10 YEARS AND 10 STATES

Trends in Provider Payment Rates for HCBS for Persons with I/DD

– presented by –

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

– sponsored by –

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New Jersey Council on Developmental Disabilities
The Alliance for the Betterment of Citizens with Disabilities

October 16, 2017

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Agenda

I. About Burns & Associates, Inc.

II. National Landscape for I/DD Services

III. Changes in Rate Methodologies Over Past Decade

IV. Examples of Recent Conversions to Fee-for-Service

V. What's Next in Rate Methodologies

VI. Other Emergent Issues in I/DD Services

VII. Working with the New Fee Schedule

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Section I: About Burns & Associates, Inc.

Burns & Associates, Inc.

- Health policy consultants specializing in assisting State Medicaid agencies and 'sister agencies' (developmental disabilities and behavioral health)
  - Rate-setting
  - Financial analyses, budget modeling, and forecasting
  - Policy development
  - Research, strategic planning, evaluation (including external quality reviews) and benchmarking, surveys, and focus groups
  - Medicaid Waiver development including design, implementation, budget neutrality demonstration, and negotiation with CMS
- Since founding in 2006, B&A has consulted in 26 states, as well as in Canada and for MACPAC

Burns & Associates, Inc. *(cont.)*

- 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, writing service definitions, updating billing guidelines, and developing implementation approaches
- Conducted I/DD rate studies in Arizona, Georgia, Hawaii, Louisiana, Maine, Mississippi, New Mexico, Oregon, Rhode Island, and Virginia
  - Recently awarded contract to conduct a review of provider rates in California
- B&A has worked on other I/DD-related projects in several other states, including Illinois, Missouri, Montana, New Jersey (for the Center for Health Care Strategies), North Carolina, North Dakota, Texas, and Alberta (Canada)

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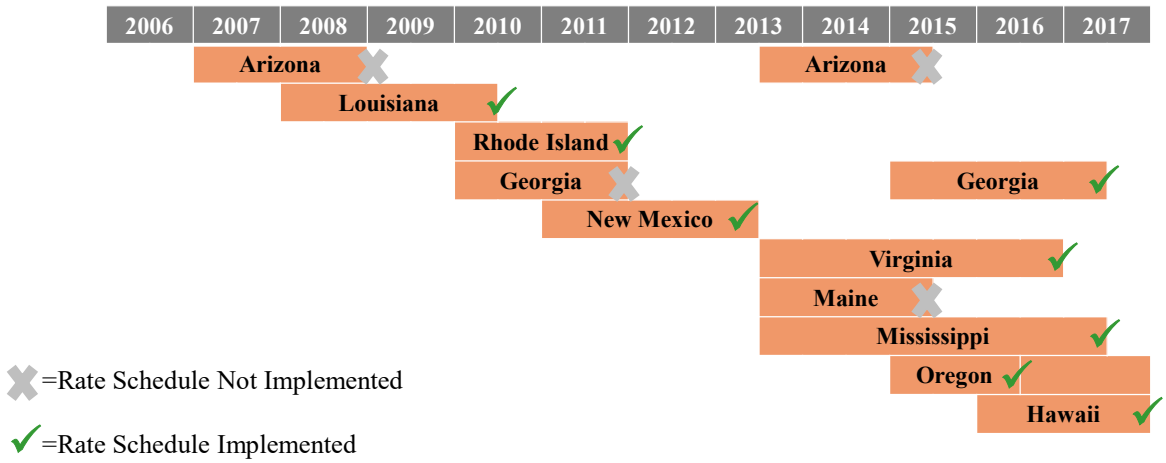
B&A - I/DD Rate Setting Projects



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Stephen Pawlowski

- B&A's Vice President
  - Joined the firm in 2009
  - Heads B&A's I/DD practice
- Previously served as Chief Financial Officer of the Arizona Department of Economic Security
  - Among other responsibilities, DES administers the State's I/DD system as a managed care organization
- Life-long New York Giants fan

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Section II: National Landscape for I/DD Services

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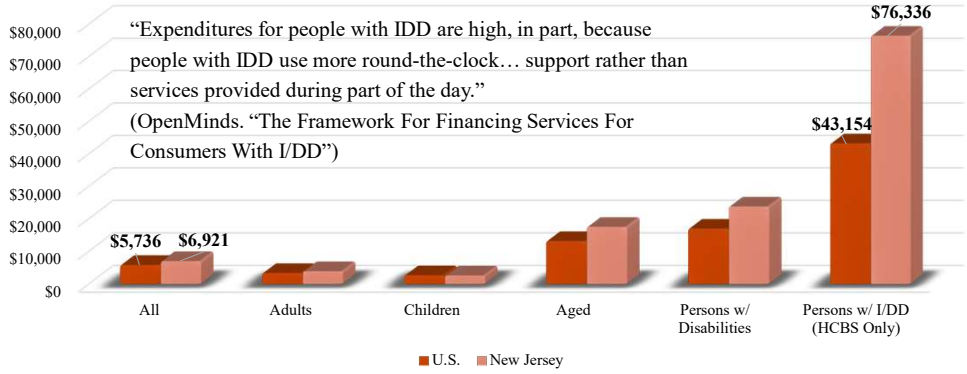
Spending on Services for Persons with I/DD

Fiscal Year 2014 Medicaid Spending Per Enrollee



Sources: Kaiser Family Foundation (persons with disabilities include all disability groups; University of Minnesota's Residential Information Systems Project.

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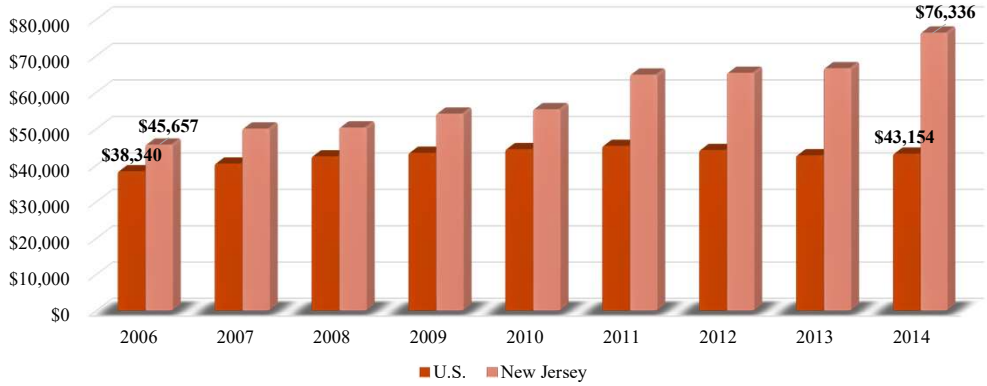
Spending on Services for Persons with I/DD *(cont.)*

Rising Cost of Care for Persons with I/DD (2006 – 2014)



Source: University of Minnesota's Residential Information Systems Project.

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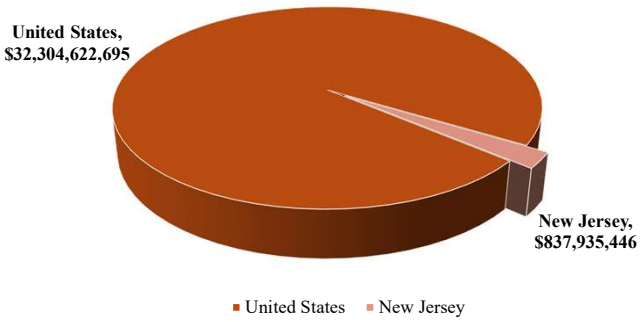
Spending on Services for Persons with I/DD *(cont.)*

Waiver Expenditures in Fiscal Year 2014



Source: University of Minnesota's Residential Information Systems Project.

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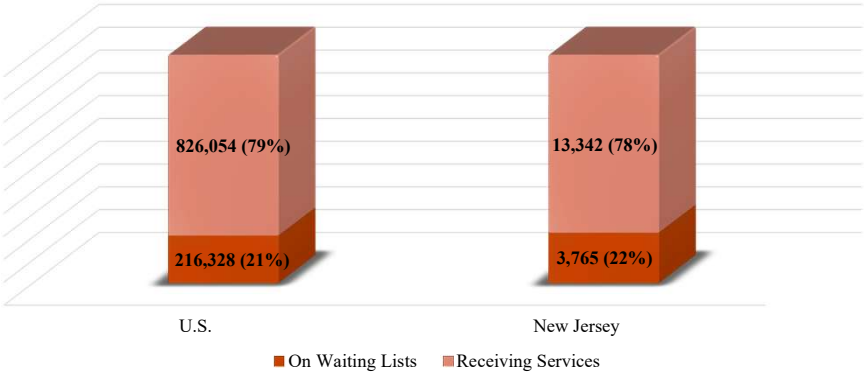
Spending on Services for Persons with I/DD *(cont.)*

Persons Receiving HCBS Services and on Waiting Lists (Fiscal Year 2014)



Source: University of Minnesota's Residential Information Systems Project.

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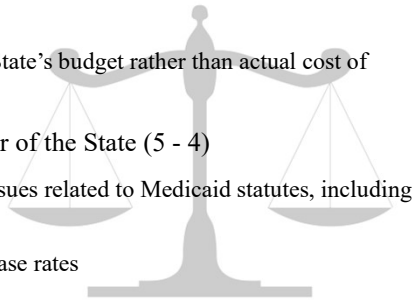
Increased Federal Scrutiny of Rates

- Armstrong v. Exceptional Child Center, Inc.
  - Lawsuit brought against State of Idaho by providers of residential habilitation services for persons with I/DD
    - Argued that reimbursement rates were driven by State's budget rather than actual cost of service
  - In March 2015, U.S. Supreme Court ruled in favor of the State (5 - 4)
    - CMS becomes the first and last stop to arbitrate issues related to Medicaid statutes, including rates
    - Effectively prevents providers from suing to increase rates



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Increased Federal Scrutiny of Rates *(cont.)*

- CMS-Issued Technical Guidance Series (HCBS)
  - https://www.medicaid.gov/medicaid/hcbs/training/index.html
- CMS Guidance – General Guiding Principles for Rate Setting
  - Payments need to be consistent with efficiency, economy, quality of care
  - Rates need to be sufficient to enlist an adequate provider network
  - In States operating Section 1915(c) HCBS waivers, rate methodologies are described in Appendix I-2-a, for which CMS defines four 'basic rules'
    1. Be specific
    2. Describe how and how often the rate methodology is reviewed and rates are updated
    3. Describe the public comment process
    4. Describe how the individual rates are available to the public

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Increased Federal Scrutiny of Rates *(cont.)*

- CMS Guidance – Five Common Rate-Setting Methods
  1. ***Fee Schedule*** – provider receives a fixed, pre-determined rate for a single service for a designated unit of time
  2. ***Negotiated Market Rate*** – provider receives the market price of a service, with an expectation that some negotiation will take place to reach an agreed-upon market price
  3. ***Tiered Rate*** – provider receives payment for one service in which the rate varies by identified characteristics of the individual, the provider, or some combination of both
  4. ***Bundled Rate*** – a waiver service that encompasses two or more discrete services with distinct purposes that are not closely related. The State must demonstrate that such bundling will result in more efficient and economical delivery of services and ensure that waiver participants have free choice of providers
  5. ***Cost Reconciliation Rate*** – providers file cost reports or cost surveys created by the State, ultimately to be reimbursed at the true cost of service

Increased Federal Scrutiny of Rates *(cont.)*

- CMS Guidance - Factors to Consider in Rate Setting
  - Base data
    - Wages, benefits, and productivity
    - Operating costs, such as facility costs, vehicles, taxes, program support, and administration
  - 'Trend' (inflation)
  - Member acuity/ level of need
  - Feedback from stakeholders
  - Geographic adjustment factors (e.g., rural v. urban settings)

Section III: Changes in Rate Methodologies over the Past Decade

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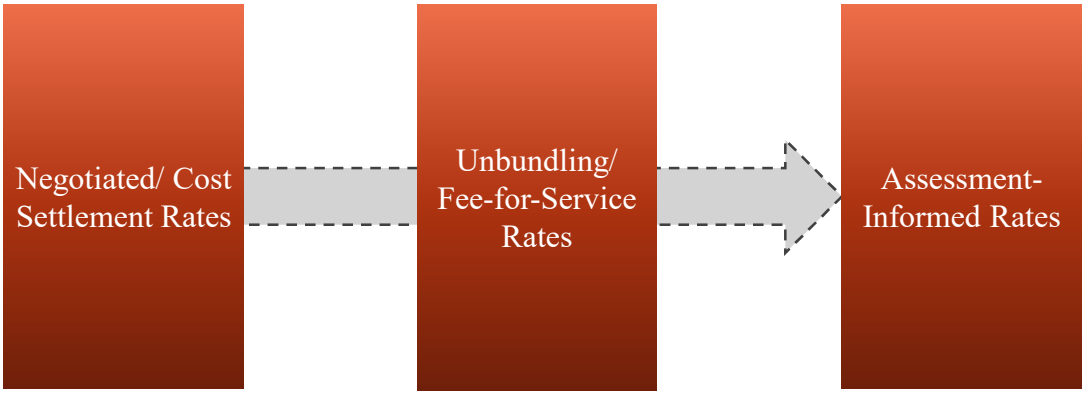
Evolution of Rate Methodologies



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Cost Settlement and Negotiated Rates v. FFS

Cost Settlement Rates	Negotiated Rates	Fee-for-Service Rates
Interim rates established and reconciled ('settled') at year's end (State pays or collects)	Providers negotiate a rate with the State	Provider receives a fixed, prospective rate for a discrete service
Provider cost reports	Negotiators' effectiveness	Provider costs and market data
Reflects providers' actual costs; may produce inefficiency and inconsistency across providers	Reflects agreement on costs; may produce inefficiency and inconsistency across providers	Produces consistency across providers; reduces flexibility and, if too low, constrains providers' ability to invest

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Factors Contributing to Shift Toward FFS

- States' limited administrative budgets and capacity
- Improving consistency and fairness across participants and providers
- Responding to abuses
- Supporting policy objectives (e.g., paying higher rates for community-based services than for center-based services)
- Moderating or reducing per-person costs
  - Rarely (in our experience) are states attempting to take money out of their I/DD systems
  - Rather, any savings are earmarked to expand services or reduce waiting lists

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Assessment-Informed Rates

- Rates should be fair to consumers, providers, and the State
  - Consumers with similar needs should receive similar services
  - For group services (e.g., group homes or day programs), it generally costs more to deliver services to individuals with greater needs
    - Higher-need individuals usually require more supervision and smaller groups, so providers' staffing costs are higher
    - Rate models should reflect these higher costs
  - For other services, higher-needs individuals may require staff with specialized training and/or credentials (e.g., LPN/RN)
- Requires a process to assign members to levels
  - Should be based on an objective assessment tool or framework

Assessment-Informed Rates *(cont.)*

- New Jersey's new rate schedule generates rate variation along two domains
  - Rate Tier
    - Based on New Jersey Comprehensive Assessment Tool (NJCAT)
    - Used to determine individual budget and service rate
    - Applies to a broad range of services, including Day Habilitation, Individual Supports, Prevocational Training, Respite, and Supported Employment
  - Member Acuity
    - Based on medical and/or behavioral concerns
    - Tier rates are increased based on higher levels of member acuity

Section IV: Examples of Recent Conversions to Fee-for-Service

Assessing the Impacts of FFS Conversions

- Often difficult to isolate the effects of changes in rate methodologies
- Rate redesigns often caught up with other system changes
  - Could include changes to eligibility, adoption of a new assessment approach, establishment of individual budgets, changes to the service array and/or service requirements
- Lack of agreement on what should be measured
- Bottom line: all rate reforms are local
  - 'Any' rate methodology can work if it the system is adequately funded

Rhode Island

- State moved from 'bundled' monthly rates to 15-minute billing (daily for residential) and adopted Supports Intensity Scale (SIS) to assess need in 2011
  - Rate study conducted by B&A
- Proposed rates released in 2011
  - Prior to implementation, General Assembly cut $24 million without regard to the proposals
  - Proposed rates had to be reduced to fit within available funding
- Rate changes since implementation of the fee schedule
  - Various changes (up and down) have been made in response to budgetary considerations
  - In some cases, current rates remain below what was originally proposed
- 2014 Settlement with the U.S. Department of Justice
  - Required the State to provide more individualized employment supports and placements

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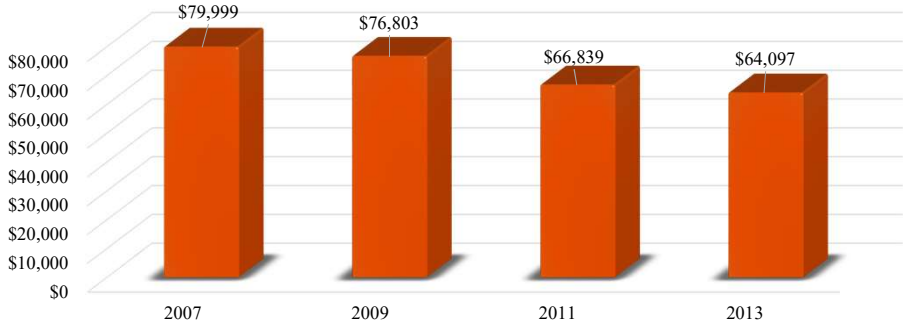
Rhode Island *(cont.)*

- Between 2007 and 2013, per member per year cost decreased by $16,000



Source: American Association of Intellectual and Developmental Disabilities (2007 – 2013). *The State of the States in Intellectual and Developmental Disabilities.*

- Since implementation of rate schedule, 3 providers have left the system

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Rhode Island *(cont.)*

- Outcomes related to individual satisfaction and access to services are in-line with national figures
  - Baseline data from prior to implementation of fee-for-service is not available

	2015-16	Natl 2015-16
Likes Home	91%	89%
Wants to Live Somewhere Else	27%	27%
Staff Have Adequate Training	88%	90%

Source: National Core Indicators

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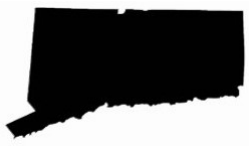
Connecticut



- Connecticut in the midst of a transition to a fee-for-service rate structure for its residential care and day/work services (not a B&A project)
  - Previously, provider rates varied widely for the same services
  - Transition began January 1, 2015
  - Projected 7.5 year timeframe for full transition to "Level-of-Need"- based rate schedule (by 2022)

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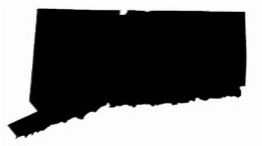

Connecticut *(cont.)*

- Between 2012 and 2014, per member per year costs decreased by $10,000 *before transition to fee-for-service*

Source: American Association of Intellectual and Developmental Disabilities (2007 – 2013). *The State of the States in Intellectual and Developmental Disabilities.*

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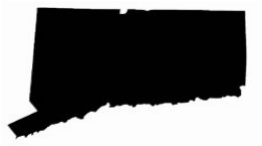

Connecticut *(cont.)*

- Although early in the implementation, no adverse impacts to individual satisfaction or access to services are yet evident

	2011-12	2012-13	2013-14	2014-15	2015-16	Natl 2015-16
Likes Home	90%	88%	87%	92%	90%	89%
Wants to Live Somewhere Else	28%	34%	25%	30%	31%	27%
Likes Day Activity	87%	96%	85%	93%	-	-
Wants Different Day Activity	36%	35%	37%	37%	-	-
Gets Needed Services	84%	83%	83%	84%	-	-
Staff Have Adequate Training	91%	93%	93%	93%	92%	90%

Source: National Core Indicators

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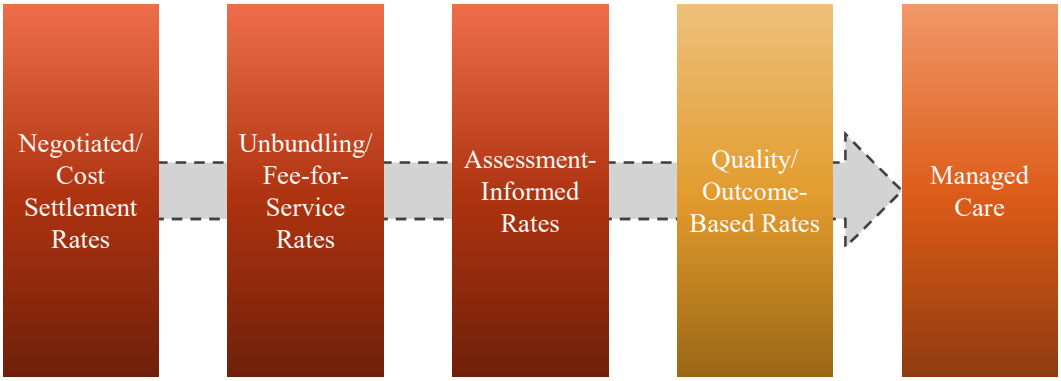
Section V: What's Next in Rate Methodologies

Continuing Evolution of Rate Methodologies



Paying for Quality and Outcomes

- Current environment
  - Emphasis on health and safety, regulatory compliance, and critical incident avoidance
  - FFS structures are not providing financial incentives for quality services
- Potential future environment – 'pay for performance'
  - Shared desire amongst CMS, states, and providers to incentivize high-quality services and meaningful outcomes…
  - …but little agreement on defining and measuring quality and outcomes
  - Outcomes for some services (e.g., employment) are more easily measured than others (e.g., residential habilitation)

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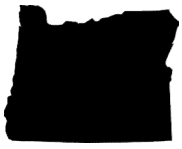
Example – Supported Employment in Oregon



- B&A completed rate schedule in 2016
- 'Milestone' payments
  - Completion of a Discovery Profile
  - Job Development payments at placement and 90-day retention
- For Job Coaching, providers bill for the number of hours that the participant works – not the hours of support provided
  - Encourages providers to maximize consumer work hours while aiding the participant to become independent
  - Rate is based on assumed ratio of work hours to support hours; CMS requires the State to review ratio annually and adjust if necessary

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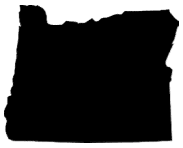
Example – Supported Employment in Oregon *(cont.)*



	Category 1	Category 2	Category 3
Discovery (completed profile)	$1,728.65	$1,975.60	$2,222.5
Development (placement)	$1,977.20	$2,471.50	$2,965.80
Development (90-day retention)	$1,235.75	$1,482.90	$1,977.20
Coaching – Initial (first 6 months)	$31.02/hr	$45.88/hr	$64.41/hr
Coaching – Ongoing (next 18 months)	$25.85/hr	$40.15/hr	$57.97/hr
Coaching – Maintenance (up to 12 months with exceptions as needed)	$20.68/hr	$28.68/hr	$51.53/hr

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Managed Care for Long Term Services and Supports for Individuals with I/DD

- States have been slow to adopt managed care for LTSS for I/DD populations
  - Individuals with I/DD are lifelong users of services compared to most Medicaid populations who cycle in-and-out of eligibility and whose care is often episodic
  - Compared to acute services, LTSS vary significantly in setting and scope, and present fewer opportunities for prevention or management
  - Less predictability in service needs/levels with I/DD population
- Supporters posit several potential benefits to managed care
  - Enhance budget predictability
  - Reduce or eliminate waiting lists
  - Facilitate more rapid transition from institutional care to HCBS

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Managed Care for Long Term Services and Supports for Individuals with I/DD *(cont.)*

Three administrative structures for managed care

- Government-sponsored plans (e.g., Arizona)
  - State/local jurisdictions act as 'independent' health authorities
- Locally-sponsored plans (e.g., North Carolina)
  - Generally nonprofit
  - Responsive to local conditions
- Commercial/national plans (e.g., Kansas)
  - Brings standardized procedures and sophisticated management tools
  - Often includes integration of LTSS with physical and behavioral health services
  - Generally lacks experience with LTSS for persons with I/DD

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Managed Care for Long Term Services and Supports for Individuals with I/DD *(cont.)*

Rate-related implications for service providers

- Rate-setting
  - MCOs generally have flexibility in setting payment rates for service providers
  - Providers negotiate with MCOs rather than the State (unless the State is the MCO)
- Potential benefits
  - Opportunities for innovative payment arrangements
  - Incorporation of quality-related measures (aligned with quality requirements imposed on MCOs)

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Example – MLTSS in Kansas

- B&A has not performed any work in the State
- In 2013-14, Kansas transitioned to managed care for nearly its entire Medicaid population – including LTSS – through contracts with 3 national MCOs
- Other system issues not necessarily related to managed care
  - Inadequate rates – State's consultant found that existing rates for most services "do not reflect the current cost" and that the tiered rate system "is not effectively reimbursing day and residential service providers for the case mix of the participants they serve"
  - Policy changes
    - 'Capable person' requirements
    - Eliminating on-call payments for residential providers

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Example – MLTSS in Kansas *(cont.)*

- Differing perspectives on results
  - State notes increase in amount of HCBS delivered and reduction in ER visits
  - Providers (with some exceptions) have been largely critical of MLTSS, pointing to increased administrative requirements, insufficient rates, and over-regulation
- In January 2017, CMS found KanCare "substantively out-of-compliance", finding:
  - Kansas did not provide sufficient MCO oversight
  - MCOs did not comply with person-centered planning requirements
  - Kansas' process for monitoring network adequacy was insufficient
  - Kansas did not have adequate mechanisms for reviewing critical incidents
- Current status
  - CMS accepted the State's corrective action plan in May 2017
  - The State intends to submit a request to extend the program in November (the current demonstration waiver expires December 31, 2017)

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Example – MLTSS in Kansas *(cont.)*

- Some evidence of a decline in individual satisfaction, but figures are generally within the margin of error

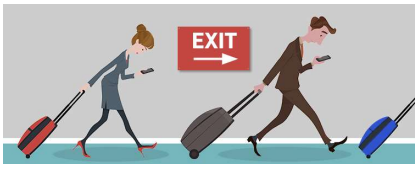
	2013-14	2014-15	2015-16	Natl 2015-16
Likes Home	92%	89%	86%	89%
Wants to Live Somewhere Else	21%	26%	23%	27%
Likes Day Activity	89%	85%	-	-
Wants Different Day Activity	25%	22%	-	-
Gets Needed Services	93%	94%	-	-
Staff Have Adequate Training	92%	89%	92%	90%

Source: National Core Indicators

Section VI: Other Emerging Issues in I/DD Services

Workforce Shortage

- ANCOR calls current workforce environment for I/DD a "perfect storm of demographic and policy trends…creating a shortage of direct service professionals"
  - High turnover: 56% of Direct Service Workers (DSWs) leave employment within a year
  - Growing demand for services (e.g., increased autism diagnoses), aging population
  - Low DSW wages/benefits
  - Lack of DSW career path/options



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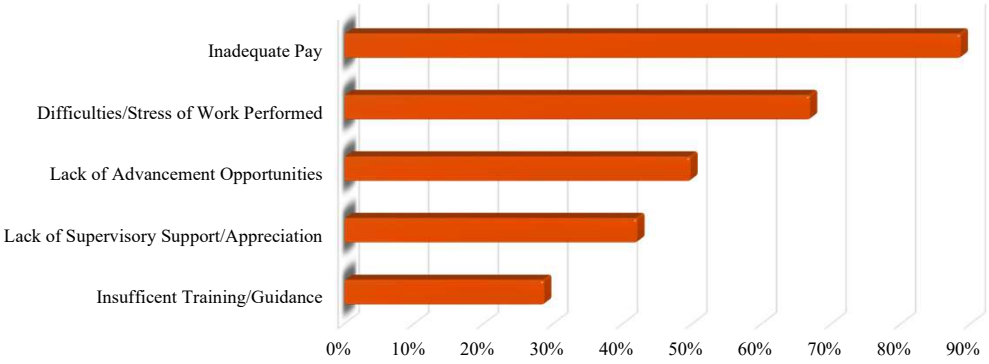
Workforce Shortage *(cont.)*

Medisked Survey Results – Top Reasons DSWs Leave Employment



Source: ANCOR (2017). *Addressing the Disability Services Workforce Crisis of the 21st Century.*

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Workforce Shortage *(cont.)*

- Aging population
  - Approximately 10,000 baby boomers retire every day
  - Multitude of implications
    - Increased demand for services as they require supports to age in place
    - Aging caregivers no longer able to care for adult children with I/DD
    - Shrinking labor pool
    - Reduced tax revenues (payroll taxes and general – incomes and sales – taxes)
- Labor force participation declining since 2000, from 67% to 63%
- Immigrants driving overall workforce growth in the U.S.
  - Without future immigration, working-age population in U.S. projected to decrease by 2035

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Strategies to Address Workforce Shortage

- Professionalize the workforce
  - Increase educational and training requirements
  - Colleges of Direct Support
  - Differentiate DSPs from personal care workers
  - Advocate for better pay and benefits
- Leverage technology
  - MIS systems for enhanced data quality and decision making
  - Consider innovations in services, such as remote monitoring

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Other Workforce Issues

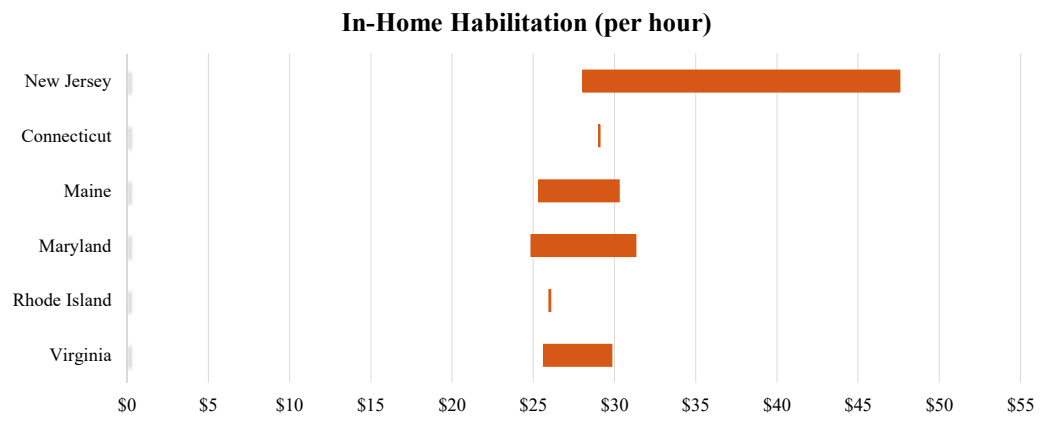
- Minimum Wage Increasing
  - As of 2017, 19 states enacted minimum wage increases
  - Seven states, including New Jersey, automatically increase their minimum wages to reflect inflation
- Changes to Fair Labor Standards Act regulations
  - Home care rule
  - Efforts to increase the minimum salary for exempt employees

Other Trends *(cont.)*

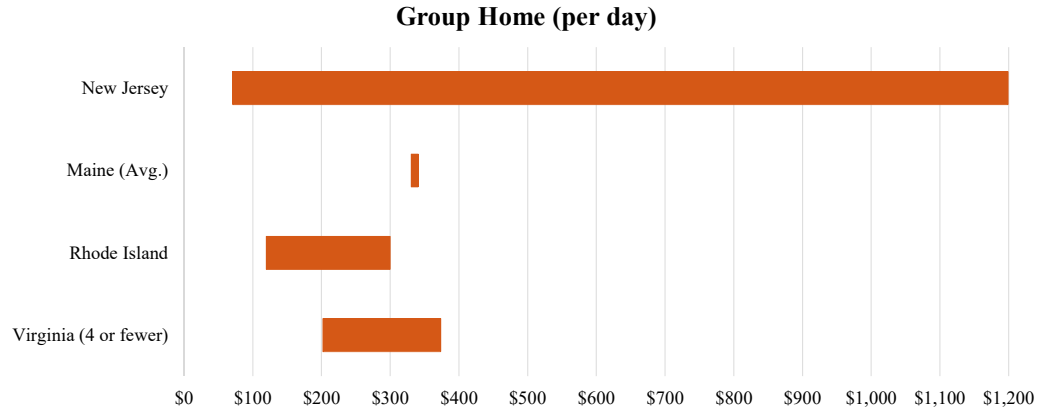
- HCBS Final Rule emphasizes access to the community living, and the opportunity to receive services in the most integrated setting appropriate
  - More individualized supports likely to increase staffing requirements
- Greater complexity in billing to accommodate FFS, rate tiers, and rates that vary by setting
- Requirements for record automation
  - Electronic Health Records
  - Electronic Visit Verification

Section VII: Working with the New Fee Schedule

Comparison of Range of Rates in Select States



Comparison of Range of Rates in Select States *(cont.)*



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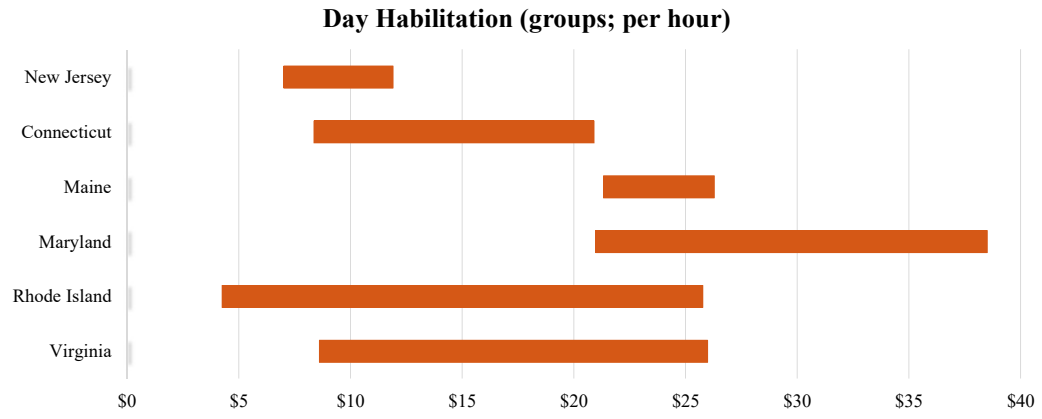
Comparison of Range of Rates in Select States *(cont.)*



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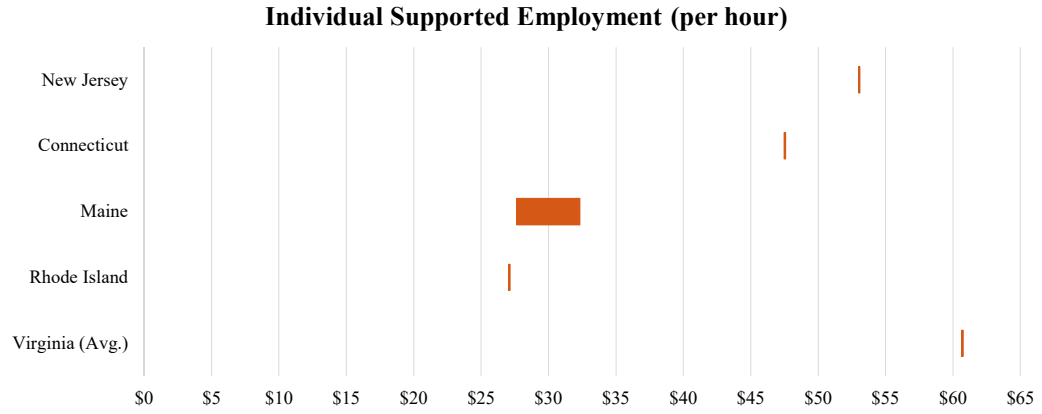
Comparison of Range of Rates in Select States *(cont.)*



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Working With the New Fee Schedule

- Work within the new framework
- Advocate for full funding of provider cost analysis
  - Consultant's final report indicates rates are funded below 100% of providers' costs
- Advocate for annual inflation increases
  - Inflation originally built into the rates appears to be adequate to this point (assumed wage for most services is $14.10 using SOC 39-9021; actual wage as of 2016 data is $13.78)
  - Monitor on an annual basis
- Periodically review the overall rate structure
  - Review key assumptions to determine whether anything has changed that requires revisions
  - Suggest changes that will improve quality or further the State's goals

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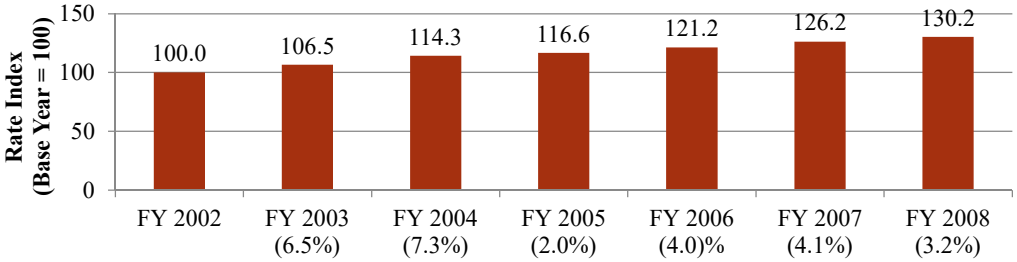
How to Work Within the New Fee Schedule – Arizona Example

- Arizona began implementing FFS in 2003
  - Could only afford to pay 93% of recommended rates
  - 'Benchmark' rates were annually increased for inflation
- Providers used this framework to successfully advocate for rate increases, reaching 100% of the benchmarks in 2008



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Working With the New Fee Schedule – Arizona Example, Postscript

- Due to declining revenues during the Great Recession, rates were cut 10% in fiscal year 2009 and then by 5% in fiscal year 2012
- Most recent rate study in fiscal year 2013 concluded that rates should be increased 26% at a cost of $188 million
- The 2013 rates have not been implemented, but rates have been modestly increased (1% - 3%) each year since then

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