

**Testimony on the Department of Public Welfare
Office of Developmental Program's Outlier Rate
Adjustment Policies**

**Kevin Casey, Deputy Secretary
Office of Developmental Programs**

**House Republican Policy Committee
September 23, 2010**



pennsylvania

DEPARTMENT OF PUBLIC WELFARE

Good morning, Chairman Saylor, Representative Oberlander, members of the committee and staff. I am Kevin Casey, Deputy Secretary for the Office of Developmental Programs (ODP) with the Department of Public Welfare (DPW). Thank you for allowing me to provide testimony today on the topic of ODP's Outlier Rate Adjustment Policies.

I want to first start off by providing some background on the subject of the current rate setting process for ODP providers. At the Centers for Medicare and Medicaid Services' (CMS') insistence and in order to meet federal standards for rate-setting purposes, DPW has had to change the manner in which providers under two of the ODP waiver services are funded.

DPW operates two waiver programs approved by CMS for individuals with developmental disabilities, the Consolidated Waiver and the Person/Family Directed Support Waiver. These waivers provide home and community based services for individuals with mental retardation and are administered statewide by the ODP. The MR Waiver Program is largely funded through two Medicaid Waivers which have been managed for the last twenty-five years by a federal-state-county partnership. The federal government lays out the general program parameters and pays for over half of the funds in this program; the state provides the program design and the balance of the funding. In the past, the counties administered the program, including the establishment of provider rates, at the local level as part of the county community-based service system established under the Mental Health and Mental Retardation Act of 1966.

CMS requires that the programs be managed on a consistent statewide basis. A person receiving services in one part of the state should be able to access the same

services in a similar manner in any other part of the state. Because there were 48 county-based programs administering the programs and negotiating provider rates at the local level, DPW could not meet this requirement. As a condition of continued federal approval of the MR Waiver Program, in FY 2004-2005 CMS required PA to change the way the MR Waiver Programs are administered and required Pennsylvania to develop a statewide rate-setting methodology. In order to continue to draw down over \$1.1 Billion (ARRA included) in federal funds to serve over 25,000 individuals through the waivers DPW has been required to transition to a new payment system.

Effective July 1, 2009, DPW started a two year transition to the new Prospective Payment System (PPS). This is a cost-based system which utilizes cost report information submitted by providers to establish rates. Under the PPS, ODP calculates provider-specific rates on an annual basis. Rates are calculated from data collected in a standardized cost report. Only those cost reports that are submitted and approved in this process are used to develop rates. This data is analyzed to calculate the average unit cost and standard deviation for each procedure code in the rate setting system.

In order to set rates for providers under the PPS, providers are required to submit a cost report to DPW outlining the costs they have incurred over the past year. This is the basis for the rates paid to providers, and without the cost reports DPW will not be able to set final rates for the providers after the two year transition is over on July 1, 2011. A group of providers have chosen to not submit cost reports and as a result, these providers have been assigned the lowest rate for each service they provide. Without reliable cost reports, DPW cannot set an accurate rate for providers and reimburse them at their costs. Without accurate cost reports, the PPS cannot function and the rate problems become compounded as we would not be able to determine final

rates to providers at the end of the transition period that will properly account for real provider costs.

For payments to Waiver Providers, there is one appropriation of funds allocated as part of the budget process to pay for all of the services provided under the two waivers. DPW applied a rate adjustment factor (RAF), which is a multiplier applied to individual provider rates to bring their expenditures in line with available funds. Despite provider misunderstanding, the RAF does not further decrease the appropriation or the amount of funding available for individuals with intellectual disabilities and their service providers.

In the current fiscal environment, we are always trying to maintain the appropriate use and control of costs and specific to this topic we are trying to monitor and look at ways to control the costs for the most complex consumers. In addition, CMS insists that we narrow the range of our rates over a period of time. As part of the rate setting process, variations in rates are accounted for in setting specific provider rates. Outliers are defined as those Attendant Care Programs (ACPs) that are more than one standard deviation (SD) above or below the average ACP for a specific service. Attachment #1 of the testimony includes examples of outlier adjustments under the PPS.

The purpose of the outlier policy is to ensure consistency and appropriate payment for providers who may have very high or very low costs outside of the standard rates. We are open to other options that would be possible and are willing to readily research any other options that will control cost and narrow rate ranges as required by CMS.

Help for Providers.

We have just discussed the rate process, however during the two year transition to the PPS, DPW has been working with individual providers to ensure that they are able to continue to provide services to individuals with intellectual disabilities. Given the change, some providers have faced financial hardships, and we have two primary ways in which we assist providers:

- Revenue Reconciliation – A provider’s payment rates do not impact the ultimate amount of revenue a provider will receive during the two year transition period. DPW recognized that there would be variations as the rate setting process was refined, and therefore put into place a process called “revenue reconciliation,” Revenue reconciliation helps to minimize the financial risk to DPW and providers. Revenue reconciliation ensures that the overall amount of revenue received by a provider in a fiscal year is comparable to what the provider received in the base year (FY 2008-09), with adjustments to reflect additional service delivery. Payment rates are used to process claims, but a provider’s final reimbursements will be reflected through the revenue reconciliation policy. As the process enters its second year, DPW will do periodic reconciliation of the revenue providers receive through PROMISE and compare that revenue to the provider’s established revenue target. If payments made to a provider in the fiscal year are less than the provider’s established revenue target, DPW will give the provider a supplemental payment to make up the difference. Conversely, if payments made to a provider in the fiscal year exceed the provider’s established revenue target, DPW will recoup funds.
- Gross Adjustment. The gross adjustment process is an advance to providers on payments that will be made to them in the future. This specifically helps

providers until revenue reconciliation can be completed. Each request is reviewed by DPW in accordance with agreed upon protocols. These advances are limited to the lower payment approved in 08/09 by the county program or 15% of the target amount for revenue reconciliation. These gross adjustments are available for FY 2009-10 and FY 2010-11.

We are committed to continue to work with individual providers through this transition to ensure that the approved waivers remain in place and that federal funds can continue to be received for the services provided under the waivers. As I said before, we continue to be open to discuss other options that may be possible and are willing to readily research any other options that help us control costs and narrow rate ranges. Thank you for the opportunity to testify today and I will take any questions you have at this time.

Attachment #1: Outlier Adjustments

- In Year 1 (2009-2010), for non-residential services, total unit costs more than two SD above or below the average were adjusted to be within two SD of the average and total unit costs more than one SD above or below the average were adjusted to be within one SD of the average. However, outlier unit costs within 10% of the FY 2008/2009 authorized rate were not adjusted
- In Year 1 (2009-2010), for residential eligible services, total unit costs more than two SD above or below the average were adjusted to be within two SD of the average. However, outlier unit costs supported by the Individual Support Plan (ISP) in HCSIS were not adjusted
- In Year 1 (2009-2010), for residential ineligible services total unit costs more than two SD above or below the average were adjusted to be within two SD of the average and total unit costs more than one SD above or below the average were adjusted to be within one SD of the average
- In Year 2 (2010-2011), for non-residential and residential ineligible services, total unit costs more than two SD above the average were adjusted to be within two SD of the average and total unit costs more than one SD above the average were adjusted to be within one SD of the average. However, outlier unit costs within 5% of the FY 2009/2010 authorized rate, or those supported by unusual circumstances as determined by ODP (e.g. merger), were not adjusted
- In Year 2 (2010-2011), for residential eligible services, total unit costs more than two SD above the average were adjusted to be within two SD of the average and total unit costs more than one SD above the average were adjusted to be within one SD of the average. However, outlier unit costs within 5% of the FY 2009/2010 authorized rate or those supported by the ISP in HCSIS were not adjusted
- In Year 2 (2010-2011), for services with total unit costs that were within one SD of the average unit cost, the other ACPs that were more than two SD above the average were adjusted, unless the adjustment was overridden by ODP based on a review of the provider's cost report