
LEGAL FRAMEWORK FOR RCAC RATESETTING AND RATESETTING APPROACHES IN OTHER STATES

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**Wisconsin Housing and Economic Development Authority
and
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TABLE OF CONTENTS

Part One – Legal Framework for RCAC Ratesetting.....1

- Allowable approaches to the ratesetting methodology3
- Allowable costs4
- Audit requirements7
- Contracts between RCAC and Counties or CMOs.....8
- Profits and Reserves9
- Requirements for financial information provided to RCAC residents11
- Room and Board.....12
- Waiver Eligibility Determination and Cost Share Requirements14
- Medicaid Card Services15
- Waiver Program Applicability for RCACs.....15

Part Two – Approaches to Assisted Living Ratesetting in Other States17

- Flat rates.....17
- Flat rates that vary by type of setting.....17
- Tiered rates.....18
- Case mix rate system20
- Modified case mix system.....20
- Care plan and fee for service rates.....21

Legal Framework for RCAC Ratesetting

This report describes the legal framework surrounding RCAC ratesetting in Wisconsin and identifies critical issues related to existing laws, regulations and policies. Any effort to develop a new ratesetting methodology must reflect a thorough understanding of relevant legal and regulatory requirements. In some instances, it may be possible to modify current requirements if necessary to achieve desired goals.

In addition, this report briefly describes approaches to assisted living ratesetting currently being used by other states.

This report was prepared by a team of long-term care and financial professionals. It is designed to provide a framework for understanding the state and federal statutory and regulatory framework impacting RCAC ratesetting. It also serves as a starting point for consideration of possible statutory and regulatory changes. It in no way constitutes a legal opinion. The advice and opinions of appropriate legal professionals and departmental staff familiar with state and federal regulatory policy and practices should be sought during the decision making process.

Part 1: Legal Framework for RCAC Ratesetting

The legal framework associated with RCAC ratesetting reflects requirements at several levels

- **Federal law**

Federal law is passed by Congress and signed by the President, and applies to the entire nation. It would require congressional action to change.

- **Federal regulations. The Code of Federal Regulations (CFR)**

This is a codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the Federal Government.

Through statute, Congress delegates regulatory authority to executive agencies.

Regulations provide additional detail needed to implement the law. Although they are not laws, regulations have the force of law, since they are adopted under authority granted by statutes, and often include penalties for violations. For RCACs, relevant regulations with respect to Medicaid waiver programs are promulgated by the Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS). Regulations with respect to housing assistance and tax credit programs are promulgated by the Department of Housing and Urban Development (HUD) and the Internal Revenue Service (IRS). Changing federal regulations requires a multi-step process involving publishing draft regulatory changes, receiving public comments, and finalizing the modified regulations.

Examples of Federal Regulations affecting RCAC ratesetting:

- *42CFR 441 Medicaid Services: Requirements and limits Applicable to Specific Services.* Outlines allowable services under Medicaid and limitations on use of Medicaid funds.
- *48 CFR Part 31-Contract Cost Principles and Procedures.*

- **Federal policy**

Sometimes federal agencies issue policy interpretations in the form of letters, memos, or guides. Federal policy must be within the scope of existing regulations. Within that limited scope, federal agencies have the ability to interpret policy.

Examples of Federal Policy affecting RCAC ratesetting:

- *State Medicaid Manual Section 4440—Home and Community Based Services—Basis, Scope and Purpose.* Outlines specific requirements for Home and Community Based Services waiver programs.
- *OMB Circular A-122-- Cost Principles for Nonprofit Organizations.*

- **State statute**

State law must be passed by the legislature and signed by the governor, and any changes to state law must go through the same process.

Examples of State Statute affecting RCAC ratesetting:

- Chapter 46, Wisconsin Statutes—Social Services. s.46.036 Purchase of care and services.
- Chapter 50, Wisconsin Statutes—Uniform Licensure. s.50.034 Residential Care Apartment Complexes.

- **State Administrative Code**

Through state statute, the Legislature provides administrative rulemaking authority to executive agencies. The rulemaking process at the state level is overseen by the legislature. Although they are not laws, state administrative code has the force of law, since it is adopted under authority granted by statutes. As at the federal level, the state rulemaking process involves publication of proposed rule changes, opportunity for public comments, and publication of final rules. The Legislature's Joint Committee for Review of Administrative Rules oversees the rulemaking. The Department of Health and Family Services (DHFS) develops administrative code for the Medicaid waiver programs. Any changes to Administrative Code must go through the same process as initial rulemaking.

Examples of State Administrative Code affecting RCAC ratesetting:

- Chapter HFS10, Wisconsin Administrative Code. Family Care regulations.
- Chapter HFS89, Wisconsin Administrative Code. Residential Care Apartment Complex Regulations
- Chapter HFS107, Wisconsin Administrative Code. Medicaid Covered Services.

- **State Policy**

State Statute also authorizes executive agencies to develop policy in certain areas. For example, DHFS is authorized to develop allowable cost policies. Departmental policy may be changed with the approval of the department secretary or his/her designee.

Examples of State Policy affecting RCAC ratesetting:

- *Allowable Cost Policy Manual.* Outlines allowable costs that may be charged to DHFS for services provided.
- *Medicaid Waivers Manual.* Provides specific requirements for Home and Community Based Waivers programs.

Legal requirements related to RCAC ratesetting fall into the following major categories

- Allowable approaches to ratesetting methodology
- Allowable costs
- Audit requirements
- Requirements for contracts between RCACs and counties
- Profits and reserves
- Requirements for financial information provided to RCAC residents
- Room and Board requirements
- Waiver eligibility determination
- Waiver program requirements for RCAC services

The discussion that follows summarizes major requirements in each of these areas, and identifies key issues and ways of resolving them. More detail is available in the grid in the Appendix to this report.

In considering RCAC rates, it is important to distinguish between “room and board costs” and “service” costs (also referred to as “care and supervision costs”). Room and board costs include rent and food and are generally paid by the resident. Service costs include costs associated with services provided by the facility, and are potentially reimbursable by Medicaid waiver programs.

Allowable approaches to the service ratesetting methodology

Section 46.036, Wis. Stats. provides the statutory framework for purchase of care and services. The statute allows three approaches to payment:

1. On the basis of actual allowable costs, *s. 46.036(3)(b) Wis. Stat.*
2. On the basis of a unit rate per client serviced multiplied by the actual client units furnished each month, *s. 46.036(3)(b) Wis. Stat.*
3. If the county has a system to monitor and assess the outcomes of a contract, and if authorized by DHFS, a county may implement a capitated payment system. Under this system, the county contracts with providers to pay in advance or after provision of services a fixed amount for each person served by the provider in return for a defined set of expected outcomes that are determined by the county, *s. 46.036(3)(g) Wis. Stat.*

Section 2.1.6 of the DHFS *Provider Agency Audit Guide* provides additional detail about each of these payment options and discusses their advantages and disadvantages. In addition to the three methodologies described above, it mentions a Performance-based contract. Under a performance-based contract, payments are tied to achieving performance goals.

Applicable Medicaid regulations do not specifically address ratesetting methodology, except to define room and board costs, require that the methodology clearly distinguish between room and board and service costs (see “Room and Board” section), and to clarify that waiver funds are not available to pay for bedhold (see “Allowable Cost” section.)

Appendix O of the *MA Waiver Manual* lists room and board-related costs that cannot be paid by the waiver program, and requires that there be a uniform methodology for determining room and board costs. It requires that room and board costs must be facility-specific.

In summary, a range of approaches for computing RCAC rate is allowable under current law. Whatever approach is used, it is essential that room and board costs not be included in the waiver rate. This could be achieved by a cost-based approach to separating room and board from service costs. However, as demonstrated by the fact that many states use a flat room and board rate (see “Assisted Living Ratesetting Approaches in Other States” section) a cost-based room and board rate calculation may not be essential from the federal perspective. Wisconsin’s Appendix O requires a facility-specific room and board rate. However, Appendix O is DHFS policy and could be changed consistent with state and federal statute and regulations.

For service costs, there clearly is a range of methodologies possible under current law. It may be possible to combine a cost-based room and board calculation methodology with a service rate methodology using an alternative approach.

Allowable costs

For the COP-W and CIPII waivers, counties must comply with state and federal allowable cost requirements within their subcontracts. Allowable cost requirements include topics such as defining direct, allocated and indirect costs; procurement and purchase of care and services; related party transactions; and revenues in excess of allowable costs.

The DHFS *Allowable Cost Policy Manual* sets forth the principles for determining the allowable costs of programs from the Department. The introduction to the *Manual* states that “the purpose of the principles is to determine costs, and they do not dictate the extent to which the Department will reimburse these costs. They are designed to provide that the Department’s programs bear their fair share of costs, except where restricted or prohibited by law or contract. There is no intent for grant recipients to make a profit or other increment above allowable costs, except where specifically authorized by Wisconsin Statutes.”

DHFS allowable cost policies incorporate federal allowable cost policies. For private non-profit organizations, these are included in OMB Circular A-122 Cost Principles for Nonprofit Organizations. For for-profit organizations these are found in 48 CFR Part 31-Contract Cost Principles and Procedures. Family Care CMOs are exempt from state allowable cost requirements.¹ Family Care CMOs receive capitated payments from DHFS—a fixed amount per member per month. Within funding received, they have considerable flexibility to determine their payment approach with vendors and what costs they will recognize.

The federal *State Medicaid Manual* Section 4442.3A15 provides that Federal Financial Participation (FFP) is not available to facilities providing services in residential settings on days

¹ Family Care is not included in the list of programs referenced in Sections 46.036(3) and (5m), Statutes, which require compliance with Allowable Cost Policies. In addition, the DHFS/CMO contract for Family Care explicitly states that CMOs are exempt from the Allowable Cost requirements.

when waiver recipients are temporarily absent and are not receiving covered waiver services. However, the Manual provides that projected bedholds may be taken into account when the rate is established.

Issues Related to Allowable Service Costs

1. Allowable costs are primarily of concern if the decision is made to go with a cost-based model. However, audit requirements under s. 46.036(4)(c), Wis. Stat. and cost recovery requirements under s.46.036 (5), Wis. Stat. would indicate that continuing attention to costs will be required. (See “Audit Requirement” and “Profits and Reserves” sections.) In addition, federal Medicaid waiver requirements require detailed cost allocation strategies to determine how the cost of waiver services in the residential setting will be determined and segregated from ineligible waiver costs (see discussion under “Room and Board”.)
2. Some RCACs are part of large corporations. Allowable cost policies provide several options for allocating corporate costs, such as central office and other overhead expenses. Each option has its own implications for the costs reported by a facility. If a cost-based approach is adopted, it will be important that all RCACs use a consistent approach towards cost allocation for the purpose of waiver ratesetting.
3. Allowable cost policies do not recognize required reserves as allowable costs. For example, lenders typically require reserves of approximately \$250 per unit per year to assure building upkeep. Lenders may also require reserves to cover cash flow deficits in the early years of a project. If these costs are not allowable, the owner must pay them from profits.

A reserve for capital needs is not a substitute for or duplication of operating and maintenance costs. Operating and maintenance costs are expense items that flow through the normal budgeting process of the property. The capital needs reserve is specifically designed to accumulate capital to pay for larger expenditures that would not be funded through daily expenses such as replacement of roofs and windows.

The DHFS allowable cost policy with respect to replacement reserves for non-profits is based on the prohibition in OMB Circular A-122 on recognizing “contingency” funds. Contingency funds are reserved for unexpected and indeterminable expenses that may or may not arise with regard to the management of a business. However, replacement reserves in this case are not contingency funds, since an established standard exists for detailing the useful life of the building components and industry experts are available to provide reliable estimates for required funding for capital replacement reserves. Since the stream of investments for maintenance of a facility can be precisely predicted and planned, replacement reserves are not contingency reserves and A-122 prohibitions may not apply. It is recommended that DHFS legal staff further review this issue.

48CFR Part 31, which includes federal allowable cost policies for for-profits, does not address the issue of replacement reserves. Therefore it appears that replacement reserves could be allowed for for-profits, in addition to their allowable profit. This would require a change in DHFS Allowable Cost policies.

Other Federal programs, including programs managed by the Department of Housing and Urban Development (HUD) or Rural Development or WHEDA specifically require reserve for replacements in order to secure the physical and financial viability of the real estate component.

4. While WI allowable cost policies allow for a 14-day bedhold payment, federal Medicaid waiver requirements forbid payment of waiver funds during an absence from a facility. (However, both Appendix O of the Medicaid Waiver Manual and the federal *State Medicaid Manual* provide that the rate structure may be developed to reflect an anticipated level of bedhold days due to temporarily hospital or nursing home stays by RCAC residents.²)
5. Allowable cost policies do not address “turnover cost”—the loss of income during the period that a unit is empty between tenants. Similarly, it does not cover costs for the period between the time that a tenant dies and his or her effects are removed from the residence. In cases where RCAC staff must remove and arrange for disposition of the tenant’s possessions, those costs are not covered. For non-profits, these costs would appear to be “contingency” costs under A-122, and would not be allowable under federal allowable cost principles. 48 CFR Part 31 does not address the admissibility of this type of cost for for-profits.
6. State allowable cost policies do not address costs associated with bad debt; however bad debt is specifically an uncovered cost per Federal cost principles.
7. Allowable cost policies do not address costs associated with vacancy.
8. The net equity calculation in a cost-based approach advantages highly leveraged facilities with mortgages. Owners with large amounts of equity in their property are disadvantaged by lower payments. This specific calculation can be manipulated and should, perhaps, be replaced with a more linear calculation that will produce a more consistent result from one development to the next. This could be achieved through changes to DHFS allowable cost policies.
9. State allowable cost policies allow 14-day bedhold. However, federal waiver requirements prohibit any bedhold payments using waiver funds.

² Appendix O of the Medicaid Waiver Manual provides that bedhold costs may be built into the rate of an alternative living arrangement. It says: “For example, if CBRF residents spend an estimated 20 days a year in hospitals or nursing homes, the annual waiver allowable support and supervision expenses could be averaged over 345 instead of 365 days per year. These costs can be built into the rate prospectively, retroactively, or during the year. The *State Medicaid Manual* contains a similar provision.”

10. In considering federal allowability of various costs, it is important to note that federal cost principles, as laid out in OMB Circular A-122 and 48CFR part 31, specifically state that the governing section does not cover every element of cost. They indicate that failure to include any item of cost does not imply that it is either allowable or unallowable. Federal policies suggest that costs not specifically addressed should be correlated to the subpart of the guidance to which it most closely correlates for determination of allowability.

These issues will need to be addressed, particularly if a cost-based approach is adopted. Consistent with federal allowable cost policies and state statutes, DHFS could change problematic areas of the Allowable Cost requirements to address identified needs. Alternatively, the legislature could amend the statutes to exempt the COP-W and CIPII programs from compliance with allowable cost requirements with respect to RCACs. (Family Care is already exempt from the allowable cost requirements)

Audit Requirements

Under s. 46.036(4)(c) Wis. Stat., entities contracting with county agencies or Family Care CMOs are subject to annual audits if contract size exceeds \$25,000. The audit must be a certified financial and compliance audit.

The DHFS *Provider Agency Audit Guide* (Introduction) defines three types of audits:

- **Agency wide audits.**
These are performed by certified public accountants in accordance with generally accepted auditing standards. An agency-wide audit is the default audit under the *Guide*. If a contract does not specify the type of audit, the provider must use an agency-wide audit.
- **Agreed upon procedures**
In an agreed-upon procedures audit, the granting agency hires an auditor to perform specific auditing procedures and to report the results of these procedures to the granting agency. Agreed-upon procedures engagements must be performed by a certified public accountant in accordance with generally accepted auditing standards. An agreed-upon procedures engagement generally provides substantially less testing than an agency wide audit.
- **Program audits**
A program audit is similar to an agreed-upon procedures engagement, except that the provider hires the auditor.

The audit requirement can be waived by DHFS if it is determined that the risks that would justify an audit are low. A granting agency other than DHFS (for example, a county administering the waiver program with DHFS funds) can waive the audit requirement only with DHFS approval.

Issues related to audit

1. Audits are often difficult to interpret, particularly for RCACs that are part of large corporations.
2. An audit requirement implies that payment is expense-based, not rate-based.
3. Some counties use audits to recover funds, while others do not.

Consideration should be given to adopting a “program audit” approach for RCACs. The modified format would have a narrower scope than a full financial audit, focusing on key cost items only. It would be easier to interpret and would assure accountability. Counties and CMOs receiving the audit would be instructed on how to interpret it, and efforts would be made to assure that it was used consistently. DHFS could authorize use of a “program audit” for RCACs and define its content. Process and responsibilities for designing the revised reporting standards and requirements regarding who pays for the new financial report would need to be addressed.

Contracts between RCACs and Counties or CMOs

Section 46.036(1), Wisconsin Statutes requires written contracts for the purchase of care and services by DHFS or county departments. The requirement for a written contract may be waived only for purchases of \$10,000 or less.

Section 46.036 outlines key contracting requirements, as follows:

- s. 46.036(1) Wis. Stat. requires contracts meeting standards authorized under this section.
- s. 46.036(2) Wis. Stat. requires care and services purchased shall meet standards established by the department and other standards set by the purchaser. The department shall establish standards for cost accounting and management information systems.
- s. 46.036(3), Wis. Stat. outlines allowable payment methods (See “Allowable Approaches to Ratesetting Methodology”) and authorizes profit add-on for for-profit organizations (see “Profits and Reserves”).
- s. 46.036(4) Wis. Stat. outlines accounting requirements and audit submission requirements. Requires that providers charge a uniform schedule of fees unless waived by the purchaser with the approval of the Department.
- s. 46.036(5) and 5m. Wis. Stat. requires that the purchaser recover from providers money paid in excess of the conditions of the contract. Sets out reserve provisions for non-profit organizations (see “Profits and Reserves”).

DHFS has developed two model contract formats that could be for these contracts: (1) the “Base Model Contract” and (2) the CBRF model contract. However, counties are not required to use these formats. The contract between the state and Family Care CMOs specifies requirements for provider subcontracts in the Family Care program. According to state administrative policy in

the Provider Agency Audit Guide, contracts must be either cost based, performance based, unit times unit price-based, or capitated.

Issues relating to contracts

1. Most identified contract issues relate primarily to allowable costs. For example, the base model contract and the CBRF model contract do not specifically address bedhold, turnover costs, profits and reserves. (See discussion under “Allowable Costs”).
2. Under the CBRF model contract, certain categories of costs assigned to room and board (household supplies and costs associated with activity space) may more appropriately be assigned to care and supervision.

If a cost-based approach is used, it will be important to assure that all relevant costs are included and that costs are appropriately divided between room and board and care and supervision. As long as the changes were consistent with WI Statutes and allowable cost policies, they could be made administratively by DHFS.

Profits and Reserves

Wisconsin Statutes provide for profits for for-profit providers, and for reserves for non-profit providers:

- Section s. 46.036(3)(c), Wis. Stat. authorizes a percentage add-on for profit for for-profit providers, according to rules promulgated by the department.
- Section s. 46.036(5m) provides for reserves for non-profit providers, as follows:
 - If revenue under a contract for a rate-based service exceeds allowable costs incurred in the contract period, the provider may retain from the surplus generated by that rate-based service up to 5% of the revenue received under the contract.
 - A provider may accumulate funds from more than one contract period. However, if at the end of a contract period the amount accumulated from all contract periods exceeds 10% of the revenue under all current contracts for that rate-based service, the provider may be required by the purchaser to return the excess. If the surplus exceeds 10% for a provider who has had the contract for 4 consecutive contract periods, 50% of the accumulated amount must be applied to reducing the unit rate per client in the next contract period.

As authorized by statute, DHFS has defined allowable profits for for-profit providers in the *Allowable Cost Policy Manual*, Section III, Item 16. The amount allowable on an annual basis is determined by applying a percentage equal to 7_% of net allowable operating costs plus 15% applied to net equity (defined as the cost of equipment, buildings, land and fixed equipment less accumulated depreciation and long term liabilities.)

The *Allowable Cost Policy Manual*, Section III, Item 17 explicitly states that reserves will only be considered allowable costs for non-profit organizations. It states that for-profit organizations are allowed a profit, but reserves are not an allowable cost for them.

Contracts between Family Care CMOs and the State include provisions concerning bonuses and profit sharing for providers.

Issues related to Profits and Reserves

1. Current law provides for reserves for non-profits and profits for proprietary (for-profit) organizations. For-profits are responsible for funding reserves out of their profit. Deducting the reserve requirements and the capital expenditures per annum may reduce the per annum return below the minimum rate of return required by investors in the real estate market, adversely affecting the ability of RCACs to attract investors into the market.
2. The restriction on non-profits allowing only a flow to reserves fails to recognize the need for the nonprofit to have cash flow at a sufficient level to allow for sustainable growth and maintain stability.
3. Consideration should be given to allowing both non-profits and for-profits to separate out a reserve for replacement. For non-profits, the reserve would be based on a standard replacement cost schedule associated with this type of facility, and all capital upgrades would be funded from that reserve. The reserve would be in addition to reserves already allowable under state statutes, and statutory change would probably be required to authorize this type of reserve. (See “Issues Related to Allowable Costs,” item 3 for a full discussion of replacement reserves.)

Federal cost principles make no direct comment on either profit or reserves in the for-profit environment except to state that remuneration should be reasonable. Therefore it appears that replacement reserves could be allowed for for-profits, in addition to their allowable profit. (See “Issues Related to Allowable Costs”, item 3.) This would require a change to DHFS Allowable Cost Policy.

4. Consideration could be given to redefining the profit calculation in the *DHFS Allowable Cost Manual* to exclude or redefine net equity. This would address inequities between highly leveraged facilities and facilities with paid-up mortgages. (See “Issues Related to Allowable Costs”, item 8.) The net equity calculation should be considered in tandem with consideration of funding for replacement reserves.

The ratesetting methodology should assure that both for-profits and non-profits have adequate funding for reserves and profit/cash flow. Assuring adequate profits for for-profits is relatively easily achieved, since state statutes authorize DHFS to set the percentage add-on for profit.

Changing reserve provisions for non-profits would require statutory change, since the statutes specify the formula for calculating reserves for non-profits.

DHFS Allowable Cost Policies explicitly forbid reserves for for-profit providers, though the statutes do not address reserves for for-profit providers and reserves for for-profit providers are not prohibited under federal cost principles. The authors recommend that the Department obtain a legal opinion as to whether DHFS policy could allow reserves for for-profits without specific statutory authorization.

Requirements for financial information provided to RCAC residents

Section 50.034 (3)(b), Wis.Stat. requires that RCACs establish a schedule of fees for their residents. This requirement is further detailed in HFS 89, Wisconsin Administrative Code (the RCAC Administrative Rule), which specifies contents of the Service Agreement between the RCAC and the resident. Key requirement relating to service fees include:

- HFS 89.25(1) RCACs shall have a written schedule of fees for services which includes all of the following:
 - (a) Separately identified charges for rent, meals and services. The agreement must clearly identify services that are included in the base service rate and those for which there are separate charges.
 - (b) The amount of any application fee, entrance fee or security deposit.
 - (c) The facility's refund policy regarding application and entrance fees, security deposits and monthly rent, meal and service charges in the event of death or termination of the contract between the tenant and the facility.
- HFS 89.25(2) The service agreement shall include the charge for the services covered by the service agreement, both individually and in total, and the time and amount of any fee increase that will occur during the period covered by the service agreement.
- HFS 89.25 (3) Copies of revised fee schedules shall be provided to current tenants and their families or representatives at least 30 days in advance of an increase in fees.

Section 50.034(3)(a), Wis. Stat. provides that for residents who are in the COP-W or CIPII program, the services identified in the service agreement must be based on a comprehensive assessment of the resident's needs and preferences conducted by the county department or aging unit.

Issues related to financial information provided to RCAC residents

1. The requirement for 30-day notice of fee changes is inconsistent with the 60-day notice requirement for federal housing voucher programs. (This is a relatively minor issue which could easily be resolved by providing 60 day notice if a federal housing voucher program is involved.)

2. It would be desirable if the components of the ratesetting methodology clearly tied to the charges that RCACs must enumerate for their residents. For example, the ratesetting methodology likely will include food costs in room and board, and meal preparation and serving costs in services. However, the administrative rule requires RCACs to list meal costs, which would combine food, preparation and serving costs.

Room and Board

In a substitute care setting, the waiver participant generally pays for room and board out of his/her personal income. 42 CFR 441.310(a)(2) explicitly provides that federal Medicaid funds cannot be used to pay for room and board. Additionally, Section 46.27(7)(cj), Wis. Stat. excludes use of state COP funds in RCACs, for any purpose.³ Family members may contribute financial support on behalf of the tenant for room and board. Other government funding may be used as long as it does not consist of federal Medicaid funds or State COP.

Appendix O of the *Medicaid Waiver Manual* outlines requirements for setting the Room and Board rate in substitute care facilities including RCACs. It states that the room and board charge must be facility specific. The following costs are not allowable waiver costs, and must either be included as room and board, be billed separately to the resident, or be paid by some other allowable funding source:

1. Rent, mortgage payments, title insurance, mortgage insurance.
2. Property and casualty insurance.
3. Building and/or grounds maintenance costs.
4. Resident's food.
5. Household supplies and equipment necessary for room and board of the individual.
6. Furnishings used by the individual (does not include office furnishings.)
7. Utilities, resident phones, cable TV, etc.
8. Property taxes
9. Specific individual dietary needs

42 CFR 441.310(a)(2) and Section 4442.3A 12 of the federal *State Medicaid Manual* provide that FFP is not available for room and board of the recipient as part of home and community based services. The Manual defines "board" as three meals a day or any other full nutritional regimen. "Room" means hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services.

The *State Medicaid Manual* Section 4442.3A 8 requires that there be a clear differentiation between waiver services and non-waiver services (e.g., room and board). There must also be a detailed cost allocation strategy provided as part of the waiver request to explain how the cost of waiver services in the residential setting will be determined and segregated from ineligible waiver costs.

³ RCACs are not included as a permissible use of state COP funds under this section.

Notwithstanding the requirements for detailed cost allocation strategies in the *State Medicaid Manual*, a number of states have taken an alternative approach to funding room and board. In *State Assisted Living Policy* (National Academy for State Health Policy, November 2002), Robert Mollica notes that states approach room and board in two ways.

1. States can set a combined rate that includes room and board and service costs. The rate caps what can be paid to the facility. The resident pays the room and board and applies any excess income to services. Medicaid can pay the difference between the resident's payment and the maximum rate. Mollica notes that this approach works best in states with lower development and capital costs since the Medicaid rate is more likely to be comparable to the actual room and board charge.
2. Mollica cites Wisconsin as an example of the alternative approach. Under this approach, the room and board charge is determined between the resident and the facility. The county does not vary its care and supervision payments based on the room and board level. Mollica states that this approach works better in states with high development costs and with residents whose income is sufficient to cover these higher costs that cannot be covered by Medicaid.

If the first approach were selected, the room and board rate would essentially be set at the rate that the resident could afford. The difference between the total rate to the facility and the room and board rate affordable to the resident would be defined as care and supervision, and thus would be payable by the waivers.

DHFS has rejected the first approach. It is concerned that setting a room and board rate below the actual cost of real estate and meals would lead to cost shifting to the service side. Waiver funds would effectively be used to pay room and board costs, exposing the state to potential disallowances.

Owner participation in federal housing programs may influence resident income requirements or allowable rent levels. These programs include equity financing from tax credits or tax-exempt bond financing, or programs through HOME, the Federal Home Loan Bank, Rural Development or HUD. Each of these programs has specific requirements for the income of the resident and rent that can be charged. None of these requirements are specific to RCACs.

Issues Related to Room and Board

RCACs incur property-related costs associated with activity space, such as arts and crafts rooms. The question has been raised as to whether this space might more appropriately be expensed to care and supervision, since it is solely associated with the service portion of the RCAC's activities. In determining whether this allocation is possible, the limitation under the room and board definition in Section 4442.3A 12 of the federal *State Medicaid Manual*, which appears to classify all real estate-related costs as room and board.

Waiver Eligibility Determination and Cost Share Requirements

To qualify for the Medicaid waiver programs, persons must meet certain income and asset limits as well as meeting functional disability requirements. Income is adjusted to take into account certain expenses (for example, expenditures for over-the-counter medications, an across-the-board personal allowance, and a housing allowance.) Depending on their income, some persons are obligated to pay a monthly “cost share” to help offset their waiver service costs. After deductions and payment of cost shares, the amount remaining is available for room and board.

Wisconsin takes advantage of all federal options designed to promote affordability of substitute care for waiver recipients. This includes providing an SSI-E supplement to federal SSI payments for people living in substitute care. It also includes exercising the federally permitted option to use a 300% of SSI eligibility level for the MA waivers. This means that more people are eligible for the waiver programs, including people with incomes that will let them cover more room and board costs than other waiver participants could afford.

Wisconsin Statutes provide for resident cost shares under s.46.036 (4)(e) Wis. Stat. which provides that cost share payments collected from clients shall offset service payments under the contract, and s. 46.286(2), which outlines cost sharing requirements for Family Care.

The process by which the resident’s cost share is determined is enumerated in Wisconsin’s Home and Community Based Waiver Application, which incorporates the requirements of 42 CFR 435.726. In the HCBW Application, Wisconsin provides that payment for waiver services is reduced by the amount remaining after deduction from the resident’s income of an amount determined as follows:

“The basic needs allowance, indexed annually by the percentage increase in the state’s SSI-E payment; plus and allowance for employed individuals equal to the first 65 dollars of earned income and _ of remaining earned income; plus special exempt income which includes court ordered support amounts (child or spousal support) and court ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over \$350 per month. The total of these 4 allowances cannot exceed 300% of the SSI Federal Benefit.”

Wisconsin could request that CMS approve a waiver amendment that would modify this formula in a way that reduces cost shares. This would increase the amount of funds residents had available to pay room and board. However, any changes must be considered very carefully:

- Cost shares offset waiver program costs. To the extent that they are reduced, waiver program costs would increase.
- Changes would potentially apply to all persons receiving Medicaid benefits, not just persons on the waiver programs residing in RCACs.
- Persons can become ineligible for Medicaid benefits if their assets exceed a certain amount. Changing cost share formulas could result in excess asset accumulation for some people.

Medicaid Card Services

Waiver participants have access to the Medicaid card to pay for medical services not covered under the waivers. Specific Medicaid card services are listed in Wisconsin's Medicaid State Plan.

The federal *State Medicaid Manual* (Section 4442.3B.8) states that no service may be provided under the waiver if it is already provided under the state plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the state plan. DHFS has determined that this policy does not apply to RCAC services, since RCACs are not covered services for persons who have access to Medicaid card services only.

However, even though first use of the card is not required, it might be possible to reduce certain waiver costs if the resident's Medicaid card, rather than the waiver, were billed for certain services. For residents of RCACs, these services could include adaptive aids, specialized medical supplies and communications aides, home health, nursing, therapies, and medical transportation. These services would need to be billed to a MA-certified provider (RCACs do not qualify as MA-certified providers.) Decisions to bill these services to the Medicaid card rather than the waivers should take into account both potential savings and potential costs (such as higher administrative costs and loss of economies of scale.)

Medicaid Personal Care can also potentially be used in RCACs, if program requirements are met. Use of Medicaid Personal Care in RCACs could reduce costs billed to the waivers, transferring those costs to the Medicaid card. While this transfer of funds would not result in savings at the state or federal levels, it has the potential to let counties spread their available waiver dollars further by shifting some costs to another source. It would be important to assure that waiver billings are actually reduced by the amount of personal care billing to the MA card.

Waiver Program Applicability for RCACs

Under federal waiver requirements, the average per capita waiver expenditure for care and supervision in an RCAC cannot exceed average per capita expenditure in nursing home. In addition, state statutes provide that the care and supervision rate for COP-W/CIPII cannot exceed 85% of statewide average daily cost of Medicaid reimbursement for nursing home care. (Family Care is not subject to the 85% cap.) Medicaid card services cannot be paid for by the COP-W and CIPII waivers (though Family Care CMOs can pay for them if the cost does not exceed what Medicaid would pay for the service.) WI Statutes prohibit the use of state COP in RCACs.

DHFS policies preclude separate billing of the following services for RCAC residents⁴: Supportive Home Care, nursing, personal emergency response systems, and home modifications. This is because these services should be provided within the RCAC rate.

⁴ This policy is included in instructions for use of the RCAC billing code.

Issues related to Waiver Program Applicability to RCACs

1. State COP can't be used in RCACs. It can be used in other forms of substitute care, including CBRFs and Adult Family Homes.
2. The cap limiting care and supervision costs to 85% of nursing home cost applies to RCACs serving COP-W and CIPII participants, but not to RCACs serving Family Care. Also, CBRFs and Adult Family Homes are not subject to the 85% of nursing home cost cap when serving COP-W and CIPII participants.

Statutory change would be required to make State COP available in RCACs. Availability of state COP would give counties administering the waiver programs more flexibility to assist residents to meet room and board costs.

Part 2: Approaches to Assisted Living Ratesetting in Other States

In *State Assisted Living Policy 2002*, Robert L. Mollica reports on a comprehensive national survey of assisted living ratesetting methodologies used by states.⁵ This section briefly describes the ratesetting approaches currently in use.

Mollica identifies six approaches to assisted living ratesetting

- Flat rates (used by 13 states)
- Flat rates varying by type of setting (2 states)
- Tiered rates (9 states)
- Case mix system (2 states)
- Modified case mix system (2 states)
- Care plan and fee-for-service rates (7 states)

Each of these approaches is described briefly below.

Flat rates

Under a flat rate system, facilities receive the same monthly payment regardless of the level of care and the staff assistance the resident requires. Mollica notes that flat rates create incentives for facilities to admit tenants who need lighter care.

Examples:

Colorado uses a flat rate system. It sets room and board at \$499 per month for Medicaid residents. Services are reimbursed at the rate of \$1094.30 per month.

Nevada reimburses room and board at \$809 per month and personal care at \$276 per month.

Illinois uses flat rates with regional variations. Service rates are set at 60% of the weighted average nursing facility rate for the region. There are seven regions, with rates ranging from \$45.54-\$61.94 per day for services.

Flat rates that vary by type of setting

Under this approach, differing rates are set for different types of facilities. They may reflect a state's preference for apartments and private occupancy, or they may reflect a judgment on the varying acuity of residents in different types of facilities.

Example:

⁵ Robert L. Mollica *State Assisted Living Policy 2002* National Academy for State Health Policy, November 2002.

New Jersey sets flat rates by category of facility. Newly constructed assisted living residences receive \$571 for room and board and \$1800 for services. Comprehensive personal care homes receive \$571 for room and board and \$1500 for services. Assisted living programs (subsidized housing) receive \$1200 per month for services. Residents are charged a percentage of their income for rent with the remaining amount subsidized by the project.

Tiered rates

Under tiered rate systems, states generally create 3-5 tiers based on the type, number and severity of ADL and/or cognitive or behavioral impairments. Mollica notes that tiered rates have been developed to more fairly reimburse facilities for the care provided to frailer residents.

Examples

Delaware has established three payment levels based for services.⁶ Payments range from \$840 per month (Level 1) to \$1300 per month (Level 2). Facilities receive an additional 10% additional payment for residents with cognitive impairments. The payment levels were devised based on an analysis of spending for Home and Community Based Services Waiver clients living in their own homes and participants in adult foster care programs.

Oregon has established 5 levels based on the impairment type and level of the resident. (It has a flat room and board rate of \$446.70 per month.) The person’s service level is determined as follows⁷

Oregon Service Priority Categories and Payment Rates: Assisted Living (1/1/02)				
Impairment Level	Service Priority	Service	R&B	Total rate
Level 5	Dependent in 3 to 6 ADLs OR dependent in behavior and 1 to 2 other ADLs.	\$1840.46	\$446.70	\$2,287.16
Level 4	Dependent in 1 to 2 ADLs OR assistance in 4 to 6 ADLs plus assistance in behavior.	\$1,490.76	\$446.70	\$1,937.46
Level 3	Assistance in 4 to 6 ADLs OR assistance in toileting, eating, and behavior.	\$1,139.93	\$446.70	\$1,587.63
Level 2	Assistance in toileting, eating and behavior or behavior AND eating or toileting.	\$861.74	\$446.70	\$1,308.44
Level 1	Assistance in 2 critical ADLs or assistance in any 3 ADLs or assistance in 1 critical ADL and 1 other ADL.	\$651.69	\$446.70	\$1,098.39

Arkansas has established a system that uses both ADLs and points to determine residents’ payment levels. Scores—and therefore rates—are the

⁶ Delaware has a flat room and board rate.

⁷ Mollica, Page 88

result of the number of ADLS with which the person needs assistance, plus the number of “points” the person gets for other behavioral needs. The Arkansas system is described in the tables below⁸:

Arkansas Tiers	
Tier 1	0-5 total ADL points & 0-39 total points in the other 5 components
Tier 2	0-5 total ADL points & 40-60 total points in the other 5 components or 6-10 total ADL points & 0-39 total points in the other 5 components
Tier 3	0-5 total ADL points & 61 or more total points in the other five components or 6-10 total ADL points & 40-69 total points in the other five components
Tier 4	6-10 total ADL points & 70 or more total points in the other five components

Arkansas Points Scale	
Task	Points
<u>ADL Points</u>	
Eating	2 points
Toileting	2 points
Ambulation	2 points
Bathing	2 points
Transfer	1 point
Body Care	1 point
<u>Points for other components</u>	
<i>Ability to take medications</i>	
Medication reminding/monitoring	.5 times number of medications
Needs RX assistance	.75 times number of medications
Dosage prep	1 times number of medications
Needs Medication Administration	2 times number of medications
<i>Speech</i> --Speech not understandable, unable to speak, unable to communicate	10 points
<i>Sight</i> : Legally blind with corrective lenses/blind	10 points
<i>Hearing</i> : Must be loud even with aides; unable to hear	10 points
<i>Psychological cognitive status</i>	
Disorientation	12 points
Memory impairment	16 points
Impaired judgment	17 points
Wandering	15 points
Disruptive behavior	20 points

⁸ Mollica, Page 88 and 89

Case mix rate system

Case mix systems are based on nursing home case-mix methodology approach. They are similar to the tiered rate approach, however case mix systems generally have more groupings. To be implemented successfully, case mix systems require extensive functional and health data on residents.

Mollica notes that tiered and case mix systems provide incentives for facilities to serve more impaired tenants. However, he warns that both case mix and tiered are subject to “gaming” or “category creep”, a tendency for facilities to interpret assessment data to support payment of the next higher rate, or to frequently request rate adjustments.

Examples:

New York modeled its system on its case-mix system for paying nursing homes. The service reimbursement rate is set at 50% of the resident’s Resource Utilization Group (RUG) that would have been paid in a nursing home. The state has set RUG rates for 16 geographic areas of the state. A resident’s RUG level is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long-term home health care program, and are reviewed by the Department of Social Services’ district office.

In Minnesota, rates for services are negotiated between the county and the provider with limits based on the client’s case mix classification. The cost of services under the HCBS waiver are capped at the state share of the average nursing home payment, and the total costs, including skilled nursing and home health aide in addition to assisted living services cannot exceed 100% of the average cost for the client’s case mix classification. Service rates in 2002 ranged from \$1070 a month to \$2473 a month depending on the case mix classification.

Modified case mix system

This approach combines a flat rate with add-ons for tenants with specific ADL impairments.

Example:

North Carolina’s payment includes a flat rate with add-ons for tenants with specific ADL impairments. In 2002 the basic payment was \$13.03 for facilities with 30 or fewer beds, and \$14.43 for facilities with more than 30 beds. Amounts were added to this rate for residents with extensive impairments. For example, extensive impairments in eating would result in an extra \$9.21 per day, toileting \$3.69, and both eating and toileting \$14.02 per day. Impairments in ambulation or locomotion would result in

an extra payment of \$2.64 per day.

Care plan and fee for service rates

Seven states base their payment on a care plan developed following an assessment of a resident's functional capacity and unmet need. Rates are determined by the number of hours of service identified in the care plan or a point system based on the assessment.

Examples:

Kansas reimburses assisted living facilities strictly on a fee-for-service basis.

Missouri pays \$13.14 an hour for personal care aides, \$15.18/hour for advanced personal care services, and \$28.07 per hour for nursing.

Missouri has a flat \$837 room and board rate.

In Montana, assessment data is converted to points and the facility receives a fixed amount per point. There is a basic rate of \$520 a month for services, and each point adds \$33 per month. For example, a resident consistently needing help with toileting would be scored a 2, and the rate paid for that resident would be increased by \$66 a month for that impairment. Montana has a flat room and board rate of \$564.

Mollica includes Wisconsin in the "Care Plan and Fee for Service" category.