Office of Developmental Disabilities Services

Review of Provider Rates for Residential and Other HCB Services

Overview of Draft Rate Models

October 18 – 19, 2017

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Agenda

- Background
- Process
- Drafts
- Next Steps

Note: Materials accompanying this presentation are drafts being released for public comment. As discussed in Next Steps, providers and others will have several weeks to offer comments that ODDS will consider prior to finalizing the rate models.

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Background – Scope of Project

- ODDS is reviewing rates for the following:
  - 24-Hour Residential
  - Attendant Care (and Skills Training)
  - Behavior Consultation
  - Transportation
- Rate models not being proposed
  - ODDS is not considering changes to Case Management or Relief Care at this time
  - Supported Living rate models will be considered in conjunction with the ONA initiative
- Small Group Employment, Employment Path, and Day Support Activity
  - Rate models were finalized in 2016, but not implemented
  - These rates will now be reconsidered as this phase of the rate study

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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 draft rate models and supporting documentation that detail assumptions
- Discuss drafts with provider advisory groups in Dec. 2016
  - ODDS held additional meetings in January to discuss policies

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Background – Remaining Activities

- Discuss revised drafts with provider advisory groups
- Post rates and related materials for public comment
  - Review comments and consider revisions to draft rates
- Submit for approval to Oregon Health Authority (OHA) and then federal Centers for Medicare and Medicaid Services
  - Additional opportunities for comment
- Implementation of the rates is dependent on availability of funding

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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')
  - Similar to the approach used to establish current rates
- A single service may have several rates due to:
  - Group size/ intensity of supports due to consumer need
  - Location of service due to wage and travel differences
  - Staff qualifications and training

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

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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, such as supervision
  - Administration
- Other factors vary by service and may include:
  - Transportation-related costs
  - Attendance/ occupancy
  - Staffing ratios
  - Program facilities and supplies costs

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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 and what ODDS is buying
- 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 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)

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Process – Rate 'Categories'

- Cost of services often varies according to intensity of need
  - Rates should recognize these differences while ensuring that members with similar needs receive similar 'intensity' of services
- Proposed rate models use current tiers
  - The six tiers are collapsed into four rate 'categories'
    - Tier 1: Category 1
    - Tiers 2 and 3: Category 2
    - Tiers 4 and 5: Category 3
    - Tier 6: Category 4 (Tier 6 was moved to its own rate category in response to feedback from stakeholders)
  - 'Tier 7' indicates an exceptional rate
- Tiers (and rate categories) will eventually be determined based on ONA results

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Process – Provider Survey

- Voluntary survey to collect data regarding costs and service design emailed to all providers
  - Given five weeks to complete and all late surveys were accepted
- Technical assistance provided throughout the survey
  - A webinar that walked-through the survey was recorded and posted online
  - B&A responded to questions by phone and email
  - B&A reviewed submitted surveys and emailed clarifying questions as necessary

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Process – Provider Survey (cont.)

- Participation
  - Of approximately 406 providers, 61 submitted a survey (15 percent)
  - These providers represent 56 percent of spending on surveyed services
  - Largest providers were most likely to complete the survey (e.g., 29 of the 50 largest providers by revenue participated)
- Survey results were one of the considerations in the development of the proposed rate models
  - See Provider Survey Analysis packet

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Process – Developing Draft 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 and individual service plans

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Process – Direct Care Worker Wage Assumptions

- Used federal Bureau of Labor Statistics (BLS) wage data for relevant occupations in Oregon to set wage assumptions
  - Service requirements compared to BLS job classification descriptions to 'construct' a position reflective of job responsibilities
  - Used median wages for selected BLS job classifications
  - Any BLS wage less than the Portland Metro minimum wage as of July 2022 ($14.75) was 'overwritten' at this wage
- See Appendix A in Draft Rate Models packet
  - Wage assumption for 24-Hour Residential and Attendant Care is $15.65 per hour

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Process – Direct Care Worker Benefit Assumptions

- Rate models include the following for all direct care staff
  - 24 paid days off per year (holiday, sick, and vacation leave)
  - $425 per month for health insurance (considered costs from BLS, DHHS Medical Expenditure Panel Survey, and health insurance exchange) with a 100 percent take-up rate
  - $75 per month for other benefits
  - Mandatory benefits: FICA, unemployment insurance, workers' comp.
- Assumptions are translated to benefit rates by wage level
  - Benefit *rate* declines as wage increases
- See Appendix B in Draft Rate Models packet

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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

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Process – Administration/ Program Support Assumptions

- Rate models include average of 26 percent for Administration and Program Support
  - Overhead funded at 15 percent of total rate for most rate models
  - Program Support includes supervision costs
    - As a percentage of total costs, averages about 10 percent across all services, but varies from service to service
- Comparison to provider survey
  - Total administration and program support rate reported in provider survey averaged about 30 percent
    - Estimate excludes 6 of 53 providers that reported overhead exceeds 50 percent of their revenue (these responses were deemed to be unreliable)
  - Administration and program support in the rate models is equal to 32 percent of current revenues

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Draft – 24-Hour Residential

- Billing procedures
  - Adopt a 'true' daily rate
  - Eliminate direct billing for absences/ bed holds
    - Rather, the daily rate is based on a 344-day year, meaning that 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
- Rate variants
  - Rates for adult residences continue to vary by tier and home size (3 or fewer residents, 4-5 residents, 6-8 residents, and 9+ residents)
    - No changes to rates for homes with 6 or more residents are planned other than the conversion to a 344-day billing year
  - Rates for child residences would become standardized based on four tiers and home size (3 or fewer, 4, and 5 residents)

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Draft – 24-Hour Residential (cont.)

- Staffing assumptions
  - Assumptions are outlined in Appendices D (for adults) and E (for children)
  - Assumed that child homes require more staffing
  - All models assume that homes are staffed 24 hours per day (that is, homes are never 'empty')
  - Assumptions are not prescriptive (that is, providers may deliver more or fewer hours than assumed in the rate model)
- Professional supports
  - Direct nursing and behavioral support are not part of the rate model and could be separately billed
  - Long-term care community nursing remains bundled into the rate model under specialized supports

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Draft – 24-Hour Residential (cont.)

- Supports outside of the home
  - Rate model staffing assumptions intended to account for in-home staff hours and activities outside the home related to the maintenance of the household (for example, grocery shopping)
  - Supports provided to members outside of the home for other activities could be separately billed as Attendant Care or Day Support Activity

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Draft – Transportation

- Applicability
  - Rate developed for transporting member to and from employment and Day Support Activity programs
  - Rate does not apply to public transportation or when billed concurrently with another service (such as Attendant Care)
- Billing procedures
  - Rate is paid by the mile
  - When multiple members are on a route, the total mileage of the route is billed at the appropriate group rate for each member regardless of what portion of the route they actually rode
  - There is a separate, higher rate for transporting members in wheelchairs regardless of the type of vehicle used
  - For services provided between 10:00 PM and 5:00 AM, there are higher rates based on a 10 percent shift differential for the driver

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Draft – Professional Behavior Services

- Rate will vary by provider education
  - Master's degree and above (or 12 years' experience)
  - Bachelor's degree (or 6 years' experience)
  - Less than Bachelor's
  - Years of experience at time of rate implementation only; going forward degree is required
- ODDS will establish a 'universal' hours cap for the various services provided
  - ISP team decides the allotment of 30 hours between the three functions: Temporary Emergency Safety Plan, Functional Behavior Assessment, and Positive Behavior Support Plan
  - Replaces 'sub-limits' such as 15 hours for a FBA, 12 hours for a PBSP, etc.
  - Annual limit of 18 hours to maintain the PBSP
  - An exceptions process would be available for additional hours

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Small Group Supported Employment, Employment Path, and Day Support Activity

- The rate models are unchanged from those published a year ago except for:
  - Incorporating new Bureau of Labor Statistics wage data
  - Adopting the newer IRS mileage rate
  - Tier 6 moved to new Category 4 rate models

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Next Steps – Public Comments

- Draft rate models and supporting documentation will be posted online for review and comment
  - Materials can be found at http://www.burnshealthpolicy.com/ODDSRates
  - An email will be sent to providers and stakeholders directing them to this site
  - B&A will record a webinar to explain the proposals
- Written comments will be accepted through November 22
  - Comments should be emailed to ODDSRates@burnshealthpolicy.com
- ODDS will review all comments and provided written responses in a consolidated document
  - Rates and policies will be revised as appropriate

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Next Steps – Implementation

- With nearly every draft rate higher than current rates, the cost of implementing the rates will be higher than the current budget allows
  - Fiscal impact will be completed once ONA results are available
- Implementation of rate changes will therefore be contingent on available funding
  - Rate model 'benchmarks' would not change so that it will be clear what the rate 'should' be
  - Allocation of future funding increases (that are less than the full amount) will be considered in relation to the 'benchmark' rates with funding targeted to rates that are most 'under-funded' or to otherwise support system goals

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