Responses from Burns & Associates to Questions from Project Sustainability Commission

1. ***Please explain the background and purpose of Project Sustainability from your perspective.***

Burns & Associates (B&A) reviewed with the BHDDH team in three days of initial kickoff meetings the goals of Project Sustainability which were enumerated to us as follows:

- A system that supports people living in the community in charge of their lives;
- A system that allows individuals to spend resources more flexibly than today;
- A system that aligns resources to individual needs – people get what they need, no more, no less;
- A system that pays equally for the same service as a matter of fairness for providers and for individuals, which makes dollars go farther and makes it easier for individuals to receive the services from who they want and from where they want;
- A system where information is transparent for all our stakeholders, service recipients, providers, the federal government, the legislature and our Governor; and
- A system that is sustainable.

After hearing from BHDDH and EOHHS leadership as to what these statements mean to them, B&A vetted ideas on how to operationalize each of these objectives. The initial result of early decisions was to form workgroups to scrutinize and make changes where it was deemed necessary to the definitions of services that are offered by BHDDH, the rates of reimbursement paid for these services, and the tool or tools used to assess the support needs of individuals. It was determined early on that the method in which individuals supported by BHDDH are authorized funding would also need to change while still adhering to the tenet above that people get what they need, no more and no less.

2. ***Please describe the benchmark setting process.***

B&A's HCBS rate-setting project typically follows these steps:

- An in-depth review of each state's service requirements (which can vary significantly for the same services across different states) and the State's goals for the service delivery system as well as discussion with provider representatives regarding their perspective on the system's strengths and needs;
- Administration of a provider survey to collect information regarding 'how' providers deliver services and the associated costs;
- Collection of benchmark data from independent, third-party sources (such as wage data from the Bureau of Labor Statistics);
- Development of draft rate models and a public comment process to solicit feedback from providers; and
- Finalization of the rate models based on public comments.

B&A followed this process in Project Sustainability. Through the Rates Workgroup, different external sources were reviewed and compared to the costs reported by providers on the survey administered to them. The Rates Workgroup also gave advice related to assumptions that were built into the independent rate models. It was known early in the process that the current funding (that is, as of January 2011) would likely not be able to fund the full array of services for the existing caseload. The benchmark rates published in the initial Public Notice of rates developed showed the benchmark rates and the models used to set the benchmark rates so that there was a transparent way to show what was the difference between the budgeted need for funding and the actual funding from the Legislature.

3. ***It was noted that this payment model would increase flexibility, yet we have heard that it ultimately created a more rigid service system. Could you explain why you believe this resulted?***

   Many of the changes were intended to produce a more flexible system *from the participant's perspective.* For example:

   - Development of separate services and establishment of 15-minute billing allows participants to choose different providers for different services rather than 'locking' them into a single provider receiving a single payment for all (or a bundle of) services.
   - Creating separate rates for center-based day and community-based day services (with higher rates for the latter) facilitates improved access to the community by paying providers higher rates for these services compared to center-based services. An additional benefit of this approach is transparency into 'where' services are provided, which are important in light of the State's settlement agreement and the 2014 HCBS final rule.

   Without understanding the specific concerns regarding the rigidity of the service system, it is impossible to respond directly. However, a fundamental precept of Medicaid fee-for-service billing is the payment to providers for eligible services delivered to eligible individuals. This allows states a means to ensure appropriate oversight of their program so that taxpayers dollars are not being used for services not covered by the program or for individuals not eligible for the program.

4. ***What recommendations do you have for the State that will strengthen our internal and external process for establishing a new rate model?***

   Given that it has been seven years since the rates were first implemented, it is past time to undertake a comprehensive review of the program's individual rates and the development of the funding method to individual participants. B&A typically recommends a complete rate 'rebasing' of a program at least once every five years.

   Although B&A has not kept track of any changes either to actual rates in BHDDH's program or the way in which they may have changed, B&A believes that the existing rate models serve as a transparent starting point. Providers and stakeholders know what is 'in' the rates and can point out those areas that they believe are deficient. This information can inform any future rate-setting process.

   From a methodological perspective, B&A has made a number of updates to its approach over the years, such as how paid time off costs are accounted for, how to account for program absences, and how to recognize departures from the 'final' rates (such as what occurred when the Legislature required funding cuts in 2011).
   B&A would recommend an approach similar to the one conducted initially, but this should start with an honest discussion about what is working well and what is not. Data should again be collected from providers. Recognizing that costs reported by providers will be, in large measure, a function of current rates, data should be collected from other sources as well. In particular, the national and state economies are much stronger now than they were when the current rate models were first established and it is likely that these independent data sources will show increased costs in areas such as wages and benefits. Rate models should be revised or rebuilt and there should be ample space to discuss the changes with providers and other stakeholders before changes are finalized.

The State should also consider outcome- or value-based rate strategies where appropriate, recognizing the limitations that exist both within fee-for-service and HCBS environments.

5. ***Describe the process followed to move from the benchmark rate, to the recommended rate, to the adopted rate. What specifically was changed and why in regards to rates? What specifically was changed and why in regards to structure (e.g. quarterly authorizations, 15-minute increments, health insurance, transportation)? Were any or all of these changes recommended by you? If so, why?***

First, some clarification of terminology. B&A uses the terms "benchmark" rate and "adopted" rate when conducting a rate development project. It is unclear what is meant by "recommended" rate. To us, the benchmark rate is the recommended rate.

B&A clarified these terms when it assisted in crafting the language in the original Public Notice of Category II Changes to Rhode Island's Global Waiver that was released on June 2, 2011. The specific language was excerpted from that document and provided here:

> *BHDDH has established a benchmark rate and an adopted rate for each service (including all sub-rates for different staffing levels). The benchmark rate is the target rate for the service if and when legislative funding is sufficient. The adopted rate for the service is the actual rate that will be paid for the service under current legislative funding.*
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> *BHDDH is still awaiting confirmation of its legislative funding authorization for State Fiscal Year 2012. At this juncture, it expects that most of the adopted rates will be at least 15 to 19 percent below the benchmark rates. The differential between the benchmark rate and the adopted rate will vary based on the service. The adopted rates are based on the Governor's Proposed Budget as of June 2, 2011. The Legislature has yet to enact a final budget. If the Legislature enacts a budget to BHDDH lower than the Governor's Proposed Budget, then some or all of the Adopted Rates shown below will be further reduced.*

Perhaps the confusion lies in what was discussed in the Rates Workgroup related to what was ultimately included in the rate models representing the benchmark rates. There was considerable discussion and debate in the Workgroup related to some of the assumptions in each of the rate models with respect to the appropriate level of funding for specific items. One example that comes to mind is the percentage of wages to apply for the amount allocated to fringe benefits. Not every suggestion put forth by Workgroup members was included in the final benchmark rate models. So this may be what some perceive as "recommended" rates. B&A did offer recommendations to BHDDH related to some assumptions built into the benchmark rates using our experience in other states as well as what we had seen in states where we did not personally set the rates.

The changes in rates—most notably from benchmark to the adopted rates—was an artifact of the available legislative funding at the time. What become more problematic at the initial change over to the new system was that two weeks after the initial Public Notice was released, the Legislature did finalize its budget for State Fiscal Year 2012. In that budget, funding to Private DD providers was cut. Thus, the rates assigned were lowered even more than the original amount shown in the June 2, 2011 Public Notice to account for the additional funding cut.

B&A always recommends to clients to use the benchmark rates when funding is available. Our recommendation was no different to the BHDDH. The reality of the budgetary restrictions imposed at the time required BHDDH to cut the rates below the benchmark rates. B&A did advise BHDDH

on ways to do this. The most common—and significant—way to do this is to reduce the assumption in each model for the hourly wage assumption for the Direct Service Professional staffing category. This is the option that BHDDH used for most rate model reductions.

With respect to the method of billing for services, there were candid conversations with EOHHS and BHDDH about the mechanism under which Private DD providers would bill for services under Project Sustainability. It was the directive of EOHHS that providers would submit some type of supporting documentation for services rendered to participants using the nationally-defined codes and not the single monthly increment that had been in place.

B&A did research and confirm to EOHHS and BHDDH that our experience nationally showed that every state that we had encountered used most, if not all, of the national codes as well. There was a candid conversation with State leaders at the time whether providers would submit the service code information as means for payment (a fee-for-service payment system) or as encounters that would support a capitation payment. B&A has seen both scenarios used by states. The directive from EOHHS was that the providers would bill under a fee-for-service arrangement.

- ***Particularly with the 15-minute increments, do other states use this model?***
  The large majority of states pay for most non-residential services (such as in-home and day program services) based on 15-minute or hourly billing units. Excluding Rhode Island, Burns & Associates has conducted or is conducting comprehensive rate studies for I/DD programs in 10 states as shown in the table on the next page. In each of these states, B&A has not converted to a new type of billing system; rather, the billing method shown in the table was in place when B&A was hired. B&A was specifically hired to update the existing rate structure. Rhode Island was unique in that we were asked to both change the billing structure and develop the rates.

Inventory of States Billing Practices that Burns & Associates has Worked

State	15-Minute /Hourly Billing for In-Home & Day Services?[1]	HCPCS Used for Billing?
Arizona	Yes	No
California	No[2]	No
Georgia	Yes	Yes
Hawaii	Yes	Yes
Maine	Yes	Yes
Mississippi	Yes	Yes
New Mexico	Yes	Yes
Oregon	Yes	No
Vermont	No	No
Virginia	Yes	Yes

[1]The table reflects whether the large majority of in-home and day services are billed using 15-minute or hourly units; in a few states, there are very limited services (used by few individuals) that may be billed based on other units.
[2]California is a regionally-driven system; in some regions, providers are paid based on 15-minute or hourly units whereas in other regions, daily or monthly billing units are employed.

B&A cannot quantify the billing policies of all other states, but based on the reviews we have conducted of different states at various times over the years, we have seen similar ratios to those shown in the table above.

States require 15-minute/ hourly billing for the same reasons that Rhode Island made the change – to increase accountability by paying providers for the services that are actually delivered, to increase transparency in terms of understanding the services that individuals receive, and to further policy objectives such as incentivizing employment or community-based services.

6. What direction were you given by the Division? What recommendations did you give to the Division? Of the recommendations, which were adopted and which were ignored? Why?

In summary, B&A was asked by BHDDH to do the following:

- Develop a fee-for-service payment system;
- Develop rates to support a fee-for-service payment system;
- Develop a systematic way to ensure that the authorization of services was trackable, reportable, and transparent to participants, providers, legislators, and CMS;
- Ensure that the service definitions created would be approved by CMS;
- Provide alternatives on converting to a new assessment tool (we were told that continuing with the current assessment tool was not a viable option);
- Assist with the implementation of a new assessment tool;
- Provide technical assistance to associate the scores in the new assessment tool to funding levels; and
- Provide technical assistance to operationalize all of the aspects above.

Specific recommendations that we made included the following:

- With respect to service definitions, we recommended that for "core" services that BHDDH not deviate too far from language suggested by CMS in order for these services to be approved. This recommendation was accepted. We did recommend that if there were other services that BHDDH was interested in pursuing to gain federal matching funds, BHDDH should be take an "aggressive" stance toward pursuing these approvals given the nature of the Global Consumer Choice waiver approved for the State (e.g., peer supports). This latter recommendation was not accepted (but our recollection was that this was an EOHHS decision, not a BHDDH decision).
- With respect to rate development, we recommended using the national codes and the parameters related to these codes (e.g., the billing increments). This recommendation was accepted by BHDDH.
- With respect to the rates themselves, B&A recommended that BHDDH aggressively pursue funding to cover the rates using the benchmark rates. This recommendation was not accepted. Other alternatives offered, but not accepted, at the time to counteract the limited funding included:
    - Eliminate the RICLAS system or use it for emergency placements only.
    - Merging the reimbursement systems for RICLAS and Private DD provider programs. In essence, put the programs on a "level playing field" which would effectively move more money into the private system.
    - If there was not enough funding for the Private DD provider program, and eliminating RICLAS was untenable, then reinstitute a waiting list so that the funding

for existing participants was not compromised by imposing deep cuts below the benchmark rates.

- With respect to the authorization system, B&A did propose that an authorization system should be created that was more trackable than the existing system. B&A recommended an annual authorization amount. BHDDH accepted the concept of changing the tracking of authorizations, but BHDDH wanted a quarterly—not an annual—authorization system. BHDDH also wanted further granularity than B&A had recommended—that is, some participants have multiple authorization records per quarter rather than just one.
- With respect to the assessment tool, B&A did recommend that BHDDH adopt the SIS. This was suggested at the outset but reinforced based on feedback from the Assessments Workgroup. This recommendation was accepted by BHDDH. B&A recommended that the individuals conducting the SIS be *neither* the State case managers *nor* provider employees. The Workgroup also recommended an external party conduct the SIS assessments. This recommendation was not accepted by BHDDH.
- With respect to the number of SIS levels and the service package assumed within each SIS level, BHDDH generally accepted the number of levels that B&A proposed. B&A's recommendations for the service package within each SIS level were driven by the feedback of the clinical validation study conducted. BHDDH accepted most all of these recommendations as well.

7. Speak to how the SIS and the funding model had to work together to meet the Division's budget targets. And, should the SIS be performed by an independent 3rd party?

Given the budget restrictions at the time, B&A recommended that the integrity of honoring the service packages defined under each SIS level be first and foremost. In other words, don't cut the service levels. If necessary, cut the rates for each per unit service but retain the units of service authorized. This is effectively what happened. Once the SIS level service packages were "locked in", then the actual per unit rates were "backed into" in order to meet budgetary restrictions.

In the first year of the engagement, Mark Podrazik met with B&A met onsite at 13 provider locations to conduct an assessment of the approach that each provider used to perform and document support coordination. Separately, individual BHDDH case managers were interviewed to learn more about their role and responsibilities related to assistance to participants in the program. In this report delivered February 25, 2011 which was never released, B&A provided 16 recommendations related to support coordination and assessment. Some of the pertinent recommendations related to this question include the following:

- Assuming that the BHDDH continues to utilize agencies for the delivery of day-to-day case management tasks, the BHDDH should consider some protections for individuals, particularly as it pertains to the following CMS requirements that individuals have a choice of case managers and that the case manager cannot restrict access to services.
- To comply with the CMS Final Rule, the BHDDH should make a decision whether the case management function provided by the agencies will be a separately payable service or if it will be bundled into another reimbursable Medicaid service. B&A recommends that BHDDH make it a separately payable service.
- It is strongly suggested that the BHDDH Social Caseworker staff be disentangled from the funding provided to individuals.

Throughout the engagement, B&A continued to strongly endorse that BHDDH hire a third party—neither the State nor a current service provider—to conduct the SIS assessments. This recommendation was not accepted due to funding restrictions and union requirements.

B&A further believes that, if the SIS instrument is used, that assessors should be trained and certified by the AAIDD (the author of the SIS) and that conducting assessments should be the person's primary responsibility. An assessor who only conducts assessments on a part-time basis – for example, a couple of assessments per month – may see their assessment skills erode.

8. ***At any point during the administration of the SIS was there a variance observed from the expected distribution of tier outcomes? If so, what was done in response?***

B&A does not have an expectation regarding the distribution of assessment results as these will vary widely from state to state based on eligibility requirements, the use of institutions or state-operated facilities, waiting list policies, and other factors.

In Rhode Island, while B&A was engaged with the State, the assessments were scheduled to be completed over a three-year cycle. The full cycle of assessments had been completed not long before the end of our engagement. To our recollection, the distribution of individuals by SIS level was not atypical of what we had seen in other states. Consequently, there was no overt action to realign the SIS levels, e.g., change the scoring algorithm to force the distribution to meet a certain target.

9. ***What impact did you anticipate Project Sustainability would have on individuals? Providers? What impact did the Division anticipate Project Sustainability would have both parties? (i.e. where did your visions align/not align?)***

B&A assumed that Project Sustainability would provide individual participants more flexibility while providing more fairness and accountability to providers. With Project Sustainability, the "money follows the person" rather than an individual being tied to one provider. Since the funding levels were just that—a total amount—by convening with their supporting provider (or providers), individuals and their families could pick and choose the services the best suited their needs. Although not entirely a self-directed model as we think of self-direction, it was more of a migration to personal choice from the current system.

For providers, the rate system developed provided the same rate of payment for the same service to every provider. This was not the case in the prior system. In fact, the variance of what was paid for the same service was often great, particularly for group home services. Project Sustainability provided equity and transparency on the rate of pay.

But the new system also held providers more accountable. Despite the fact that rates were cut due to budget restrictions, in the aggregate in Year 1 it was found that individuals only used 88% of their authorized budget. In the previous methodology, these dollars would have been retained by providers. One of the tenets of Project Sustainability was that each individual got what they needed—no more, no less.

Reflecting back, it seems that BHDDH was in a bind due to severe budget restrictions. There was an absolute resistance to a waiting list. This meant that fewer dollars had to be stretched across more participants. BHDDH had not even received a budgetary allocation for caseload increases in years. This further stretched tight budgets. BHDDH was looking for ways to redistribute some dollars to those that needed it from those that did not. This was the impetus for the change of the assessment tool as well (we believe).

10. Describe the competency and capacity of the Division to implement Project Sustainability.

B&A perceived that, at the aggregate level, there was neither the capacity nor the competency at the Division to implement Project Sustainability. As such, in addition to what we expected to do which was one-time external development tasks, B&A often served as the "extra set of hands" to help out on operational items since there were few individuals at BHDDH who could perform these functions. This included draft updates to the regulations, maintaining the data for authorizations submitted to DXC, updating rates, writing policies, developing reports and financial tracking.

B&A built out mockups of databases and other tracking mechanisms to help provide efficiencies to, admittedly, was limited staffing at BHDDH. Some of these methods were adopted by BHDDH and others were not. In our view, the greatest limitation at BHDDH was the information systems used at BHDDH which were antiquated, inefficient and often required unnecessary repetitive actions. There were not personnel to implement more efficient information systems even if the funding was available to do so.

Our perception was that when the Consent Decree became effective, there was neither the vision nor the staffing to implement strategies to adhere to the requirements of the Consent Decree.

There were some individuals who exhibited the drive and competency to move things forward. The first CFO that B&A worked with was heavily invested in ensuring the success of Project Sustainability. The first DD Director that we worked with also wanted to do right by the participants and the providers but was often overwhelmed in his day-to-day duties. Other staff members were helpful but did not appear, in our opinion, to have the drive to make sure that Project Sustainability worked for all parties—the participants, the providers and the State. Our perception was that the Director was put in a precarious position trying to balance the needs of participants, ensuring access to services from a diverse provider network, keeping expenditures within an ever-shrinking and highly-scrutinized budget, and implementing the interests of the Executive branch of government.

11. Why was this system redesign only applied to Private DD, and not RICLAS (especially through the lens of the billing increments)?

The question of whether RICLAS was in or out was discussed right at the outset. Given some of our team member's previous experience in Rhode Island, B&A had recommended from the start to gradually terminate the RICLAS program and transition individuals served in RICLAS to private providers. This recommendation was shut down immediately with the reason being a protracted fight with the unions. B&A then recommended, at minimum, reforming (i.e., lower) the reimbursement of the services provided in the RICLAS program. This was also shut down. It was apparent early on that there were funds to be redistributed between RICLAS and the Private DD system, but there was no appetite to do so. It is unclear exactly where this directive was coming from within state government, but that was the directive given to B&A.