Meeting Notes
Re: South Dakota DDD Rate Rebase Workgroup Meeting 3

Location: Drifters - 325 Hustan Ave, Fort Pierre, South Dakota

Date: September 30, 2019

Attendance:

- CSP Representatives:
  - Randy Meendering, ED, CFI, – Huron, SD
  - Pam Hanna, ED, LifeQuest – Mitchell, SD
  - Steve Watkins, CEO, LifeScape – Sioux Falls, SD
  - Bob Bohm, ED, DakotAbilities – Sioux Falls, SD
  - Brad Saathoff, ED, BHW – Rapid City, SD
  - Melony Bertram, ED, CCI – Winner, SD
  - Dan Cross, ED, CSPofSD

- DDD
  - Darryl Millner, Director
  - Julie Hand, Assistant Director
  - Liliana Borcea, Financial Program Manager
  - Julie Johnson-Dresbach, Transitions Manager
  - Barb Hemmelman, Employment and Community Life Engagement Manager
  - Kelli Anderson, Community Capacity Manager
  - Jaze Sollars, Waiver Administrator
  - Bianca Villapudua, Waiver Program Specialist

- DHS
  - Denice Houlette, Director, DHS B&F
  - Alana Suiter, PR&G Manager, DHS B&F

- LRC
  - Amanda Doherty-Karber, Fiscal and Program Analyst

- Brown & Peisch
  - Caroline Brown (by phone for the first hour)

- Optumas
  - Steve Schramm

- A&M
  - Wanda Seiler, Senior Director, Alvarez & Marsal
  - David Vince, Manager, Alvarez & Marsal (by phone)
1. **Introductory Remarks**
   - Introductory remarks offered by Darryl Millner regarding the purpose of our efforts is for the Department of Human Services (DHS) to establish a rate-setting methodology for services delivered by community support providers within the CHOICES program and the workgroup to perform rate modeling analysis.
   - Darryl commented on the current state of SDs HCBS waiver and the need for change to comply with CMS regulations, specifically pointing to:
     - What data is used in the rate methodology
     - How costs appear in the cost report
     - The use of Activity Logging
     - How ICAP data can be used in the rate structure
     - CMS is paying close attention to home-like settings including home size and access to community
     - The pending phase out of sheltered workshops
   - SD DDD and stakeholders will need to prioritize immediate non-negotiable changes to avoid action by CMS in the coming years.

2. **Caroline Brown Presentation**
   - Caroline presented professional background prior to beginning discussion of three prevailing legal principles governing HCBS waivers that she believes the workgroup needs to consider
     - ‘Any Willing Provider’ – Beneficiary has the freedom to choose any qualified provider who is willing to provide the service and accept the Medicaid rate
       - States can seek an exception to this requirement, but SD does not have such an exception
     - Only the provider who is actually providing the service can receive payment from Medicaid
       - Common exception: payment can be made to an organized health care delivery system (OHCDS) as done in SD, but individual providers and beneficiaries cannot be required to go through an OHCDS
       - OHCDS administrative expenses cannot be considered part of the cost of service delivery, they must be recorded and expensed separately
     - States cannot bundle services, except in very limited circumstances provided it does not impact service. The leniency for bundling services is based on how closely the services in question are related. Beneficiaries must still be permitted to choose unbundled services from individual providers
     - **On its face, SD’s HCBS waiver complies with the CMS rules, but in practice it does not**
3. Further Discussion of Bundled Rate
   - SD does not have bundled service in its waiver, but is paying a bundled rate, creating complexity and exposing SD to risk
     o Reimbursement is not broken out by cost-per-service but rather a percentage which is difficult to understand and may expose SD to CMS scrutiny
     o Vulnerabilities: restricted freedom of choice, providers are not permitted to only provide a single service, and providers are receiving reimbursement for services they did not directly provide. Currently we don’t allow people to just deliver a single service – we can’t restrict this
     o Need to do a better job accounting for unallowable costs

4. Following Caroline’s Departure, Wanda Seiler Presented Slide Deck to Workgroup Detailing Proposed Rate Rebase Plan Moving Forward (please refer to distributed slide deck for presentation details).

5. During and following the presentation several issues and concerns were raised by provider representatives.
   - Issue: The proposed rate rebase will be based on historical data. Providers are concerned that costs are not reflective of what it takes to provide HCBS services. Providers have already absorbed several cuts since 2011. Relying on historical cost data will not produce sufficient reimbursement rates.
     o Answer: CMS requires the use of historical cost data as an input in the model, but this comprehensive approach would also seek to include additional inputs beyond historical data, to better understand the needs of providers to ensure an equitable rate is provided. A major component of this rebase is to identify where the holes are. By working collaboratively through this process, we can build a more sustainable system. In addition, SDCL 28-22-4 requires rate determination resulting from rate modeling analyses utilizing historical cost report information shall be adjusted in a manner to be applied in a prospective fashion subject to federal requirements.
   - Issue: The system would produce new inefficiencies by requiring additional reporting on transitions from residential to day services.
     o Answer: While the concern is real, the existing efficiency limits beneficiary choice, which must be avoided moving forward.
   - Issues: How do you plan to mitigate unintended consequences from the rate rebase?
o **Answer:** Steve – we typically recommend reviewing the model and rates throughout the process, before the rates are finalized to minimize disruption from unintended consequences. We strongly believe in working with providers through a collaborative approach.

- **Issue:** Although providers agree with the proposed workplan to establish a rate setting methodology, providers mentioned a current gap in the reimbursement rates for staff wages that needs to be addressed in the near-term. Providers cannot wait two years for the workplan/rebase to be completed.
  o **Answer:** Given the appropriations cycle, the two-year timeline is the fastest we can expect to complete the rate rebase and request appropriations.
    - However, SD DDD appreciates provider needs in the short-term and this long-term plan does not preclude providers from seeking funding for FY21.

6. Conclusion

- The workplan is a long-term plan and provider’s needs for additional funding for staff wages are immediate.
- A&M will provide a written summary of the plan/approach to include a listing of the issues raised by providers for more immediate solutions to financial concerns. A&M will also provide a summary of CMS’ expectations related to home size and community integration.
CSP of SD Feedback: September 30, 2019 Rate Rebase Workgroup Meeting

1. It is the CSPs understanding that the current waiver complies with CMS regulations (as discussed during the meeting) and any proposed changes by the state are anticipatory and the state is not currently being directed by CMS to make changes to the waiver. We understand that the legal review presented identified potential risks, but the current minutes imply that the waiver is out of compliance and requires immediate changes when this does not appear to be the case.

2. While CMS is wanting all states to move towards more integrative services, it is our understanding that CMS has not called for the outright elimination of sheltered workshops.

3. While using historical cost report information was included in the meeting minutes and mentioned as a CMS requirement, there was discussion on how the 6.5% increase received last legislative session would play into any rebase effort. This discussion was not included in the meeting minutes and CSPs feel that including the 6.5% will be important if a rebase were to occur.

4. CSPs interpreted the legal requirement of SDCL 28-22 as a mandate to provide a mutually agreed determination of the funding gap for this year’s legislative session. We do understand that identification of a gap is not an indicator of funding. However, identification of this gap provides a basis for the legislature to use to help resolve our immediate funding needs, whether it is this year, or over a longer period. This is a critical issue for CSPs and while the meeting minutes do reflect this concern, its importance cannot be understated. (See below for more information)

5. The CSP workgroup members are not opposed to the workplan’s larger remodel effort, which is predicted to take a significant amount of time. However, the CSP association’s position is that identification of existing gaps should take place prior to any larger remodel effort.

6. During the meeting there was not a consensus on moving forward with the current workplan without an analysis examining the current funding gap. While the meeting minutes do raise this as an issue, they did not indicate the failure to arrive at a consensus. It is our position that the workgroup can determine critical elements (e.g. staff wages, health insurance costs, etc.) as a part of examining the current funding gap. We also feel that the workgroup can produce sufficient data supporting and legitimizing these elements.

7. The CSP association believes that the work thus far is more reflective of remodeling the service delivery system, rather than analyzing the current reimbursement system to identify funding gaps.