COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
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Dear Chief Executive Officer:

The Office of Developmental Programs (ODP) has calculated your proposed payment rate(s) for services identified on the first enclosure with this letter, which are the services entered in the Support and Services Directory (SSD) as of December 31, 2009. Payment rates for services added to the SSD after that date are being calculated on an ongoing basis, and you will receive another rate letter when those rates are calculated.

The proposed payment rate(s) are based on the information your organization submitted in the cost report in October 2009, or as otherwise explained below, if the procedure codes and service locations in your approved cost report were not the same as those entered in the SSD as of December 31, 2009. The proposed payment rate(s) set forth on the enclosure are effective for services delivered between July 1, 2010 and June 30, 2011.

As you review the information in this letter and the enclosures, please keep the following points in mind:

- Although the attached payment rate(s) will be used to process claims submitted to PROMISe during fiscal year (FY) 2010-2011, revenue reconciliation will determine final payments to providers in FY 2010-2011. We are currently reviewing the methodology for calculating revenue reconciliation targets and expect to be able to notify you shortly of when the targets will be issued.
- For planning purposes in the next fiscal year, it might be useful to think of your revenue reconciliation target as being similar to the allocations you have received in the past from the Administrative Entities and the payments from PROMISe as the mechanism to bill in the interim, pending reconciliation to the interim and final revenue reconciliation targets.
- The proposed payment rates on the enclosure reflect program changes that were effective July 1, 2009, before the time period reported in the cost reports, such as changes to service definitions and unbundling of services, so the proposed payment rates are likely to be different from what they would have been if those program changes had not been implemented.
- ODP will work with providers who experience a cash flow issue despite good faith efforts to use the new payment system and will in limited cases issue a gross adjustment. Please refer to the enclosure titled, Protocol for Gross Adjustments for Providers of Waiver Services - Cash Flow Concerns - FY 2010-2011.
- Payment rates will be recalculated for FY 2011-2012 based on approved cost report(s) providers submit showing program costs for FY 2009-2010.

- ODP will continue to refine the rate-setting procedures based on the information we receive through the cost reports that providers have submitted, as well as other input from the community.

The proposed payment rates were developed from the data in the cost reports submitted by providers and approved in the desk review process, when available, where the procedure codes and service locations in the cost reports were the same as those entered in the SSD as of December 31, 2009. Procedure codes and service locations included in the cost reports but not entered in the SSD as of December 31, 2009, were not included in calculating payment rates.

FY 2008-2009 data in the approved cost reports were adjusted to account for changes in need and for changes in provider responsibilities for staffing and transportation resulting from changes to some service definitions that took effect July 1, 2009. These adjustments were calculated based on data submitted by providers through the supplemental data request in December 2009 and January 2010 (Attachment 1), unless information submitted in Attachment 1 showed that an adjustment to the data submitted in the cost report was unnecessary. These adjusted costs were then divided by the reported utilization (units of service available for residential services; units of service provided for non-residential services) to calculate the unit cost for each procedure code. Utilization data in the cost report were adjusted to correct errors or miscalculations such as incorrect unit size or inconsistency between reported utilization and reported program capacity.

ODP analyzed the resulting adjusted unit costs for each procedure code to determine whether additional adjustments were needed. The methodology used to make that determination is set forth in the enclosure titled, "Methodology for Calculating Unit Costs."

After the unit costs for each procedure code were adjusted as described in the attachment, a total cost of living increase of 0% (0% for FY 2008-2009 and 0% for FY 2009-2010) was applied to the FY 2008-2009 unit costs for each procedure code to establish each provider's proposed payment rates for FY 2010-2011. Finally, total FY 2010-2011 waiver expenditures were projected using the proposed payment rate(s) and projected utilization, and those projected expenditures were compared to the available proposed waiver appropriation for FY 2010-2011. A rate adjustment factor (RAF) of -4.73% percent — calculated as described in the RAF policy initially issued in draft form by letter from me on January 23, 2009 — was applied to the unit costs for all waiver services except fee schedule, outcome-based, and vendor services, so that the estimated waiver expenditures would not exceed the available waiver appropriation.

In cases where approved cost report data were not available for a procedure code at a specific service location entered in the SSD as of December 31, 2009, ODP assigned a rate using the following guidelines:

1. If a provider's approved cost report(s) did not include a procedure code at a service location in the SSD, but did include the procedure code at other service locations that were entered in the SSD, so that the costs for the procedure code at the other service locations for the provider were available, the weighted average of the provider's rates at the other service locations was assigned to the service location not included in the approved cost report(s).

2. If a provider's approved cost report(s) did not include a procedure code that was entered in the SSD, but the provider submitted an approved cost report for at least one other procedure code at any service location that was entered in the SSD, the weighted average rate for the procedure code based on the cost report data for all providers with approved cost reports, adjusted to account for cost differences associated with different geographic areas, was assigned to the procedure code not included in the approved cost report(s).

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3. If the data in the SSD showed that a new provider started delivering services on or after July 1, 2009, or that an existing provider started delivering a new service on or after July 1, 2009, the weighted average rate for the procedure code based on the cost report data for all providers with approved cost reports, adjusted to account for cost differences associated with different geographic areas, was assigned to each procedure code for the service(s) the provider started delivering on or after July 1, 2009.

The proposed payment rate(s) is contingent on the final budget enacted by the General Assembly. We are providing this information to you now, so that it is available to you for planning purposes. You will receive another letter, advising whether the rate is final, when the final budget is enacted. Please retain the enclosures to this letter.

If you have any questions about how your proposed rate(s) was calculated, you may submit a request for clarification in writing to ra-ratesetting@state.pa.us. Please include the following information with your request: your MPI number; the procedure code(s), service location code(s), and rates in question; the reason for your request for clarification; if the reason is that you believe a rate was calculated incorrectly, a description of your calculation of each rate in question, including 1) the cost per unit, as reported in your approved cost report; 2) any adjustments made based on the supplemental data you submitted to ODP in Attachment 1; and 3) the RAF adjustment (-4.73%); and any additional documentation that you believe supports your rate calculation(s). ODP will contact you after reviewing the information.

Sincerely,

Kevin T. Casey

Kevin T. Casey

Enclosures

Cc: ODP Fiscal Accountability Section

METHODOLOGY FOR CALCULATING UNIT COSTS

After calculating the adjusted unit costs for each procedure code for the services delivered by each provider, as described in the accompanying letter, ODP analyzed the resulting adjusted unit costs to calculate the average and standard deviation values both for the total unit cost for each procedure code and for two allowable cost parameters (explained below) for each procedure code with at least 20 unique unit costs. "Extreme outliers" (defined as unit costs that were generally 40% more or less than the nearest unit cost for the procedure code) were removed from consideration in the calculation of the average and the standard deviation values of both the total unit cost and the allowable cost parameters for each procedure code.

Average and Standard Deviation Values

The average and standard deviation values were calculated for both the total unit cost and allowable cost parameters based on standard statistical formulas, as follows:

- Average = (Sum of all Data Points)/N, where N is the number of Data Points for each procedure code included in calculating the average and N is at least 20
- Standard Deviation = Square Root of [{Sum of (Data Point-Average Data Point)^2 for each Data Point}/(N-1)], where N is the number of Data Points included in calculating the average and N is at least 20

The average unit cost, the maximum unit cost below one standard deviation above the average unit cost and the maximum unit cost below two standard deviations above the average unit cost are set forth in the attached table, Statistical Unit Cost Analysis Summary

Allowable Cost Parameters

The following two allowable cost parameters were calculated for each procedure code with 20 or more unit costs:

- Salary and Employee Related Expenses (ERE) Unit Cost —The combined impact of a provider's staffing levels and Salary and ERE expense levels for direct care staff (calculated using the data reported on Schedule A, Lines 1 and 2 of the cost report, adjusted to account for adjustments reported on Attachment 1, and divided by the reported utilization, as modified to correct errors)
- Administration Expense Percentage —The administration expenses as a percentage of the total expenses (calculated using the data reported on Schedule A, Lines 6, 7, 9, 10, 13, 14 and 15 of the cost report divided by the reported utilization, as modified to correct errors)

After calculating the average and the standard deviation of the total unit cost and the allowable cost parameters for each procedure code, ODP reviewed the total unit costs and allowable cost parameters for each procedure code, applying the following principles :

Total Unit Costs

- Total unit costs that were below the average unit cost for the procedure code were not adjusted.
- Total unit costs that were within one standard deviation of the average unit cost for the procedure code were not adjusted.

- Total unit cost "outliers" (defined as total unit costs that were more than one standard deviation above the average unit cost for the procedure code) were adjusted at the total unit cost level as follows:

  - Total unit costs that were more than one standard deviation above the average unit cost but were within 5% of the provider's fiscal year 2009-2010 payment rate for the procedure code were not adjusted.
  - Total unit costs that were more than one standard deviation above the average unit cost and more than 5% higher than the provider's fiscal year 2009-2010 payment rate for the procedure code were compared to the currently authorized Individual Service Plans (ISPs) for the service location, as entered in HCSIS.

    - Total unit costs that were supported by the ISPs in HCSIS were not adjusted.
    - Total unit costs that were more than one standard deviation but less than two standard deviations above the average unit cost and not supported by the ISPs in HCSIS were adjusted down to the maximum unit cost value within one standard deviation of the average unit cost for the procedure code.
    - Total unit costs that were more than two standard deviations above the average unit cost and not supported by the ISPs in HCSIS were adjusted down to the maximum unit cost value within two standard deviations of the average unit cost for the procedure code.

Allowable Cost Parameters

For procedure codes with total unit costs that were not identified as outliers, ODP reviewed the allowable cost parameter values for each provider to determine if either allowable cost parameter was more than two standard deviations above the average allowable cost parameter for the procedure code. In the vast majority of cases, ODP identified either an error or a misclassification of the data in the cost report. ODP adjusted only two procedure codes as a result of analyzing the allowable cost parameters, and the administration expense percentages for those two procedure codes were 80.5% and 62.4%, respectively. The administration expense percentage for these two procedure codes was adjusted down to the maximum allowable cost parameter value within two standard deviations of the average for the procedure code.

ODP will use the information gathered in the analysis of the allowable cost parameters to assist providers in completing Year 3 cost reports more accurately.

Protocol for Gross Adjustments for Providers of Waiver Services
Cash Flow Concerns - Fiscal Year 2010-2011

The Department of Public Welfare (DPW) understands provider concerns that the transition to a prospective cost-based system may result in cash flow issues for some providers. During this transition period, DPW is willing to work with providers who experience a cash flow issue, and in limited cases, provide a gross adjustment to providers. While DPW is willing to work with providers in these instances, providers must first show a good faith effort toward attempting to use the new payment system prior to receiving any gross adjustment. At present approximately 95 percent of bills submitted by providers are approvable as "clean claims".

The Department, through its Office of Developmental Programs (ODP), will consider a request for a gross adjustment when a provider encounters a significant cash flow issue that impacts its ability to operate that is related to billing issues, particularly if that issue can impact its ability to pay staff salaries or otherwise compromises the health and safety of Medicaid recipients.

Action	Expected Completion Date
1. A provider experiencing cash flow problems submits an Emergency Funding Request Form to the appropriate ODP regional office.	As soon as the problem is discovered
2. The ODP regional office reviews the request and determines if the problem: a. is related to a billing issue; b. impacts the provider's ability to pay staff salaries or vendors; or c. otherwise affects the health and safety of waiver participants; or d. is an unusual circumstance that for other reasons requires intervention. If the billing issue can be resolved quickly at the regional level, regional office will work with the provider to resolve the issue. Situations which cannot be quickly resolved at the regional level will be sent to the ODP Central Office for resolution.	Within 2 business days
3. ODP Central Office and the Office of Budget review the issue to determine whether it meets the criteria for a gross adjustment. ODP will also provide a detailed explanation of any denial. If the determination is made that the request meets the criteria for a gross adjustment, ODP will send a request for a gross adjustment to the Comptroller's Office and to the Office of Medical Assistance Programs (OMAP).	Within 5 business days
4. OMAP approves and issues remittance advice (RA). Both the credit and the debit for this gross adjustment will be entered into PROMISe and reflected on the RA. The debit and credit will be entered for the provider service location code so when the billing issue is resolved the receivable is properly offset.	Within between 5 and 10 business days
5. Payment is made.	Usually within 8 business days from the issuance of the RA.
6. Payment made through gross adjustment is offset through PROMISe against the paid claim after resolution of the billing issues which caused the cash flow issue and future billings by the provider.	Within 30 days of payment of the claim absent agreement for a different time period.

Commonwealth of Pennsylvania
Office of Developmental Programs

Statistical Unit Cost Analysis Summary

Service[1]	Service Description	Average Unit Cost	Maximum Unit Cost below the "Average + 1 Standard Deviation"	Maximum Unit Cost below the "Average + 2 Standard Deviations"
W6090	Licensed One-Individual Home - Community Homes - Eligible	$545.30	$713.50	$869.47
W6091	Licensed One-Individual Home - Community Homes - Ineligible	$77.29	$113.54	$147.64
W6092	Licensed Two-Individual Home - Community Homes - Eligible	$367.81	$487.16	$606.16
W6093	Licensed Two-Individual Home - Community Homes - Ineligible	$51.38	$69.97	$90.27
W6094	Licensed Three-Individual Home - Community Homes - Eligible	$268.34	$372.01	$468.29
W6095	Licensed Three-Individual Home - Community Homes - Ineligible	$39.95	$53.67	$66.47
W6096	Licensed Four-Individual Home - Community Homes - Eligible	$224.71	$298.94	$370.09
W6097	Licensed Four-Individual Home - Community Homes - Ineligible	$35.43	$46.96	$59.47
W6098	Licensed Five-to-Ten-Individual Home - Community Homes - Eligible	$174.39	$222.21	$277.92
W6099	Licensed Five-to-Ten-Individual Home - Community Homes - Ineligible	$30.85	$40.02	$52.92
W7037	Unlicensed Family Living Home - One Individual - Eligible	$97.76	$129.98	$149.67
W7038	Unlicensed Family Living Home - One Individual - Ineligible	$14.80	$21.97	$21.97
W7057	Unlicensed Home and Community Habilitation - Basic Staff Support	$5.11	$7.99	$10.84
W7058	Unlicensed Home and Community Habilitation - Level 1	$4.67	$5.50	$7.03
W7059	Unlicensed Home and Community Habilitation - Level 2	$6.17	$9.10	$13.33
W7060	Unlicensed Home and Community Habilitation - Level 3	$7.57	$10.75	$13.97
W7061	Unlicensed Home and Community Habilitation - Level 3 Enhanced	$13.09	$19.73	$25.32
W7072	Licensed Day - Adult Training Facilities - Basic Staff Support	$2.88	$3.87	$4.72
W7073	Licensed Day - Adult Training Facilities - Level 1	$3.53	$4.97	$5.40
W7074	Licensed Day - Adult Training Facilities - Level 2	$4.50	$5.59	$6.73
W7075	Licensed Day - Adult Training Facilities - Level 3	$8.74	$12.01	$14.20
W7078	Unlicensed Residential One-Individual Home - Eligible	$122.62	$178.08	$220.97
W7079	Unlicensed Residential One-Individual Home - Ineligible	$33.44	$53.04	$68.49
W7080	Unlicensed Residential Two-Individual Home - Eligible	$106.58	$151.53	$212.04
W7081	Unlicensed Residential Two-Individual Home - Ineligible	$21.27	$29.66	$36.14
W7087	Prevocational Services - Basic Staff Support	$2.10	$2.65	$3.37
W7088	Prevocational Services - Level 1	$2.59	$3.38	$4.08
W7089	Prevocational Services - Level 2	$3.88	$5.56	$5.97
W7090	Prevocational Services - Level 3	$8.12	$10.39	$11.50
W7235	Supported Employment	$15.39	$26.40	$32.48
W7237	Transitional Work Services - Basic Staff Support	$4.11	$4.98	$7.83
W7250	In-Home Respite: 24 Hours - Level 2	$254.30	$386.56	$502.04
W7258	In-Home Respite: 15 Minutes - Level 2	$5.96	$7.87	$9.89
W7291	Licensed Adult Family Living Home - One Individual - Eligible	$107.60	$153.92	$196.65
W7292	Licensed Adult Family Living Home - One Individual - Ineligible	$18.04	$26.69	$39.73
W7293	Licensed Adult Family Living Home - Two Individual - Eligible	$88.99	$123.60	$153.56
W7294	Licensed Adult Family Living Home - Two Individual - Ineligible	$14.41	$20.83	$20.83

[1] Only includes services with 20 or more unique unit costs.