



MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

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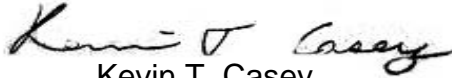
NUMBER

00-06-06

SUBJECT:

Interim Rate Setting Procedures
For FY 2006/2007

BY:


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Deputy Secretary for Mental Retardation

SCOPE:

County Mental Health/Mental Retardation Administrators
Non-County Administrative Entity
Supports Coordination Entities
Community Home Directors
Family Living Directors
Adult Training Facility Directors
Vocational Facility Directors

PURPOSE:

The purpose of this bulletin is to communicate interim rate setting policies to counties, administrative entities and providers. These policies will be used to develop Fiscal Year (FY) 2006/2007 rates. This bulletin describes prospective rate setting and provides information on proposed modifications to parts of Title 55 Pa. Code § 4300 "County MH/MR Program Fiscal Manual". County MH/MR programs and administrative entities should ensure that these procedures are distributed to providers in their county.

All counties, administrative entities and providers will use the policies and procedures in this bulletin for developing and administering interim rates for FY 2006/2007. The Centers for Medicare and Medicaid Services (CMS) requires a standard methodology for setting rates that is applied consistently statewide.

BACKGROUND:

The Office of Mental Retardation (OMR) is committed to implementing the goals and objectives of "Everyday Lives", the "Multi-Year Plan", the "Waiting List Plan" and the federal requirements of the Medicaid Waiver Program. These documents incorporate the principles of self-determination.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Appropriate Regional Program Office

The rate setting procedures in this bulletin support and promote the principles of self-determination by enabling consumers and families to manage their individual budgets and to make decisions about what services they will purchase.

A significant change is the move from program funding service providers to paying for services that are actually delivered based on prospective rates. Currently, service providers are reimbursed based on the allowable cost standards listed in Title 55 Pa. Code § 4300, entitled "*County MH/MR Program Fiscal Manual*". Cost settlement occurs at the end of the contract period. These regulations do not require that actual services delivered be considered during cost settlement.

Prospective rate setting requires that rates be determined in advance of the delivery of services. Based on these rates, payment is then made for actual services delivered.

Prospective rate setting supports self-determination in that monies are not committed to providers through program funding. Therefore, qualified providers can make themselves available to consumers and families to increase choice. Because funding is committed to the consumer's individual budget and not to particular providers, it is available to support consumer and family choices.

This change increases the financial risk to providers because they cannot rely on a commitment from the County MH/MR program to fund their budgets. Providers must position themselves to have consumers and families choose them, and they must rely on the generation of revenues based on services delivered. Therefore, these procedures increase the opportunity for providers to realize retained revenue.

Because increased choice will result in more competition among providers, there has been some discussion about market forces setting rates. Arguments have been made that providers should be given the responsibility for establishing their own rates. At this time, the extent to which a competitive market will develop is not known. Therefore, this bulletin will establish the basis for rate setting as opposed to market forces. To explain and reconcile some of these apparent conflicts, this has been referred to as a "Structured Market Model". The Structured Market Model is intended to improve consumer choice through competition in an open market while ensuring specific quality and accountability standards through structure and oversight.

To summarize, the following principles underlie rate setting:

1. Consumers and families have a choice of providers that are state qualified and have a state approved rate.
2. Consumers and families have information about services, providers, rates and consumer satisfaction.
3. Providers may provide any services in any location as long as the agency is qualified and has a state approved rate.
4. Provider rates are adequate to enable economically and efficiently managed agencies to provide services that meet individual needs as specified in the Individual Support Plan (ISP) and ensure the health, safety and welfare of the people served.
5. The risks presented to providers by fee-for-service reimbursement and consumer choice are balanced by rate setting practices that recognize reasonable and

necessary costs. This includes the opportunity for economically and efficiently managed providers to retain earnings or revenue.

6. Limits are placed on retained revenue or earnings over a rolling five year time period. The policies give providers an opportunity to realize retained revenues, but do not guarantee it.
7. Reimbursement is adequate and timely to sustain a network of financially stable, economically and efficiently managed providers to ensure that consumers and families have choices.

DISCUSSION:

These interim policies are being communicated in order to solicit comments and to give counties, administrative entities and providers an opportunity to “practice” rate setting for FY 2006/2007 and FY 2007/2008. It is anticipated that final policies will be issued by the end of the 2007 calendar year to be implemented in FY 2008/2009.

Comments:

1. Comments and recommendations may be submitted to Joe Gualtier via email to jgualtier@state.pa.us or mailed to the Office of Mental Retardation, Attn: Joe Gualtier, Health and Welfare Building, P.O. Box 2675, Harrisburg, Pennsylvania 17105.
2. Comments may be submitted through August 1, 2006. The comments should reflect the experience of counties and providers in using these policies to set rates for the FY 2006/2007 practice year. These comments will be considered in the development of revised policies for the FY 2007/2008 practice year. The target date for releasing a revised bulletin is October 1, 2006.
3. Additional comments may be submitted through August 1, 2007, to reflect the experience of setting rates for the FY 2007/2008 practice year. These comments will be considered in the development of final policies that will be used for rate setting beginning in FY 2008/2009.

FY 2006/2007 and FY 2007/2008 Practice Years:

1. Providers will be reimbursed based on the Chapter 4300 regulations. This means that the allowable cost standards will apply without modification, and cost settlement will occur.
2. These practice years will provide an opportunity to gain experience in prospective rate setting while minimizing the risk in transitioning to this methodology. It also recognizes that counties may need flexibility to adjust their particular circumstances during this transition period.
3. All county programs must take advantage of the practice years to set interim rates based on the proposed policies. The experience that will be gained extends to the use of the new standard service and unit definitions, as well as rate setting assumptions.
4. Interim rates based on the prospective rate setting methodology should include all services in the standard service definitions (MR Bulletin 00-06-04, entitled “*Revised Units for Service Definitions and Procedure Codes for Healthcare and Non-Healthcare Waiver and Base Services*”) whether funded under the Person/Family Directed Supports (P/FDS) Waiver, Consolidated Waiver or Base Funding.

RATE SETTING:

Services will be reimbursed based on a prospective rate setting methodology. Prospective rate setting is defined as setting rates for defined services and service units prior to the delivery of services. The standard service and service unit definitions will be used for rate setting. Payment will be made for services delivered.

A site, as described below, is defined as a permanent, provider controlled location, not a mobile location or a post office box. The home office/headquarters is considered to be the site for individuals who travel to various locations to provide services.

The responsibility for rate determination is defined as follows:

1. If a county program/administrative entity purchases services from a site within their county, the county program or administrative entity will determine the rate, even if there are multiple counties purchasing services from that site.
2. If the county/administrative entity in which the site is located does not purchase services from that site, the county program/administrative entity that purchases services from that site will determine the rate.
3. If more than one county program/administrative entity purchases services at a site, and the county where the site is located does not purchase services at that site; then the county programs purchasing services may designate one or more county programs to determine rates for that site.
4. The preceding examples also apply to base site rates for residential services. However, any additional costs to meet special residential needs of an individual specified in their ISP will be determined by the purchasing county.

RATE CHANGES: (This policy is being reconsidered to allow retroactive rate changes by July 1, 2007.)

1. Providers and counties may request changes to contracted rates at any time during the fiscal year.
2. Rate changes during the year require an amendment to the contract.
3. Rate changes are effective when the contract is amended or modified, or at a subsequent date if provided in the amendment.
4. Rate changes cannot be retroactive. (NOTE: This proposed policy will not have an operational effect in FY 2006/2007 and FY 2007/2008 because of cost settlement).
5. Consumers and families must receive a minimum of 60 days notice of rate changes.
6. The proposed rate change must be approved or denied by the county program or administrative entity within 45 days of receipt of a request from a provider.

BILLING FOR SERVICES:

1. Providers may bill for services that are authorized and delivered in accordance with an approved ISP which includes standard service and service unit definitions. Providers may not bill for reserved days, "no shows" or other occasions where a person is scheduled/enrolled in service, but the service is not provided.

TITLE 55 PA CODE § 4300:

1. The contracted agency allowable cost standards, sections 4300.81 through 4300.108, will be used as cost principles for determining rates and calculating retained revenue.
2. Rates will not be adjusted for reported or audited actual costs and compliance with the cost principles for negotiating the rates. (NOTE: This proposed policy will not have an operational effect in FY 2006/2007 and FY 2007/2008 because of cost settlement).
3. All other sections of the Chapter 4300 regulations will remain in effect unless waived, replaced or modified by this bulletin.
4. The following sections of the contracted agency allowable cost standards have been modified or replaced by this bulletin:
 - § 4300.4 Definitions
 - § 4300.83 Compensation
 - § 4300.94 Agency Indirect Costs (as applied to administrative costs)
 - § 4300.106 Title to Fixed Assets
 - § 4300.108 Retained Revenue
5. This bulletin includes a new policy regarding marketing costs. This policy is still under review to ensure that it complies with all federal requirements.

EXECUTIVE COMPENSATION:

55 Pa. Code § 4300.83 (c) addresses compensation costs eligible for Departmental participation for chief executive officers (CEO). Attachment I of this bulletin replaces the 55. Pa Code § 4300.83 regulations.

1. Participation in allowable executive compensation is determined by combining salaries and benefits.
2. There shall be a maximum participation level in executive salaries that will be published annually by OMR. That participation level shall be determined at the time that the median market compensation is calculated. (See Attachment I for the compensation grid).

3. For the purpose of determining executive compensation, total agency size shall be considered.
4. Median market compensation shall be determined by periodic studies of CEO salaries reported on IRS 990 forms obtained from www.guidestar.org.
5. For the purpose of calculating allowable executive compensation, salaries are based on median market compensation for the CEOs of non-profit agencies of equivalent size.
6. The benefit rate for calculating allowable executive compensation will be determined in accordance with § 4300.83 (d).
7. This policy for allowable executive compensation will apply to the CEO, or equivalent position, and all executives and managers who report directly to the CEO or Board of Directors; with the exception of medical directors.
8. Compliance with IRS requirements on reasonable compensation is required.

ADMINISTRATIVE COSTS:

The following provision modifies the policy in § 4300.94.

Policy:

1. The costs for general administration must be allowable under the Chapter 4300 cost principles as modified by this bulletin.
2. The costs for general administration may be accumulated in a cost pool for the purpose of allocating costs to services in a consistent and equitable manner.
3. Providers may include general administration costs that are equal to or less than 15 percent of allowable costs, less general administration, in rate proposals.
4. These policies apply to multi-county providers and single county providers.
5. This policy is not negotiable when the provider complies with all requirements.

Definition of General Administration:

General administration expenses are those expenses that have been incurred for the overall general executive and administrative functions of the agency including:

1. Compensation of executives, managers and personnel in the offices of the CEO, chief financial officer, chief information officer, human resources officer, purchasing officer and other general business services.
2. Space used for general administration.
3. Supplies and equipment used for general administration.

4. Capital costs associated with general administration.

Review of Cost Allocation Plans:

1. The provider shall provide each county with a cost allocation plan to document compliance with the § 4300 allowable cost principles as modified by this bulletin.
2. The provider's independent auditors shall provide an affirmative attestation that the methodology used for distributing costs in the cost allocation plan results in the fair, consistent and equitable distribution of costs.

Definition of Fixed Assets:

Fixed assets are major items, excluding real estate, which can be expected to have a useful life of more than one year, or which can be used repeatedly without materially changing or impairing their physical condition by normal repair, maintenance or replacement of components with a purchase price of \$5,000 or more.

Titles to Fixed Assets:

All fixed assets shall be depreciated and the titles will remain with the contracted provider. This policy will apply to fixed assets purchased after this policy is final. Fixed assets purchased prior to that time will be "grandfathered" with the prior policies applying over their useful life.

RETAINED REVENUE:

This provision replaces § 4300.108 of the § 4300 regulations.

Policy:

1. Providers may include retained revenue up to three percent of gross allowable costs in their rate proposals.
2. Providers may retain revenues exceeding actual, allowable costs for a contract period. The amount of unrestricted retained revenue cannot exceed five percent of the actual, allowable costs. (Note: This proposed policy will not have an operational effect in FY 2006/2007 and FY 2007/2008 because of cost settlement).
3. This policy provides accountability for the use of public funds to ensure that resources are used for intended purposes and that the levels of retained revenue are appropriate for ensuring quality services, adequate capacity and choice. It is to support providers in building a capital base and to accommodate the increased risk assumed by providers in a choice driven, prospective rate system.
4. Retained revenue not exceeding five percent shall be used at the discretion of the provider.
5. This policy is not negotiable when the provider complies with all requirements.

The five percent retained revenue cap at the close of each contract period will be determined as follows:

1. The retained revenue cap will be calculated based on the provider's statewide actual, allowable costs for MR services.
2. Retained revenue up to the five percent cap shall be treated as an allowable cost.
3. The retained revenue calculation will be based on a rolling five-year period. At the end of the contract period, the actual, allowable costs and excess revenues for the contract period and the prior four years will be determined. For the purpose of determining unrestricted retained revenue, the calculation is based on five percent of the actual, allowable costs for this five-year period. The resulting number is compared to the excess revenues for the five-year period to determine the amount of excess revenue that is unrestricted. The provider's independent auditors shall provide a supplemental report consistent with procedures developed under OMR's direction for the calculation of the provider's retained revenue and reserve if applicable.
4. Any amounts that exceeded five percent and were adjusted against the provider's retained revenue for a contract period will be removed from the five-year rolling calculation in subsequent years.
5. There will be an implementation phase for this policy when the calculation cannot be based on the contract period and the four prior years. In such cases, the calculation will be made on the number of years for which costs and revenues are available until a five-year period is available. For the first four years, retained revenue cannot exceed eight percent in any single year.

The provider's statewide actual, allowable costs and excess revenues used for calculating retained revenue will be determined through provider audits. The audit shall have a supplemental report and auditor attestation that unrestricted retained revenues do not exceed the five percent cap. However, information from government audits may be used to adjust these calculations. A central entity will review the audits for the purpose of monitoring and adjusting retained revenue.

MARKETING:

The costs of marketing services are allowable. Marketing involves a range of activities that ensure that an agency is meeting the needs of its consumers. Components include market research, analyzing competition, responding to consumer and family inquiries, consumer satisfaction surveys, positioning a service, pricing services, web development and promoting services through advertising and public relations.

RATE SETTING PROCESS:

The rate setting process will be communicated in a separate document.

A provider rate dispute resolution process is being developed and will be issued at a later date. Disputes will be taken to the Office of Mental Retardation.

RATE EVALUATION:

- Rates must be evaluated to ensure that the transition to the proposed rate setting methodology results in reasonable rates that do not unjustifiably reduce or increase provider revenues. The evaluation is based on a comparison of the estimated payment based on the proposed rates to a prior year payment. It is expected that the proposed methodology must not result in a change in the cost of a service.
- A final prior year payment made to the provider from the county/administrative entity will be used to evaluate the rates. It will be the most recent year for which a final total payment is known. The payment should be adjusted to account for changes funded by the administrative entity in the intervening years such as Cost-of-Living Adjustments (COLA's), recruitment and retention initiative funding, new sites, annualization of partial year operations, etc.
- The evaluation can occur in one of two ways as determined by the administrative entity. The county/administrative entity may give the provider an amount based on the adjusted payment before the provider submits rate proposals. This will give the provider a dollar amount by which it can prepare and evaluate its rate proposal(s) prior to submission to the county/administrative entity. The evaluation can also occur after the provider submits its rate proposals to the county/administrative entity. Based on this evaluation, rate proposals may have to be changed if the evaluation occurs after rate proposals are submitted.
- The evaluation should be made by service if possible. If the county/administrative entity determines that is not possible, then the evaluation can be for aggregate estimated and prior year payments.

ADVANCES:

Counties may provide advances to providers as long as they are reconciled with payments for delivered services.

AUDITS:

1. The provider's independent auditor shall provide supplemental schedules on the cost, profit and loss associated with each rate as directed by OMR.
2. This information may be used by counties and providers in subsequent rate setting.
3. Audit requirements and guidelines are under development and will be issued at a later date.

MONITORING RATES:

OMR will monitor the payment process used by administrative entities to ensure that they follow the standardized rate setting methodology identified in this bulletin. OMR will monitor rates to ensure that they are consistent with economy, efficiency and quality of care. OMR will require corrective action plans when problems are identified.

START-UP COSTS:

Policies regarding the funding of start-up costs are being developed and will be issued at a later date.

ATTACHMENTS

Attachment I is the Executive Compensation Reimbursement Grid.

Attachment II is rate setting guidelines. These guidelines provide an overview of the rate setting process, including steps to prepare for rate setting, and provide information that may help clarify some concepts.