Testimony
Department of Human Services
Long-Term Care Interim Committee
Representative Gary Kreidt, Chairman
July 14, 2010

Chairman Kreidt and members of the Long-Term Care Committee, I am JoAnne Hoesel with the Department of Human Services (DHS) and Cabinet Lead for Program and Policy which includes the Developmental Disabilities Division (DD). I am here to provide a status report of the study of the methodology and calculations for the ratesetting structure for public and private licensed developmental disabilities and home and community-based service providers pursuant to Section 1 of 2009 House Bill No. 1556.

As noted in earlier testimony to this committee, DHS contracted with Burns & Associates, Inc. (B&A) to analyze the assessment tools and criteria used to identify individuals who are medically fragile and/or behaviorally challenged. B&A was tasked to evaluate the adequacy and appropriateness of compensation for developmental disability providers serving people with extraordinary behavioral and medical needs.

The contract requires eight (8) deliverables.

1	Final Data Request	Complete
2	Three Day On-Site Visit and Materials	Complete
3	Evaluation of the Current Reimbursement, Appropriation, Assessment and Change Request System	Complete

4	Options for Assessment Scales, Resource Allocation Models, Other States Use of Scales, Options for Rate Adjustments Based on Changing Client Needs and Implementation Considerations	Complete
5	Preliminary Cost Estimates	Complete
6	Refined and Final Cost Estimates	Complete
7	Interim Final Report	Received July 7, 2010
8	Final Report	Due Aug 15, 2010

B&A uses a number of sources in their evaluation.

1. A detailed walk-through of the current system provided by staff of the DD Division with supporting documentation,
2. Focus groups, interviews, and written comments received from stakeholders,
3. Quantitative analysis of assessments, claims, and payments/costs,
4. B&A, Inc.'s experience with rate-setting systems and assessments in other states,
5. Review and analysis of assessments used in other states and in North Dakota,
6. A survey of providers asking for estimated costs related to reimbursement and assessment activities,
7. A report from DHS on the administrative costs related to provider budgeting, rate-setting, audit, and reconciliation as well

as administrative and use of the progress assessment review (PAR) and Oregon assessment tools.

The interim report was received July 7, 2010. Today's testimony is a synopsis of the interim report. The interim report will be revised by B&A based on feedback received by August 5, 2010.

I. Overview of Current System

Assessments

The currently used Oregon Behavioral, Oregon Medical, and PAR were reviewed to see how well they perform in predicting provider rates.

Reimbursement System

The reimbursement system currently used is retrospective and cost-based. The State makes payments in the current year based on an interim rate setting process that is driven by submittal of a budget by providers. Final payments are cost settled after an audit. A target number of budget limitation is used to control both interim rates and cost settlement. Providers do make requests for exceptions/enhancements based on the special needs of their clients. The consultant has found that over 50% of clients were budgeted and processed as exceptions. Exceptions increase time for providers and state staff.

Interim rates are established based on the assumption that providers are 95% occupied. If a provider experiences higher occupancy they will owe DHS at the time of cost settlement and if they experience less than 95%, they can experience a loss. This was done many years ago to control costs and avoid scattered openings while leaving only the most difficult to serve clients not chosen.

Cost reports are submitted by providers and desk reviewed by DD staff. The cost reports are then transferred to the provider audit unit. In general, provider audits are two years subsequent to the year for which they are used to reconcile interim rates. Audits are very comprehensive.

II. Findings Related to Current System

Assessment Findings

- **Oregon Behavioral** -discontinue for both child and adults as it predicts no costs nor appropriately identifies individuals.
- **Oregon Medical** does have predictive value for children but it is no better than the currently used PAR to predict costs for adults. If both the PAR and Oregon Medical are used, it results in a duplication of effort with no added value.
- **PAR** is seen as a powerful tool and predicts 43.1% of the current DD expenditures.

B&A identified the **Support Intensity Scale (SIS)** for consideration. It is the most frequently used tool today and is considered state of the art. It is used in twenty (20) states, two Canadian Provinces, and several European countries.

Findings related to reimbursement systems

- The current 'bucket' system plus the cost-based reimbursement process is seen by providers to adequately pay in total for services and supports but the dollars are not always distributed

to the individuals who are medically fragile and/or behaviorally challenged.

- B&A found that most providers recognize that they receive about five percent more than their estimated costs during the interim rate-setting process because of the occupancy factor of 95% and they monitor spending and set aside funds for the year-end payback.
- In their analysis, it appears that bucket payments may be targeting the same individuals who are identified through the PAR in the reimbursement system – this will result in duplication.

Other State Reimbursement Systems

- Other states that base payment on the needs of individuals do not use cost-based reimbursement systems.
- Most states that adjust payment based on assessed need, include all of an individual's needs and not a subset such as the medically fragile and/or behaviorally challenged.

Administrative Burden

- North Dakota's reimbursement system is slow and very resource intensive.

"Burns & Associates has found the current system to be inefficient; staffing is inadequate to handle the workload. Providers and the state agency are continuously 'chasing their tails' to discover where they really began at least two years ago. It is very difficult to manage a provider agency, DD, and appropriated dollars when key information on expenditures is not known for several years into the future."

III. Options Identified for Adults and Children

Four options for serious consideration by North Dakota have been offered by B&A– two options for adults and two options for children. One of the options for children and adults retains the current cost-based reimbursement system. The others involve moving to a perspective reimbursement process.

Adults

A – Revise and shorten the PAR – the PAR identifies individuals that are behaviorally challenging and medical fragile. Keep the cost-based, retrospective reimbursement process.

B – Adopt a new assessment tool and move to a perspective reimbursement process. The Supports Intensity Scale (SIS) is recommended.

Children

C- Pilot Child SIS – This tool is still in development stages but North Dakota could become a pilot site. This tool is used for children over 5 years of age up to the age of 16. B&A continues to look for an under 5 assessment tool. None found to date meet the needs of North Dakota. This option involves moving to a perspective reimbursement process.

D- Oregon Medical tool and add the Cal locus or other such tools. This options focuses on identifying those who have challenging behaviors and keeps the current cost-based, retrospective process.

IV. Cost Estimates

Options A and D assume no change in the cost-based retrospective reimbursement structure. Options B and C Adult and Child SIS, contemplate moving to a resource allocation framework. It should be noted that Option A revised PAR could also be used as the basis of a resource allocation model and it would result in similar program savings reports for Options B and C SIS.

"Replacing the PAR with the SIS would be more costly initially both in terms of time and dollars as it requires new assessments to be performed on all consumers and the results of those assessments to subsequently be used to develop a resource allocation model and prospective rates. This process would take an estimated two years. The rate-setting and resource allocation model is twelve to fifteen months with nine months overlapping the SIS assessment processing. The cost estimates are for a five year period of time with Years 1 and 2 as development years."

Information on the assumptions made in arriving at the cost estimates are identified in details in the Interim Report.

Impact on people served

Table 6.1

Provider impact of Options

Table 6.2

State Impact of Options

Table 6.3

Overview of the cost estimate of the five-year project comparing the current system versus the four options

Table 7.3

V. Summary and Conclusion of Interim Report

B&A identify the administrative burden on providers and state in the current system and state that, "The process of accounting for every dollar and ensuring that providers are paid according to their own individual costs is a tremendous task. Our estimate is that approximately $2.6 million per year is spent just to operate the reimbursement system. This includes the provider's costs but since their costs are reimbursed by the State it is really all State and Federal cost. About $1 million per year of State staff resources are committed to this process every year."

"Adopting a prospective rate system that paid a fixed fee for each unit of service such as an hour or day of service provided would free the State staff from having to audit and prepare reconciliations once the cost-base system is closed out. The State could use filed cost reports to perform rebasing periodically (e.g. every three to five years) or could choose to audit the year used in rebasing. This audit process is not done by a number of states. Because of the demands of health care reform on state Medicaid agencies, North Dakota will need to weigh this project in the context of the additional population, physician reimbursement, eligibility, and system changes required by the Patient Protection and Affordability Care Act."

In summary, the Interim Final Report will be revised by B&A based on feedback from the State and stakeholders received by August 5, 2010.

In addition to these revisions, the Final Report will add graphics and print features designed to make the report more reader friendly and to highlight key findings.

I’d be happy to answer any questions.

Table 6.1 Consumer Impact of Options

	Options A and D Cost Based	Options B and C SIS, Prospective Rates and Resource Allocation Levels
How are resources (dollars and support hours) distributed?	Provider Cost	Consumer Assessed Needs
Are the resources (dollars and support hours) distributed fairly? (Meaning do consumers with comparable needs and natural supports receive comparable resources)	To some extent	Absolutely
What is the rate paid for each service?	The interim provider rate based on the budget submitted by the provider – rates vary by provider	Prospective standardized rates that provide consumers confidence of the hours of support they will receive regardless of the provider of service
Is the reimbursement system consistent with the concepts of Self-Direction?	Self-direction is almost impossible in a cost settlement environment	Consumers are allocated resources based on their own needs which is completely consistent with Self-Direction
What is the impact of the option on the consumer's role in care planning?	None	Consumer and family role is much more extensive
Will consumer's win or lose under the option?	Yes	Yes but a three year transition is proposed so that no change is too big too fast
Is the system more transparent for the consumer and family?	No	Yes consumers know the dollars/hours of support and can use them to directly meet their needs
Will consumers have more flexibility than under the current systems?	No	Yes

Table 6.2 Provider Impact of Options

Function	Current System	Option A Revised PAR	Option B Adult SIS	Option C Child SIS	Option D Oregon Medical/ CALOCUS for Children
PAYMENT FOR SERVICES	Cost-based	Cost-based	Independent Rate Models establish standardized rates Stable	Independent Rate Models establish standardized rates Stable	Cost-based
Transparency	Black box	Black box	Independent Rate Model and Benchmark rates completely transparent	Independent Rate Model and Benchmark rates completely transparent	Black box
PROVIDERS FUNCTIONS					
Care Planning	Provider plays significant role	Provider plays significant role	Consumer and family with the Program Manager are central	Consumer and family with the Program Manager are central	Provider plays significant role
Assessment	Providers perform Oregon Medical and Behavioral Assessment	Provider does not perform assessments but will interact with assessor	Provider participate as a potential respondent	Provider participate as a potential respondent	Provider does not perform assessments but will interact with assessor
Rate-setting	Provider submits budget and interim rate is assigned	Provider submits budget and interim rate is assigned	State establishes prospective rate	State establishes prospective rate	Provider submits budget and interim rate is assigned
Exception or Enhanced Budget Requests	Provider submits exception /enhancement requests, currently more than 50% of clients	Provider submits exception /enhancement requests, currently more than 50% of clients but should be	Consumer submits exception request in 1 to 6 percent of cases	Consumer submits exception request in 1 to 6 percent of cases	Provider submits exception /enhancement requests, currently more than 50% of clients

Table 6.2 Provider Impact of Options

Function	Current System	Option A Revised PAR	Option B Adult SIS	Option C Child SIS	Option D Oregon Medical/ CALOCUS for Children
		reduced			
Cost Reporting	Provider completes and submits cost report	Provider completes and submits cost report	Provider completes and submits cost report	Provider completes and submits cost report	Provider completes and submits cost report
Audit	Provider responds to state audit findings	Provider responds to state audit findings	No state audit	No state audit	Provider responds to state audit findings
Reconciliation to Determine Final Rates	Provider receives final rates two years after the interim rate year	Provider receives final rates two years after the interim rate year	None	None	Provider receives final rates two years after the interim rate year
Resource Allocation Based on Client Assessed Needs	PAR levels/ID of medically fragile and behaviorally challenged	Revised PAR levels	Clients receive resource allocation and plan for support services with Program Managers	Clients receive resource allocation and plan for support services with Program Managers	PAR levels and Oregon ID medically fragile, CALOCUS ID of behaviorally challenged

Table 6.3 State Impacts of Four Options

Function	Current System	Option A Revised PAR	Option B Adult SIS	Option C Child SIS	Option D Oregon Medical/ CALOCUS for Children
STATE DDD (unless specified)					
Care Planning	Providers, Program Managers are key	Providers, Program Managers are key	Consumers and families with Program Managers are central Program Managers implement Resource Allocation Guidelines	Consumers and families with Program Managers are central Program Managers implement Resource Allocation Guidelines	Providers, Program Managers are key
Assessment	Program Managers perform PAR	Program Managers perform a revised PAR	Dedicated SIS unit with DDD or contractor perform SIS	Dedicated SIS unit with DDD or contractor perform SIS	Program Managers perform Oregon Medical and CALOCUS
Rate-setting	Interim rates established annually based on budget and targets Bucket payments distributed based on Oregon scales quarterly to providers	Interim rates established annually based on budget and targets Bucket payments combined with all payments and distributed based on PAR levels or based on a weighted score for medically fragility and behavioral only	Prospective independent rates are calculated by service across providers with some distinctions. Rates are inflated each year and rebased periodically No bucket payments	Prospective independent rates are calculated by service across providers with some distinctions. Rates are inflated each year and rebased periodically No bucket payments	Interim rates established annually based on budget and targets No change from the current system
Exception or Enhanced Budget	More than 50% of clients are exception or	Improved PAR levels should reduce	Exception processing is reduced to 1%	Exception processing is reduced to 1%	No impact

Table 6.3 State Impacts of Four Options

Function	Current System	Option A Revised PAR	Option B Adult SIS	Option C Child SIS	Option D Oregon Medical/ CALOCUS for Children
Requests	enhanced budget requests the state must process	exceptions	- 6%	- 6%	
Cost Reporting	State requires annual cost reporting	State requires annual cost reporting	State requires annual cost reporting	State requires annual cost reporting	State requires annual cost reporting
Desk Review	State desk reviews cost reports	State desk reviews cost reports	State desk reviews at least in the year of rebasing	State desk reviews at least in the year of rebasing	State desk reviews cost reports
Audit	Provider Audit performs audit. Audits performed and are completed two years later	Provider Audit performs audit. Audits performed and are completed two years later	Not required	Not required	Provider Audit performs audit. Audits performed and are completed two years later
Reconciliation to Determine Final Rates	Recon. process two years subsequent to cost report year	Recon. process two years subsequent to cost report year	None	None	Recon. process two years subsequent to cost report year
Resource Allocation Based on Client Assessed Needs	PAR Levels used as guideline	Revised PAR Levels used as guideline	Resource allocation model developed that distributes dollars based on client support needs	Resource allocation model developed that distributes dollars based on client support needs	None

Table 7.3 Five Year Project Current System Versus Options

Current System	OPTIONS A AND D		OPTIONS B AND C SIS	
	LOW	HIGH	LOW	HIGH
State Administrative Cost	$1,422,000	$1,665,000	$2,459,000	$2,879,000
$1,021,000	$1,252,000	$1,297,000	$2,582,000	$3,023,000
$1,072,050	$1,314,000	$1,362,000	$1,586,000	$1,586,000
$1,125,653	$1,380,000	$1,430,000	$1,666,000	$1,666,000
$1,181,935	$1,449,000	$1,501,000	$818,000	$818,000
$1,241,032	$6,817,000	$7,255,000	$9,111,000	$9,972,000
$5,641,670				
Provider Administrative Cost	$1,602,000	$1,625,000	$1,704,000	$1,816,000
$1,590,660	$1,730,000	$1,755,000	$1,840,000	$1,961,000
$1,717,913	$1,868,000	$1,895,000	$1,371,000	$1,501,000
$1,855,346	$2,017,000	$2,047,000	$1,480,000	$1,621,000
$2,003,773	$2,178,000	$2,211,000	$766,000	$918,000
$2,164,075				
Total Administrative Cost		$3,290,000	$4,163,000	$4,695,000
	$3,024,000	$3,052,000	$4,422,000	$4,984,000
$2,611,660	$2,982,000	$3,257,000	$2,957,000	$3,087,000
$2,789,963	$3,182,000	$3,477,000	$3,146,000	$3,287,000
$2,980,998	$3,397,000	$3,712,000	$1,584,000	$1,736,000
$3,185,709	$3,627,000			
$3,405,107				
		$16,788,000	$16,272,000	$17,789,000
$14,973,437	$16,212,000			