DDS Vendor Rate Study
Project Overview

Presentation to the California Disability Services Association

Stephen Pawlowski, Vice President, Burns & Associates, Inc.

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BURNS & ASSOCIATES, INC.
Health Policy Consultants

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Section I: Project Team

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Burns & Associates, Inc.

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- 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

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B&A's Subcontractors

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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

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

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Section II: Previous I/DD Rate Studies

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Previous I/DD Rate Studies – Arizona

- B&A consultants have assisted in three comprehensive rate studies since 2003, most recently in 2013
- First rate study resulted in a series of rate increases totaling more than 22 percent between 2004 and 2008
  - State cut rates during the Great Recession without regard to the rate models
- Most recent rate study recommended an overall increase of 26 percent ($188 million)
  - Not funded, but Legislature has provided small increases in recent budgets

Previous I/DD Rate Studies – Georgia

- 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

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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)

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Previous I/DD Rate Studies – Maine

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- Conducted rate study in 2013
- 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

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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

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Previous I/DD Rate Studies – Oregon

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- Reviewed day habilitation and employment rates
- 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)
- 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

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

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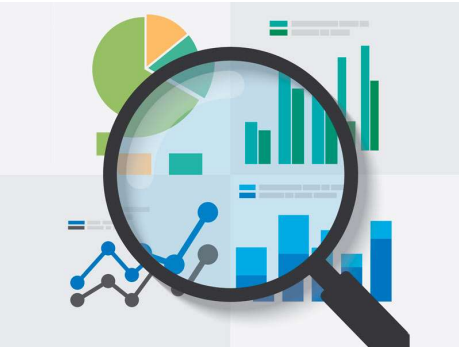

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Consultants' Role

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- 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

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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

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The Independent Rate Model *(cont.)*

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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.)*

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- 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

	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**

Model Example – Nursing

- 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

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Advantages to Independent Rate Model

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- 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

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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

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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

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Project Tasks

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- **Research and analysis** of the DDS system, including service requirements, current utilization patterns, etc.
- **'Kick-off' meetings** with DDS, DS Task Force and Rates Workgroup
- **Provider survey** to collect data regarding providers' service delivery and costs from a representative sample of providers
- **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.*)

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- **Draft rate models** that outline specific cost assumptions and prepare initial fiscal impact analysis
- **Comment process** to provide opportunity for DS Task Force, Rates Workgroup, and other stakeholders to offer feedback on the draft rates
- **Finalize rate models** after consideration of public comments
- **Final report** completed by March 2019

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Contact Information

Stephen Pawlowski, Vice President and Project Manager
Burns & Associates, Inc.
spawlowski@burnshealthpolicy.com
(602) 241-8519

3030 North 3rd Street, Suite 200
Phoenix, Arizona 85012
www.burnshealthpolicy.com