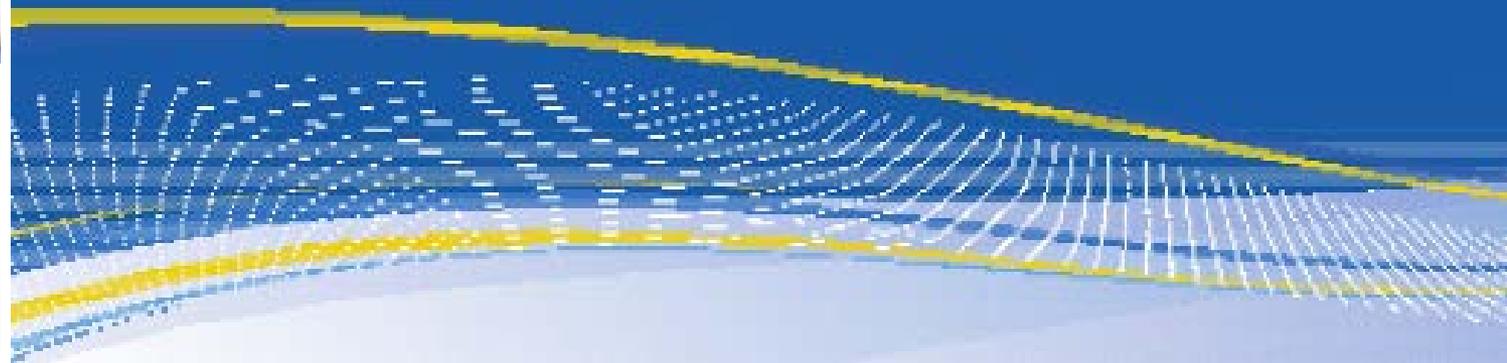




Financial Accountability



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



Training Objectives

- Provide an overview of common challenges observed while reviewing Appendices I and J of §1915(c) new waiver and renewal applications, which specifically address financial accountability measures.
- Review promising practices for addressing common challenges in accordance with the §1915(c) Home and Community-Based Services (HCBS) Technical Guide and Review Criteria.

Data Analysis Background

Data Collected and Analyzed by CMS

- This training includes application trends related to Appendices I and J.
 - Based on data from two new waiver applications and 87 renewal applications submitted between March 2015 and July 2016.
 - Data was collected from initial submissions (i.e., before an informal request for additional information is issued).
 - Because many states were missing information, data was only included for applications with relevant information.
 - For example, only 70 renewal applications included sufficient rate setting methodology information in Appendix I-2-a.

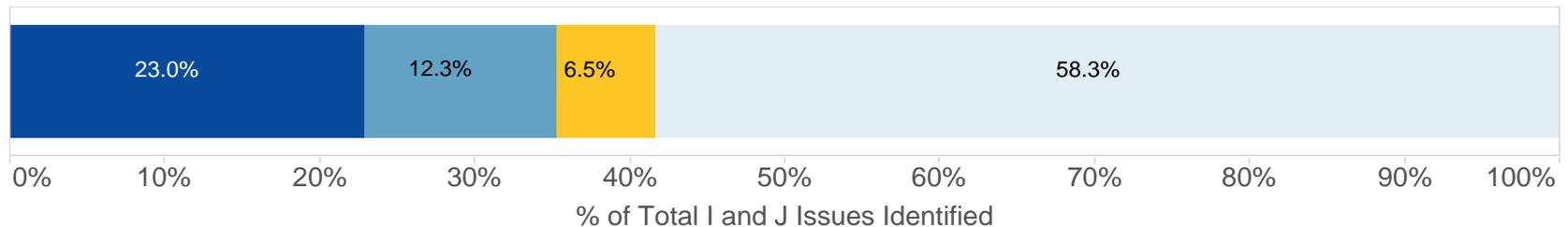
Data Analysis Background

Why Look at Initial Submissions?

- CMS routinely issues requests for additional information (RAIs) to ensure waiver applications meet federal requirements as described in the 1915(c) Technical Guide.
- Including sufficient detail in the waiver application prior to submitting it to CMS:
 - Reduces the number of questions in the RAI and reduces the amount of time required for CMS developing and the state responding to the RAI
 - Maximizes the information available for public comment

Data Analysis Background

Top 3 Issues in Appendices I and J Leading to RAIs for New and Renewal Applications (based on 89 applications and 38 categories for issues)



-  Insufficiently documented the basis of Factor D, D', G and G' estimates. (Appendix J-2-c) **23.0 percent**
(121 of 527 issues)
-  Insufficiently documented rate setting methods for each waiver service. (Appendix I-2-a) **12.3 percent**
(65 of 527 issues)
-  Insufficiently documented the post-payment financial audit program. (Appendix I-1) **6.5 percent**
(34 of 527 issues)
-  All other deficiencies related to Appendices I and J. **58.3 percent**
(307 of 527 issues)

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates (Appendix J-2-c)

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

- The factor derivations described in Appendix J-2-c demonstrate the cost neutrality of the waiver.
 - **Factor D:** Estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.
 - **Factor D':** Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.
 - **Factor G:** Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for individuals served in the waiver, were the waiver not granted.
 - **Factor G':** Estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.
 - **Cost Neutrality Formula:** $D+D' \leq G+G'$.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- States are expected to use 372 reports as the basis for estimating factors D, D', G and G'.
- Another basis can be used (e.g., Consumer Price Index), as long as the basis is **explained** and **justified** in the 1915(c) waiver application.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- 41 of 89 applications (46 percent) did not sufficiently document the basis for factor estimates. This included:
 - No explanation for how estimates were trended
 - Explanations that include a growth percentage, but no explanation for how this percentage was established
 - Discrepancies between 372 reports and factor estimates when the application indicates 372 reports were used
 - Insufficient detail regarding an alternate basis for CMS to validate the state's calculation

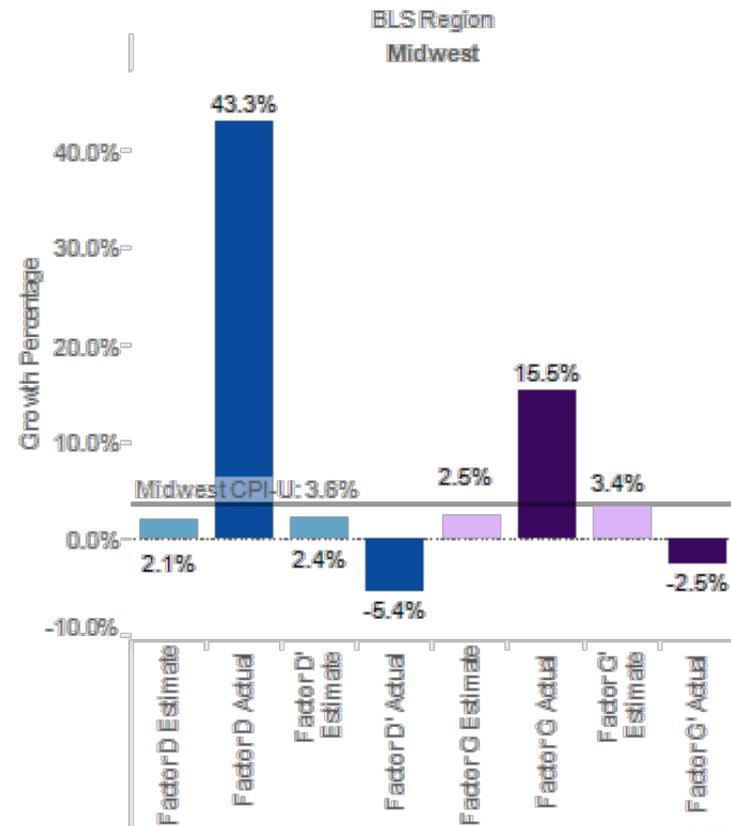
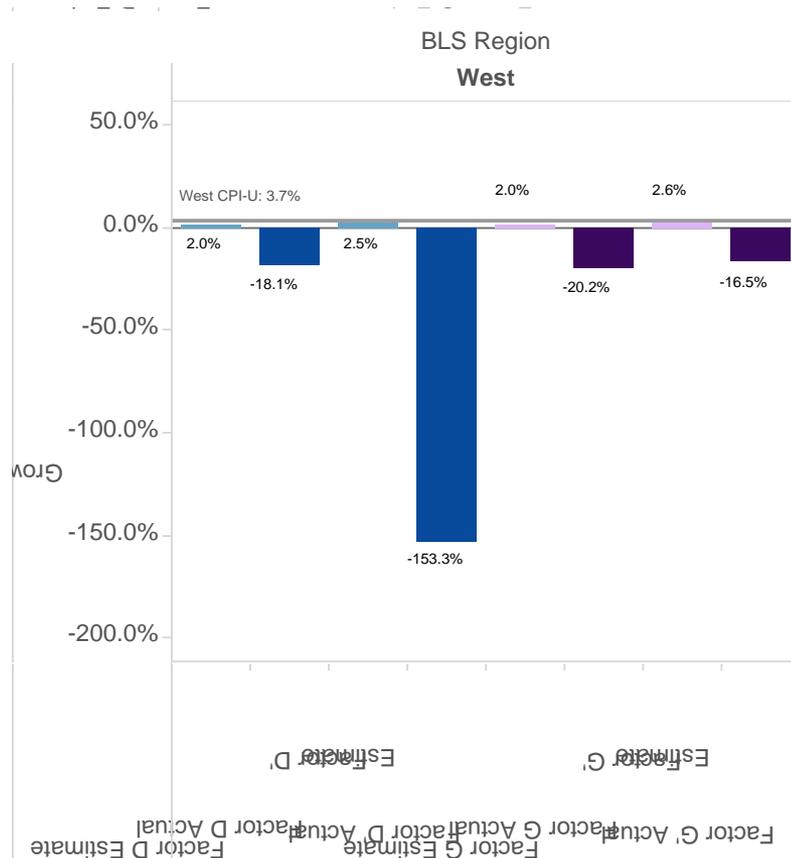
Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- To illustrate the importance of documenting deviations from 372 reports, estimated factor growth from applications were compared to:
 - Actual growth based on 372 reports
 - Regional Consumer Price Indices for all Urban Consumers (CPI-U), an inflation/trending metric commonly used as an alternate basis for estimating factor growth
- Comparisons were divided by Bureau of Labor Statistics (BLS) regions to account for regional cost differences

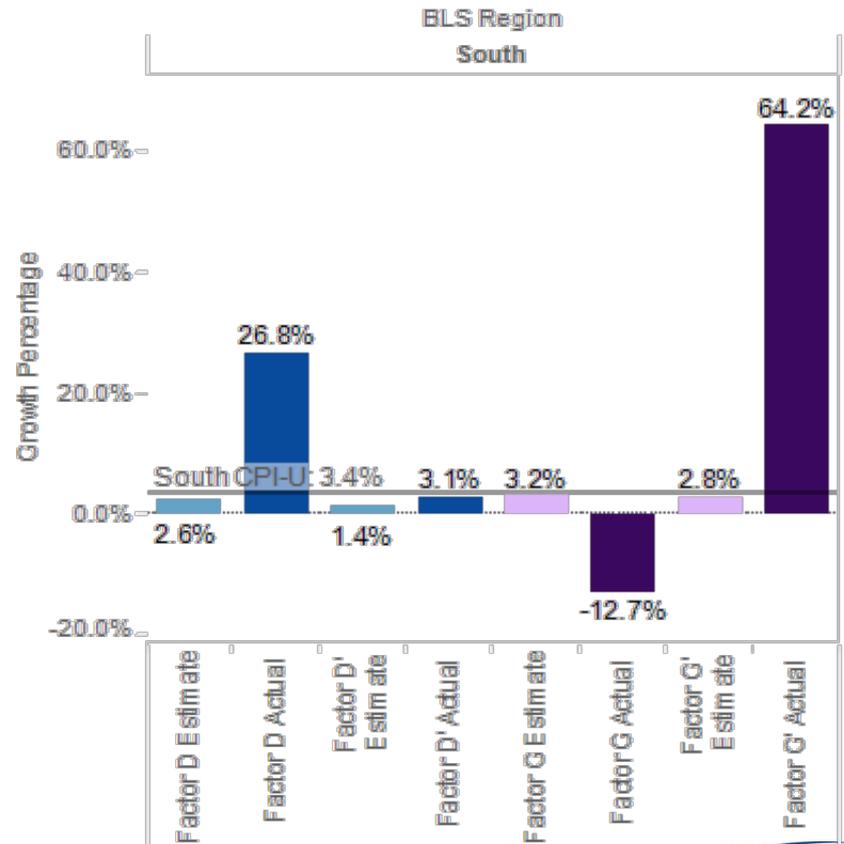
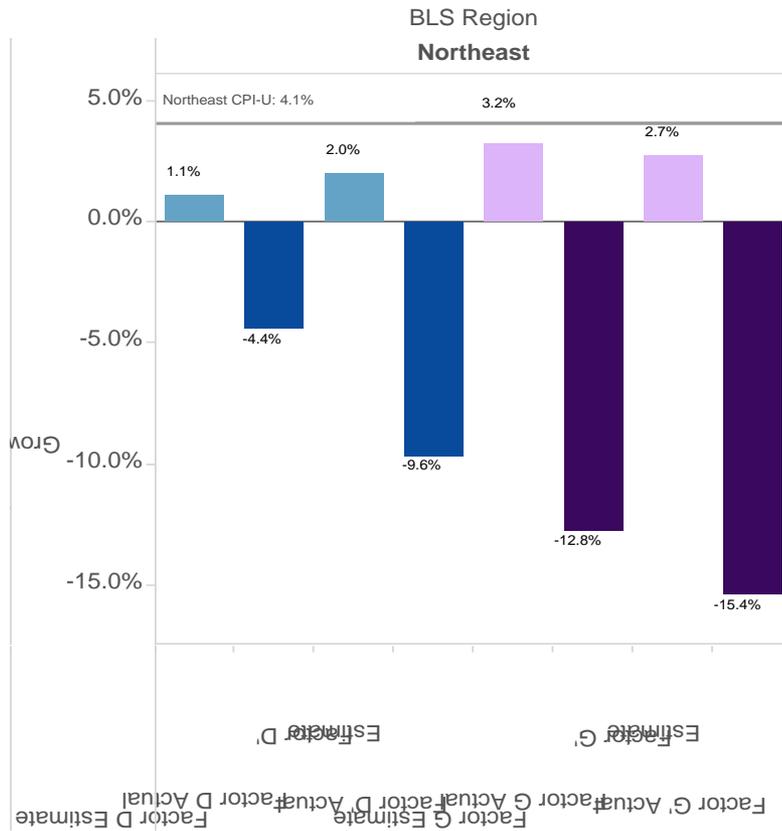
Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Comparison of Estimated Growth, Actual Growth and Regional CPI-U



Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Comparison of Estimated Growth, Actual Growth and Regional CPI-U



Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- Overall, factor growth estimates more closely aligned with CPI-U than with historical 372 data.
- This may be because waiver applications with major programmatic changes (e.g., addition or removal of services) skew 372 data.
- Without proper documentation for deviations from 372 data, CMS cannot ascertain why estimated factor trends differ significantly from 372 trends.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Additional Considerations for Factor Derivation

- It is important that estimated calculations in Appendix J-2-d (Factor D Derivation) match the basis documented in Appendix J-2-c. Trends compound annually, so deviating from the proposed basis by even 0.2% can have a large impact on estimates.
- For example, the average cost of services provided under the waiver per year is \$153 million. If an application states estimates are based on a CPI-U of 3.4%, but calculations show 3.6% annual growth, there is a \$3.3 million difference in estimated costs after 5 years.

Year	Inflation: 3.4% (A)	Inflation: 3.6% (B)	Difference (B-A)
1	\$ 153,000,000.00	\$ 153,000,000.00	
2	\$ 158,202,000.00	\$ 158,508,000.00	\$ 306,000.00
3	\$ 163,580,868.00	\$ 164,214,288.00	\$ 633,420.00
4	\$ 169,142,617.51	\$ 170,126,002.37	\$ 983,384.86
5	\$ 174,893,466.51	\$ 176,250,538.45	\$ 1,357,071.95
Total Difference Over Five Years			\$ 3,279,876.81

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Promising Practice Checklist for Determining if an Alternate Basis is Appropriate

- Does your 372 data have outliers (e.g., abnormally large increases and decreases in participant counts, service utilization, service costs, etc.)?
- Are there new services that are not reflected in 372 data?
- Are there services that have been removed since the last 372?
- Has the waiver experienced changes in the scope or definition of services?
- Are there external reasons for service cost or utilization changes (e.g., the addition of a specific number of slots or legislative budgetary increase)?
- Document the reason for deviating from 372 trends in Appendix J-2-c.
- Document the alternate basis used to estimate factors and explain why this approach was used.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Promising Practice Checklist for Documenting Factor Estimates in Appendix J-2-c:

- Does the state document the source of the baseline for Factors D, D', G and G'?
If this is not the 372, does the state include the baseline in the application?
- Does the state include the percentage used to trend the baseline?
- Does the state explain and justify every percentage in Appendix J-2-c?
 - If the percentage is based on inflation, does the state indicate the population, area, series title and index base period for the inflation metric?

➤ **Special Considerations for Factor D**

- Does the state describe the basis for calculating the elements used in Factor D estimation (i.e., estimated number of users, units per user, average cost per unit, and overall average length of stay)?
- If the application includes a new service, has the state included the basis of estimates?
- Is the basis of factor estimates described in Appendix J-2-c consistent with the growth trends in Appendix J-2-d?

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Promising Practice Checklist for Documenting Factor Estimates in Appendix J-2-c: (continued)

➤ **Special Consideration for Factor D'**

- If the state develops D' through sampling a comparable population, does the state provide information on the process used, including specific data sources?
- Does the application explicitly describe how the state excluded the costs of prescribed drugs for individuals eligible for Medicare Part D?

➤ **Special Consideration for Factors G and G'**

- Does the state's data only include the level(s) of care indicated in the waiver request?
- Does the application explicitly describe how the state excluded the costs of prescribed drugs for individuals eligible for Medicare Part D?
- If Factor G' is greater than Factor D', does the state explain why?

Issue 2: Documenting Rate Setting Methods for each Waiver Service (Appendix I-2-a)

Issue 2: Documenting Rate Setting Methods for each Waiver Service

- CMS analyzed issues in Appendix I-2-a of 125 amendment, new and renewal applications with RAIs.
- The top 5 issues identified were:
 1. The state does not indicate when current rates were set, when they will be rebased or both. **38 percent** of applications (48 of 125)
 2. The state insufficiently documents how the Medicaid agency solicits public comments on rate determination methods. **33 percent** of applications (41 of 125)
 3. The state insufficiently documents what cost factors were used to develop the rate and how the final rate was calculated. **32 percent** of applications (40 of 125)
 4. The state does not specify which rates correspond to which services, or does not include a rate methodology for a subset of services. **28 percent** of applications (35 of 125)
 5. The state insufficiently documents the basis of annual trends (i.e., COLA, CPI, and other inflationary measures). **26 percent** of applications (33 of 125)

Issue 2: Documenting Rate Setting Methods for each Waiver Service

- States need to add detail regarding the rate setting methodologies used for waiver services.
 - States must adequately document the inputs and calculations used to develop final rates.
 - States must detail this information for **every** waiver service. The state's description may group services when the same method is employed.
- Lack of detail regarding the rate methodology can make it difficult to:
 - Monitor whether states are reviewing rate sufficiency in accordance with §1902(a)30(A) of the Act
 - Demonstrate compliance with the sub-assurance “the state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle”

Issue 2: Documenting Rate Setting Methods for each Waiver Service

Promising Practice Checklist for Documenting Rate Setting Methods in Appendix I-2-a:

- Does the application provide sufficient detail for an independent party to understand how rates were developed?
 - What is the rate setting methodology (e.g., fee schedule, negotiated market price, cost reconciliation, etc.)?
 - What data sources are used to determine rates (e.g., provider cost survey, wage data, etc.)?
 - If applicable, what cost factors (i.e., base wage, employee expenses, administrative expenses, program expenses, productivity adjustments, and inflation) and cost assumptions does the state use to determine rates?
 - If you have a tiered rate setting methodology, what differences in cost assumptions produce the tiered rates?

Issue 2: Documenting Rate Setting Methods for each Waiver Service

Promising Practice Checklist for Documenting Rate Setting Methods in Appendix I-2-a: (continued)

- Does the application list differences between agency-directed and self-directed service rate setting, if any?
- Does the application indicate when the rate methodology was set?
- Does the application indicate when the rate was last reviewed*?
- Does the application include rate setting information for **each** waiver service? Remember that the state may group services where the same method is employed.

***Note:** CMS requires states review rates every five years, consistent with the waiver renewal cycle.

Issue 3: Documenting Post-Payment Financial Audit Program (Appendix I-1)

Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

- Applications sometimes lack detail in describing post-payment activities, particularly the scope of reviews.
 - **Methods:** 15 of 89 applications (17 percent) did not detail the type of post-payment activity conducted.
 - **Scope:** 52 of 89 applications (58 percent) did not describe how providers, individuals, records or claims are selected for review.
 - **Frequency:** 28 of 89 applications (31 percent) did not describe how frequently reviews are conducted.

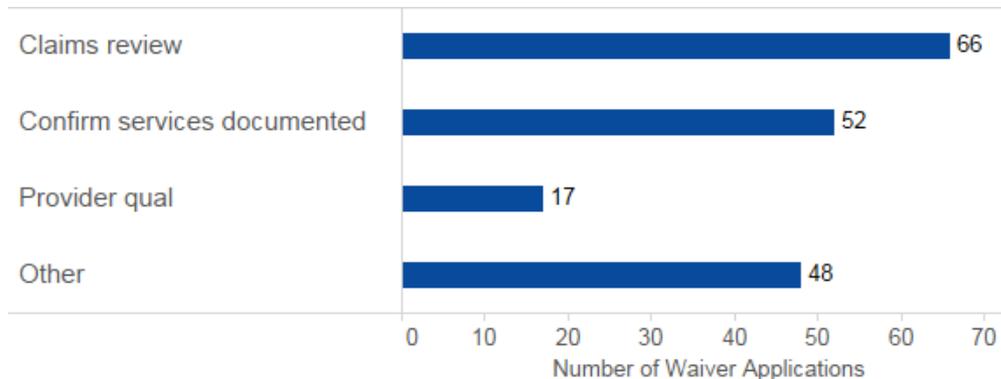
Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

- The following are application trends for states that **did** include sufficient detail.
- **Methods**
 - Many waiver applications indicate states use multiple methods for validating payments, including reviewing claims data, confirming services are documented, and verifying provider qualifications.

Top 3 Methods of Post-Payment Review

Based on 74 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

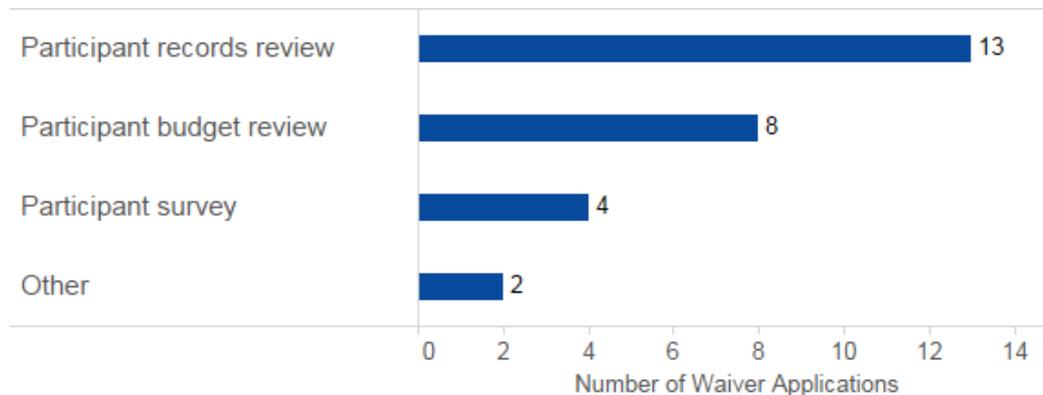
Trends in Appendix I-1

➤ **Methods** (continued)

- **39 percent of applications** with self-direction opportunities (15 of 38) included methods for post-payment reviews of self-directed services in Appendix I-1.
- Records review is the most common method of validating payments in self-direction.

Top 3 Methods of Post-Payment Review in Self-Direction

Based on 15 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

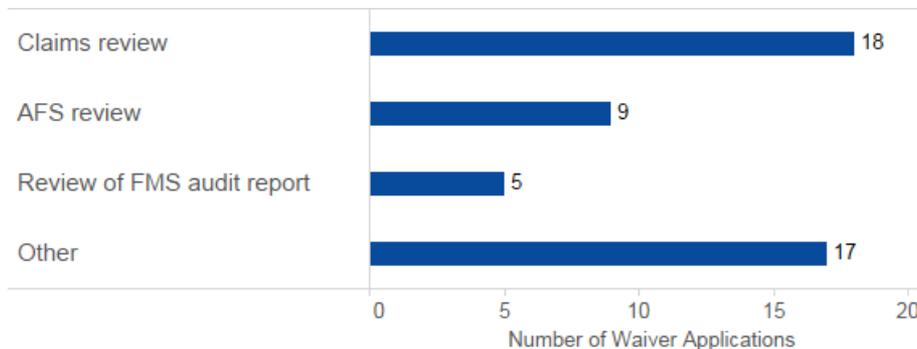
Trends in Appendix I-1

➤ **Methods** (continued)

- **55 percent** of applications with a Financial Management Services (FMS) entity (18 of 33) included information about how the state reviewed the FMS entity.
- Notably, **three** applications included information regarding automated reporting systems used to verify contract compliance.
- **One** application also indicated the state reviewed all of the FMS' standard operating procedures.

Top 3 Methods of Reviewing FMS Entities in Self-Direction

Based on 18 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

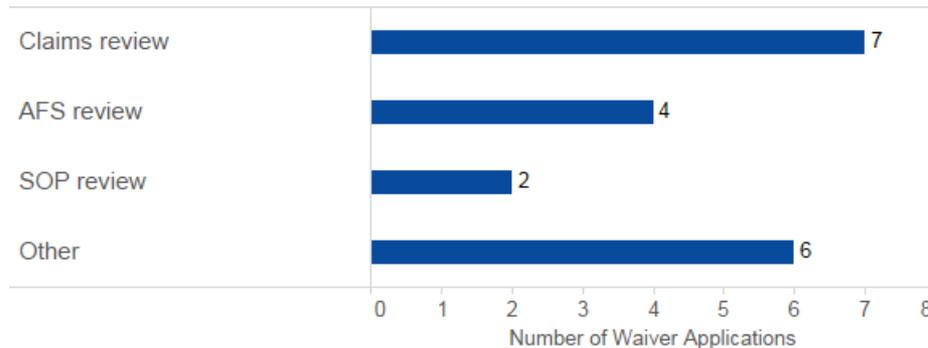
Trends in Appendix I-1

➤ **Methods** (continued)

- Seven applications included information about how the state reviewed Organized Health Care Delivery Systems (OHCDS).
 - **Two** applications indicated the state reviewed all of the OHCDS' standard operating procedures.
 - **One** application specified the state reviewed all provider records to verify the OHCDS properly validated provider qualifications.

Top 3 Methods of Reviewing Organized Health Care Delivery Systems (OHCDS)

Based on 7 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

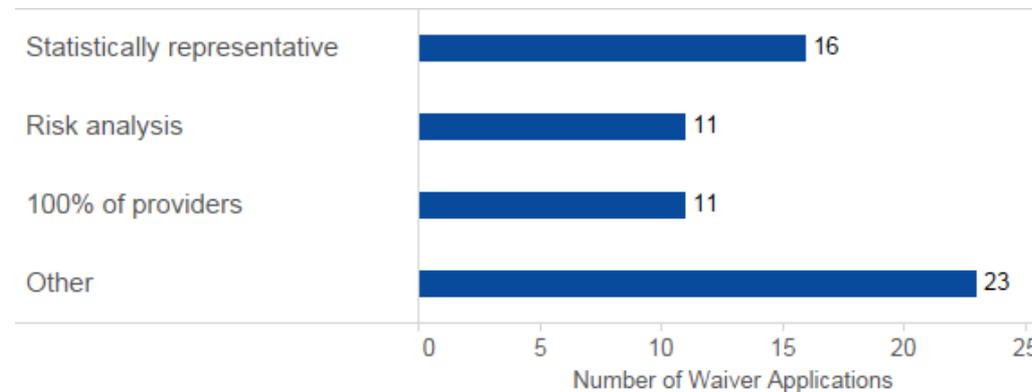
Trends in Appendix I-1

➤ Scope

- Although most applications indicate they select a statistically representative sample of providers for post-payment reviews, **11** (of 37) applications indicated the state identifies providers with the highest risk of fraud, waste and abuse.

Top 3 Methods of Selecting Providers for Review

Based on 37 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

- **Scope** (continued)
 - Risk analyses include:
 - Prior findings.
 - Compliance with plans of correction.
 - Incident reports.
 - Fraud allegations.
 - Total dollar value of claims.
 - Number of individuals served.
 - Rank of provider claims compared to other providers of similar services.

Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

➤ **Scope** (continued)

- **11** (of 37) applications indicate the state reviews 100% of providers.
 - In three applications, these are all on-site reviews.
 - Larger waiver programs may review providers on a cycle (e.g., every two years) to manage resources.
 - One state reviews all providers each of the first three years after a provider begins furnishing billable services. The state then uses a risk analysis to determine whether to review providers annually or every two years.

Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

➤ Frequency

- **Nine** (of 61) applications listed the frequency of post-payment reviews as “ongoing.”
 - States should be more specific in defining how often post-payment activities are conducted (e.g., utilization reviews conducted monthly, or desk reviews conducted annually).

Issue 3: Documenting Post-Payment Financial Audit Program

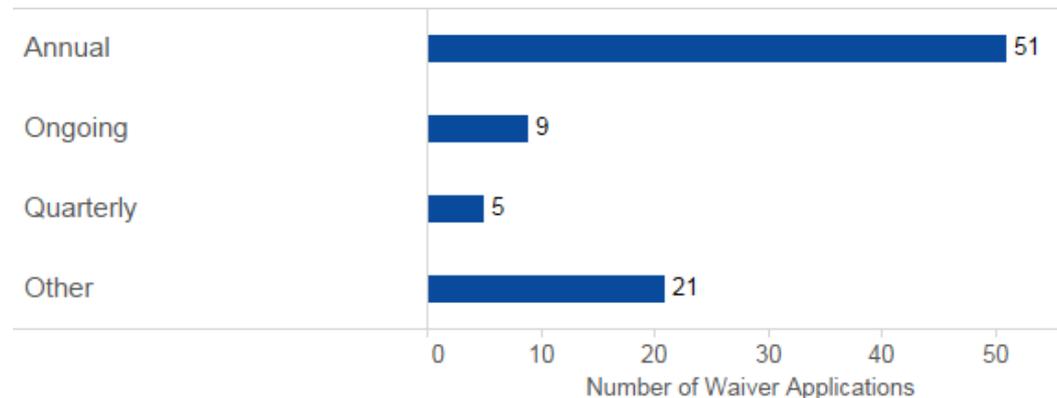
Trends in Appendix I-1

➤ Frequency

- It is most common for states to conduct post-payment reviews annually (51 of 61 applications).
- Some states indicate they review services with a higher risk of fraud, waste and abuse more frequently (e.g., monthly, twice a month, quarterly).

Top 3 Frequencies for Post-Payment Reviews

Based on 61 applications that provided this information

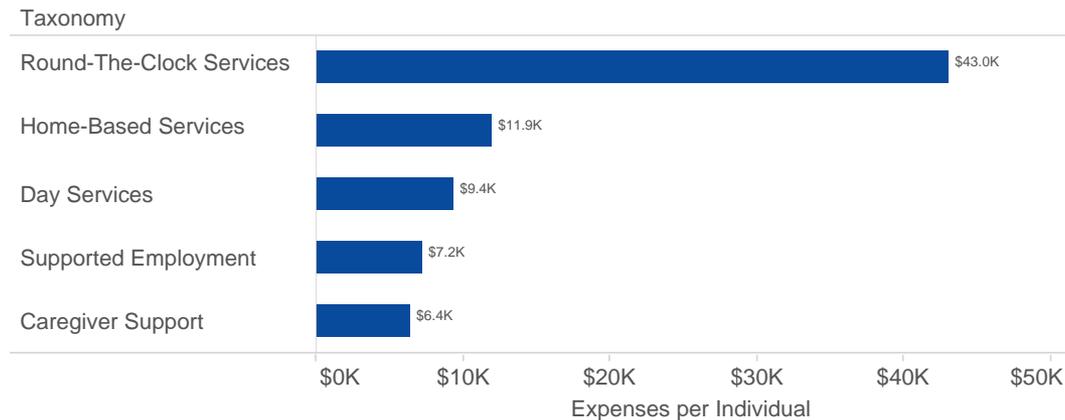


Issue 3: Documenting Post-Payment Financial Audit Program

Consideration for States

- 372 data from 2011-2013 shows that spending per individual is highest for five taxonomies:

Top 5 Taxonomies by Expenses per Individual



- States should consider additional post-payment review / financial accountability requirements for services in these taxonomies.*

* **Note:** For ideas specific to personal care services (home-based services taxonomy), see the CMS training “Increasing Fiscal Protections for Personal Care Services.” A link is available on slide 38.

Issue 3: Documenting Post-Payment Financial Audit Program

Promising Practice Checklist for Documenting Appendix I-1:

- Does the application describe how data is selected for review? Does this differ by service?
 - Data source (e.g., MMIS claims)?
 - Frequency (e.g., annually)?
 - Sampling methodology (e.g., 100% of providers, representative sample with a 95% confidence level and +/- 5% margin of error, etc.)?
 - Time period (e.g., one year of claims data)?
- Does the application indicate the method of the review (i.e., what the reviewer is validating)? Does this differ by service?
 - Are these desk or on-site reviews?

Issue 3: Documenting Post-Payment Financial Audit Program

Promising Practice Checklist for Documenting Appendix I-1 (continued):

- Does the application detail how the results of reviews are communicated to providers?
- Does the application indicate whether corrective action plans are required from providers?
 - If so, does the application describe how the state ensures corrective action plans are followed by providers?
- If applicable, does the application describe how the state performs billing / post-payment reviews of claims processed by a FMS or OHCDSS entity?

Summary

- Based on our application reviews, the most challenging areas of Appendix I and J are Appendices I-1, I-2-a, and J-2-c.
- In Appendix I-1, it is important to remember that there are three separate audit requirements and that the primary goal is to describe a post-payment system sufficient to assure fiscal integrity.
- In Appendix I-2-a, states must be sure to revisit their rate setting methodology once every five years and provide adequate detail for the rate setting methodology they have selected to use.
- For Appendix J-2-c, states must be sure to provide a justifiable basis for their estimates.

Additional Resources

- Additional rate setting resources are available on the website below. Topics include:
 - Rate Methodology in a FFS HCBS Structure
 - Fee Schedule HCBS Rate Setting: Developing a Rate for Direct Service Workers
- <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>

Questions & Answers

For Further Information

For questions contact:

HCBS@cms.hhs.gov

**Thank you for attending
our session!**