BURNS & ASSOCIATES
A DIVISION OF
HEALTH MANAGEMENT ASSOCIATES

Study of Payment Rates and Individual Budgets Provider Kickoff Meeting

- prepared for -

Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

February 2, 2022

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Agenda

- About Burns & Associates
- Rate Study Approach
- Rate Study Tasks
- Individual Budgets Tasks
- Next Steps
- Open Discussion

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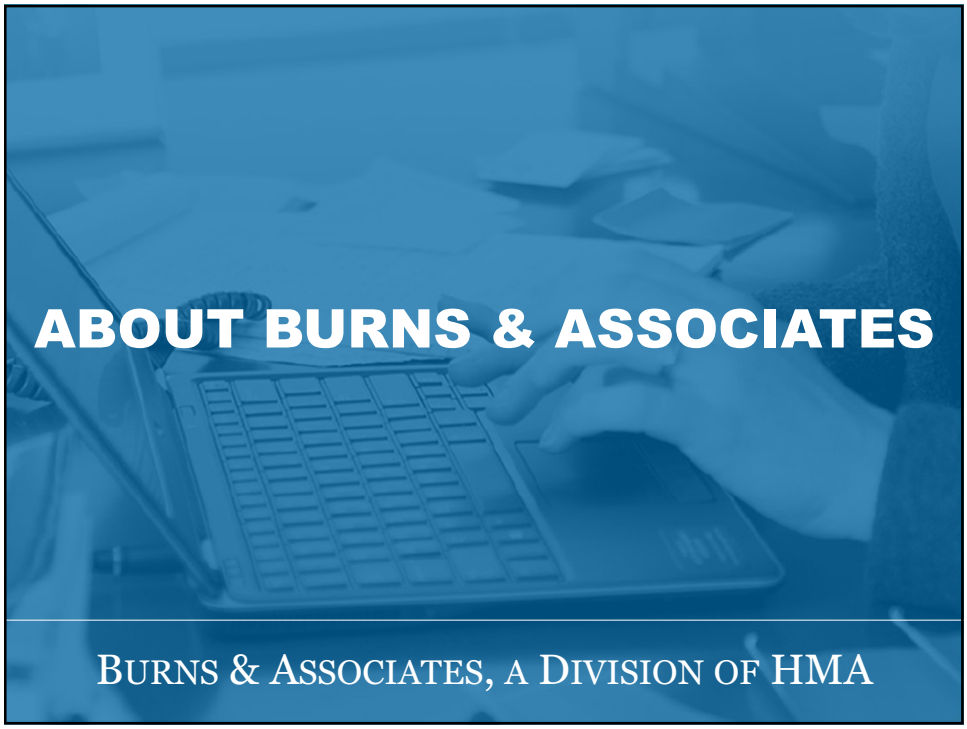

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Overview of Burns & Associates

- Health policy consultants specializing in assisting state Medicaid agencies and related departments (developmental disabilities and behavioral health authorities)
  - Consulted in approximately 30 states since its founding in 2006
  - Acquired by Health Management Associates in September 2020
- Experience in the intellectual and developmental disabilities field
  - Policy development, including service standards and billing rules
  - Rate-setting
  - Using assessment instruments to inform individualized budgets
  - Program operations, including performing fiscal analyses and developing implementation approaches
- Primary consultant on BHDDH's Project Sustainability initiative

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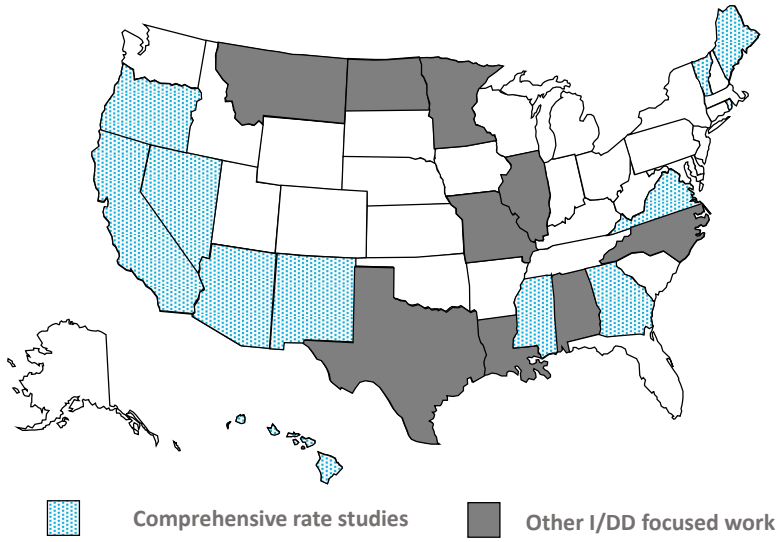
Burns & Associates' I/DD Experience



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Burns & Associates' I/DD Experience

+ Results and status of HMA-Burns' rate study projects

State	Implementation Status	Fiscal Impact and Funding Status
Rhode Island	Implementation began in 2011	Proposed rates not implemented (Legislature imposed reductions requiring rates to be scaled back)
New Mexico	Implementation began in 2013	($10 million), funds were retained in the system
Arizona	Rates adopted in 2015*	$188 million (about $50 million added in the years after the study)
Virginia	Implementation began in 2016**	$58 million, fully funded
Oregon	Implementation occurring in phases between 2016 and July 2022	$195 million, fully funded
Georgia	Implementation began in 2017*	$74 million, fully funded
Hawaii	Implementation began in 2017**	$26.5 million, fully funded
Mississippi	Implementation began in 2017	$20 million, fully funded
California	Implementation occurring in phases between January 2020 and July 2025	$2.3 billion, fully funded
Maine	Implementation began in 2021*	$2.5 million, fully funded
Nevada	Implementation under consideration	$38.2 million, proposed to fund with ARPA dollars
Vermont	Rate study still in process	N/A
*Implementation status based on most recent HMA-Burns' rate study ** More recent studies currently under executive/ legislative consideration (both recommend add'l. increases)		

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Summary of Previous Rhode Island Rate Study

- Goals of previous rate study
  - Transition from bundled payments to fee-for-service rates
  - Align payment with individuals' assessed needs
- Proposed rates published in May 2011, but never implemented
  - Before the rates could be implemented, the Legislature cut the program's budget by $16 million
  - BHDDH directed Burns to reduce the rates by about 18 percent to conform to the reduced budget
  - Until the July 2021 rate increases, many payments remained below what Burns proposed in 2011

Overview of Human Services Research Institute

- HSRI serving as a subcontractor
  - Will support efforts to engage individuals and families and evaluate all aspects of individual budgets
- National nonprofit, tax-exempt corporation founded in 1976
  - Works to improve supports for people with disabilities and other underserved populations
- Experience in the intellectual and developmental disabilities field
  - Supporting system redesigns, including service design
  - Engaging self-advocates and families
  - Adopting person-centered practices
  - Using needs assessments to inform individualized budgets

Project Leadership

- Stephen Pawlowski, HMA-Burns Managing Director
  - Joined B&A in 2009 and has led B&A's HCBS practice since 2015
  - Previously served as Chief Financial Officer of the Arizona Department of Economic Security, which administers the state's I/DD system
- John Agosta, HSRI Senior Policy Fellow
  - Joined HSRI in 1983, total of 40 years of experience working with people with disabilities
  - Been involved with nearly all of HSRI's projects involving assessment-informed budgets

Purpose of Independent Rate Model Approach

- Rate models should reflect the reasonable costs providers incur to deliver services consistent with the state's requirements and individuals' service plans
  - Rate models are developed without consideration of budgetary targets to ensure a transparent accounting of costs
  - Models may not be fully implemented due to budgetary constraints (e.g., they may be scaled-back [transparently], phased-in over time, etc.)
- Consider data from multiple sources rather than depending on any single source
  - Policies, rules, and standards
  - Provider and stakeholder input (e.g., provider survey, public comments)
  - Published sources (e.g., BLS wage data, IRS mileage rates)
  - Special studies (e.g., analysis of regional differences in transportation-related costs)

Development of Independent Rate Models

- 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 multiple rates to account for various differences
  - Individuals' levels of need (affecting staffing levels, staff qualifications, etc.)
  - Service setting (e.g., facility or community-based)
  - Staff qualifications and training (e.g., RNs and LPNs)
  - Geography (e.g., urban and rural)

Development of Independent Rate Models

- Five factors in all HCBS rate models
  - Direct care worker wages
  - Direct care worker benefits
  - Direct care worker productivity (time spent on billable vs. non-billable activities)
  - Program support
  - Administration
- Other factors vary by service
  - Staffing ratios
  - Attendance/ occupancy
  - Transportation-related costs
  - Program facilities and supplies

		Personal Care
	Unit of Service	Hour
Direct Care Staff Wages and Benefits	- Percent of Direct Care Staff Working Full-Time	70%
	- Direct Care Staff Hourly Wage	$15.89
	- Employee Benefit Rate (as a percent of wages)	22.37%
	- Workers' Compensation Rate (as a percent of wages)	4.83%
	Hourly Staff Cost Before Productivity Adj. (wages + benefits)	$20.21
	Productivity Adjustments	
	Total Hours	34.60
	- Travel Time Between Individuals	0.58
	- Recordkeeping and Reporting	0.58
	- Supervision and Other Employer Time	0.90
	- Training	0.67
	- Paid Time Off	3.04
	"Billable" Hours	28.83
	Productivity Factor	1.20
	Staff Cost After Productivity Adj. per Billable Hour	**$24.25**
Mileage	- Number of Miles Traveled per 40-Hour Week	60
	- Number of Miles Adjusted for Mix of FT and PT Staff	52
	- Amount per Mile	$0.575
	Weekly Mileage Cost	$29.90
	Mileage Cost per Billable Hour	**$1.04**
Supervision	- Supervisor Hourly Wage	$23.03
	- Supervisor Benefit Rate (as a percent of wages)	19.77%
	- Workers' Compensation Rate (as a percent of wages)	4.83%
	Hourly Supervisor Cost (wages + benefits)	$28.70
	Weekly Supervision Cost	$1,148.00
	- Number of Direct Care Staff Supervised	15
	Supervision Cost per Billable Hour	**$2.65**
Admin. and Prog. Operations	Cost per Hour, Before Program Operations and Administration	$27.94
	- Daily Program Operations Costs	$10.00
	Program Operations Cost per Billable Hour	**$1.73**
	- Administration Percent	12.0%
	Administration Cost per Billable Hour	**$4.05**
	Rate per Billable Hour	**$33.72**

Rate Model Example – Personal Care

- Direct care staff wages and benefits
  - Largest component of costs (60-80 percent) when including productivity
  - Data gathered from multiple sources
    - Review of staff qualifications and responsibilities
    - Provider survey
    - Bureau of Labor Statistics data
- Accounting for 'productivity'
  - Rate models seek to reflect a 'typical' week for direct care staff by establishing productivity adjustments for non-billable time
  - Examples include training, travel, documentation, and employer time

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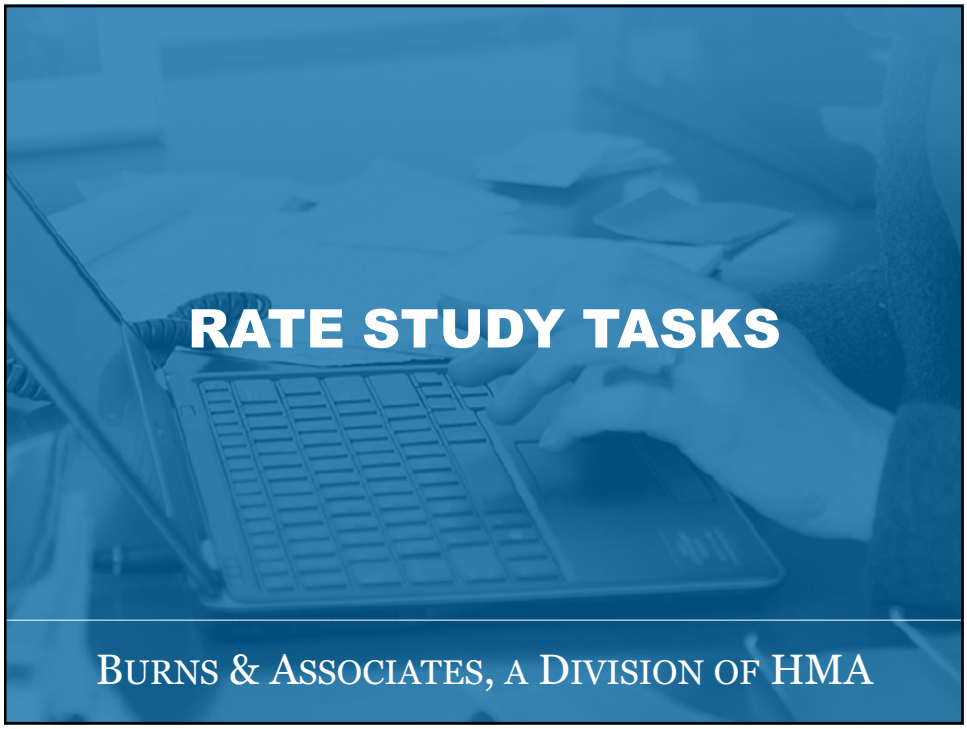
Rate Model Example – Personal Care

- Program support costs
  - Activities that are program specific, but not billable
  - Examples: supervision, training, and program development
- Administrative costs
  - Organizational costs that are not program-specific
  - Examples: executive management, accounting, and human resources
- Other costs vary by service
  - Examples: mileage, staffing ratios, program attendance rates, and program facility and supplies costs

Benefits of Independent Rate Model Approach

- Transparency
  - Models detail the factors, values, and calculations that produce the final rate
- Ability to advance policy goals/objectives
  - For example, improving direct care staff salaries or benefits, reducing staff-to-client ratios, incentivizing community-based services, etc.
- Efficiency in maintaining rates
  - Models can be scaled and adjusted for inflation or specific cost factors (e.g., IRS mileage rate) or to meet budget targets



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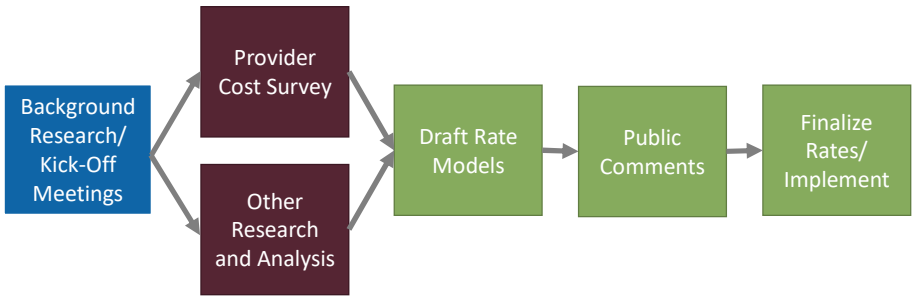
Rate Study Process



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Background Research and Kick-Off Meetings

- "When you've seen one I/DD system…you've seen one I/DD system"
  - For example, day habilitation requirements can vary significantly in terms of staffing ratios, transportation, meals, and community participation
- Key subtasks
  - Review and document service requirements to identify primary cost drivers, appropriate rate structure for each service, and possible value-based approaches
  - Review changes to federal or state policies to evaluate potential impacts on rates (e.g., Rhode Island's consent decree, CMS' final rule on community integration, electronic visit verification, $15 minimum wage) as well as the effects of the Covid-19 pandemic
  - Evaluate existing 1115 waiver and suggest any needed changes
  - Kick-off meetings with BHDDH and providers

Provider Survey

- Design survey to collect information regarding costs and service delivery issues (e.g., direct care staff productivity, staffing ratios, and mileage)
  - Results inform, but do not dictate, rate model assumptions
- Provide technical assistance
  - Written instructions, recorded webinar to walk-through the survey, dedicated contact for questions
- Analyze survey results
  - Perform desk reviews of submitted surveys, perform statistical analysis, present results

Other Research and Analysis

- Survey individuals and families
- Collect benchmark data for individual cost drivers (e.g., BLS wage data)
- Consider potential changes to procedure codes and billing rules
- Compile current rate and payment data to develop a fiscal impact model that will be used to estimate impacts of potential changes to services and rates
- Identify benchmark payment rates for comparable services paid by other programs in Rhode Island and in other states

Draft Rate Models

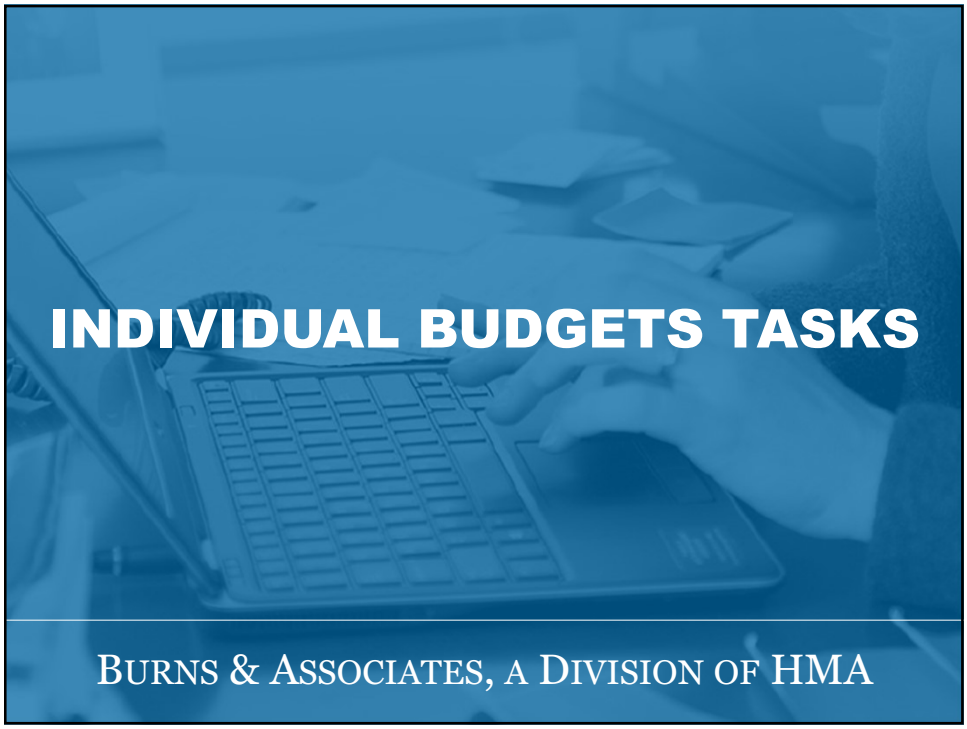
- Develop draft model structures identifying cost factors for each service
  - Consider rate model structures (e.g., changes to billing units, bundling or unbundling activities, value-based options, etc.)
  - Evaluate potential rate variants (e.g., individual acuity, geographic area, etc.)
- Populate rate models with cost assumptions
  - Consider provider survey and other independent data sources
  - Develop rate model appendices and other supporting documentation
- Estimate fiscal impact
  - Estimate using historical claims as baseline expenditures, including consideration of Covid-related impacts

Public Comments

- Post rate models and supporting materials online
  - Present to providers and stakeholders
  - Record webinar to explain the proposals
- Accept written comments
  - Typically allow about four weeks for comments
- Review and summarize comments

Finalize Rate Models and Implement

- Revise rate models based on public comments as warranted
- Provide implementation support as necessary
  - Estimate fiscal impact and provide support in state budget process
  - Create briefing materials
  - Develop phase-in plan as needed
  - Provide support with 1115 waiver amendments



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Using Assessment Results to Inform Rates and Individual Budgets

- Evaluate current assessment framework
  - Number of levels
  - Criteria for each level
  - Supplemental questions and verification process
- Consider other factors to determine individual needs
  - Exceptional medical or behavioral needs
  - Issues associated with primary caregivers
  - Other individual characteristics

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Evaluating Current Service Packages

- Evaluate current service packages
  - Consider types and amounts of support built into the service package for each cohort
  - Analyze historic authorization and service usage by cohort to identify areas where usage is substantially above or below the service package assumptions
  - Review requests for exceptions
  - Gather feedback from BHDDH and stakeholders

Analyzing Management of Individual Budgets

- Evaluate management of individual budgets
  - Consider services included/ excluded from individual budgets
  - Consider ability to move funds between services or service groupings
  - Review exceptions process
  - Consider relationship to self-direction
    - Extent to which individual budgets offer comparable access to services compared to those using traditional agency services
    - Comparison of utilization across those who do and do not self-direct
  - Gather feedback from BHDDH and stakeholders

Benchmarking Rhode Island's Methodology to Other States

- Conduct comprehensive review of Medicaid-financed HCBS programs across the country
  - Assessment instrument used and other factors considered
  - Level-based systems versus an algorithm that produces a specific budget for every possible combination of assessment results
  - Services included/ excluded from individual budgets
  - How self-direction is incorporated in the framework
  - Ability to move funds between services or service groupings
  - Exceptions process

Recommending Potential Changes to Individual Budgets

- Consider all aspects of the individual budget framework
  - Assessment framework
  - Service packages
  - Management of budgets
- Incorporate any changes to payment rates
- Gather public comments as part of the process described above

Next Steps

- Document current system
  - Review materials (e.g., waiver, policies, previous reports)
  - Analyze authorizations, claims, and exceptions
  - Gather feedback from BHDDH and stakeholders
- Draft provider survey
  - Review with providers before finalizing
- Draft individual and family survey
  - Gather input regarding current experiences and priorities
- Note: Final recommendations must be issued by December 1
  - Will require all participants (consultants, BHDDH, providers, stakeholders) to meet deadlines

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Open Discussion

- Perspectives on the current system (services, rates, budgets, etc.)
  - What is/ is not working well?
  - What do you see as opportunities and threats?
- Study of rates and individual budgets
  - What do you hope this study achieves? What are your goals?
  - What concerns/ fears do you have about this study?
- Other insights
  - How have external factors (settlement agreement, final rule on community integration, Covid-19) affected your programs?
  - What would you like us to keep in mind as we conduct this study?

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