EXECUTIVE SUMMARY

House Bill 225 of the 150th General Assembly requires 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.*

DHSS contracted with Burns & Associates, Inc. (B&A) to provide technical assistance in the development of this report. B&A is a consulting firm founded in 2006 whose primary client base is social services departments within state governments, including Medicaid, mental health and substance abuse, intellectual and developmental disabilities (I/DD), and services to children. Since its founding, B&A has worked with 33 state agencies in 26 states. A large component of B&A's work centers around the development of provider rates and associated tasks related to rate setting.

This report provides an assessment of the methodologies used to set rates. B&A does not make an assessment of the adequacy of any particular rate per se. The over-arching goal is to provide a framework for which the DHSS can assess on a regular basis the adequacy of the rates it uses by measuring against statewide or national benchmarks.

Background on Rate Setting

There is not a single rate schedule or rate methodology in place to pay for ***medical services***. In fact, the Centers for Medicare and Medicaid (CMS) have 17 different rate methodologies to cover the array of services covered in the Medicare program. Some methodologies, such as diagnostic related groupings for inpatient hospital services, were first introduced in 1983. Others, such as for home infusion therapy and opioid treatment, were just introduced in the last year. Section II of this report provides more information on the rate methodologies used by Medicare.

Unlike many of the medical service categories, there are no standard methodologies set by CMS for ***home- and community-based services*** (HCBS) in Medicaid waivers, primarily because these are not services offered in the Medicare program. As a result, State Medicaid Agencies have taken many approaches to developing the rates paid for HCBS. Compared to medical services, the approaches to rate setting for HCBS, though not brand new, are not as pervasive in the field as many of the methodologies for medical services.

Recommendations

Based on our review of claims and managed care encounter data from the State's data warehouse, the in-person interviews with staff involved in rate setting within each DHSS Division, and our experience setting and reviewing rates for a variety of medical and social services for other state agencies, B&A

offers recommendations to improve the rate setting process across DHSS. These recommendations relate to medical services administered by the Division of Medicaid and Medical Assistance (DMMA), to HCBS services administered by multiple DHSS Divisions, and to contracts administered by most DHSS Divisions. Specifically, we offer recommendations on how to easily pinpoint wide variations from either industry standards or third-party benchmark data such as the prevailing wage for job categories that are employed by various provider agencies. Therefore, our recommendations are centered around ways to adapt Delaware's DHSS to common industry standards as well as ways to strengthen rate methodologies that are specific to Medicaid-covered services.

The specifics around each of the nine recommendations shown below appear in Section VIII of this report. The recommendations are provided in summary format below.

1. ***DHSS is encouraged to build rate methodologies that are specific to each service that is purchased and not to build a uniform "one size fits all" methodology. That being said, some service categories can have rate methodologies that are common in the way that they are built. The difference lies in accounting for variations based on the definition of the service being purchased***.

   B&A's experience has found that there is never a single "rate schedule" covering all services that are paid by health purchasers. This is true in the commercial market as well as the public sector markets (Medicare, Medicaid, Department of Defense and Veteran's Affairs). As an example, Exhibit 1 on page II-4 itemizes the 17 different rate schedules developed for the Medicare program.

   Although B&A has offered a prioritization to focus resources on areas of opportunity within the DMMA service array, B&A does not believe that this needs to be the highest priority. Specific recommendations for DMMA services appear later in this list of recommendations.

   Instead, B&A suggests that priority be centered on rate schedules for which there is no CMS benchmark. B&A offers a specific recommendation below on how to build consistency in the rate methodology for these services while also adapting to the specifics of each service definition.

2. ***DHSS is encouraged to develop a long-term roadmap for assigning the periodicity of updates of rates for all of its services.***

   More specifically, any guiding roadmap should also include the following:

   - Track if Medicare has a comparable methodology in place that could be considered;
   - Track whether DHSS will incorporate a value-based component to its rate methodology;
   - Identify the resources (both internal and external) to make changes to the methodologies;
   - Assess where there are gaps in current resources to complete this work;
   - Identify the modes of communication to external stakeholders required when changes occur;
   - Prepare, in advance, the timing and cadence of updates to align with annual budgeting;
   - Prepare, in advance, the timing needed to introduce value-based initiatives into each rate methodology where it is warranted and any associated quality-based reporting needed to ensure that the value-based initiative has a positive return on investment.

B&A believes that the development of a roadmap such as the one described above could be prepared within six months to cover all significant service categories delivered by DHSS Divisions.

3. ***B&A recommends that DHSS consider augmenting the existing staff currently used to develop and maintain rate methodologies and to clearly define roles and responsibilities for the staff that perform this function***. Specific staffing suggestions, by Division, appear in Section VIII.

4. ***B&A recommends to all DHSS Divisions that a more formalized Public Notice process be initiated to inform providers and other stakeholders when rate changes are being contemplated***. CMS uses the process of issuing Proposed Rules, then allows for a period of public comment, then issues a Final Rule when rate changes are made.

5. Although a Public Notice is helpful, B&A has found that ongoing communication with providers on upcoming rate changes is also essential. Therefore, ***B&A recommends that when rate methodology changes are undertaken, DHSS should build a project-specific work plan that incorporates periodic meetings with the providers affected by the rate change throughout the project***.

6. B&A found that the accuracy and completeness of the manuals that describe the rate methodologies and billing guidance to providers across DHSS were mixed or non-existent. ***B&A recommends that, for each major category of service, there should be a dedicated section in the Provider Manual that describes the rate methodology in detail and that this section is updated timely when any rate changes occur***.

7. ***With respect to opportunities to modernize the rate methodology for HCBS (non-medical services), B&A recommends that DHSS develop a process to capture provider actual costs as well as independent market-based costs to use as a comparison when setting HCBS rates. Rates for these services can be built on a model that is built "from the ground up" and specific to the Division's needs***.

   <u>The services covered in this recommendation pertain most specifically to Division of Developmental Disability Services, the Division of Substance Abuse and Mental Health, the Division of Services for Aging and Adults with Physical Disabilities, and the Division of Social Services for child care support</u>.

   There is not a uniform method in which provider costs are captured to deliver HCBS services like there is, for example, with hospitals and nursing facilities. Even when costs can be captured, there is often a "chicken-and-egg" scenario. If the rate of payment is below-market for a service, then the costs that providers will report will be below-market because that is what the provider can afford to spend to remain financially viable.

   B&A proposes that, although the rates themselves will differ, the process upon which how rates are developed can be fairly standardized if the following principles are applied for each service:

   a) C
      arefully review the definition of the service and the unit of measurement (e.g., per hour, per day) to ensure the Division is cognizant of what it wants to pay for.
   b) T
      rack and maintain if there are specific federal or state rules or policies that must be factored into the cost of delivering the service.

c) Collect cost information from providers to inform the development of a new rate.

d) Collect market-based data *outside of provider costs* to benchmark against the costs reported by providers. For example, a provider's wage costs may be lower than the going market rate because the current rate only supports hourly wages below market.

e) Build and continually updated (such as annually) a "benchmark rate"—that is, what is the rate that could be supported if funds were available. The benchmark rate factors in actual provider costs and market-based conditions (e.g., the continual increase in personnel health insurance costs).

f) When state resources are limited, if the benchmark rate is not affordable, work towards parity to get all services up to a threshold level.

Within a service category, B&A recommends that the methodology and approach be consistent to set the rates, but that there may be variations required to account for the following:

- A client's level of need (e.g., support in the home will vary for someone with underlying medical complexities than for someone without these medical conditions);
- The group size (e.g., a 1:1 service is much more expensive than staffing a 1 employee:4 client group);
- The service setting (e.g., in-home or facility-based);
- Staff qualifications or training (e.g., RN vs LPN, licensed psychologist vs peer support);
- Geography (e.g., urban vs rural); and
- Provider supply (e.g., if providers are limited in a specific area of the state to meet the need)

B&A recommends that the following costs always be captured for consideration in the development of rates for HCBS:

- Direct worker wages
- Direct worker benefits
- Direct worker productivity (e.g., how much of an 8-hour day is client facing versus travel time, record keeping, attending training, etc.)
- Program support (e.g., the non-labor costs specific to deliver the service)
- Administration (e.g., back office costs)

It should be noted that DDDS has adopted this approach for recent updates it has made for services delivered by providers to persons with intellectual and developmental disabilities. Benchmark rates

has been developed for each service, but the funding was not available to always set the rate at the benchmark level.

The DMMA has received a federal grant to examine the rates paid for delivering services to individuals with substance use disorder. The process described above will be used to assess the rates to pay to providers who deliver these services. The project is just starting in June 2020 with the goal for recommendations to rate changes to be completed by March 2021.

8. Using the theme as described in the prior recommendation, other Divisions can also use this method when entering contract negotiations even if the actual rate is not published. ***B&A recommends that Divisions that use the contracting method to pay providers to develop a rate corridor that they are willing to accept from providers in the bid process that is driven by market data***.

   In other words, Divisions that do not publish fee schedules per se can still use the benchmarking method to determine the range of acceptable rates offered by a bidder that they would accept under a specific service contract. Prior to accepting a provider's proposed rate, the Divisions could conduct research to "build up" the cost components of a rate to determine this acceptable range. Further, any opportunities where a value-based component such as performance targets should be explored that may influence the final rate negotiated with the provider. The Division may or may not choose to publish what this acceptable rate range would be.

   This approach is most likely appropriate for the Division of Public Health, the Division of State Service Centers, the Division for Visually Impaired, and the Division of Social Services for services other than child care support.

9. With respect to services covered by the Division of Medicaid and Medical Assistance (DMMA), the DMMA has adopted protocols to keep current with Medicare rates and rate methodologies on most of the services that it sets rates for. When this protocol is used, it is often the case that the Medicaid rate is on par or just slightly less than the Medicare rate. An example of this is the annual update for most physician and other professional services.

   Whereas the DMMA has built more refinement and processes into the services that it is responsible for than some of the other Divisions, B&A does offer some specific recommendations related to the methodology for some acute health care services:

   - ***For inpatient hospital services, DHSS should consider changing its reimbursement methodology from a per discharge rate that is not based on patient acuity to a per discharge rate based on patient acuity using a diagnosis related grouping (DRG) system.*** This would align the DMMA with the way that 37 other State Medicaid Agencies and Medicare pay for hospital services.

   - ***For outpatient hospital services, DHSS should consider changing its reimbursement to a more sophisticated rate structure that incentives value and efficiency such as the Medicare Outpatient Prospective Payment System or 3M's Enhanced Ambulatory Patient Grouping***. For services where hospitals bill the DMMA different amounts and the payment, therefore, is hospital-specific, there is an opportunity for the DMMA to modernize this portion of the payment methodology by using the Medicare or 3M systems that follow the principal of paying for a combined group of related services in an outpatient visit together in one rate versus piecemeal.

- ***Although the actual per diem rates paid may differ from Medicare's, DHSS should consider immediately migrating to CMS's new methodology to pay for nursing facilities since the current methodology that has been in place for over 20 years will not be supported by CMS beginning in October 2020***. Beginning in October 2019, CMS changed its methodology to what is called the Patient-Driven Payment Model (PDPM). The PDPM is based on a new classification system that better reflects the supports needed for today's nursing facility residents which is different from the previous grouping method established more than 20 years ago. CMS is phasing out support of its old system on September 30, 2020. This requires Medicaid agencies to follow Medicare's new PDPM method or develop an alternative to the current method.

Process Used to Inform the Recommendations

B&A used both a qualitative and quantitative approach to collecting and analyzing the rates paid for services across DHSS. In October 2019, B&A staff members convened in-person interviews with representatives from each DHSS Division to learn more about the services for which they were responsible, the clients that they serve, and the providers that they contract with. The B&A team queried each Division about the source data, if any, used to inform how individual rates are set; the process for setting rates and whether it is uniform across service categories; the current state of the provider base to deliver services and whether any challenges exist to attract and/or retain providers; and any suggestions on how the rate setting process could be improved at their Division.

In addition to collecting this feedback, the B&A team requested and received individual claim-level detail for services that are billed by providers to the Delaware Medicaid Enterprise System (DMES). B&A coordinated with a state Core Team comprised of staff from DHSS and the Office of Management and Budget (OMB) on the analytics to complete on this data and the method of presentation for this report. Additionally, measures were developed to inform a hierarchy of the recommendations that B&A would make related to opportunities for developing state-of-the-art rate methodologies across DHSS services. Because of the vast array of services delivered by DHSS, the services were categorized into three major groupings:

- Services covered in the Medicaid program administered by the DMMA or its contracted managed care organizations. For the review of these services, the primary data source was claims from the DMES.

- Services that are delivered in the home or community that are not medical in nature, including services offered in Medicaid waivers and administered by the DMMA or other Divisions in DHSS. Claims from the DMES were also used in this review, although there are some instances where not all data is available in the DMES.

- Services administered by other DHSS Divisions for which providers are paid by contract and not by individual claim. For the review of these services, B&A requested information from each Division through a survey instrument.

How Results are Organized in this Report

For each of the categories mentioned above, a 1-page dashboard report was created to display key information about each service category. In Section V, there are 20 dashboard reports to show information on the DMMA services. In Section VI, there are five dashboard reports to show information

on the HCBS services. In Section VII, there are five dashboard reports to show information about contracts from other Divisions' services.

Within the DMMA scope of services, rankings were assigned to each of the 20 categories that assess the relative viability for rate reform. Six domains were used to make this assessment, including:

- Percent of dollars spent on this service of the total Medicaid budget (including waiver services);
- Percent of service dollars spent on this service in Medicaid managed care;
- Rates of usage of the service among Medicaid enrollees;
- Measurement of the provider base using a ratio of providers-to-Medicaid enrollees;
- Level of opportunity for DHSS to modernize its rate methodology (i.e. is there a Medicare standard); and
- Level of opportunity to add a value-based component to the rate setting methodology.

The final scoring for each service category across these domains appears in a Summary Scorecard on page IV-3 of the report.

On each dashboard report, information is also presented that states the last time the rate(s) for the service were updated, the top five procedures or revenue codes and their associated rates, and information about whether there is a Medicare equivalent rate. Where possible, DHSS's rate as a percentage of Medicare's rate is shown.

Information on HCBS rates is displayed in a similar manner in Section VI, although some items shown in Section V do not appear on Section VI reports because they are not relevant (e.g., comparisons to Medicare where none exist). Information on other DHSS Division contracts are shown in Section VII, including the total dollars contracted, the method of contracting (e.g. competitively bid or not), and the top contracts (based on dollars) for services delivered to Delawareans.

In the appendix, a listing all of all current rates available, by service category, are provided.