**Monthly Rate Calculator (MRC)**

**Frequently Asked Questions**

**Transitioning:**

1. By what date do sites have to transition from the Daily Rate Application (DRA) to the Monthly Rate Calculator (MRC)?

All sites in which two or more people share Homemaker/Personal Care (HPC) services delivered by an agency provider must have a date to transition from DRA to MRC identified by 12/31/19.

The majority of sites should be transitioned to MRC by 1/1/20. However, some sites, such as those transitioning on span dates that begin in January or February may be transitioned no later than 3/1/20.

1. How will transition dates be selected?

The county board and provider must work together to identify the date on which site(s) will transition from DRA to MRC. All individuals in a site must transition on the same date.

The transition date may be the annual span start date of someone in the home or may be another date agreed upon by the county board and provider agency.

1. Will county boards and providers be able to run reports to see which sites have transitioned and which sites remain in DRA?

Yes. There will be a link within the reports section of the Medicaid Services System (MSS) for boards/providers to run a report that includes the sites needing to transition and the date on which those transitions scheduled.

1. Will new sites be able to be created in DRA after the new rule (5123-9-31) goes into effect?

No. All new sites established after 1/1/19 must be set-up in MRC. No new sites may be created in DRA after 1/1/19.

**Alerts:**

1. How will county boards and providers be alerted when the actual hours delivered are more than 3% above or below the number of hours projected for the month?

Within the Monthly Rate Calculator (MRC) both county boards and providers will be able to see an alert for each month in which the final monthly service hours are above or below the 3% margin.

In addition, county boards and providers will be able to run reports from the data warehouse beginning in February.

**Date of service:**

Ohio Administrative Code 5123-9-31 (B)(5) defines “date of service” as a date on which an individual resides at the site where homemaker/personal care services are shared. "Date of service" excludes any date on which an individual is admitted to an intermediate care facility for individuals with intellectual disabilities (ICF) or a nursing facility.

1. Are claims for the daily billing unit (DBU) able to be submitted on dates when the person is not physically present in the home?

Yes. DBU claims may be submitted for any date on which the person remains a resident of the home in which services are shared and is not admitted to an ICF or nursing facility

This includes, but is not limited to, temporary absences from the home related to:

* Planned vacations
* Visits with family or friends
* Respite services
* Hospital visits
1. Are county boards still required to submit Notification of Individual Change in Status when a person is admitted to a hospital, ICF, or nursing home or when a person is incarcerated?

Yes. NICS are still required whenever a person enrolled in a waiver is receiving other Medicaid-funded institutional services or when s/he is incarcerated. The Payment Authorization for Waiver Services (PAWS) will be suspended to prevent unauthorized claims from paying.

The Medicaid Billing System (MBS) will allow only DBU claims, including ADL (services provided by staff not eligible for the competency-based add-on) and AQL (services provided by staff who are eligible for the competency-based add-on) claims, to pay when the PAWS is suspended.

1. Why is it permissible for a provider to be paid on a date when the person is not physically present in the home?
* Planned absences:

All planned absences from the home are required to be included in the cost projection tool (CPT) when projecting costs for the person’s 12-month waiver span. The new Monthly Rate Calculator (MRC) will capture all the person’s homemaker/personal care and on-site/on-call costs for each calendar month and will divide those costs by the total dates of service in that month, including those on which the person is expected to be away from the home. This enables providers to have a consistent/predictable revenue each day of the month, based on the person’s individualized cost projections.

Example:

A typical service pattern in a 31-day month costs $4100. ($4100/31 = $132.26 DBU)

In July, a person will not need HPC/OSOC for 7 days due to vacationing with family. Total July costs = $3190. ($3190/31 = $102.90 DBU)

Due to the decreased amount of HPC/OSOC projected in July, the provider receives a lower DBU for every day that month.

* Unplanned absences:

The new DBU was designed to minimize unnecessary change to individuals’ cost projections by recognizing that minor fluctuations in day-to-day service needs are common. After analyzing authorizations and service utilization for over 10,000 people who share residential services, it was determined that most people actually use very close the amount of service, within +/- 3%, projected at the start of the span.

If, due a person’s absence from the home, the service hours required in the home drop more than 3% below the number projected, the new Monthly Rate Calculator (MRC) will recalculate the provider’s DBU. This occurs even if no changes are made to the cost projection tool to prevent a provider from being paid a rate that is too high when providing less than 97% of all projected service hours.

1. When should a person who is temporarily absent from the home due to a hospitalization or incarceration be removed from the site in the Medicaid Services System (MSS)?

The county board should remove a person from the MSS site whenever the provider is expected to deliver more than 3% less than the projected service hours, as a result of the person’s absence from the home. The person may be returned to the site upon discharge from the facility.

1. What type of service documentation is required on dates of service when the person is not present?

The provider should reflect on the documentation sheet that the person was absent for the day.

The provider may continue to document any “on-behalf-of” service delivered while the person was away, such as housekeeping, money management, shopping, etc.

**Planning:**

1. What type of documentation is required when a provider is seeking an adjustment to CPT when actual hours delivered are more than 3% above the number of hours projected?

There is no prescribed format or type of documentation required. However, the provider must demonstrate that the additional hours were needed as a result of one or more people in the home requiring additional support.

Examples of situations necessitating increased hours include, but are not limited to, work or day program closures, illnesses/injuries requiring increased hands-on care, changes in behavioral status, etc.

Unacceptable examples include having additional staff on-site for training, unauthorized on-behalf-of services, other reasons not related to individuals’ needs.

1. Can unscheduled time still be used with the Monthly Rate Calculator?

Yes. Typical staffing patterns should be added to the calendar in the Medicaid Services System (MSS). However, unscheduled time may still be used when a person is likely to require additional hours in addition to these routine patterns.

It is important to add unscheduled time in the month(s) that it is likely to be used. When a lump sum of unscheduled hours is added for an entire waiver span, rather than being added to specific months, the hours are divided equally across the calendar months. This may increase the likelihood that the actual number of service hours delivered are more than 3% above or below the number of hours projected.

Teams should look at historical service usage to identify when a person tends to use more hours and how many additional hours are usually needed. For example, teams should consider patterns of work or day program closures, illnesses, medical appointments, etc.

1. Once the cost projection has been finalized, can it be changed for any reason other than moves in/out, start/stop of day program, or variations from projected hours of more than 3%?

Nothing in Ohio Administrative Code 5123-9-31 prevents plans from being amended or authorizations from being updated to reflect a person’s significant change in status. This includes making prospective changes when it is likely that a person’s services needs will vary from the hours originally projected by more than 3% or updating authorizations when a person’s eligibility for rate add-ons changes.

Authorizations may not be changed, however, for minor fluctuations in a person’s day-to-day service needs, such as pick-up or drop-off times.

1. Can a request for prior authorization be approved if an adjustment to the plan is requested after the end of the waiver span?

No. In accordance with Ohio Administrative Code 5123:2-9-07 (C)(4), DODD shall not consider a request for prior authorization submitted after the end date of the waiver eligibility span for which the request is made.

**Payment:**

1. If a provider delivers more hours than what was originally projected, will the provider receive a higher DBU?

If the provider delivers up to 3% more or 103% of the number of hours originally projected, the provider may be paid the DBU originally projected by the Monthly Rate Calculator.

If the provider delivers more than 103% of the hours originally projected the provider may request the cost projections be adjusted. When doing so, the provider must present evidence of the need for the additional hours by one or more people living in the home.

When no request for an adjustment is made, the provider may be paid up to the originally projected DBU.

1. How is the DBU recalculated when a provider delivers more than 3% less than the hours originally projected?

MRC will determine the new monthly cost for the site by multiplying the hourly rate originally projected by the number of hours actually delivered and attributing the costs to each person, based on the percentage of total services they receive.

Example:

Site costs for June = $3,000.00

Projected hours for June = 500

Hourly rate = $6.00/hour

Actual hours = 400

Actual hours x hourly rate = adjusted site costs = $2400.00

* How much service does each person use that month?
	1. Person A: 60% = $1400
	2. Person B: 25% = $600
	3. Person C: 15% = $360
* Divide each person’s monthly cost by the total number of service days:
	1. Person A: $1400/30 = $48.00/day
	2. Person B: $600/30 = $20.00/day
	3. Person C: $360/30 = $12.00/day
1. Will providers still be able to submit claims up to 350 days after the service was provided, in accordance with Ohio Administrative Code 5123:2-9-06?

Yes. Ohio Administrative Code 5123-9-31 only requires that providers enter the actual service hours delivered within 30 days of the end of the month. It does not require claims to be submitted monthly.

1. How will the competency-based add-on be applied to the new DBU?

Providers will enter the total number of hours delivered each month and will also enter the actual number of those total hours delivered by staff who are eligible for the add-on.

Once the provider indicates the monthly actuals are complete, MRC will divide the total competency-based hours by the total number of service dates in each actuals span and will apply an additional $1.56/hour to the projected daily billing unit.

 Example:

* The projected DBU for a site is $200/day.
* The provider enters actual hours, including 100 hours delivered by staff eligible for the competency-based add-on.
* 100 hours at the additional $1.56/hour = $156
* MRC divides the $156 of additional costs proportionally between the two people who share services in the home
	+ Person A contributes 60% of the services in the site - $93.60
	+ Person B contributes 40% of the services in the site - $62.40
* Next, MRC divides that additional cost by the dates of service to calculate the amount added to the DBU
* For a month with 30 dates of service,
	+ Person A: the DBU would be $200 + $3.12 or $203.12/day
	+ Person B. the DBU would be $200 + $2.08 or $202.08/day
1. Will providers be able to bill each week, or will they be required to bill monthly?

Providers will maintain the flexibility to submit ADL/AQL claims weekly, monthly, or at whatever interval they choose, as long as all claims are submitted within 350 days of the service delivery date.

Submitting claims monthly, as opposed to weekly, may be beneficial in the following situations to avoid the need for claims adjustments:

* One or more people in the home have had schedule changes that may impact the number of service hours delivered that month (illnesses, absences from work, day program closures, etc.)
* One or more people in the home have been admitted to an ICF or nursing facility
* Variable hours in the home are delivered by staff who are eligible for the competency-based add-on

Example:

* The projected DBU for a site is $200/day.
* The provider enters 100 competency-based hours for the first 14 days of the month.
* When submitting claims only for the first 14 days, MRC will spread the additional $156 costs across two people living in the home for only those 14 days
* The costs will be added proportionally to the two people who share services.
	+ Person A contributes 60% of the costs in the site - $6.69 added to DBU for this 14-day actuals span
	+ Person B contributes 40% of the costs in the site - $4.46 added to DBU for this 14-day actuals span
* The competency-based add-on will not be disbursed to the actuals spans (weeks) during which no competency hours were submitted.
	+ Competency hours submitted for the first 14 days as noted above.
	+ No competency-based hours were submitted for the remaining 16 days of the month. The DBU for these 16 days remains $200/day when the provider completes all actuals for the month.
1. Will claims for the DBU be paid when a person is receiving other services funded through a “daily rate?”

DBU claims, including ADL (services provided by staff not eligible for the competency-based add-on) and AQL (services provided by staff who are eligible for the competency-based add-on) can be paid on the same day that an individual receives any of the following daily rate services:

* Vocational Habilitation
* Adult Day Support
* Community Respite
* Residential Respite

 DBU claims cannot be paid on days when a person is receiving Shared Living services.

**Compliance:**

1. What should a provider do if a county board fails to comply with the required actions or timelines?

Providers are encouraged to talk with supervisors at the board regarding concerns and to follow the board’s complaint resolution process. If the concerns are unable to be resolved locally, providers should contact DODD’s Office of Provider Standards and Review (OPSR) regarding the issues they are experiencing. A special regulatory review may be conducted for patterns of non-compliance.

Nothing in Ohio Administrative Code 5123-9-31 alleviates a board’s requirement to comply with other waiver administration requirements.

Examples of requirements include, but are not limited to:

* Projecting for the person’s full 12-month span (OAC 5123:2-9-06 and OAC 5123-9-31)
* Making changes identified by the team that effect service authorization within 10 calendar days of receiving the recommendation from the team (OAC 5123:2-9-06)
* Allowing access to the cost projection tool by the provider (OAC 5123:2-9-06)
* Requesting prior authorization upon determining the costs of a person’s needed services will exceed the Ohio Developmental Disabilities Profile (ODDP) funding range, rather than waiting until the end of the span (OAC 5123:2-9-07)
* Adjusting cost projections, upon receiving a request and verification of increased service needs from the agency provider, within 30 calendar days (OAC 5123-9-31)
1. What should a county board do if a provider fails to comply with required actions or timelines?

Boards are encouraged to talk with agency representatives regarding concerns. If the concerns are unable to be resolved locally. If needed, a special regulatory review may be conducted for patterns of non-compliance.

Nothing in Ohio Administrative Code 5123-9-31 alleviates a provider’s requirement to comply with other waiver requirements.

Examples of requirements include, but are not limited to:

* Entering actual service hours within 30 calendar days of the end of each calendar month (OAC 5123-9-31)
* Providing supporting documentation of the need for increased service hours (OAC 5123-9-31)
* Notifying the service and support administration upon becoming aware of revisions needed to the service plan (OAC 5123:2-1-11)