Appendix I – Rates FE Waiver (PT 48, 57, 59)

The Division of Health Care Financing and Policy (DHCFP) determines all rates. Documentation of the assumptions, inputs, rate development methodology, and fee-schedule payment rates are maintained by the DHCFP. The rate determinations are done in house with programmatic staff, stakeholders as well as at the direction of the Nevada Legislature. Oversight of the rate determination process is done at the Administrative level of the DHCFP. Waiver reimbursement rates are available to all waiver participants at the DHCFP's website, listed by provider type at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

Effective January 1, 2018, Chapter 422 of the Nevada Revised Statutes (NRS) requires review of sufficiency of all Nevada Medicaid services scheduled for review no less than every 4 years. Details of the schedule are currently under review.

As a requirement of the Frail Elderly (FE) Waiver Renewal, the DHCFP initiated a complete review of waiver service rates and documentation of rate methodologies in October of 2019 and completed in February of 2020. This review was required due to lack of detailed documented historical data concerning waiver rates and methodologies.

Previous FE and PD Waiver renewals and subsequent amendments referenced methodologies developed from a comprehensive rate study conducted by EP&P for the State of Nevada and completed in 2002. The inputs and assumptions outlined in the 2002 rate study are updated to the most currently available reference data and the resulting rates are benchmarked against other states with similar waiver services, Nevada Medicaid State Plan service rates, Nevada Medicaid Agency staff, provider input from a Wage and Benefit Survey, and data from the fiscal reporting system.

The 2019 rate review included an electronic wage and benefit survey of waiver service providers with opportunity for providers to complete a paper-based survey. Providers were given a full four months to respond before the survey was closed and the results were analyzed and compiled. The respondent provider pool represented 17% of FE waiver providers who provided waiver services to 21% of FE waiver recipients. The survey was determined to return enough reliable data regarding wages, full and part-time status of direct caregivers, averages for travel and documentation time, and provided benefits to inform the rate review study. Also, interstate comparison of adjoining states and other states with similar waiver services was used for the rate review, researching a total of 6 states.

Nevada's FE Waiver Fee Schedule services are grouped by category and rate methodology. An established fee-schedule or Fee-for-Service (FFS) reimbursement type is utilized by Nevada Medicaid for the FE Waiver, paying uniform rates across all providers. Rates for the HCPCS waiver billing codes are developed utilizing a defined rate methodology structured to reflect service delivery provisions, inputs and cost assumptions. The resultant rates are scaled to the appropriate unit (per 15 minutes, per diem and maximum yearly amount). Rates are compared to other states with similar services, similar state plan and waiver services, as well as provider surveys, input from Nevada Medicaid operating agency staff, and data from provider enrollment and fiscal reporting system. Nevada compared services with Arizona Home and Community Based Services, Idaho Home and Community Based Services, Utah's Aging Waiver (adjoining states), as well as Ohio's Home and Community Based Services, Colorado's Home and Community Based Services, and Indiana Division of Aging HCBS Waiver. All services were compared where at least 2 other states had comparable rates.

Enrollment statistics (2014-2019) show steady increase in new FE waiver providers each year, averaging 5.70%, and a total increase of 24.1% over 5 years. This steady increase in provider capacity indicates the rates are sufficient to attract new providers into the market. The State believes these rates are sufficient to enlist enough providers to ensure access to services for recipients while still being consistent with efficiency, economy, and quality of services. The Rates Unit requested and reviewed records and invoices for service delivery for prior years (2017 – 2018). The records confirmed standardized bid and provider work assignment processes were in place for these services. The caseworkers were asked if there were problems accessing these services or finding providers and indicated providers pools and funds were enough to provide recipients with needed waiver services.

Direct Care Services

Fee-for-Service Direct Care Rate Methodology

Direct Care Waiver Services include:

S5120 – Chore Services

S5130 - Homemaker

S5135 – Adult Companion Services

S5150 – Respite (15 minutes)

S5151 – Respite (per diem)

The rate model is developed from an hourly base wage and increased to reflect service definitions, provider requirements, operational service delivery and administrative considerations.

The following elements are used to determine the rates:

1. Wage information is taken from provider surveys and compared to wages for similar services in other states, as well as wages identified by Medicaid staff as comparable to similar State Plan Services.

2. Employee related expenses (ERE) percentage of 27% is based on input from Medicaid Staff and approved State Plan direct care service methodologies. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.

3. Productivity adjustment factor accounts for non-billable time spent by staff. This includes the time for staff to complete required documentation and record keeping, and average travel time reported in survey. Productivity assumptions are based on input from waiver policy staff and provider survey.

Non-billable time is calculated with the assumption that during an 8-hour day, a waiver service provider will spend 30 minutes documenting the services provided to recipients and will spend about 48 minutes (from 2018 provider survey) traveling between recipients. This is time spent outside of providing direct care services and cannot be billed. This nonbillable time is subtracted from the total 8 hours, equaling 6.7 hours of “billable” time. A factor is derived by dividing the total hours by the billable hours and is “factored” back into (and increasing) by multiplying the ERE-adjusted hourly wage by the productivity factor.

4. Administrative overhead of 10% is the percentage of service costs allowed by Nevada Medicaid's State Plan for non-direct care activities including insurance, administrative staff, operations and management activities and office supplies. This does not exceed the percentage allowable by state law.

The following steps are used to determine the rates:

1. The State will use the hourly base wage for each service.

2. The hourly amount is increased by the 27% ERE.

3. A productivity factor is applied to the hourly compensation increased by the ERE calculated in Item 2.

4. Administrative overhead (10%) is applied to the adjusted hourly rate. (Item 3).

5. Total hourly rate is the sum of the adjusted hourly rate and increased by the administrative overhead (Item 4).

6. Total hourly rate is scaled to the proper unit based on the unit of service.

The rates are compared to other states with similar waiver services, data from a Provider Wage and Benefit Survey, as well as similar state plan services. Documentation of the assumptions used, rate development methodology and fee schedule payment rates will be maintained by DHCFP.

Rates that are active in the system as of August 15, 2020 and rates calculated after this date will be reduced by 6%.

Non-Direct Care Waiver Services Fee-Schedule

S5160 – Personal Emergency Response System (PERS) Install

S5161 – PERS Monthly

PERS Install and PERS Monthly - The rate calculation for PERS is based on the actual cost billed to ADSD by the service provider in 2002. The rates for one-time installation charge and subsequent monthly amount were set in 2002, reviewed in 2014, and in 2018. Rates were comparable to those of other states with similar services and found to be consistent with efficiency, economy and quality of services. These rates will be reviewed in the future according to the 2018 legislated rate review schedule currently in development.

In 2014, a national average review of "Medical Alert Systems" compared Nevada's PERS installation of $45.00 and monthly charges of $40.00 to Life Station, Life Alert and Medical Guardian, which averaged $42.27. At that time, Nevada's rates were also compared to Utah, Idaho and Montana's rates for PERS. The interstate average rate for installation charges equaled 65.52, 30% higher than Nevada's rate of 45.00. Nevada's monthly charge of 40.00 was 40% lower than the Interstate average of 66.00. The 2018 Interstate comparison review shows the gap between Nevada's rates and interstate comparison has shrunk to approximately 15%.

Rates that are active in the system as of August 15, 2020 and rates calculated after this date will be reduced by 6%.

Other Services

Case Management Public and Private

Private Case Management Wage-based

Augmented Personal Care Service

Adult Day Care

Public Case Management - The Aging and Disability Services Division (ADSD) set the initial rates in 2002 using actual costs for case management. In 2005, the rate was reviewed, and a 20% increase was proposed by ADSD again using actual costs for case management in 2005. The rate increase was approved by DHCFP. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case managers must, at a minimum, have monthly contact with recipients and/or the recipients authorized representative of at least 15 minutes per recipient, per month. Only costs directly attributable to case management services and a reasonable allocation of indirect costs are included in the rate. Indirect costs are developed in conformance with the Division's cost allocation plan and include agency administrative costs and travel, as ADSD is currently the single provider of case management services, including all rural Nevada. Rates that are active in the system as of August 15, 2020 and rates calculated after this date will be reduced by 6%.

This rate ~~has not changed and~~ will be reviewed in the future on a legislated schedule, at least every 4 years.

Private Case Management - This is a wage-based rate developed in 2006 as part of the Behavioral Health Redesign approved by the 2005 Legislature. Through analysis of the skill level of individuals rendering service and the delivery model, a rate model was developed from an hourly base wage and increased to reflect service definitions, provider requirements, operational service delivery and administrative considerations.

1. Wage information is taken using State of Nevada Personnel 2006 Compensation Schedule for a Licensed Clinical Social Worker (SWSII). 2. Employee related expenses (ERE) percentage of 27% is based on input from Medicaid Staff and approved State Plan direct care service methodologies. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.

3. Productivity adjustment factor accounts for non-billable time spent by staff and includes "no shows", phone calls, etc. leaving "billable hours" equal to 6.4 hours per day or 80% based on an 8-hour day. Productivity assumptions are based on input from waiver policy staff and experience of ADSD case management staff.

4. Supervision Allowance of 5% is added to the base wage for supervision of case managers and divided by the number of individuals supervised (5) to arrive at an average supervisory cost per hour.

5. Administrative overhead, 10%, is the percentage of service costs allowed by Nevada Medicaid's State Plan for non-direct care activities including insurance, administrative staff, operations and management activities and office supplies. This does not exceed the percentage allowable by state law.

-Augmented Personal Care – According to DHCFP's historical data rate were established based on Oregon's Medicaid rates for 2006. When the new Augmented Personal Care level 4 was approved along with a 15% increase, the DHCFP used Oregon's rate for level 4, to remain consistent, and then added the 15% rate increase approved by the Legislature. The rates were then rounded up to the nearest dollar.

Rates that are active in the system as of August 15, 2020 and rates calculated after this date will be reduced by 6%.

Adult Day Care – The ADSD set the initial rates in 2004 using actual costs for Adult Day Care. In 2017, the State Legislature approved a 5% increase in the rate.

The following steps are used to determine the rates:

1. The State will use the hourly base wage.

2. The hourly amount is increased by the 27% ERE.

3. A productivity factor is applied to the hourly compensation increased by the ERE calculated in Item 2.

4. The wage arrived at in Step 2 is increased by the allowance for supervision.

5. Administrative overhead (10%) is applied to the adjusted hourly rate. (Item 4).

6. Total hourly rate is the sum of the adjusted hourly rate, increased for supervision and increased by the administrative overhead (Item 5).

7. Total hourly rate is scaled to the proper unit based on the unit of service.

Rates that are active in the system as of August 15, 2020 and rates calculated after this date will be reduced by 6%.

This rate ~~has not changed and~~ will be reviewed in the future on a legislated schedule, at least every 4 years.