HEALTH MANAGEMENT ASSOCIATES

Activities Related to DHSS Provider Rate Changes: Building a Roadmap

Burns & Associates, a Division of Health Management Associates
March 31, 2021

TOPICS IN PRESENTATION

1. **Initial Rate Methodology Report and Follow-up**
   (Epilogue language in response to initial report)
2. **Rate Development Terminology**
3. **Key Activities in Rate Development**
4. **Proposed Roadmap to DHSS for Rate Development**
5. **Key Questions When Conducting a Rate Rebase**
6. **Status of Work Towards Initial Recommendations from June 2020**

AGENDA ITEM 1

INITIAL RATE METHODOLOGY REPORT AND FOLLOW-UP

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INITIAL RATE METHODOLOGY REPORT

- **Delivered to Legislature in May 2020**
  (with presentation to some legislators in June)
- **Detailed current rates and rate methodologies used across DHSS Divisions**
- **20 Medicaid service categories included along with services delivered by DDDS, DSAMH, DSAAPD**
  - **Dashboard report created for each service category addressing total payments, provider base, last rate update, options to benchmark to Medicare, options to create value-based component to rate development process**
- **Contracts reviewed for services paid for by other DHSS Divisions (DPH, DSSC, DSAMH, DSAAPD, DDDS)**
- **Appendix lists out rates for all services reviewed**
- **Nine recommendations offered based on key findings from report**

https://www.dhss.delaware.gov/dhss/pubs.html

On webpage, look up *Independent Rate Study of Rate Methodologies Used by DHSS (June 2020)*

EPILOGUE LANGUAGE SENATE BILL 260, 150th GENERAL ASSEMBLY

- **Section 42 requires Department of Health and Social Services (DHSS) to "outline a path forward in addressing the recommendations of the report including milestones to assess progress"**
- **Focus of today's presentation is on the recommendation related to creating a Roadmap for rate development. Elements of the Roadmap, as recommended, include:**
  - *Tracking if Medicare has a methodology in place that could be considered in whole or in part by DHSS;*
  - *Tracking whether DHSS will incorporate a value-based component to its rate methodology or quality reporting on the services being paid;*
  - *An identification of the resources (both internal and external) to change methodologies and later to update rates periodically;*
  - *Current resources and identified gaps in resources to complete the work;*
  - *Modes of communication to external stakeholders required when changes occur;*
  - *The timing and cadence of updates to align with annual legislative budget preparations; and*
  - *The timing needed to introduce value-based initiatives into each rate methodology (where deemed applicable) including the timing associated to prepare for quality-based reporting to ensure the initiative if effective.*

AGENDA ITEM 2

RATE DEVELOPMENT TERMINOLOGY

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TERMS USED IN RATE DEVELOPMENT AND IN THIS PRESENTATION

Methodology: The approach used to establish the rates paid for services rendered by providers.

Utilization: The count of services rendered by providers in a service category for a defined time period.

Costs: The costs incurred by providers to deliver a service.

Payments: The amount paid to providers to render the service using the rates set per service.

Fee-for-service rate: The amount paid out by DMMA for a Medicaid eligible that is not enrolled in managed care as well as for services paid on a per service basis by other divisions in DHSS. Note that Medicaid MCOs are not required to use the fee-for-service rate, but it may serve as a guide to them.

Rate Rebase: A more involved process to change the rate of payment to providers that often includes a review of provider costs to deliver services. May also entail a wholesale change to the methodology used to set the rates assigned. A rate rebase could yield an increase, decrease or no change in total provider payments in the service category. It could also mean a combination of increases and decreases.

Rate Update: Less involved than a rate rebase, an update may include minor adjustments to existing rates without considering costs, changes in utilization, or changes to the methodology used to set rates.

Systems updates: Changes to IT related to processing the claims (invoices) that providers submit to be paid under the rate methodology. This is often required when new methodologies are implemented.

Stakeholders: May include providers who deliver/are paid for a service, advocates of those receiving the service, legislators, other divisions in DHSS besides the one setting the payment rates, IT systems staff, or actuaries that compute the method that Medicaid managed care companies are paid.

AGENDA ITEM 3

KEY ACTIVITIES IN RATE DEVELOPMENT

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12 KEY STEPS IN RATE DEVELOPMENT

Each step shown below is reviewed in more detail on the next slides

STEP 1 Review service definitions or specifications	STEP 2 Conduct orientation with stakeholders about the rate development process	STEP 3 Collect cost and other related information from providers
STEP 4 Collect information from sources other than providers to benchmark against	STEP 5 Compare and contrast data from various sources	STEP 6 Build rates using costs and other relevant information
STEP 7 Use recent utilization to assess financial impact of payments with today's rates against expected payments with new rates	STEP 8 Present initial results to stakeholders, adjust rates as necessary	STEP 9 Identify and plan for systems updates required to use new rates
STEP 10 Conduct public comment process on new rate methodology and new rates	STEP 11 Finalize rates, fiscal impact. Develop documentation of process and billing guidance.	STEP 12 Secure federal approval of new rates when required. Finalize systems updates.

STEP 1
Review service definitions or specifications

+ Service definitions may define staffing level requirements. This will help inform assumptions around labor costs.

+ Some services may be delivered in multiple units (e.g., per 15 min vs per hour, per hour vs per day). The rate developed needs to factor in the unit of time assumed to deliver the service.

+ Some services may require specific documentation (e.g. a client assessment). Time to complete documentation must be factored in addition to client face-to-face time.

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

STEP 2
Conduct orientation with stakeholders about rate development process

+ Recommended to conduct project "kickoff" with stakeholders to orient them to project timing, roles and responsibilities, and overview of process.

+ Important to convey when periodic meetings with stakeholders will occur throughout the project tied to key milestones.

+ Opportunity for providers to convey specific ideas for consideration in the rate methodology development.

Step 1	**Step 2**	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

Step 1	Step 2	**Step 3**
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

STEP 3
Collect cost and other related information from providers

+ Use a standardized cost report (e.g. Medicare's) or customized survey tool to collect costs from providers.
+ When a customized survey is developed, there are often service-specific questions asked in addition to cost (e.g., client group size, travel time to/from client if service is performed in client's home).
+ Provider surveys typically in the field for one month to allow providers to respond. Validation is completed on surveys received.

STEP 4
Collect information from sources other than providers to benchmark against

+ Other sources in addition to provider costs may be useful in rate development.
+ If providers tie their costs to current payments and payments are below-market, then costs will be below market as well.
+ For example, provider wages can be matched against Bureau of Labor Statistics average hourly rates paid for different labor categories in Delaware.

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

STEP 5
Compare and contrast data from various sources

+ Providers will inevitably report different costs to deliver the same service. These costs may also differ from industry standards.

+ It is important to assess which costs best represent economically efficient service delivery. May be provider-reported, external source-reported, or somewhere in between.

+ It is also important to factor in when variation in provider costs is justified (e.g., regional labor cost differences, credentials of staff delivering the service).

Step 1	Step 2	Step 3
Step 4	**Step 5**	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

Step 1	Step 2	Step 3
Step 4	Step 5	**Step 6**
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

STEP 6
Build rates using costs and other relevant information

+ Guiding principle is that rates are built so that the costs of an economically efficient provider can be reimbursed for their costs.
+ In other words, goal is not to cover each individual provider's costs, particularly if individual providers report very different costs to deliver the same service.
+ Even if goal is to cover full costs of an efficient provider, financing limitations (the state budget) may limit the State's ability to cover full costs.

STEP 7
Use recent utilization to assess financial impact of payments with new rates

+ A common practice is to collect utilization for services paid to providers for a recent period, such as 12 months.
+ Actual payments are recorded for each provider using the current rates in place. Then, this utilization is 'repriced' using the new rates proposed. Differences are computed by provider for payments using current and proposed rates.
+ Oftentimes, when a state implements a significant rate methodology change, the change is stair-stepped in over time. Example: if new rates show an increase in payments of 15%, then year 1 is capped at +5%, year 2 at +10%, year 3 at +15%.

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

STEP 8
Present initial results to stakeholders, adjust rates as necessary

+ Recommendation is to show a fiscal model if rates were changed unencumbered by fiscal limitations. In other words, the “benchmark” rates.

+ Alternative fiscal models may show the realities of available funding and more likely rates to be implemented. In other words, the “adopted” rates.

+ Showing difference in the fiscal models using the benchmark and the adopted rates quantifies the gap in resources required to meet the benchmark in a transparent way.

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	**Step 8**	Step 9
Step 10	Step 11	Step 12

STEPS IN RATE DEVELOPMENT

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	**Step 9**
Step 10	Step 11	Step 12

STEP 9
Identify and make systems updates required to use new rates

+ Every rate change requires updates to claims payment systems. Some updates are straightforward, others very involved.

+ Often, when a new rate methodology is implemented, the system changes are quite involved. This requires sufficient planning and resource allocation to ensure readiness when new rates go in.

+ Discussions early in the rate development process are important on this topic. Systems update can take as much as 12 months to implement.

STEP 10
Conduct public comment period on new rate methodology and new rates

+ Although it is recommended that key stakeholders are involved in rate development throughout the process, it is required by CMS to allow for a more formal public comment process on any new rates to obtain all stakeholder feedback.

+ The Centers for Medicare and Medicaid follows this process for all Medicare rate changes.

+ If sufficient interaction with providers occurred during the rate development, this public comment process should yield few surprises from comments already expressed.

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	Step 12

STEP 11
Finalize rates and fiscal impact; document the rate setting process and billing guidance

+ Occurs after intake and consideration of any comments received in Public Notice.

+ Recommendation is for the methodology used to set the new rates should be documented and made publicly available.

+ Prior to the new rates being implemented, any guidance to providers pertaining to changes in how services are billed should also be documented and shared with providers.

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	**Step 11**	Step 12

Step 1	Step 2	Step 3
Step 4	Step 5	Step 6
Step 7	Step 8	Step 9
Step 10	Step 11	**Step 12**

STEP 12
Secure federal approval of new rates when required

+ If the service is covered by Medicaid, then federal government is contributing to total expenditures and has the authority to approve or deny the rate methodology.
+ Approval is required within 90 days of when rates are implemented.
+ To ensure federal approval, rule of thumb is to gain approval prior to implementation. Need to allow approx. three months for CMS approval process.

A RATE REBASE PROJECT IS OFTEN 24 MONTHS IN DURATION
EXAMPLE TIMELINE BELOW WITH 12 STEPS OF RATE SETTING PROCESS

JANUARY TO JUNE IS PREPARATION PERIOD
If outside subject matter expertise is needed, release Request for Proposals.
Review proposals and award contract.
Initiate engagement with provider community about upcoming project.

STEP 1 - JUL
Review service definitions and specifications

STEP 2 - AUG
Conduct orientation with stakeholders about rate development process

STEP 3 - SEPT
Collect cost and other information from providers

STEP 4 - OCT
Collect information from other sources to benchmark against

STEP 5 - NOV
Compare and contrast data from sources

STEP 6 - DEC
Build rates using costs and other relevant information

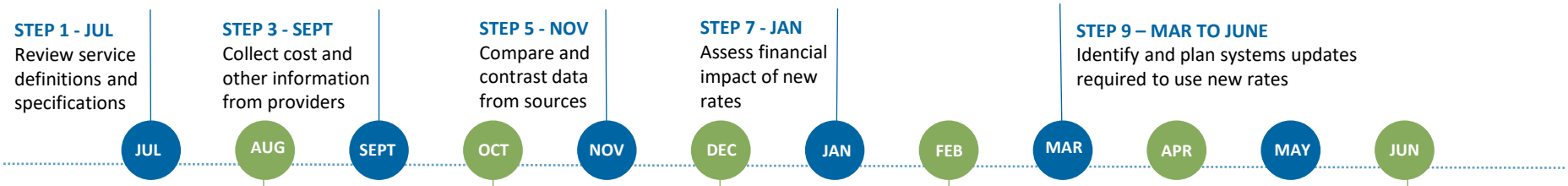
STEP 7 - JAN
Assess financial impact of new rates

STEP 8 - FEB
Present initial results to stakeholders

STEP 9 – MAR TO JUNE
Identify and plan systems updates required to use new rates

MARCH TO JUNE
Allows for education and feedback from legislators on potential funding changes related to rates

STEP 10 - JUN
Conduct public comment period on new methodology and new rates



STEP 11 - JUL
Finalize rates and fiscal impact. Develop documentation.

STEP 12 – AUG TO NOV
Secure federal approval of new rates when required. Finalize systems updates.

JAN 1
Rates take effect Jan 1

JULY TO DECEMBER IS IMPLEMENTATION PERIOD
Finalize all tasks outside of actual rate setting to enact new rates.

RATE REBASE VS RATE UPDATE

Whereas a Rate *Rebase* will require all 12 steps, a Rate *Update* may be condensed if the methodology is not changing. Steps in gray may not be required for a rate update.

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EXAMPLES OF A RATE UPDATE

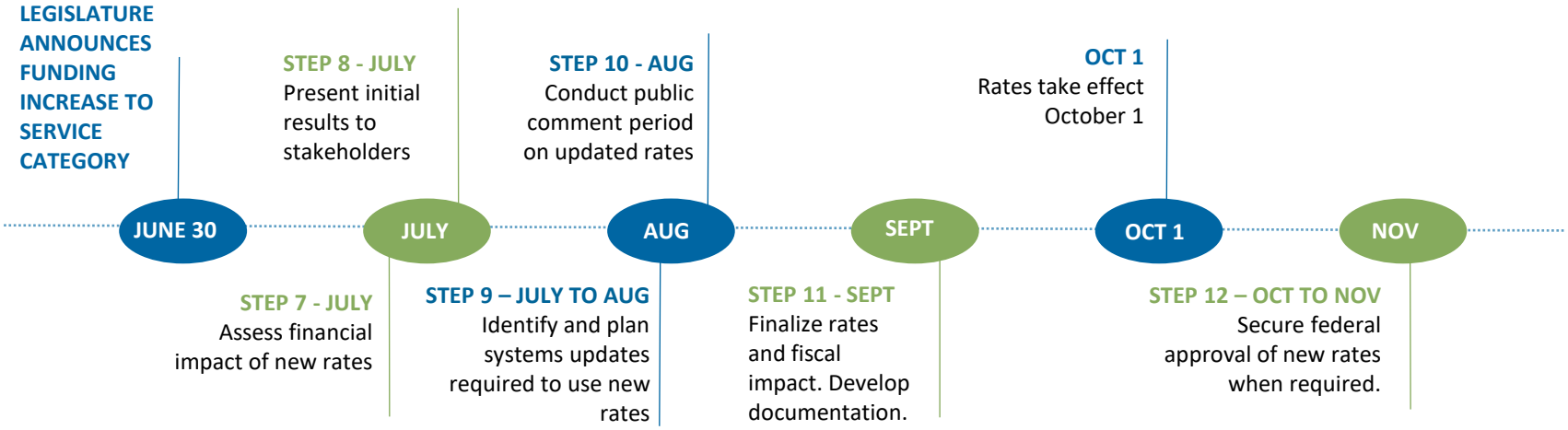
- Example 1: Legislature appropriates an additional $1,000,000 in funding for xxx service provider group.
  - Does each service receive the same across-the-board increase to spend the $1,000,000? Or
  - Should only certain services receive an increase to "close the gap" between the established benchmark rate and the current adopted rate?

- Example 2: Delaware's fee-for-service rate schedule for service category yyy keys off Medicare's fee schedule. CMS announces changes to the rates in its fee schedule.
  - If Delaware pays for this service at 100% of the Medicare rates, and the Medicare rates are increased, what is the dollar impact to Medicaid to adopt Medicare's new rates? Or
  - If Medicaid funding is limited to current levels, and the new Medicare rates would yield an increase in payments to Medicaid, what level below 100% of Medicare's rates does Medicaid need to adopt in order to keep total payments constant?

UNLIKE A RATE REBASE PROJECT, A RATE UPDATE COULD TAKE AS LITTLE AS ONE MONTH OR AS MUCH AS SIX MONTHS

TIMING MAY BE INFLUENCED BY SYSTEM CHANGES, CMS GUIDANCE

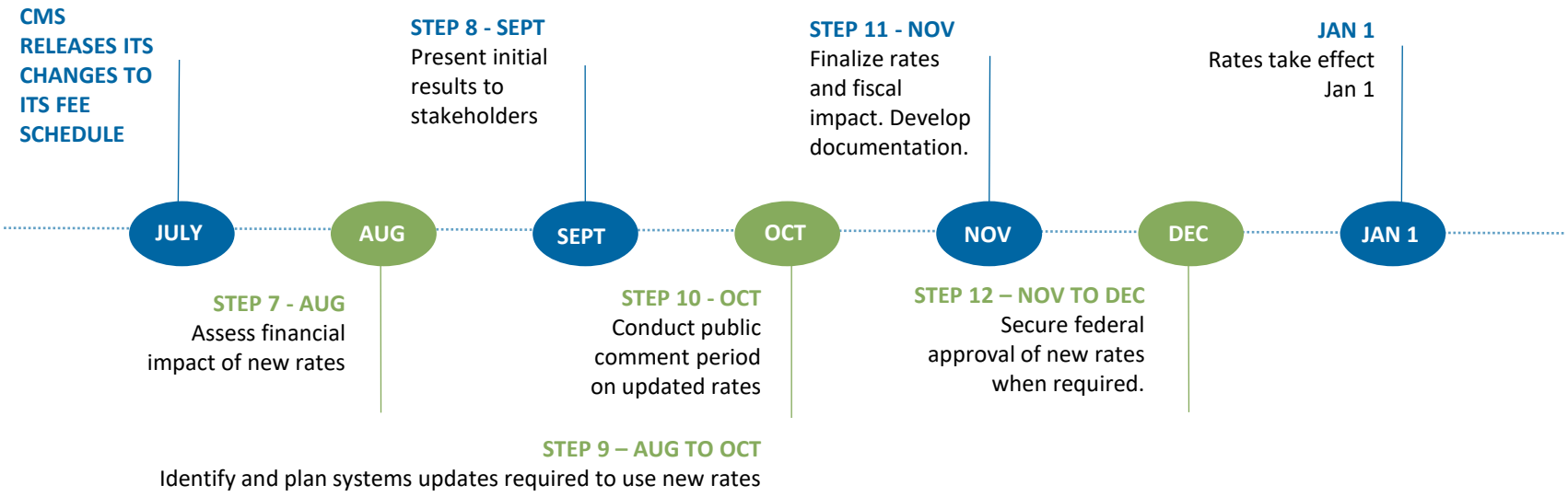
CALENDAR SHOWN BELOW USES ASSESSMENT OF A LEGISLATIVE APPROPRIATION AS AN EXAMPLE



UNLIKE A RATE REBASE PROJECT, A RATE UPDATE COULD TAKE AS LITTLE AS ONE MONTH OR AS MUCH AS SIX MONTHS

TIMING MAY BE INFLUENCED BY SYSTEM CHANGES, CMS GUIDANCE

CALENDAR SHOWN BELOW USES ADOPTION OF AN UPDATED MEDICARE FEE SCHEDULE AS AN EXAMPLE



AGENDA ITEM 4

PROPOSED ROADMAP TO DHSS FOR RATE DEVELOPMENT

HEALTH MANAGEMENT ASSOCIATES

WHAT IS THE ROADMAP?

- A Roadmap gives the DHSS an illustration that assumes a 4-year period to ensure that all provider service rates are addressed either through a rate rebase, a rate update, or both.
- Services may fall under different rate development "categories":
  - Some services never need a rate rebase because DHSS keys off a Medicare fee schedule (therefore, the rates are updated for DHSS by CMS). These services, however, are likely candidates for a rate update every year (e.g., physician and other professional services, laboratory, radiology, medical equipment)
  - Some services should have a rate rebase at least every four years, but may not need a rate update for the in-between years
  - There could also be services that fall under a combination approach. A rate rebase is recommended at least every four years, but these service may also be considered for a rate update for the in-between years. This is particularly true for services where rates need to "make up ground" to better align with current market factors (e.g., many services delivered in the home or in community-based settings)
- Recommended guidelines for the Roadmap:
  - If a service is only subject to a rate update, this is completed every year
  - If a service is subject to a rate rebase, this is completed once every four years
  - If a service is subject to a rate rebase and a rate update, the rebase is completed every four years. The rate update may occur in Years 2, 3 or 4 after the rate rebase.

DEVELOPMENT OF THE ROADMAP

- Services that are paid by DHSS on a rate schedule (as opposed to a global contract) were placed into categories.
- Each of the service categories was examined for rate development purposes:
  - Rate update, no rate rebase necessary
  - Rate rebase every four years
- DHSS resources were considered to distribute the work for rate rebase categories across four cycles in the Roadmap.
- As an example, the Roadmap could occur over four years (e.g., CY 2021-2024). Then the Roadmap timeline would repeat in the next 4-year cycle (e.g., CY 2025-2028).
  - Refer to slide on next page for an illustration of the Roadmap for all service categories
  - *Note that this is an illustration of the cadence to conduct rate setting. The assignment of specific service categories to specific years may change due to a number of factors*.

EXAMPLE OF A ROADMAP FOR DHSS SERVICES

Upper (green) box represents service categories for Rate Updates (*Medicare fee schedule)
Lower (blue) box represents service categories for Rate Rebase

Cycle 1	Cycle 2	Cycle 3	Cycle 4
Professional Services* Dental Laboratory* Radiology* Hospice* Dialysis Centers* Ambulance* Medical Equipment and Supplies* Home Health Nursing Facility Assisted Living	Professional Services* Dental Laboratory* Radiology* Hospice* Dialysis Centers* Ambulance* Medical Equipment and Supplies* Home Health Nursing Facility Assisted Living Clinic – Acute Care	Professional Services* Dental Laboratory* Radiology* Hospice* Dialysis Centers* Ambulance* Medical Equipment and Supplies* Home Health Nursing Facility Assisted Living Clinic – Acute Care	Professional Services* Dental Laboratory* Radiology* Hospice* Dialysis Centers* Ambulance* Medical Equipment and Supplies* Clinic – Acute Care
Substance Use Disorder Services (Community and Residential) FQHCs and RHCs** Child Care	Behavioral Health Services (Community and Residential) Institutions for Mental Disease (IMD) Inpatient Hospital Acute Care	I/DD Services (Community and Residential) Outpatient Hospital Acute Care Ambulatory Surgical Ctr	Community Services for Elderly and Physically Disabled Home Health Services Nursing Facilities Assisted Living

*Professional Services include physicians, nurses, therapists
** Federally Qualified Health Centers and Rural Health Clinics

RATE REBASE PROJECT DURATIONS

As stated previously, rate rebase projects can vary based on the type of changes contemplated, the variety of services offered in the provider category, the level of systems changes required under a new system, and the timing to allow for federal approval when required.

The time durations shown to the right reflect best estimates for each service category proposed for a rate rebase in the 4-Year Roadmap.

+ Substance Use Disorder Services, 12 to 18 months
+ Behavioral Health Services, 12 to 18 months
+ Community Services for I/DD Population, 12 to 18 months
+ Community Services for Elderly/Physically Disabled, 12-15 mo
+ FQHCs and RHCs, 12 to 15 months
+ Child Care, 9 to 12 months
+ Inpatient Hospital, 18 to 24 months
+ Outpatient Hospital, 18 to 24 months
+ Ambulatory Surgical Centers, 12 to 15 months
+ Institutions for Mental Disease, 9 to 12 months
+ Home Health Services, 12 to 15 months
+ Nursing Facilities and Assisted Living Facilities, 12 to 18 mo

AGENDA ITEM 5

KEY QUESTIONS WHEN CONDUCTING A RATE REBASE

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QUESTIONS WHEN CONDUCTING A RATE REBASE

DHSS is encouraged to consider the following questions for the service categories identified for a rate rebase every four years.

1. Which DHSS Divisions pay for this service?
2. What are nearby states paying for this service?
3. What data sources are needed to set new rates?
4. Is the same methodology being applied? Or is an entirely new methodology being considered?
5. How long is the project estimated to take from start to finish?
6. Are systems changes needed?
7. What resources (state staff and possibly external) are needed to conduct the rebase work?

Question 1
Which DHSS Divisions pay for the service?

+ If multiple Divisions pay for the service, it is important to know what the current rates paid by each Division are and when each Division conducted its last rate update.

+ When Divisions pay a different rate, it may be because the actual service is defined differently across Divisions or the staffing requirements vary. This should be considered when comparing rates.

+ Wherever possible, the DHSS is encouraged to set comparable rates for the same service across the Divisions if the service definition is also the same or similar.

Question 2
What are nearby states paying for this service?

+ Although other state rates can be used as a basis for comparison, they should be considered with caution.

+ Similar to DHSS Divisions, other states may use different definitions for a service. This may be the reason for the rate differential. Where possible, obtain each state's service definition.

+ Depending upon the service, a rate on file may not be the only way that providers are paid. If a state's rate is much lower than other states, look for other mechanisms providers may be paid.

Question 3
What data sources are needed to set new rates?

+ Are provider costs needed/recommended to rebase rates? Will these costs be collected from a standardized template (e.g. cost report) or from non-standardized sources?
+ If a provider's source for costs is not reported in a standardized format, it is strongly recommended to develop a provider cost survey so that information is reported in a standardized manner.
+ Providers will need time and assistance to complete a project-specific cost survey. Suggestion is to offer an educational webinar on how to complete the survey and 1:1 consultation where needed.

Question 4
Is the same methodology used? Or another one considered?

+ Some rebase project are more straightforward: the methodology is the same, but the reason for the rebase is to update cost data.
+ Rebase projects that not only update costs but also the method in which rates are set are more complicated. These projects typically require more systems updates and, thus, a longer timeframe.
+ Rebase projects may use the same methodology with updated costs, but also include additional features not present in the current methodology. An example would be adding a quality component.

Question 5
How long is the project expected to take from start to finish?

+ The work to actually compute new rates may not be the component of the project that takes the longest to complete.
+ Factors such as systems changes can often extend project timelines.
+ Even if rates are ready and DHSS is awaiting systems changes, it is advised to provide notice to providers months in advance of rate implementation so that providers can also plan ahead.

Question 6
Are systems changes needed?

+ Recommendation is to meet with the systems developers early on in a rate rebase project to explain the "concept" around the rate rebase.
+ Systems developers should offer high-level estimates of resources (costs to change) and timing (amount of time to make the changes and run tests that the changes are working properly).
+ Systems developers should be kept apprised throughout a project. Their concern is not so much what the rate amount is paid to a provider, but how it is paid out. Changes in the "how" can cause delays.

Question 7
What resources are needed to conduct the rebase work?

+ Who will be DHSS lead on the rate rebase project? What other resources does she/he need?
+ If outside subject matter expertise is needed or advisable, does a Request for Proposals need to be drafted to establish a contract for this expertise?
+ Are resources needed from DHSS outside of the Division responsible for the rate rebase? Who and what resources? Where do these resources fall into the project work plan?

+ At the start of any rebase project, a questionnaire should be developed and completed by the DHSS Project Officer responsible for leading the rate rebase project.
+ It is assumed that the DHSS Project Officer will need to consult with subject matter experts within DHSS to answer questions in the tool.
+ Responses to the questionnaire will help to inform what other preparatory work is required prior to initiating the rebase project itself.

QUESTIONNAIRES PRE-POPULATED

In an effort to assist in getting components of the Roadmap started for DHSS, the Burns & Associates team has filled in the Questionnaires for the 13 services that have been identified as subject to a rate rebase (the services in the blue boxes on slide 30).

The pre-populated questionnaires reflect information known as of the time of this presentation (March 2021).

The questionnaires themselves have been delivered to DHSS under separate cover along with the documentation of research compiled from nearby states.

The information shown on the next two slides is a visualization of what the questionnaires look like for each of the 13 services identified for rate rebase in the Roadmap. The italicized information describes the type of information that is filled in for each section of the questionnaire.

EXAMPLE OF PRE-POPULATED QUESTIONNAIRE, PAGE 1 OF 2

QUESTIONS WHEN CONDUCTING A RATE REBASE

Date this Questionnaire Completed:	
Service Category:	*This section will identify the service category and the specific services that fall under this category.*
Services under this category:	

Legend	
DMMA	Division of Medicaid and Medical Assistance
DSAMH	Division of Substance Abuse and Mental Health
DDDS	Division of Developmental Disability Services
DSAAPD	Division of Services for Aging & Adults with Physical Disab.

1 Which DHSS Divisions pay for this service?

	DMMA	DSAMH	DDDS	DSAAPD
Last Rate Update				
Is the Policy Manual Published?				
Last Update to Policy Manual				
Is the Billing Manual Published?				
Last Update to Billing Manual				

This section gives information about the last time the rate(s) for this service category were updated for each DHSS Division shown in the legend above. It will indicate of other materials describing the rate methodology are available and last udpates (year).

Enter notes about potential considerations for rate rebase

When completing the questionnaire, information can be recorded for considerations by DHSS when planning for the next rate rebase.

2 What information is available about how nearby states pay for this service?

	Fee Schedule Online?	Methodology Described Online?	Methodology Compared to DHSS	Regular Rate Update?	How Are Services Paid?	References from other states
Pennsylvania						
New Jersey						
Maryland						
District of Columbia						
New York						

Information is recorded in this section that gives specific information about nearby states and how they pay for the service. A quick reference guide shows if the methodology documentation is also available online.

This section contains the specific links to the documentation referenced in the section to the left. For the Roadmap project, the Burns & Associates team downloaded and compiled all available information for DHSS as of February 2021.

3 What data sources are needed to set new rates?

Source	# States Use this Source	(out of 5 above)
Provider costs		
External sources		
Other		

This is a quick reference to show which states use each data source for rebase.

Enter notes about potential considerations for rate rebase

Based on information researched about other state data sources, notes can be made here for items for DHSS to consider.

EXAMPLE OF PRE-POPULATED QUESTIONNAIRE, PAGE 2 OF 2

QUESTIONS WHEN CONDUCTING A RATE REBASE (continued)

4 For this rebase, is the same methodology being applied?

Methodology Components	In Today's Methodology?	Considering for Rebase?
Adjustments for acuity	*Factors that may be considered in the methodology for a rate rebae are tracked here and compared to current*	
Adjustments for group size		
Adjustments for locality		
Quality-based incentive		
Payment for outcomes		

Enter notes about potential considerations for rate rebase

Based on information researched about other state data sources, notes can be made here for items for DHSS to consider.

5 How long is the project estimated to take from start to finish? (Timeframe assumes systems and subject matter resources are available)

From 9 to 12 months	From 12 to 24 months
From 12 to 15 months	From 18 to 24 months

One selection from the options to the left is made to estimate the total project timeline.

6 Are systems changes needed? (Time needed assumes systems resources and subject matter resources are available)

	If Yes, Category of Changes			Time Needed
Yes, definately	Significant	Medium	Minor	6-12 months
Yes, probably	Significant	Medium	Minor	
No				

Describe system changes that may be needed

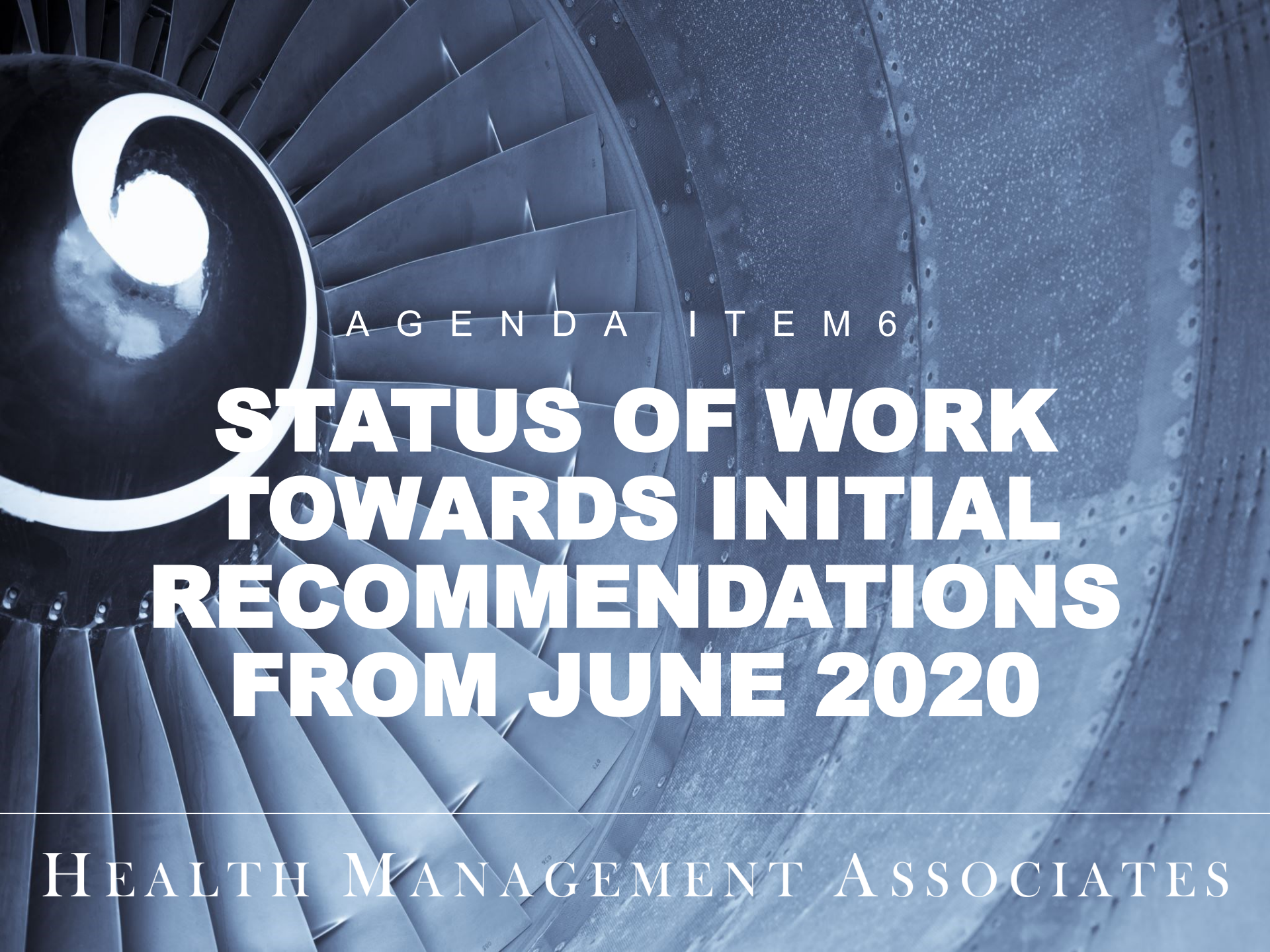
Selections are made from options to the left about whether systems changes may be needed related to the rate rebase, the level of changes, and timing needed.

7 What resources (internal and external) are needed to conduct the rebase work?

	Type of Resource Needed
DMMA	*Specific resources (job title) needed to assist in this project from each area are identified. If none are needed from a specific are, "none" is indicated.*
DSAMH, DDDS	
DHSS	
Gainwell (systems changes)	
External consultant	
Providers	
MCOs	
CMS	

Describe process to coordinate/obtain resources

Phrases entered here may include "coordinate with Director of Division" or "write RFP to obtain external consultant" or "establish a provider workgroup".



AGENDA ITEM 6

STATUS OF WORK TOWARDS INITIAL RECOMMENDATIONS FROM JUNE 2020

HEALTH MANAGEMENT ASSOCIATES

STATUS OF INITIAL 9 RECOMMENDATIONS MADE IN JUNE 2020 REPORT

1. **DHSS is encouraged to develop a long-term roadmap for assigning periodicity of updates for rates.**
   - Completed. Described in this presentation and supporting materials.
2. **Consider changing inpatient hospital reimbursement methodology.**
3. **Consider changing outpatient hospital reimbursement methodology.**
4. **Consider migrating to CMS's new methodology to pay nursing facilities.**
   - Inpatient services currently slated for Cycle 2 of 4 in the Roadmap. Outpatient services slated for Cycle 3 of 4. Nursing facilities slated for Cycle 4 of 4.
5. **Modernize rate methodologies for home- and community-based services (HCBS) by building rates "from the ground up" that are specific to each Division's needs.**
   - This process has already begun with the building of rates for substance use disorder services (in process now) and will continue for HCBS services in Cycles 2, 3 and 4.
6. **For Divisions that do not set individual rates, leverage information from Recommendation #5 to establish acceptable rate corridors in contract negotiations.**
   - Information will be factored into new contract negotiations as rates for comparable services are rebased for services in Cycles 1 through 4 of the Roadmap.
7. **Build a project-specific work plan for each rate rebase that includes stakeholder feedback.**
   - Questionnaires have been completed for each rate rebase category to help build the project-specific work plans. Estimated timeframes for each project are listed in Slide 31.
8. **Utilize a more formalized Public Notice process to inform stakeholder of rate changes.**
9. **Update Provider Manuals for each major category of service to describe rate updates.**
   - Recommendation #8 is Step 10 of the 12 Steps in Rate Development that was created. Recommendation #9 is Step 11 of the 12 Steps (refer back to slide 9 for details).