 programs

Payment Methodology: Fee-for-service, actual cost, negotiated

- Fee-for-service 15-minute unit rate is used for the payment of case management services and based on provider cost reports and time study data
- Supplies/Vendor services provided at market/retail rates
- Rates for Personal Care, Respite, Companion Care and Supported Employment are negotiated by the participant with their provider
  - Participants must follow Fair Labor Standards Act including state and federal minimum wage requirements

South Dakota DHS DEPARTMENT OF HUMAN SERVICES

Current Methodology for Payment

DHS Community Based Providers – Family Support

DDD Family Support - FY17					
FY17					
Current Codes	*Duration of Current Units*	*Current Description*	*FY16 Rate*	*FY17 Rate*	*Monthly Limits*
T1016	15 minutes	Service Coordination	$16.27	$16.82	n/a
T1020		Companion Care, adult; per 15 minutes	Billed Charges	Billed Charges	$1,000
T1005	15 minutes	Respite Care Services	Billed Charges	Billed Charges	$1,000
A9900		Specialized Medical Equipment, not otherwise specified, waiver	Billed Charges	Billed Charges	$2,500
T1019	15 minutes	Personal Care Services	Billed Charges	Billed Charges	$1,500
G0154	15 minutes	Personal Care 2 Services	Billed Charges	Billed Charges	$750
S5165		Home Modifications, per service	Billed Charges	Billed Charges	$5,000
B4222		Medical foods for inborn errors of metabolism	Billed Charges	Billed Charges	$500
T2018	15 minutes	Habilitation, supported employment, waiver; per 15 minutes	Billed Charges	Billed Charges	$750
T2039		Vehicle modifications, waiver; per service	Billed Charges	Billed Charges	$5,000

http://dss.sd.gov/medicaid/providers/feeschedules/dhs/

Current Methodology for Payment

DHS Community Based Providers – Assistive Daily Living Services (ADLS)

(Case Mgmt., Personal Attendant, Nursing, Personal Care, Respite, Environmental/Vehicle Modification)

FY15 Expenditures: $3,414,754 Providers: 3

Payment Methodology: Fee-for-service, actual cost

- Fee-for-service payment rates for ADLS are based on the same fee schedule that is utilized by the Community Based Services program within DSS and derived from provider costs reports and time study data
- Supplies/Vendor services provided at market/retail rates

Current Methodology for Payment

DHS Community Based Providers – ADLS

DRS - FY17

FY17					
Standard Code	*Duration of Standard Units*	*Standard Code Description*	*FY16 Rate*	*FY16 Mid-year Rate Adjustment*	*FY17 Rate*
T1019	15 minutes	Personal Care Services, per 15 minutes	$5.04	$5.88	$6.29
T1016	15 minutes	Case Management, each 15 minutes	$15.50	$15.50	$16.03
S5115	15 minutes	Home Care Training, nonfamily, per 15 minutes	$9.51	$9.51	$9.84
S5161		Emergency Response System, service fee, per month	$45/month	$45/month	$45/month
T1000	15 minutes	Private Duty/Independent Nursing Service(s) - licensed, up to 15 minutes	$9.73	$9.73	$12.40
T5999		Supply, not otherwise specified	$100/month	$100/month	$200/month
T1005	**15 minutes**	**Respite, per 15 minutes**	N/A	N/A	$6.29
A9900		**Specialized Medical Equipment & Supplies**	N/A	N/A	$2,500/month
T2039		**Vehicle Modifications**	N/A	N/A	$5,000 per service
S5165		**Environmental Accessibility Adaptations**	N/A	N/A	$5,000 per service
		Attendant Care - 100% General - **Non-Medicaid**	$11.80	$11.80	$12.20

http://dss.sd.gov/medicaid/providers/feeschedules/dhs/

Governor's Rate Study

- Governor Daugaard formed an internal agency workgroup to collect data regarding provider rates and cost report information. Output used to develop data driven decisions regarding provider rates.
- Reviewed most recent cost report information for 20 provider types – over 866 providers
- Findings organized into a spreadsheet comparing current reimbursement rates to cost reports
- Three tiers created
- Goal: Get all providers to at least 90% of methodology costs over 3 years.

Governor's Rate Study – General Funds

Provider Reimbursement										
		With 2.1% Provider Inflation		After 2.7% Provider Inflation		Year 1 of 3			After Year 3	
	Most Recent Cost Report Available	General fund cost to get to 90% of Methodology	Percent of Methodology Currently Paid	General fund cost to get to 90% of Methodology	Percent of Methodology Paid	1/3 Cost	Remaining 2/3 cost to get to 90% of Methodology	Percent of Methodology Paid	Remaining cost to get to 90% of Methodology	Percent of Methodology Paid After 3 Years
MS- In Home Services (Homemaker/Nursing)	2010 Full - 2014 Partial	$ 973,292	61%	$ 960,487	63%	$ 320,162	$ 640,324	72%	$ -	90%
MS- Outpatient Psychiatric	2012	$ 536,003	67%	$ 526,361	68%	$ 175,454	$ 350,907	76%	$ -	90%
MS-Emergency Transport	N/A	$ 895,990	70%	$ 876,407	71%	$ 292,136	$ 584,271	78%	$ -	90%
MS - Hospitals	2013	$ 177,502	78%	$ 170,532	79%	$ 56,844	$ 113,688	83%	$ -	90%
ASA- In Home Services (Homemaker/Nursing)	2010 Full - 2014 Partial	$ 1,210,918	78%	$ 1,162,973	79%	$ 387,658	$ 775,315	83%	$ -	90%
In Home Services (ADLS waiver)	2010 Full - 2014 Partial	$ 176,788	82%	$ 165,401	83%	$ 55,134	$ 110,267	85%	$ -	90%
ASA- Assisted Living	2010	$ 228,597	85%	$ 200,186	87%	$ 66,729	$ 133,457	88%	$ -	90%
CPS Group Care	2010		91%		92%			92%		92%
Nursing Homes	2012		92%		93%			93%		93%
Group Care	2010		92%		93%			93%		93%
Behavioral Health-Substance Abuse	2012		95%		96%			96%		96%
Medicaid Eligible (IRT/PRTF)	2012		96%		97%			97%		97%
ASA- Senior Meals	2014		96%		98%			98%		98%
Community Support Providers (CSPs)	2014		97%		98%			98%		98%
Behavioral Health-Mental Health	2012		97%		98%			98%		98%
Medical Services/CPS-Psychiatric Residential Treatment	2012		98%		99%			99%		99%
Centers for Independent Living	2014		100%		100%			100%		100%
Independent Living	N/A		100%		100%			100%		100%
Foster Care	N/A		100%		100%			100%		100%
Sequel Transition Academy	N/A		100%		100%			100%		100%
Community Based Services	N/A		100%		100%			100%		100%
		$ 4,199,091		$ 4,062,346		$ 1,354,115	$ 2,708,230		$ -	

Governor's Rate Study

Governor's FY17 Recommended and Final Appropriation

Provider Reimbursement Rate Adjustment Scenarios

		SFY16 Budget (Total Funds)	Total Cost to Reach Methodology	FY16 Budget plus Fiscal Impact Cost (Total Funds)	Percent of Methodology Currently Paid	General fund cost to get to 90% of Methodology	1/3 of General Fund Cost	1/2 of Year 2 General Fund Cost	2.1% Inflation General	Additional 0.6% General	Additional 0.72% General	Total General Funds	Percentage Increase	Percent of Methodolgy Paid
DSS	MS- In Home Services (Homemaker/Nursing)	$ 4,650,814	$ 2,873,340	$ 7,524,154	61.8%	$ 960,487	$ 320,162	$ 160,081	$ 44,819	$ 12,806	$ 15,367	$ 553,235	25.92%	76.5%
DSS	ASA- In Home Services (Homemaker/Nursing)	$ 10,544,598	$ 2,947,086	$ 13,491,684	78.2%	$ 1,162,973	$ 387,658	$ 193,829	$ 167,807	$ 47,945	$ 57,534	$ 854,772	10.70%	84.9%
DHS	In Home Services (ADLS waiver)	$ 4,135,671	$ 887,566	$ 5,023,237	82.3%	$ 165,401	$ 55,134	$ 27,567	$ 39,855	$ 11,387	$ 13,665	$ 147,608	7.78%	87.0%
DSS	MS- Outpatient Psychiatric	$ 3,502,032	$ 1,686,912	$ 5,188,944	67.5%	$ 526,361	$ 175,454	$ 87,727	$ 33,749	$ 9,642	$ 11,571	$ 318,143	19.80%	79.4%
DSS	MS - Hospitals	$ 2,531,571	$ 711,063	$ 3,242,634	78.1%	$ 170,532	$ 56,844	$ 28,422	$ 24,396	$ 6,970	$ -	$ 116,633	10.04%	84.3%
DSS	MS-Emergency Transport	$ 7,112,494	$ 2,959,693	$ 10,072,187	70.6%	$ 876,407	$ 292,136	$ 146,068	$ 68,542	$ 19,584	$ -	$ 526,330	16.13%	80.5%
DSS	ASA- Assisted Living	$ 10,318,587	$ 1,700,000	$ 12,018,587	85.9%	$ 200,186	$ 66,729	$ 33,365	$ 99,439	$ 28,411	$ 34,093	$ 262,037	5.53%	88.8%
DSS	CPS Group Care	$ 3,367,463	$ 301,420	$ 3,668,883	91.8%				$ 70,717	$ 20,205	$ 24,246	$ 115,167	3.42%	93.0%
DOC	Group Care	$ 3,002,761	$ 245,207	$ 3,247,968	92.5%				$ 63,058	$ 18,017	$ 21,620	$ 102,694	3.42%	93.7%
DSS	Nursing Homes	$ 140,246,628	$ 11,700,000	$ 151,946,628	92.3%				$ 1,351,543	$ 386,155	$ 463,386	$ 2,201,084	3.42%	93.5%
DSS	ASA- Senior Meals	$ 5,191,468	$ 161,000	$ 5,352,468	97.0%				$ 109,021	$ 31,149	$ 37,379	$ 177,548	3.42%	98.3%
DSS	Behavioral Health-Substance Abuse	$ 17,888,355	$ 941,122	$ 18,829,477	95.0%				$ 357,459	$ 102,131	$ 122,558	$ 582,148	3.42%	96.3%
DSS	Behavioral Health-Mental Health	$ 27,675,075	$ 679,544	$ 28,354,619	97.6%				$ 444,677	$ 127,051	$ 152,461	$ 724,188	3.42%	98.9%
DOC	Medicaid Eligible (IRT/PRTF)	$ 10,085,624	$ 340,047	$ 10,425,671	96.7%				$ 97,194	$ 27,770	$ 33,324	$ 158,288	3.42%	98.0%
DSS	Medical Services/CPS-Psychiatric Residential Treatment	$ 21,177,404	$ 345,421	$ 21,522,825	98.4%				$ 209,364	$ 59,818	$ 71,782	$ 340,964	3.42%	99.7%
DHS	Community Support Providers (CSPs)	$ 124,273,516	$ 3,387,150	$ 127,660,666	97.3%				$ 1,197,611	$ 342,175	$ 410,610	$ 1,950,396	3.42%	98.6%
						$ 4,062,346	$ 1,354,117	$ 677,058	$ 4,379,252	$ 1,251,215	$ 1,469,593	$ 9,131,235		

Governor's Rate Study

	FY16 Rate	FY17 Rate	
Personal Care Aide	$23.52	$25.16	hourly
Private Duty Nursing (RN)	$38.92	$49.60	hourly
Nursing (LPN)	$23.46	$27.16	hourly
Assisted Living	$37.53	$40.50	per day
Psychiatric Diagnostic Evaluation	$93.26	$96.06	fixed rate
Psychiatric Treatment /Family 60 Minutes	$82.34	$96.06	hourly
Ambulance Basic Life Support	$98.56	$170.52	fixed rate
Ambulance Advance Life Support	$219.98	$249.72	fixed rate
Air Fixed Wing	$1,016.43	$1,417.87	fixed rate
Air Helicopter	$1,270.55	$1,600.60	fixed rate
Wheel Chair Van	$17.57	$18.85	fixed rate
Stretcher Van	$28.95	$70.06	fixed rate
Loaded Miles	$2.88	$3.83	per mile
Inpatient Psychiatric Hospital	$635.84	$699.50	daily

Governor's Rate Study

Next Steps

- Compiling updated cost reports- goal is to get 2014-2015 cost reports for all provider groups.
- Update spreadsheet with aggregate data by provider group.