

DDS Vendor Rate Study Project Overview

Presentation to the Developmental Services Task Force

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BURNS & ASSOCIATES, INC.

Health Policy Consultants

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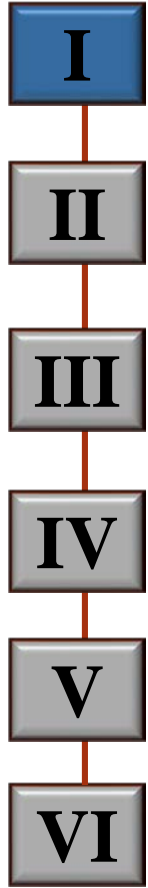
Questions and Answers

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Burns & Associates, Inc.



- Health policy consultants specializing in assisting State Medicaid agencies and ‘sister agencies’ (developmental disabilities and behavioral health authorities)
- Significant focus in the intellectual and developmental disabilities field
 - Rate-setting
 - Using assessments to inform individualized budgets and provider rates
 - Program operations, including fiscal analyses and funding, writing service definitions, updating billing rules and guidelines, and developing implementation approaches
- Conducted I/DD rate studies in Arizona, Georgia, Hawaii, Louisiana, Maine, Mississippi, New Mexico, Oregon, Rhode Island, and Virginia

B&A's Subcontractors

I

Human Services Research Institute (HSRI)

- Non-profit working in the intellectual/developmental disabilities field since 1976
- Emphases include quality improvement; systems design promoting person-centered thinking, self-direction, and community integration
- Developed National Core Indicators (NCI) with NASDDDS to measure quality across 100 consumer, family, systemic, cost, and health and safety outcomes

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Mission Analytics Group

- San Francisco-based firm with focuses on long-term services and supports; developmental disabilities; children, youth, and families; and health care delivery
- DDS' risk management contractor since 2005
- National technical assistance provider for CMS assisting states on HCBS self-direction and the Balancing Incentive Program

Section II: Previous I/DD Rate Studies

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Previous I/DD Rate Studies – Arizona

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- B&A consultants have assisted in three comprehensive rate studies since 2003, most recently in 2013

II

- First rate study resulted in a series of rate increases totaling more than 22 percent between 2004 and 2008

III

- State cut rates during the Great Recession without regard to the rate models

IV

- Most recent rate study recommended an overall increase of 26 percent (\$188 million)

V

- Not funded, but Legislature has provided small increases in recent budgets

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Previous I/DD Rate Studies – Georgia

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- Initial rate study in 2010
 - Recommended rates were cost neutral overall
 - Proposals were not implemented due to concerns with changes to use of an assessment instrument to ‘tier’ rates, day program billing policies, and host home rates
- Undertook a new study of residential, in-home, and respite rates in 2015
 - Recommended an overall rate increase of 24 percent (\$74 million)
 - Funding was provided and implementation began in March 2017

Previous I/DD Rate Studies – Rhode Island

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- State moved from ‘bundled’ monthly rates to 15-minute billing (daily for residential) and adopted Supports Intensity Scale (SIS)
- After rates were proposed, the General Assembly cut the budget by more than \$24 million without regard to the proposals
 - Proposed rates had to be reduced to fit within available funding
- Implementation of new rates began in 2011
 - Various changes have been made in response to budgetary considerations
 - In some cases, current rates remain below what was originally proposed

Previous I/DD Rate Studies – New Mexico

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- In response to legislative report noting an “inadequate” assessment process, a growing wait list, and other findings; and other pressures
 - State adopted the SIS to assess needs (though has recently ceased use)
- Implementation of new rates began in 2013
 - At the time, estimated overall reduction of 4 percent (\$10 million)
 - Many rates increased, but change in assessment process resulted in fewer individuals assigned to highest level or outlier
 - In addition to assessments, concerns included restriction in residential placements and use of therapy and behavioral services
 - Targeted rate increases instituted since that time
 - Total waiver spending was effectively unchanged between 2012 and 2014 (any savings due to reduced services or rates were reinvested in reducing the wait list)

Previous I/DD Rate Studies – Maine

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- Conducted rate study in 2013

II

- Recommended an overall rate decrease of 4 percent (\$10 million)
 - Proposal was not implemented
 - Primary objection related to group home services, recommended increase in revenue per staff hour, but fewer staff hours per member
 - Day program rates also would have been reduced; most other rates would have increased

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Previous I/DD Rate Studies – Mississippi

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- Included establishment of tiered rates based on ICAP assessment results, updates to service requirements, and establishment of new services
- Recommended an overall rate increase of 40 percent (\$20 million)
 - Funding was provided and implementation began in May 2017

Previous I/DD Rate Studies – Virginia

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- Rate study undertaken as part of waiver redesign initiative
 - Other components included eligibility changes, establishment of new services, and use of the SIS for tiered rates, changes in certain billing units
- Recommended an overall rate increase of 9 percent (\$58 million)
 - Later reduced to \$45 million after capping nursing rates
 - Funding was provided and implementation began in 2016

Previous I/DD Rate Studies – Oregon

I

- Reviewed day habilitation and employment rates

II

- Recommended an overall rate increase of 7 percent (\$5 million)
 - Due to funding limitations, have not implemented all rates
 - Only employment-related rates were implemented in 2016 (overall increase of 8 percent)

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- Currently reviewing rates for residential, in-home, transportation, and professional services

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Previous I/DD Rate Studies – Hawaii

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- Rate study performed as part of waiver reauthorization, which included use of SIS to assess needs and establishment of new services
- Recommended an overall rate increase of 25 percent (\$26.5 million)
 - Funding was provided and implementation began in July 2017

Section III: B&A's Independent Rate Setting Approach

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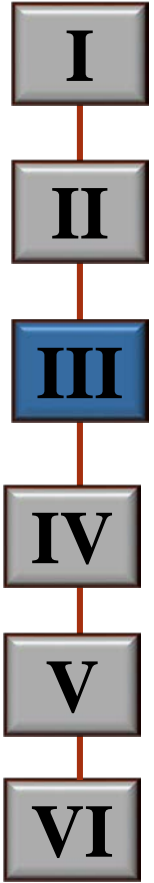
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Consultants' Role



- To assist DDS as it reviews and considers changes to provider rates
- Tasks will include:
 - Reviewing service requirements and DDS' goals
 - Communicating with and involving stakeholders
 - Data collection and analysis
 - Developing detailed rate models
 - Considering impacts relating to provider network sufficiency, FLSA and HCBS compliance, outcomes/quality, disparities in underserved populations/areas, and budget
 - Providing implementation support

The Independent Rate Model

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- Rate models are constructed based on costs providers face in delivering a particular service
- Data is collected from a variety of sources rather than any single source, including:
 - State policies, rules and standards
 - Provider and stakeholder input (e.g., provider survey)
 - Published sources (e.g., BLS wage data, IRS mileage rates)
 - Special studies

The Independent Rate Model (*cont.*)

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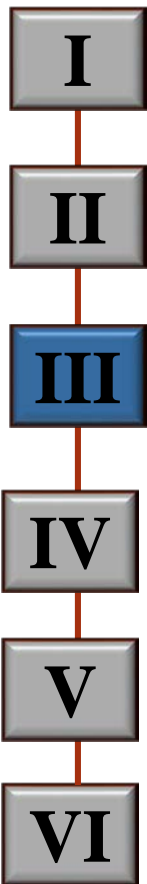
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- Specific model assumptions are detailed (e.g., staff wages and benefits, staffing levels, transportation, etc.)
 - Assumptions are not mandates (i.e., a provider does not have to pay the wage assumed in the rate)
- A single service may have several rates due to:
 - Individuals' levels of need
 - Group size (due to consumer need or other reasons)
 - Service setting (e.g., facility or community-based)
 - Staff qualifications and training (e.g., LPN v. RN)
 - Geography (e.g., urban and rural)

The Independent Rate Model (*cont.*)



- Five factors included in all HCBS rates:
 - Direct care worker wages
 - Direct care worker benefits
 - Direct care worker productivity
 - Program support
 - Administration
- Other factors vary by service and may include:
 - Transportation-related costs
 - Attendance/ occupancy
 - Staffing ratios
 - Rent for program facilities
 - Supplies

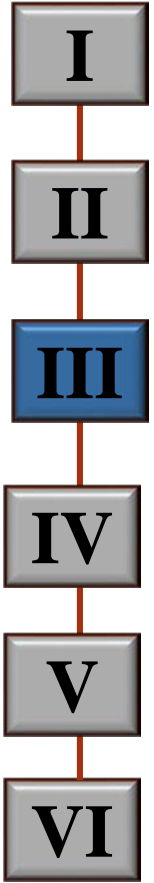
Model Example – Nursing

Unit of Service		15 Minutes	
Direct Support Staff Wages and Benefits	- Direct Staff Hourly Wage	\$44.37	
	- Employee Benefit Rate (as a percent of wages)	16.6%	
	Hourly Staff Cost Before Productivity Adj. (wages + benefits)	\$51.74	
	Productivity Assumptions		
	Total Hours	40.00	
	- Travel Time (Between Participants)	6.75	
	- Collateral Contacts	1.13	
	- Missed Appointments	0.45	
	- Recordkeeping and Reporting	1.13	
	- Employer and One-on-One Supervision Time	0.45	
	- Training	0.46	
	- Paid Time Off	3.54	
	"Billable" Hours	26.09	
	Productivity Adjustment	1.53	
Staff Cost After Productivity Adj. per Billable Hour		\$79.16	
Mileage	- Number of Miles Traveled per Week	275	
	- Amount per Mile	\$0.540	
	Weekly Mileage Cost	\$148.50	
	Mileage Cost per Billable Hour	\$5.69	
Supply Costs	- Annual Cost of Equipment and Supplies	\$2,000.00	
	Weekly Cost of Equipment and Supplies	\$38.46	
	Equipment and Supplies Cost per Billable Hour	\$1.47	
Program Support and Administration	- Program Support Funding per Day	\$15.00	
	Program Support Cost per Billable Hour	\$2.87	
	Cost per Billable Hour Before Administration	\$89.19	
	- Administration Percent	10.0%	
	Administrative Cost per Billable Hour	\$9.91	
Total Cost per Billable Hour		\$99.10	
Rate per 15 Minutes		\$24.78	

- Direct care staff wages and benefits
 - Largest component of HCBS rates (60-80 percent) of the total rate *when including productivity*
 - Data is typically gathered from multiple sources
 - Review of staff qualifications and responsibilities
 - Provider survey
 - Bureau of Labor Statistics data
 - State standards

- Adjusting wages and benefits to account for ‘productivity’:
 - The rate models seek to reflect a ‘typical’ week for direct care staff by establishing productivity adjustments for non-billable time
 - Non-billable activities may include training, travel, employer time, documentation, and planning time

Advantages to Independent Rate Model



- Transparency
 - Models contain the factors, values, and calculations that produce the final rate
- Ability to advance policy goals/objectives
 - Examples could include improving direct care staff salaries or benefits, specifying staff-to-client ratios, and incentivizing natural environments rather than clinics
- Efficiency in maintaining rates
 - Models can be easily scaled and adjusted for inflation or specific cost factors (e.g., gasoline costs), or to meet budget targets

Section IV: DDS Vendor Rate Study – Project Principles and Overview

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Project Guiding Principles

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- Utilize the independent approach to rate setting (provider cost data will be one source – but not the only source – of information)
- Rates will reflect and support – to the extent practicable – DDS requirements and goals, such as:
 - Efficient payment structures (e.g., billing codes and units of service)
 - Provider network sufficiency, including for underserved areas/ groups
 - Supporting quality services and desired outcomes (supporting people at home, encouraging natural supports, community integration, employment)
 - Compliance with HCBS and FLSA rules
 - Rates that can be maintained and sustained

Project Guiding Principles (*cont.*)

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- Rate-setting process should be inclusive and transparent
 - There will be meaningful opportunities for input from the DS Task Force, provider groups, and other stakeholders
 - Rate models that detail cost assumptions and sources of information used to develop these assumptions will be posted online
- Rates should be developed independent of budgetary considerations
 - Budgetary impact will be considered as part of implementation planning

Project Tasks

I

- **Background research and analysis** of the DDS system, including service requirements, current utilization patterns, etc.

II

- **‘Kick-off’ meetings** with DDS, DS Task Force and Rates Workgroup

III

- **Provider survey** to collect data regarding providers’ service delivery and costs from a representative sample of providers as well as provider site visits

IV

- **Other research and analysis** including benchmark data (e.g., industry wages), comparable rates in other programs and states, and geography-based differences

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Project Tasks (*cont.*)

I

- **Draft rate models** that outline specific cost assumptions and prepare initial fiscal impact analysis

II

- **Comment process** to provide opportunity for DS Task Force, Rates Workgroup, and other stakeholders to offer feedback on the draft rates

III

- **Finalize rate models** after consideration of public comments

IV

- **Final report** completed by March 2019

V

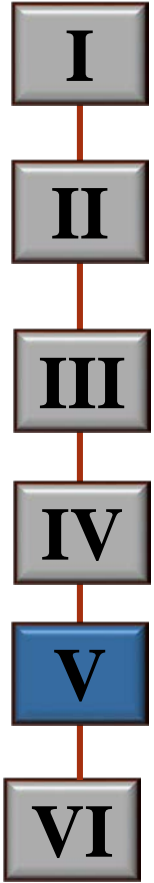
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Section V: Role of DS Task Force/ Rates Workgroup and Other Groups



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Role of DS Task Force/ Rates Workgroup



- Represent the larger of community of stakeholders
 - Provide information to your colleagues and share their input
 - Answer questions/ encourage participation
- Provide ‘on-the-ground perspective’ throughout the project
 - What works/ what doesn’t
 - Drill-down on specific issues
- Review materials
 - Provider survey and instructions as well as survey results
 - Drafts of rates
- Provide feedback on draft rate models

Anticipated Meetings with DS Task Force/ Rates Workgroup

I

- Kick-off meeting

II

- Presentation of draft provider survey
 - Follow-up meeting to discuss feedback

III

- Presentation of provider survey results

IV

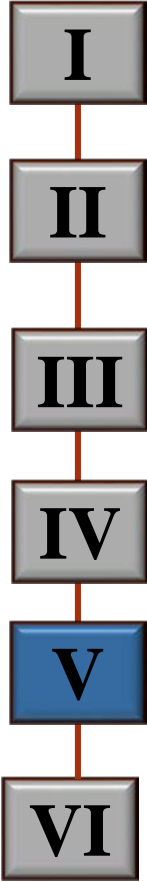
- Presentation of draft rate models
 - Follow-up meeting to discuss feedback

V

- Presentation of public comments and final rate models

VI

Interactions with Other Groups



- Association of Regional Center Agencies
 - Discussion of use of service codes
 - Presentation of draft rate models and follow-up meeting
 - Presentation of public comments and final rate models
- Provider associations
 - Presentation of draft rate models and follow-up meeting
 - Presentation of public comments and final rate models
- Other groups as needed/ requested

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