Briefing to Stakeholders on Independent Study of Rates Paid by the Divisions within the Delaware Department of Health and Social Services

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Topics for Presentation

1. Purpose of the Study
2. Approach to Conduct the Study
3. Concepts Related to Rate Setting
4. Specific Content Contained in the Report
5. Summary of Findings
6. Recommendations to Improve DHSS Rate Setting Processes

Purpose of the Study

Legislative Requirement

- House Bill 225 of the 150th General Assembly required DHSS to review the methodologies and rates paid to providers for services across all Divisions.

  Section 182. *The Secretary of the Department of Health and Social Services shall work in partnership with the Director of the Office of Management and Budget and the Controller General on a comprehensive review of the multiple and differing methodologies used for provider rates for services delivered across the department for vulnerable and at-risk populations. Said review shall include a listing of provider rates by service, the populations served, associated federal matching funds and the most recent rate increase provided for such service. Further, the review shall include options for consideration, to the extent practical, to create a uniform and consistent methodology for addressing provider rates, to be considered annually through the budget process, in a manner that promotes access to service, addresses the workforce needs of the provider community, and establishes outcomes and metrics for the services delivered. The review and options shall be submitted to the Joint Finance Committee and the Governor by April 1 of this fiscal year.*

Background on the Study

- DHSS contracted with Burns & Associates, Inc. (B&A) to provide technical assistance in the development of the report.
  - B&A was founded in 2006, primary client base is State Medicaid and other social service organizations.
  - B&A has worked with 33 state agencies in 26 states.
  - A large component of B&A's work is in the development of provider rates and associated tasks (e.g., service definitions, billing, CMS approvals, provider engagement).

- Timeline requested in the legislation slightly delayed due to Covid-19
  - Draft report to DHSS in March 2020.
  - Final report to DHSS in April 2020.
  - Briefing to key Joint Finance Committee members June 15, 2020.

Approach to Conduct the Study

Approach to Conduct the Study

- Qualitative Elements
  - Interviews with key informants at each DHSS Division (Oct 2019).
  - B&A inquired about methodologies in use for rate setting, source data used, formal processes in place (if any).
  - Specific discussion around current provider base, challenges (if any) to attract and/or retain providers.

- Quantitative Elements
  - B&A read in individual claim details for services billed by providers to DMES, the Delaware Medicaid Enterprise System (services funded by DMMA, DDDS and some from DSAMH).
  - For services not in stored DMES, B&A collected data through a survey instrument to Divisions (DPH, DSAMH, DSAAPD, DSSC, a small portion from DDDS).

Approach to Arraying the Services

- Services categorized into three major groupings:
  - Services covered by Medicaid and administered by DMMA (fee-for-service) or one of its contracted managed care organizations.
    - ➢ Findings appear in Section V of the Report
  - Non-medical services covered through Medicaid waivers or other Divisions on a per service basis.
    - ➢ Findings appear in Section VI of the Report
  - Services administered by DHSS Divisions where payment is through a contract mechanism as opposed to an individual claim.
    - ➢ Findings appear in Section VII of the Report

Method to Aggregate Service-specific Data

- For medical services and waiver services, B&A relied primarily on the categories of service that the State uses for federal reporting.
  - B&A worked with the State Core Team on this project to align some related categories together into one group.

- Claim-level data was examined over a three-year period (State Fiscal Years 2017, 2018, 2019) to ensure data completeness and no unusual trends.
  - Data reviewed services paid in both the fee-for-service and managed care setting.

- Note that, as agreed by the State team, pharmacy is excluded from the study.

Service Categories Displayed in Report Section V

Major Section	Sub-Section
Acute Care	Inpatient Hospital
Acute Care	Skilled Nursing Facilities and Assisted Living Facilities
Acute Care	Institutions for Mental Disease aka Psychiatric Hospitals
Acute Care	Home Health Services except Private Duty Nursing
Acute Care	Hospice Care
Outpatient Facility Care	General Acute Outpatient Hospital
Outpatient Facility Care	Ambulatory Surgical Centers
Outpatient Facility Care	End Stage Renal Disease (Dialysis) Services
Clinic Services	Federally Qualified Health Centers
Professional Services	Evaluation and Management Services (general office visits)
Professional Services	Procedure (specialty) Services
Ancillary Services	Physician-Administered Drugs
Ancillary Services	Independent Laboratory and Radiology
Ancillary Services	Durable Medical Equipment, Prosthetics and Orthotics
Substance Use Disorder	SUD Services Delivered in an Outpatient Setting
Substance Use Disorder	SUD Services Delivered in a Residential Treatment Setting
Other Medicaid Services	Children's Dental Services
Other Medicaid Services	Vision and Hearing Services
Other Medicaid Services	Emergency (Ambulance) and Non-Emergency Transportation
Other Medicaid Services	Private Duty Nursing

Service Categories Displayed in Report Section VI

HCBS Services Delivered by MCOs in Medicaid Managed Care (PLUS Program)
HCBS Services Delivered by the Division of Developmental Disabilities Services
HCBS Services Delivered by the Division of Substance Abuse and Mental Health (PROMISE Program)
Children's Behavioral Health Services Administered by the Department of Children, Youth and their Families
School Based Health Services

HCBS = Home- and Community-Based Services

PLUS Program = the Diamond State Health Plan-Plus program in Medicaid managed care administered by DMMA in partnership with DSAAPD to enhance community-based long-term services and supports

PROMISE = Promoting Optimal Mental Health for Individuals through Support and Empowerment, the program to enhance community-based behavioral health supports

Examples of Services in Section VII of Report

- Within the Division of Public Health (DPH)
  - Services funded under the federal Ryan White Act
  - School-based health services
  - Healthy Women Healthy Babies program
  - Home visiting services

Examples shown here are not the exhaustive list of services covered.

- Within the Division of Substance Abuse and Mental Health (DSAMH)
  - Crisis intervention, mobile and non-mobile settings
  - Peer support services
  - Substance use disorder residential treatment

- Within the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
  - Home delivered nutrition
  - Personal care and attendant services

- Within the Division of State Service Centers (DSSC)
  - Emergency Assistance services
  - Transitional housing

Concepts Related to Rate Setting

Rate Setting Background

- There is not one pre-defined method for how to pay for the services that DHSS is responsible for.
  - In the opinion of B&A, it is not advisable to consider this as an option.
  - The vast array of services provided, the definition of the services delivered, and the periodicity of payment (e.g. per service, per visit, per hour, per day, per episode) make this option not viable.

- Methodologies to pay for services vary greatly in complexity and maturity in the market.
  - Many medical services have long-standing methodologies considered "industry standards". Examples: hospital services, physician and other professional services, laboratory tests
  - Other medical services have methodologies that are relatively newer to the market. Examples: hospice care, dialysis, some medical equipment
  - For home- and community-based services, there is no "industry standard". Since these services are almost solely funded by Medicaid, each State Medicaid agency has effectively done a "go it alone" approach.

Medical Service Methodologies are Evolving

- Even well-established rate methodologies for medical services vary in their evolution of sophistication, particularly when it comes to value-based or quality-based components.

- CMS has been an innovator in some regard to evolve its long-standing rate setting methodologies. Some examples:
  - Quality reporting is required of hospitals, nursing facilities, home health agencies and physicians. Rate increases/decreases to providers can occur as a result of the quality measure results.
  - CMS introduced a "competitive bid" component to its payment method for durable medical equipment and supplies to instill more market competition.
  - Nursing facility reimbursement was recently changed by Medicare to use an assessment tool that measures a multiple array of NF resident needs. The prior tool was heavily-weighted to the need to therapies only.

- Still, most CMS payment methodologies remain under a "fee-for-service" approach that rewards volume over value.

Variation in CMS Methodologies

		Acuity Adjustment?	Value Based Component?	Quality Reporting?
Per Service Rate	Ambulance	No	No	No
	Ambulatory Surgical Center	No	in progress	No
	Clinical Laboratory	No	No	No
	Durable Medical Equipment, Prosthetics & Orthotics	No	Yes	No
	Clinics	No	No	No
	Hospital Outpatient Services	No	No	No
	Physicians and Nurse Practitioners	No	Yes	Yes
Per Diem Rate	Home Infusion Therapy	Yes	No	No
	Hospice Care	No	No	Yes
	Hospital Inpatient Psychiatric Care	Yes	No	No
	Skilled Nursing Facility	Yes	No	Yes
Per Case Rate	Hospital Inpatient Acute Care	Yes	Yes	Yes
	Hospital Inpatient Rehabilitation Care	Yes	No	Yes
	Hospital Long Term Care	Yes	No	Yes
Per Episode Rate	End Stage Renal Disease Dialysis	Yes	No	Yes
	Home Health (nursing/therapies)	Yes	No	Yes
	Opioid Treatment	No	No	No

Methodologies for HCBS are Fragmented

- Many states do survey the providers who deliver the services to the state's clients to obtain cost information.
- One challenge of relying only on provider costs is the "chicken/egg" issue. For example:
  - A state's published rate for an HCBS service is $15.00 per service. Prevailing costs (particularly labor and employee benefits) suggest that the rate could be as high as $20.00.
  - If a state surveyed its providers for labor costs, it is likely that the providers would report an average hourly rate in the range of $11.00 per hour.
  - The current market rate, however, for this labor category is a rate of $15.00 per hour.
  - Providers will be paying out only up to what they are being paid.
- Many state rate methodologies also do not factor in a "productivity adjustment". For example, the provider's employee works 8 hours per day, but the provider can only bill out 6 hours per day of face-to-face client time.

Specific Content Contained in the Report

Key Information

- Items that are contained in the study:
  - Inventory of the methodologies used
  - Inventory of the current rates paid
  - Inventory of all meaningful contracts for services not paid on a per service basis
- Information shared in the report:
  - A methodology about how to prioritize changes to rate methodologies
  - Recommendations about how to change current rate *methodologies*
- Information that is not shared in the report:
  - Recommendations about changes to specific service rates

Dashboard Report to Assess Opportunities

- For medical services, a single-page dashboard was created to assess opportunities for reforming the State's current rate methodology for the service category.
  - Each of the 20 medical service categories that appear in Section V of the report were assessed.

- A scoring of low (1 point), medium (2 points) or high (3 points) was assigned to six different domains to assess impact of a change:
  - Percent of the total Medicaid budget
  - Percent of managed care expenditures
  - Volume of beneficiary users of the service
  - Medicaid providers per 1,000 Medicaid enrollees
  - Opportunity to modernize the payment system
  - Opportunity to integrate a value-based component

- With a possible score of 6 to 18, services with a score closer to 18 were deemed as having the highest priority for review.

Individual Service Category Dashboard Reports

- Applies to services that appear in Sections V (medical) and VI (HCBS) of the report.
- A one-page summary report that includes supporting information used by B&A to make assessments of future rate setting options as well as to comply with specific items requested in the legislation.
- Four sections appear on the individual dashboard reports:
  - General Information (colored in blue)
  - Information Related to Rate Setting Methodology (colored in peach)
  - Information Related to Value-Based Methodology (colored in green) *Note that this appears only in Section V
  - Average Payment Per Unit for the Top 5 Revenue Codes or Procedures (colored in yellow)

Example of General Information Section

GENERAL INFORMATION			
Expenditure Information on State Fiscal Year 2019 Incurred Services:			
Service Expenditures, SFY 2019 (in millions)	**$89.9**	Percent of Medicaid Service Budget (incl. waivers)	4.4%
Federal Share* of Expenditures (in millions)	**$51.8**	Classification: % of Medicaid Service Budget	**Medium**
State Share of Expenditures (in millions)	**$38.2**		
*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.			
Population Information:			
Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	3,057
Total Unique Users, SFY 2019	**165,335**	Total Providers per 1,000 Users, SFY 2019	18.5
Classification: % of Total Population Served	**High**	Classification: Provider Base	**Low**
		**The count of providers is derived from billing ID numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**97.2%**		
Percent of MCO's Service Expenditures	5.5%	Number of Provider Specialties in Category	168
Classification: % of MCO Expenditures	**Medium**		

Example of Rate Setting Section

INFORMATION RELATED TO RATE SETTING METHODOLOGY			
Overview of Current Rate Methodology			
DHSS pays 100% of Medicare's resource-based, relative-value system (RBRVS) for E&M codes. Updated annually. Unlike other services, non-physician clinician rates for primary care are not discounted based on place of service. There are two rates on file--one for facilities (billed by a hospital), one for non-facilities (billed by a physician practice).			
Last rate update for this service	**2019**	Does Medicare have a rate methodology for service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available?	No
Total Unique # of CPT/HCPCS Codes	**78**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			**Low**
Nothing specifically			

Example of Value-Based Section

INFORMATION RELATED TO VALUE-BASED METHODOLOGY			
Does the State use value-based methods as part of these payments?	Yes	Level of opportunity to modernize current methodology	**Medium**
A description of those methods include:			
The State is providing per member, per month payments for care management to primary care physicians.			
Options for adding a value-based component (if level of opportunity is rated Medium or High above)			
As detailed in the Delaware State Innovation Model (SIM) Final Report (2015-2019), Delaware supported primary care practice transformation and behavioral health integration, which could serve as the basis for development of value-based components.			

Example of Top Services Section

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES						
Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Non-Facility Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Office visit, established patient, 25 min	99214	30.6%	$27,529,595	$109.85	$107.80	$106.73
Office visit, established patient, 15 min	99213	29.4%	$26,457,063	$75.06	$72.89	$72.58
Office visit, new patient, 45 min	99204	6.0%	$5,372,108	$166.35	$163.75	$172.00
Office visit, new patient, 30 min	99203	5.7%	$5,117,135	$109.66	$108.18	$115.25
Office visit, established patient, 40 min	99215	4.1%	$3,714,742	$147.20	$143.37	$159.20

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which differs from the standard rate.

Fee Schedules

- The legislation required the DHSS to report on the last rate update for each service as well as the rate paid for each service.
- The service dashboard report indicates the last update to the rate. This information also appears in the appendix to the report.
- Contents of appendices:
  - 27 different reports (Appendix A through AA)
  - 24 appendices cover services paid by DMMA
  - 3 appendices cover services paid by other Divisions
  - A short narrative at the top of the appendix describes the methodology used.
  - Each appendix references one of the service-specific dashboard reports.
  - Because there are thousands of service codes, the appendices cover 467 pages combined.

Example of an Appendix in Report

APPENDIX J

Delaware Division of Medicaid and Medical Assistance
Fee Schedule for Evaluation and Management Services
Dashboard Number 4.1

Last FFS Rate Update: 1/1/2020

The DMMA pays 100% of the Medicare rate for Evaluation and Management (E&M) services.
Medicare updates E&M rates every Jan 1. E&M Services are typically standard office visit codes used by physicians, physician assistants and nurse practitioners. The 'facility rate' would be billed by a hospital. The 'non-facility rate' would be billed by a physician's office.
Sometimes, the rate is split between a professional (modifier 26) and technical (TC) component.
The professional component is performed by a human being. The technical component pays for equipment use.

Procedure Code	Modifier	Description of Procedure	Facility Rate	Non-Facility Rate
99201		OFFICE OUTPATIENT NEW 10 MINUTES	$26.83	$46.33
99202		OFFICE OUTPATIENT NEW 20 MINUTES	$51.15	$76.79
99203		OFFICE OUTPATIENT NEW 30 MINUTES	$76.53	$108.67
99204		OFFICE OUTPATIENT NEW 45 MINUTES	$130.89	$165.91
99205		OFFICE OUTPATIENT NEW 60 MINUTES	$170.95	$209.58

Division Dashboard Reports

- A one-page summary report was created for the DHSS Divisions that use contract vehicles to pay for services. These are services not covered by Medicaid and for which claims are not submitted by providers for each individual service delivered.

- Contents of the individual Division dashboards:
  - Description of the Division's mission
  - Total Division Expenditures in SFY 2019, federal and state share
  - Total number of provider contracts
  - Type of contract mechanisms (e.g. competitive bid vs. sole source, offeror bids a price or Division names the price)
  - Key information on top dollar contracts, including the amount, percent of all contract dollars spent by the Division, estimate of clients services, total vendors in contract category, most recent contract update

Example of Division Report *(not complete list)*

DPH: The Division of Public Health

The Division of Public Health protects and promotes the health of all people in Delaware. The current priorities focus on improving health-related lifestyles; improving access to integrated, prevention-focused quality and safe health care as part of health system reform; achieving health equity; preventing opiate abuse and misuse; and improving performance through performance management and improving organizational culture.

CONTRACT INFORMATION

Total Division Expenditures, SFY	**$ 28,861,629**
Federal Share of Expenditures	**$ 9,439,685**
State Share of Expenditures	**$ 19,421,945**
Total Number of Provider Contracts	94

Contract Types

Among the highest dollar contracts shown below, 10 were developed through a competitive bid process where the provider bid a price. Other contracts have rates set by legislation or use the Medicaid fee-for-service rates.

Top Contracts (by total dollars):

Type of Services	Contract Amount	% of Contract Dollars	Clients Served	Number of Vendors	Most Recent Update
Ryan White	$ 10,725,363	37.2%	1,621	12	Not available
School Based Health Services	$ 4,543,246	15.7%	11,430	7	2017
Home Visiting	$ 3,721,506	12.9%	5	5	Not available
Healthy Women Health Babies	$ 2,300,000	8.0%	7	7	Not available
Child Development Watch Programs	$ 1,627,533	4.3%	100s	1	Not available
HIV/AIDS Prevention Services	$ 1,165,348	4.0%	10,019	5	1/1/2019

Summary of Findings

Findings Related to Medical Services

1. DHSS, through DMMA, has adopted protocols to keep current with Medicare rates and Medicare methodologies on many services.

2. When the Medicare methodology is used, DMMA is usually on par with or just below the prevailing Medicare rate.

3. When DMMA does use Medicare payment methodologies, there are some opportunities to add value-based components like Medicare has done.

4. Areas where DMMA is not aligned with Medicare rate setting methodology:
   - Inpatient hospital services
   - Outpatient hospital services
   - Nursing facility services (DMMA had been in alignment with Medicare, but starting in Oct 2019, Medicare fundamentally changed to a next generation resident classification system for payment)

Findings Related to Community Services

1. DDDS recently conducted a provider survey to capture costs to deliver the services in this Division's purview. Some rates were updated. In some cases, legislative appropriations limited the extent that rates could increase.

2. DSAMH had developed a methodical approach to setting rates for many of its services, but the last update to these rates occurred in 2014 or 2015.

3. There is presently a review of substance use disorder rates and rate methodology underway through a SAMHSA grant.

4. DSAAPD does not have a consistent process to review and update rates.

5. The level of provider/stakeholder interaction in the rate setting process and the level of transparency varies across Divisions and service lines.

Findings Related to Contracted Services

1. The contract mechanism, as opposed to a fee schedule method, appears to be the logical route for many of the services paid for by many Divisions.

2. Almost all contracts of meaningful dollar significance were awarded through a competitive bid process.

3. When bidders are competing for the same service contract, when the Division awards multiple contracts, there does not appear to be a standardized approach to accepting, rejecting or renegotiating the rate proposed by the bidder.

4. There appear to be opportunities using the contract-based payment vehicle to add either a value-based component to the payment or key performance indicators in the contract to assess the vendor's performance.

Recommendations to Improve DHSS Rate Setting Processes

#1 Develop a Long-Term Roadmap for Assigning the Periodicity of Updates of Rates for Medical Services

- Includes tracking the following:
  1. If Medicare has a methodology that could be used in whole or in part.
  2. Whether there is a potential to add a value-based component to the rate methodology.
  3. Resources required (internal and external) to change to a new methodology and/or perform periodic updates.
  4. Current resources and any gaps in resources to complete the work.
  5. Modes of communication to external stakeholders when changes occur (e.g., in-person meetings, provider bulletins, updated billing manuals).
  6. The timing and cadence of updates to align with annual legislative budget preparations.
  7. The timing needed to introduce value-based initiatives (e.g. introduce a new methodology as Phase 1, then introduce the value-based component as Phase 2).

#1 Long-Term Roadmap, Timing

- B&A believes that a roadmap such as the one recommended here can be prepared within six months to cover all high-dollar service categories within DHSS.
  - Roadmap will require additional resources.
  - B&A's assessment is that none of the Divisions that deliver Medicaid-covered services (DMMA, DSAMH, DDDS or DSAAPD) have sufficient staffing to undertake significant rate changes immediately.
  - External resources may be considered for either a one-time 'changeover' to a new methodology. Then, State staff can maintain for periodic updates.

#1 Long-Term Roadmap, Staffing for Rate Reviews

- B&A's recommendations in the report for staffing among medical service categories is as follows. Note this is separate from staff who do contracting.
  - DMMA: 5 FTEs (1 manager/value-based lead, 1 hospital, 1 nursing facility and other nursing, 1 professional services, 1 Medicaid-only services).
  - DSAMH: 2 FTEs (1 for mental health, 1 for substance use disorder).
  - DDDS: 1 FTE
  - DSAAPD: 1 FTE
  - DMS: 1 partial FTE to maintain oversight of rates/policies for services that cross multiple Divisions
- B&A's recommendations in the report for areas where external subject matter expertise is prioritized:
  - Hospital services, nursing facility services, home health, mental health services, community-based services delivered by DSAAPD and DMMA

#2, #3, #4
Recommendations for Specific Medical Services

- Recommendation #2: Consider changing the inpatient hospital reimbursement methodology from a per discharge rate that is not based on patient acuity to a per discharge rate based on acuity such as diagnosis related groupings (DRGs).

- Recommendation #3: Consider changing the outpatient hospital reimbursement methodology to a rate structure that incentives value and efficiency (e.g. Medicare Outpatient Prospective Payment System or 3M's Enhanced Ambulatory Patient Grouping).

- Recommendation #4: Consider migrating to CMS's new methodology to pay for nursing facilities using the Patient-Driven Payment Model (PDPM) and away from Resource Utilization Groups (RUGs). Whereas the RUGs payment was heavily-weighted to the number of therapies that a resident received, the PDPM considers other factors in the complexity of resident care.

#5 Develop a Process to Capture Provider Actual Costs as well as Independent Market-Based Costs as a Comparator for HCBS

- This recommendation applies most specifically to the Divisions that provide home- and community-based services (HCBS) including DSAAPD, DDDS, DSAMH and some services in DMMA.
- Specific components to the recommendation:
  1. Carefully review the definition of the service and unit of measurement (e.g., per hour, per day) in assessing costs to perform the service.
  2. Collect cost data from the providers who deliver the service.
  3. Collect independent market-based data to benchmark to provider costs.
     - Example: If current rate is low, the provider's costs for labor will likely also be lower than market. Use Bureau of Labor Statistics results for the labor category, or equivalent, to compare to.
  4. Build rate "from the ground up" and specific to Division's needs.
  5. When State resources are limited, if the market-based rate is not affordable, publish the "benchmark" rate and the "adopted" rate (the rate that can be afforded at the time).

#6 Develop a "Rate Corridor" when the Service is Paid on a Contract, rather than FFS, basis

- This recommendation applies most specifically to the Divisions that pay for services through a contract as opposed to receiving bills for each unique service provided. Includes DPH, DSSC, DCSS, DSS, DVI, and some services paid by DSAMH, DSAAPD, and DDDS.
- Specific components to the recommendation:
  1. Review the definition of the service and unit of measurement (e.g., per service, per client) in assessing costs to perform the service.
  2. Collect independent market-based data to benchmark to provider costs.
  3. Build rate "from the ground up" and specific to Division's needs.
  4. Determine the acceptable range around the rate built up by the Division to assess offers proposed in the contracting process.
  5. Determine if some portion of this contract can include a value-based or performance-based component to payment.
- Unlike Recommendation #5, items in this recommendation may be done for internal Division purposes only.

#7, #8, #9
Recommendations for Rate Setting Processes

- Recommendation #7: Initiate a more formalized Public Notice process to inform providers and other stakeholders when rate changes are being contemplated. This would include an opportunity for stakeholder feedback.

- Recommendation #8: When rate methodology changes are undertaken, build a project-specific work plan that incorporates periodic meetings with providers affected by the rate change throughout the project. Recommendation #7 is useful, but the providers affected by a rate change should know the general direction the State is taking prior to Public Notice.

- Recommendation #9: Strengthen the accuracy and completeness of Provider Manuals in sections specific to rate payment methodologies. This would include not only the actual calculations, but also any changes to billing or other operational changes related to the rate change.