SD Rate-Setting for Community-Based Human Services

DHS Division of Developmental Disabilities Rebase Workgroup Meeting 1

Meeting on 6/28/2019. (See PPT deck for a list of Attendees)

- Welcome and introductions. The workgroup includes providers and other stakeholders representing the community-based system which delivers services to people with intellectual and developmental disabilities.
    - Workgroup members are to represent the entire service delivery system.
- Explanation of rate setting methodology rebase vs remodel framework; this workgroup's deliverable is NOT a rate rebase nor a remodel. Our deliverable is to create a workplan such that the DHS Division of Developmental Disabilities has tasks, timelines and scope for the approach decision makers will settle on.
    - This plan will allow for DDD to advocate during 2020 legislative session for the resources for this transformation.
    - Distinction in timeline—the rebase and remodel will not go into effect until appropriated resources may be available.
    - Quality of cost report data and structure will be important determinant of the length of the work plan. For example, existing cost report data lacks waiver service specific costs, requiring changes to the cost report template that should be distributed to providers prior to the beginning of the fiscal year that providers are required to gather data at that level.
    - In addition to immediate deliverable of work plan, our goal is to help build processes to meet SB147 requirements of having a schedule for regular reviews.
- Workgroup Goals and Priorities:
    - Flexibility, particularly with regards to individual needs that are more intensive than the general population.
    - All relevant costs are recognized and relative changes in costs are accounted
        - Ex: Sioux Falls is paring down public para-transit system; norm was ~$4 round trips—now using private providers to pick up slack and costs are ~$30 per trip. Also fixed route transit isn't keeping up with the physical growth of communities—jobs and houses are more and more spread out.
    - Acknowledge rising health costs in general and narrow margins of providers without private payors. Providers are reliant on Medicaid (only) reimbursements.
    - Consideration of evolving to individualized & small group supports, as they cost more than large groups.
    - Acknowledge nuances of doing good employment training/placements.
    - Recruiting and retaining good workers requires resources.
    - Would like to see model able to quickly reflect changes in political and business conditions.
    - We want a best in class model.
    - Need to acknowledge how federal policy changes will drive changes in provider operations, including the HCBS settings rule and the need to end sheltered workshops.
    - Data/methodology to track the talents/skillsets required in the system to meet people's needs and what other industries are paying for those skills.
    - Potentially revisit ICAP and other data sources.
    - Flexibility to reimburse for new and innovative service models such as incorporating remote monitoring technology.

    - We must be cognizant of federal expectations and needs, although CMS expectations can and will oscillate over time—for example bundled vs. fee for service rates fallen in and out of favor.
    - A model that recognizes intensive behavioral, medical and staffing needs of an individual.
    - The model conceptually relies on averages, but the reality of I/DD is that the needs of people receiving services typically fall two standard deviations from the mean.
    - CMS expects public engagement on any changes.
    - There is general acceptance that group home size should be below four people.
    - SD needs to catch up—right now average size is 5.5, one provider averages 11.
    - Sheltered workshops need to go, particularly because of new settings rule.
- Provider Cost Reporting
    - CMS has been approving applications and renewals fairly quickly and liberally but is now doing substantial audits looking for unallowable costs.
        - Unallowable costs in this context include specialized rates that are not specifically outlined in the waiver. As SD has not done that.
        - Costs that cannot be included in a rate build up – room & board; participant wages in a sheltered workshop.
    - Assumption is that SD CSPs are doing well in appropriately accounting for unallowable costs, however there may need to be refinements in the either the cost report instructions or the report templates.
- Current rate setting methodology – Service Based Rates (SBR) version 3
    - SBR was a pioneering model
    - SBR takes inequities out of the system
    - One limitation has been the lack of ability to link SBR and quality.
- We're going to look at three years of cost reporting to see how categories of costs have grown and shrank over the last three years. This will be a cursory review, but the actual rebase and remodel will involve extensive analysis. We're in part concerned with making sure reporting structure is ready to support the process.
    - Need to incorporate recent CMS guidance
    - Day and residential services are currently rolled up into aggregate sums, we may need details on specific waiver services
- Model currently involves economic variables; there is a diminished focus on differences between locality.
- Activity logging (time study) data was critical to the SBRv.3 model, but we recognize there are limitations in what information is being collected (time, not intensity of time) and burden on providers and state staff
    - Several CSPs were concerned that they are understaffed and activity logging will not truly capture an individual's needs.
- Activity logging could be done, but only if providers can be convinced that there would be substantial benefits. Instead, we're proposing looking at staffing and costs at each congregate setting and dividing costs/staff either equally between clients or based on provider estimates of the proportion each client utilizes.
- Certain individuals lose substantial funding once they're no longer legally children.
- Model incorporates age right now, but there are conceptual and practical reasons it may not be appropriate-largely because needs don't change on birthdays.

- Provider Gain/Loss was intended as a cushion for losers during implementation back in 2004. It is still in place, but the size of the adjustment has decreased. Other states with Gain/Loss systems typically phase them out quicker.
    - This may be a major stumbling block in this process-are we ready to accept winners and losers?
    - Provider feedback: if we're trying to get home sizes below 4 across the state, the cost of doing that shouldn't be a part of gain/loss, it should just be appropriated and reimbursed to providers.
        - Providers expressed sentiment that the crucial thing is getting cost drivers correct in the model; if that foundation of the model is right providers will be able to get on board.
- SBR has a great adjusted R-squared (a measurement of cost prediction accuracy); it may drop in the next model.
- We must distinguish between what is achievable in this rate review and building capacity such that more ambitious reforms can be part of the regular 5-year reviews part of SB 147.
- Should we keep using ICAP? Some states have built their own tools, others have bought tools, but there is no silver bullet. The most important thing is having a reliable tool that has been validated. Advantage of long history w/ICAP and therefore a wealth of data.
    - Concern by provider that ICAP gets watered down for certain individuals.
    - Concern that ICAP has arbitrarily changed instructions for scoring some fields and these have impacted rates. Idea that definitions are being changed after data has been gathered and these impact provider reimbursement.
        - Unfortunately, these elements and the issue of definitional drift is found in almost any tool.
    - Ultimately, there are problems with every tool, but ICAP is most appropriate here. ICAP also has good inter-rated reliability in most sections, which is crucial.

- Case management carve out- of the case management funds, 52% carved out of model, 48% left in the system.
    - Providers claim residual costs of case management didn't go away due to the level of workload that remained with CSPs.
- How commonly do clients request multiple providers for different services?
    - Is there will to bring in more providers to do business in SD? For example, do we want to try to bring in those firms who do innovative things in employment?
        - Likewise, enabling existing SD CSPs to focus on excelling at one service instead of offering all of it.
    - Moving to a higher staffing ratio within employment, particularly with the need to get rid of sheltered workshops, will be painful.
        - Bringing more employment services providers into system may ease that burden.
    - Move away from idea that new providers need to do all services to get certified?
    - Provider input: some of these services are "profit negative" and can only really be offered because they're being subsidized by other services.
        - If this is the case, then opening the market may not bring in any more providers.
    - Is the solution here to improve the resources available for these services?

- Do providers want much past a refresh of SBR (modernize parameter estimates and values)?
    - Wanda's perception today is that there may be an appetite for a more substantive remodel
    - Provider response is that they're potentially open to a remodel if they can be convinced that it will better reimburse them for their real cost drivers and be more flexible in recognizing changing costs in the future.
- Issue to be aware of—we may encounter difficult questions, particularly about participant choice issues.
    - CMS may want to eliminate the requirement that providers deliver all services and push for allowing providers to focus on delivering a small number of services, such as day/employment services. Providers point out that this will make workforce recruitment/retention more difficult and potentially raise costs if the new providers bid up wages.
        - Particularly in rural areas. Difficulty is that the areas that currently have the least client choice will also have the smallest pool of qualified workers.
        - Other issue is whether there is volume to have multiple providers in some of these areas
        - There is some demand from providers looking to only deliver residential, day or employment. Particularly community engagement services, who are typically leaner.
        - From a regulatory perspective, a serious look at this topic and willingness to implement potential changes may be required by CMS.
            - CMS urged other rural states to allow more access to market; one state is now at 400 providers. Some difficulties in health and safety there.
            - CMS has been prioritized this issue within other states.
- Lack of standardized data on behavior and medical risk is problematic; we suggest adopting a tool.
- As mentioned above, some of the parameters need to be rethought.
- Bundled rates for day and residential may not be approved again in the future.
- Darryl posits that if we're able to develop a realistic plan to reduce home sizes and end sheltered workshops, CMS may be more forgiving on some of these other issues.
- Exception funding needs more explicit criteria.
- Change management also needs attention.
    - SBR has a comparably light administrative burden for both providers and state, but reality is that CMS driven changes will result in a more demanding model.
    - Therefore, there is a need for capacity—IT, HR, Admin, etc.—to deal with this burden and find strategies to ease this transition.
- There are some opportunities, which can also be combined into some sort of hybrid
    - Fee for Service: Easier to understand and build rates around, but 15-minute billing blocks result in a significant administrative burden.
        - Providers think this will reduce their compensation while increasing their administrative costs. Can hourly or partial day/day services be an option?
    - Bundled/Managed Care model would require some additional CMS waiver, maybe a 1915(b)(c) combo or a 1115 waiver.
        - Iowa did this, but Iowa did it in a way that created a lot of chaos because they made a lot of other changes at the same time.

        - Arizona implemented a successful 1115 waiver program, in part because they made providers MCOs (managed care organizations) and the state remained in the role of administrator.
        - Essentially a b/c combination would allow SD to treat providers as MCOs.
    - Outcome/Milestone Payments are not the same thing as Value Based Purchasing.
        - For outcome/milestone payments, instead of fee for service system, payment is delivered at certain milestones or outcomes. Can be done without MCO.
        - Value based purchasing pays more for better results. Would require 1115 or (b)(c)
            - Would also require more and better outcome data.
    - A hybrid can use different payment types for different services—potentially keep SBR for residential, but move to outcome payments for employment?
- There will be a fiscal impact—the state understands that there will be a price tag on any plan. There will be a tension between the costs of implementation and the fact there are still only finite resources for these services.
    - This is a point of contention for providers. Frustration that CMS has demands, legislature has demands, but nobody wants to fund the process that will implement those demands.
    - There will be a dollar figure produced at the end of this as a price tag.
    - 2016 SB 147 is partially a reaction to how often DDD has asked for more from the legislature. Our goal here is to give them one price tag for addressing the litany of current AND looming issues.
        - In part, there seems to be two related sets of issues-the staleness of the SBR and then the evolving demands of the state and the CMS.
- An SBR refresh is looking less likely after this discussion. There are broken elements in this model.
    - Crux of the issue: we cannot promise providers money, but changes need to be made.
- Next meeting, we will bring back options.
- The model is just too old, has bad parameters, and isn't achieving intentions with regards to home size reduction and increasing integrated competitive employment opportunities.
- Next steps
    - We're doing a data review and will provide more information in future meetings.
    - Two more meetings: one to make decision, one to hone paths and fine tune details.
    - There is also a remodel meeting on the horizon
- Pleased with: that we're acknowledging that the model isn't working in all cases, the open dialogue, experienced perspective, the hope moving forward, the diversity of perspectives at the table, chance to frankly talk about SBR, and that there was an acknowledgement of the changing cost drivers.
- Concerns: Impacts on relationships with state and providers, concern that we must ensure we are moving forward in a unified manner, that this may be a long and time consuming process, change may be difficult, that if this becomes about getting more funding there may be pushback from legislature, don't want to "limp to finish line"—want a model that works, lack of resources for implementation, concern that if we leave anything out we'll have major problems later, funding needs and funding available may not be equal—we need to ensure a sustainable solution, capacity to absorb another round of change in the system, CMS and SD may have different priorities and goals, that this may get caught up in larger policy and legal fights, complexity of the project and fitting it into stages.

- Question if legislators are being kept in loop, and they are through regular meetings. LRC staff were present at this meeting and are welcome to attend future meetings.

  **Wanda and Darryl will be in touch with data requests and points of clarification between meetings as well as logistics for future meetings.**