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Provider Rate Setting of Community Services

Mercer Government
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Medicaid is the primary payer supporting populations that need long-term services and supports, including individuals who are aging and those with physical or developmental disabilities. Even though people are generally living longer, it is a statistical fact that as people age, the prevalence of disabilities and disease increases. Surveys and studies show that people prefer to remain in their homes and communities rather than be institutionalized. To support these preferences, states have implemented home and community-based services (HCBS) programs, typically through Medicaid waivers.

Mercer has assisted several states in updating or creating fee-for-service (FFS) provider fee schedules for community services, including HCBS waiver programs, for various populations. We have a solid understanding of the Centers for Medicare & Medicaid Services (CMS) requirements related to fee development and the most recent Access and HCBS Final Rules, a strong grasp on key HCBS cost components and significant experience working collaboratively with stakeholders. Mercer has strong expertise in this area, assisting states to obtain waivers and FFS rate approvals from CMS in addition to evaluating the impact on related managed care delivery systems. This positions us well to help states who are embarking on community service payment initiatives.

Key Applicable Regulatory Requirements

Often times, a state may go many years without re-basing or updating its FFS provider fee schedule for HCBS programs. During this time, there could be numerous changes in the program, specific to policies or federal provider requirements that can have a direct or indirect impact on HCBS providers (e.g., Department of Labor guidance, HCBS final regulations, etc.), and can lead to inadequate or inappropriate rates.

CMS requires a waiver renewal at least once every five years, which includes a review of the provider fee schedule. Mercer can help states with various requirements within the waiver, including the rate methodology description, public comment process and Appendix J projections.

Many Medicaid beneficiaries who receive HCBS access the services through FFS programs that states administer via 1915(c), 1915(i), or 1915(k) waiver authorities. HCBS allow Medicaid beneficiaries to receive services in their own home or community rather than institutions, nursing facilities, or other isolated settings. These services can be delivered to a variety of populations, including:

- Aging populations,
- Persons with physical or developmental disabilities, or
- Persons in need of mental health and substance use disorder care

In addition, we can work with states to identify and evaluate all current regulations impacting its HCBS programs to determine the impact on rates, including:

- CMS Regulations[1], including the recent Access and HCBS Final Rules
- Exploration of alternative payment arrangements, such as value-based payments
- Electronic Visit Verification (EVV)[2] as a cost component in fee development
- Minimum Wage Regulations
- Inflation Impact on Provider Service Delivery

1 Home & Community Based Services Final Regulation / Medicaid
2 Electronic Visit Verification (EVV) / Medicaid

Mercer Can Help

Determining impacts on your delivery system whether managed care or FFS. Given that states have flexibility to design services specific to the population served, many states appreciate Mercer's ability to provide a broad-based perspective. We present market information in addition to information from other states, to consider other state approaches and fees (for comparison purposes). Mercer can also evaluate the impact of fee schedule revisions on providers and the state budget, and develop appropriate communication strategies for various stakeholder groups.

Mercer can provide comprehensive assistance to states for their community services, including HCBS waiver programs. Our service offerings include:

- Modeling a *range of fees* for each service based on the service definition, available market and provider-specific data, and consideration of federal or state-specific policy changes impacting provider payment. Developing a fee range allows flexibility to select fees that are appropriate and align with a state's available budget.
- Conducting budget impact analyses based on projected fees and utilization.
- Conducting analysis of projected changes in provider revenue based on fee schedule updates.
- Developing provider surveys/data requests to inform the modeling of fee ranges.
- Developing communication strategies and facilitating discussions with various stakeholder groups, including CMS and the provider community.

Mercer has assisted several clients to develop market-based fees for various community services, conduct rate studies and national environmental scans.

For more information

Visit our website at www.mercer-government.mercer.com to view our experience, services, and client feedback.

You may also reach out to:

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