Review of Waiver Provider Rates

Overview of Proposed Rate Models and Policy Considerations

– conducted on behalf of –
Hawaii Division of Developmental Disabilities

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Agenda

- Background
- Process
- Proposed Rates
- Next Steps
Review of Waiver Provider Rates
Overview of Proposed Rate Models and Policy Considerations

Background – Reasons for Rate Study

- Rates have not been thoroughly reviewed for at least 10 years
- States must renew waiver programs every five years
  - Hawaii’s developmental disability waiver was renewed in 2016
  - Rate methodology for waiver services must comply with CMS requirements
  - Existing methodology does not comply so CMS granted conditional approval of the waiver, requiring completion of a rate study
- Consider implications of policy and regulatory changes
  - Adopting Supports Intensity Scale (SIS) to assess individuals’ needs
  - Federal home and community based services rule
  - Wage changes (federal ‘white collar’ and ‘home care’ rules and State minimum wage)

Background – Scope of Project

- Almost all waiver services were included in the rate review:
  - Personal Assistance/ Habilitation (PAB)
  - Residential Habilitation (‘new’ – formerly part of PAB)
  - Addl. Residential Supports
  - Therapeutic Living Program
  - Adult Day Health
  - Community Learning Service (‘new’ – formerly part of ADH and PAB)
  - Individual Employment Support
  - Discovery and Career Planning, and Benefits Planning (‘new’ – formerly part of Prevocational)
  - Training and Consultation
  - Skilled Nursing
  - Non-Medical Transportation
  - Respite
  - Chore
  - Waiver Emergency Services

- The national consulting firm Burns & Associates, Inc. (B&A) is assisting DDD
Background – Burns & Associates, Inc.

- Health policy consultants specializing in assisting Medicaid programs and ‘sister agencies’ including developmental disabilities and behavioral health authorities in:
  - Medicaid rate-setting, including home and community based service, institution, and physician rates
  - Long term care program management and home and community based services policy
  - Financial analyses
  - 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

Background – Burns & Associates, Inc. (cont.)

- Since its founding in 2006, B&A has consulted in more than 20 States and 1 Canadian province

- Recent focus has been partnering with the Human Services Research Institute (HSRI) to assist developmental disabilities authorities in implementing assessment-based budgeting and updating provider rate schedules
Background – Overview of Activities to Date

- Review service definitions
  - Consider policy goals and federal requirements

- Collect input from provider community
  - Meet with provider advisory groups to discuss project approach, review draft provider survey, present survey results
  - Survey on costs and service designs sent to every provider

- Research of benchmark data to support rate models
  - Example: Bureau of Labor Statistics wage and benefit cost data

- Develop proposed rate models and supporting documentation that detail assumptions
  - Release for public comment

Process – Independent Rate Model

- Rate models are constructed based on the costs providers face in delivering a particular service
  - State determines service requirements (defines what it ‘wants to buy’)

- A single service may have several rates due to:
  - Group size/ intensity of supports due to consumer need
  - Service setting (e.g., facility- or community-based)
  - Location of service due to wage and/or travel differences
  - Staff qualifications and training (e.g., LPN v. RN)
Process – Independent Rate Model (cont.)

- Data is collected from multiple sources rather than any single source
  - In particular, rate models do not rely only on provider financial data because these costs are usually a function of current rates

- Sources include:
  - DDD policy decisions
  - Stakeholder input
  - Provider survey regarding costs and service design
  - Published sources
  - Special studies

Process – 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
  - Program facilities and supplies costs
Process – Advantages of the Independent Cost Model

- **Transparency**
  - Models contain the factors, values, and calculations that produce the final rate
  - Stakeholders may not agree on the values, but they will know exactly what has been assumed

- **Ability to include policy objectives**
  - Examples may include improving direct care staff salaries or benefits, reducing staff-to-client ratios, or paying higher rates for services provided in the community rather than at a center

- **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

Process – Provider Survey

- **Voluntary survey to collect data regarding costs and service design emailed to all providers**
  - Given four weeks to complete and all late surveys were accepted

- **Technical assistance provided throughout the survey**
  - A webinar that walked-through the survey was posted online
  - B&A responded to questions by phone and email
  - B&A reviewed submitted surveys and emailed clarifying questions

- **Participation**
  - Of approximately 60 providers, 25 submitted a survey (42 percent)
  - Participants represent 60 percent of spending on surveyed services

- **Survey results were one of the considerations in the development of the proposed rate models**
  - See Provider Survey Analysis packet
Process – Rate ‘Tiers’

- Rates should be fair to consumers, providers, and DDD
  - 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 special training or credentials
  - Requires some process to assign members to levels (e.g., based on an assessment tool)

Current rate tiers for certain services based on presence of nurse-delegated tasks or behavioral support plans

Current approach to be replaced through the use of the SIS to assign individuals to levels of need

- Propose to adopt a seven-level system used by several other states
- Levels collapsed into three rate ‘tiers’
  - Levels 1 and 2: Tier 1
  - Levels 3 and 4: Tier 2
  - Levels 5, 6, and 7: Tier 3
Process – Big Island Rates

- Analysis of claims data demonstrates that providers on the Big Island must travel longer distances to provide services
- Greater travel increase costs for labor (staff time spent driving to or transporting members) and for mileage
- As a result, there are separate, higher rates for services provided on the Big Island
- Big Island rates include a four percent general excise tax
  - Rates for other islands include a 4.5 percent general excise tax, consistent with Oahu tax rates (although the rate will apply to other islands, as well)

Process – Developing Proposed Rate Models

- Analysis of provider survey and other data sources
  - Each rate model built ‘from the ground up’
- Rate models include specific assumptions regarding direct care staff wages and benefits, transportation costs, staffing ratios, administration and program support, etc.
  - In general, model assumptions are not mandates (for example, providers are not required to pay the wage assumed in the rate model for a given service)
  - Rather, providers are able to design their own programs consistent with service requirements
Process – Direct Care Worker Wage Assumptions

- Used federal Bureau of Labor Statistics (BLS) wage data for relevant occupations in Hawaii as benchmark
  - Service requirements compared to BLS job classification descriptions to ‘construct’ a position reflective of job responsibilities
  - Used median wages for selected BLS job classifications

- See Appendix A in Draft Rate Models packet

Process – Direct Care Worker Benefit Assumptions

- Rate models include the following for all direct care staff
  - 23 paid days off per year (holiday, sick, and vacation leave)
  - $400 per month for health insurance (based on BLS, DHHS Medical Expenditure Panel Survey, and health insurance exchange)
  - $50 per month for other benefits
  - Mandatory benefits: FICA, unemployment insurance, workers’ comp.

- Benefits for consumer-directed services are somewhat less
  - 23 paid days off per year (holiday, sick, and vacation leave)
  - $300 per month for other benefits
  - Mandatory benefits: FICA, unemployment insurance

- Assumptions are translated to benefit rates by wage level
  - Benefit rate declines as wage increases

- See Appendix B in Draft Rate Models packet
Process – Direct Care Worker Productivity Assumptions

- 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 (e.g., meetings), documentation, and planning time
  - Example
    - An employee earning $15 per hour (wages and benefits) and working 40 hours per week is paid $600 per week
    - However, if the employer can only bill for 30 hours per week due to travel time, staff meetings, etc., the agency must be able to bill $20 per service hour to cover the cost of the wages and benefits
    - Thus, a productivity adjustment of 1.33 is required (work hours divided by billable hours)
  - Considered provider-reported data and service requirements
  - See Appendix C in Draft Rate Models packet

Process – Administration/Program Support Assumptions

- Administration funded at 10 percent of total rate
- Program Support funded as a fixed per-day amount
  - Models include $15 per day
  - As a percentage of total costs, averages about 11 percent across all services, but varies from service to service
Proposal – Summary

- Rates for most, but not all services are proposed to increase
  - When fully implemented, total rate increase is estimated to be approximately 17 percent (about $21 million in total funds)
  - Impact will vary across individuals and providers based on assigned levels of need and mix of services
- Rate changes will be phased in over next four fiscal years as individuals receive SIS assessments
  - Waiver enrollment divided into three ‘cohorts’ with each transitioning over a 12-month period over the next three fiscal years
- Fiscal impact
  - Budget request: $2.8 million in state funds ($8.7 million in total funds) for fiscal year 2018 and $7.1 million ($18.4 million) in 2019
  - Full implementation is estimated to cost $20.9 million in total funds

Proposal – Personal Assistance/ Habilitation

- Limited to in-home services; other supports being decoupled
  - Full-time residential care in an adult domiciliary home, adult residential care home (ARCH), expanded ARCH (EARCH), or adult foster home would bill Residential Habilitation, and therapeutic living programs (TLP) would bill the new TLP rate
  - Services in the community would bill Community Learning Service
- Elimination of rate tiers
  - There will not be different staff and supervisory qualifications for staff based on individual’s assigned levels of need
- New rates for services provided by registered behavior techs.
- Groups and multiple staff
  - Establish rates for one staff serving two or three individuals
  - Eliminate rates for four staff to serve one individual (rates for two-to-one and three-to-one services continue to exist)
Proposal – Residential Habilitation

- Rate variants
  - Three rate tiers based on individuals’ level of need
    - Rate is determined by individual, not by home and there is no requirement or expectation that persons with similar levels of need have to live together
    - Rates vary by home size (3 or fewer beds, 4 beds, and 5+ beds)
    - Rates are the same across all residential types
      - Adult foster homes will bill the rate for three or fewer beds
    - Separate rate for therapeutic living programs
  - Billing procedures
    - Service is billed in daily units
    - Accounting for absences
      - Rate based on a 344-day year, meaning a provider earns a full year of revenue after billing 344 days, thereby holding providers harmless for up to 21 absences per year
      - Providers are therefore limited to 344 billing days per members’ plan year
    - Propose to move funding for DD domiciliary home additional payments [HRS § 321-15.9(h)] to partially fund rate increase

Proposal – Residential Habilitation (cont.)

- Staffing assumptions
  - Model built on a ‘house manager’ model with this person residing in the home
  - Other staff support hours vary based on individuals’ level of need
  - Therapeutic Living Program staffing assumptions are outlined in Appendix D of the rate model packet

- Additional supports
  - New service – Additional Residential Supports – for instances when individuals need more support than assumed in the rate model
    - Provider must first demonstrate that it is delivering the total number of hours assumed in the rate model for all residents in the home
    - Service is billed in 15-minute increments
  - Skilled Nursing and Training and Consultation can be billed for individuals receiving Residential Habilitation
Proposal – Adult Day Health

- Rate variants
  - Rate vary based on individuals’ level of need (with smaller assumed group sizes for persons with more significant needs)

- Staffing
  - Assumed group sizes range from six individuals per staff to three individuals, based on level of need
  - Regardless of the individuals receiving services, providers will be expected to maintain a staffing ratio no greater than six-to-one

- Requirement that providers offer a lunch is eliminated

- Billing procedures
  - Service to be billed in 15-minute increments rather than current day/half-day units
  - Services in the community would bill Community Learning Service

Proposal – Community Learning Service

- New service to provide higher rates for PAB and ADH services delivered in the community
  - Intended to support compliance with HCBS rule

- Rate variants
  - Individual and group services
    - Group services tiered by individuals’ level of need
    - Largest allowable group is three individuals per staff
  - Rate for persons who require multiple staff
  - Rate for services provided by registered behavior technicians
  - Consumer-directed option
Proposal – Employment-Related Services

- Continuum of supports to encourage employment
  - Discovery and Career Planning, and Benefits Planning (replaces Prevocational Services)
  - Job Development (break out of Individual Employment Supports)
  - Job Coaching (break out of Individual Employment Supports)

Proposal – Respite, Chore, and Transportation Services

- Respite
  - Daily rate being eliminated in order to ensure compliance with overtime laws
  - Individuals will be able to receive up to 720 hours of respite per year (equivalent to 30 days)
  - New rates for instances when a single staff person serves multiple individuals
  - Includes a consumer-directed option

- Chore
  - Includes a consumer-directed option

- Non-Medical Transportation
  - Continues to be billed by the mile
Proposal – Skilled Nursing and Training and Consultation

- Skilled Nursing
  - Different rates for registered nurses and licensed practical nurses
  - Rates for instances when a nurse serves two individuals

- Training and Consultation
  - Eliminating codes for psychiatrists and audiologists
  - Adding codes for registered nurses and LMFT/LMSW/LCPC

Proposal – Waiver Emergency Services

- Crisis Mobile Outreach
  - Adopt Adult Mental Health Division’s rate for Crisis Mobile Outreach – $27.50 per 15 minutes

- Out-of-Home Stabilization (formerly Crisis Shelter)
  - Use the same rate as for Therapeutic Living Programs – about $500 per day
Next Steps – Public Comment

- DDD is accepting public comments on these proposals and the overall waiver amendment through February 3, 2017
  - By email: doh.ddcrb@doh.hawaii.gov
    (Please identify in the subject line: Waiver Amendment)
  - By mail:
    Department of Health
    Developmental Disabilities Division
    Attention: Community Resources Branch
    3627 Kilauea Avenue, Room 411
    Honolulu, Hawaii 96816

- Comments will be considered and revisions made as necessary
- Waiver amendment incorporating new rates will then be submitted to CMS for approval

Next Steps – Implementation

- Phase 1 (July 2017 – June 2018)
  - Cohort 1 (persons receiving residential habilitation) based on service plan date
    - Transition to new daily Residential Habilitation rates
    - Adult Day Health and Community Learning Service based on assigned level
  - For all members based on service plan date
    - Access to reconfigured employment-related services: Discovery and Career Planning, Benefits Planning, Job Development and Job Coaching
    - Phase-out of eliminated services (no new authorizations): Daily Respite, Training and Consultation for psychiatrists and audiologists
    - Implementation of most rates that do not vary by tier: Hourly Respite, Chore, Non-Medical Transportation, Skilled Nursing, Training and Consultation
    - Transition to 15-minute billing for Adult Day Health and Group Community Learning Service: members without a SIS (that is, those not in Cohort 1) will be assigned to the same level of service they currently receive
  - Contingent on available funding
Next Steps – Implementation (cont.)

- Phase 2 (July 2018 – June 2019)
  - Cohort 2 (persons who do not receive residential habilitation, but do receive Adult Day Health) based on service plan date
    - Transition to new PAB rates and Individual Community Learning Service
    - Adult Day Health and Group Community Learning Service based on assigned level

- Phase 3 (July 2019 – June 2020)
  - Cohort 3 (everyone not in the first two cohorts) based on service plan date
    - Transition to new PAB rates and Individual Community Learning Service

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