North Dakota Department of Health and Human Services

North Dakota HCBS Rate Study

Summary of Current Methodology

CBIZ Optumas

Consultants • Actuaries • Economists

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Introduction

The North Dakota Department of Health and Human Services (DHHS) entered into a contractual engagement with CBIZ Optumas (Optumas) on July 1, 2022 to complete an in-depth review of the State's home- and community-based services (HCBS) rates and provide a summary report that:

- Identifies rate trends across the applicable Medicaid and state-funded HCBS programs;
- Compares other states' HCBS rates; and
- Presents innovative methods for adjusting HCBS rates in a way that promotes uniformity and equity.

Optumas anticipates reviewing rates for the following HCBS programs:

- 1915(c) waivers for aging, autism, medically fragile, and children's hospice (4 waivers total);
- 1915(i) state plan amendment;
- All HCBS services included in the Medicaid State Plan; and
- The State-funded Service Payment to the Elderly and Disabled (SPED) and Expanded Service Payments to the Elderly and Disabled (Ex-SPED).

The contract specifies that a comprehensive rate review of the Developmental Disabilities (DD) waiver services is not required. However, an assessment should be completed to determine if and whether there are similar services in the DD waiver offered in the other programs being reviewed, along with a comparison and recommendation on comparable services.

A key goal of this initiative is to better incentivize services that increase accessibility to HCBS services for people eligible for North Dakota's HCBS. This engagement is funded through the American Rescue Plan Act (ARPA) of 2021, Section 9817. This first deliverable summarizes Optumas' findings regarding the current landscape of HCBS waivers in the State.

Department of Justice Settlement Agreement

On December 14, 2020, the State of North Dakota announced a settlement agreement with the U.S. Department of Justice (DOJ) under the Americans with Disabilities Act (ADA). The agreement is intended to resolve complaints that North Dakota unnecessarily institutionalizes people with disabilities, placing them in nursing facilities rather than providing services needed to live at home and in communities. The agreement specifies the following actions North Dakota agreed to take, listed below.

- Review the adequacy of current reimbursement rates.
- Conduct a rate analysis to determine discrepancies in rates paid to in-home providers and Skilled Nursing Facility (SNF) staff.
- Conduct a Qualified Service Provider (QSP) Rate Innovations and Gap Analysis.
    - This strategy aims to identify innovative ways to adjust QSP rates such that services with potentially high impact on access to HCBS services for older adults and people with disabilities are better incentivized.

  - Examples include a shift differential for QSPs providing care at night, on weekends, and holidays; respite care; a system of "backup" or emergency care providers-of-last-resort to address high need cases or staff emergencies, and rates adjusted for intensity.
- Seek to better align authorization processes, reimbursement systems, and reimbursement rates to reduce disparities in compensation for nursing facility and HCBS provider staff for the same or similar services, regardless of location or setting.
- Compare daily average nursing home rates to the overall daily average cost of providing an appropriate package of services for placement in a community setting, determine the extent of the disparity, and determine potential rate adjustments or other steps that could reduce the disparity without jeopardizing HCBS cost-effectiveness or cost neutrality.
- Align reimbursement rates for nursing facilities and Qualified Service Professionals (agencies and individuals) sufficiently to encourage reduction or elimination of disparities in wages paid to staff providing the same or similar services in different settings, considering factors such as overtime, commuting times, benefits offered, etc.

Program Descriptions

North Dakota utilizes Medicaid waivers and state plan services to provide home and community based services. Each of the waivers provides an array of services to a defined population of eligible individuals. Individuals who qualify for the waiver programs must be both Medicaid-eligible and meet the necessary level of care (LOC). Individuals who qualify for state plan programs need to be Medicaid-eligible and meet the needs-based criteria for that specific program. The details of each program and the population served are described below.

Children's Hospice (0834.R02.00)

The Children's Hospice waiver provides services to individuals who are medically fragile between the ages of birth and 21 years. A diagnosis of less than one year to live must also exist. The services provided include:

- Case management;
- Respite;
- Hospice;
- Skilled nursing;
- Bereavement counseling;
- Equipment and supplies;
- Expressive therapy; and
- Palliative services.

Autism Spectrum Disorder (ASD) Birth through Fifteen (0842.R02.00)

The Autism Spectrum Disorder waiver provides services for individuals with autism between the of ages 0 and 15 years. The services provided include:

- Respite;
- Service management; and
- Assistive technology.

Medicaid Waiver for Home and Community Based Services (0273.R06.00)

The Medicaid Waiver for Home and Community Based Services provides for individuals who are aged 65 and above, and individuals with physical and other disabilities aged 18-64 years. The services provided include:

- Adult day care;
- Adult residential care;
- Case management;
- Homemaker services;
- Residential habilitation;
- Respite care;

- Supported employment;
- Adult foster care;
- Chore services;
- Community support services;
- Community transition services;
- Companionship services;
- Emergency response;
- Environmental modification;
- Extended personal care;
- Family personal care;
- Home delivered meals;
- Non-medical transportation with or without escort;
- Residential habilitation
- Specialized equipment and supplies;
- Supervision;
- Supported Employment;
- One time transition costs;
- Transition Support Services; and
- Transitional living services.

Medicaid Waiver for Medically Fragile Children (0568.R03.00)

The Medicaid Waiver for Medically Fragile Children serves individuals who are medically fragile between the ages of 3 and 17 years. The services provided include:

- Institutional respite;
- Program management or case management;
- Dietary supplements;
- Environmental modifications;
- Equipment and supplies;
- In-home supports;
- Individual and family counseling; and
- Transportation.

Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver (0037.R08.00)

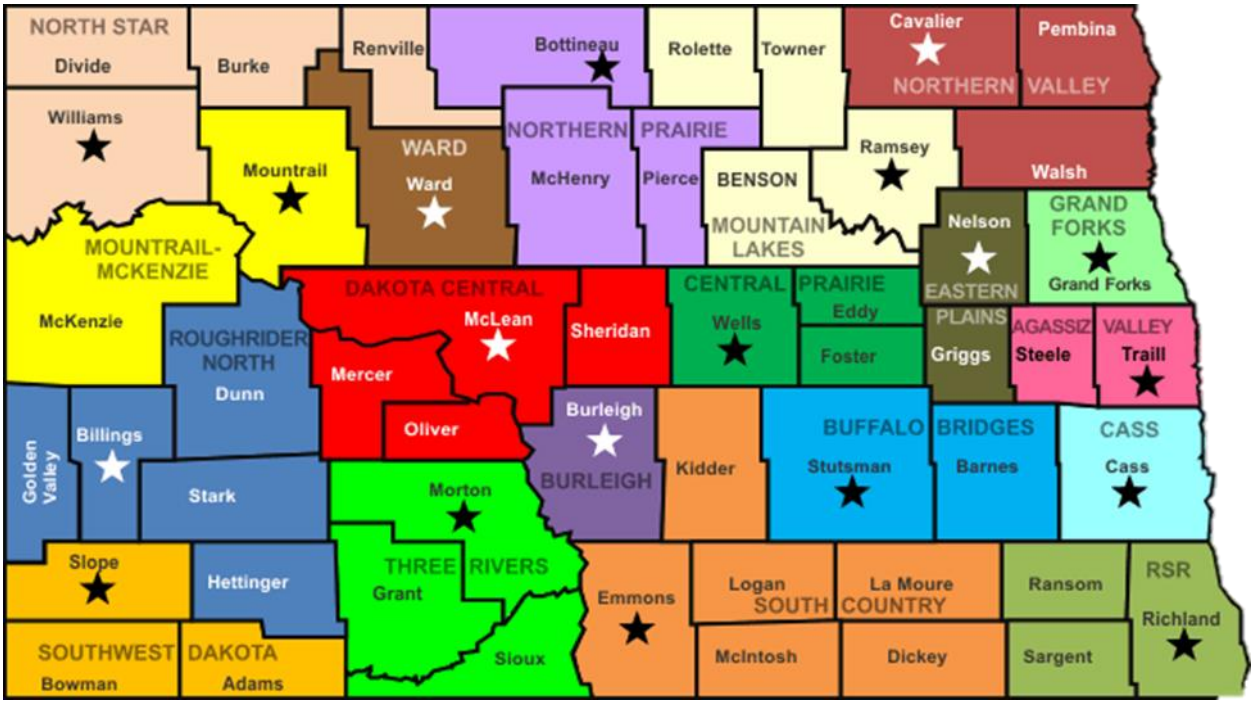
The North Dakota traditional Intellectual Disabilities and Developmental Disabilities HCBS waiver provides services for individuals with intellectual disabilities and developmental disabilities ages 0 and above. The services provided include:

- Day Habilitation;
- Homemaker Services;
- Independent Habilitation;
- Individual Employment Support;
- Prevocational Services;

- Residential Habilitation;
- Extended Home Health Care;
- Adult Foster Care;
- Behavioral Consultation;
- Community Transition Services;
- Environmental Modifications;
- Equipment and Supplies;
- Family Care Option;
- In-home Supports;
- Infant Development;
- Parenting Support; and
- Small Group Employment Support.

1915(i) State Plan Amendment

The North Dakota Medicaid 1915(i) State Plan Amendment approved by the Center for Medicare and Medicaid Services (CMS) allows the state Medicaid program to pay for HCBS services to support people with behavioral health conditions. Eligibility is determined by staff in the Human Services Zones Human Services Zones are State agency operated in 19 locations serving the 53 counties. Below is a map of the Human Services Zones.



Individuals receiving State Plan HCBS are included in an eligibility group covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). In addition, the World Health Organization Disability Assessment Schedule (WHODAS) is used to assess and determine

an individual's needs. The WHODAS is a multi-faceted, generic assessment tool that assesses the following:

- Cognition – understanding and communicating;
- Mobility – moving and getting around;
- Self-care – hygiene, dressing, eating, and staying alone;
- Getting Along – interacting with other people;
- Life activities – domestic responsibilities, leisure, work, and school; and
- Participation – joining in community activities.

The above domain scores are considered in the person-centered plan of care (POC) process. The WHODAS also provides a reliable overall complex score, ensuring an individual meets the established needs-based eligibility criteria. A comprehensive complex score of 25 or above is required for 1915(i) eligibility. The World Health Organization (WHO) has confirmed that the tool is suitable for use with individuals across the lifespan.

Services provided through the 1915(i) waiver will be furnished to eligible individuals in the following settings:

- Their own homes;
- Provider-owned and controlled residential settings (such as Sober Living Homes, Group Homes, Foster Homes, Treatment Foster Homes, and Transitional Living Homes);
- Non-residential settings (e.g., adult day care or other community services); and
- The community at large.

Medicaid State Plan – Personal Care Services

North Dakota has one additional HCBS program in the Medicaid State Plan not already discussed in this report. Referred to as the Medicaid State Plan – Personal Care Services (MSP-PC), this program helps people with daily living activities such as bathing, dressing, transferring, toileting, cooking meals, housework, or laundry, enabling eligible individuals to continue living in their homes and communities. This program has three tiers, referred to as levels A, B, and C. Criteria for the Level A Personal Care Service program and common criteria for all three tiers include:

- Must be eligible for Medicaid;
- Must have needs expected to last 30 days or more; and
- Must be assessed by a case manager on how much help the individual needs with activities such as bathing, transferring, toileting, dressing, laundry, and housework. The amount of help an individual needs will determine qualification for services.

Individuals approved for Level A Personal Care Service may receive up to 120 hours of help per month. Individuals approved for Level B can receive up to 240 hours of help per month. In addition to Level A Service criteria, Level B adds that a case manager will determine whether the individual meets a nursing facility or intermediate care facility-intellectually disabled (ICF/IDD) LOC. Individuals eligible for Level C Personal Care Services can receive up to 300 hours of help per month if they meet all previous criteria and

are impaired in at least 5 ADLs. However, help with laundry, shopping, and housework are not available under Level C.

Another option for this program is referred to as Daily Rate Personal Care Service Criteria and Personal Care in Basic Care. Individuals may be eligible for this program if they live in a basic care facility and require daily service or live with their provider and want to establish a daily rate for care up to the program max. Criteria for eligibility are the same as the previously discussed three levels. All LOCs in this program may require a client share or recipient liability, a monthly amount that must be paid before Medicaid will pay for the care provided. This functions as a monthly deductible.

Service Payment to the Elderly and Disabled (SPED)

The SPED program provides services to people who are older or physically disabled, and who have difficulty completing tasks that enable them to live independently at home. Covered services include:

- Adult foster care in a State-licensed setting;
- Adult day care;
- Case management;
- Chore services;
- Emergency response system;
- Environmental modifications;
- Extended personal care;
- Family home care reimbursement of a family caregiver who meets specific relationship requirements defined in State law and lives in the client's home 24 hours per day;
- Homemaker services;
- Home delivered meals;
- Non-medical transportation with or without escort.
- Personal care attendants; and
- Respite care for temporary relief of the full-time caregiver.

For an individual to be eligible for SPED, they must have less than $50,000 in liquid assets, an inability to pay for services, impairment in two Activities of Daily Living (ADLs) involving basic needs such as bathing, dressing, toileting, eating, or in four Instrumental Activities of Daily Living (IADLs) totaling (4) points if living alone or (6) points if living with an adult. Those impairments must have lasted (or be expected to last) three months or more. If an individual is younger than 18 years of age and needs nursing facility level of care (NF LOC), is not eligible for the Aged and Disabled waiver, and is not living in an institution, dormitory, or congregate care, they may also qualify for limited services based on additional criteria.

North Dakota's SPED program was recently highlighted by the National Academy for State Health Policy (NASHP) as a unique approach to addressing workforce shortages in rural areas. The program provides payment and supports to family caregivers of individuals not eligible for Medicaid. SPED was initiated in 1983 to serve the 50% of North Dakota's population living in rural and frontier areas. NASHP's white paper on the topic stated:

> "SPED has proven to be highly cost-effective. According to state reports, from 2019 to 2021, about 1,200 people per month used SPED benefits. North Dakota spent about $13.8 million on the program, making the per person per month cost about $480. These numbers are consistent with pre-pandemic figures, with a monthly average cost per person of $498 in the previous two years. North Dakota spent roughly $8,265 per person per month on nursing facility residents from 2019 to 2021, making SPED a far less costly alternative for those with a family caregiver."

Expanded Service Payment to the Elderly and Disabled (Ex-SPED)

Ex-SPED recipients must have challenges completing at least three of four of the following IADLs: housecleaning, laundry, preparing meals, or administering medications. Alternatively, recipients may need supervision for health, safety, or welfare issues. Recipients must not have significant issues with the ADLs of bathing, transferring and toileting. They can be eligible for Supplemental Security Income (SSI) but are not required to receive it. Medicaid enrollment as well as income at or below the SSI amount are required.

Services available are the same as those available under SPED, with the exception of personal care. The complete cost of care is covered for Ex-SPED beneficiaries, while SPED beneficiaries may be charged a fee for services.

Rural Differential (RD)

The purpose of the RD rate is to create greater access to HCBS for clients who reside in rural areas of North Dakota by offering a higher rate to qualified service providers (QSP) willing to travel to provide services. QSPs willing to travel at least 21 miles (round trip) to provide care to authorized individuals in rural areas will be reimbursed at a higher rate. QSPs are not paid for the time they drive to and from the client's home. The RD rate may only be used for the time spent actually providing services. Individuals living in rural areas who are enrolled in the HCBS waiver, Medicaid state plan personal care, SPED and EX-SPED can receive services reimbursed using a RD rate.

North Dakota's Rural Differential (RD) rate is authorized by the HCBS case manager, and they add or remove the RD rate from the person-centered plan depending on the distance the QSP must travel to provide services to an eligible client. It can only be authorized for clients living in rural or frontier areas who are receiving services under Medicaid State Plan Personal Care (MSP-PC), Medicaid Waiver (MW), SPED, or EX-SPED.

- Personal Care
- Homemaker
- Chore Labor (does not include snow shoveling)
- Extended Personal Care
- Respite Care
- Transitional Living
- Supervision
- Companionship

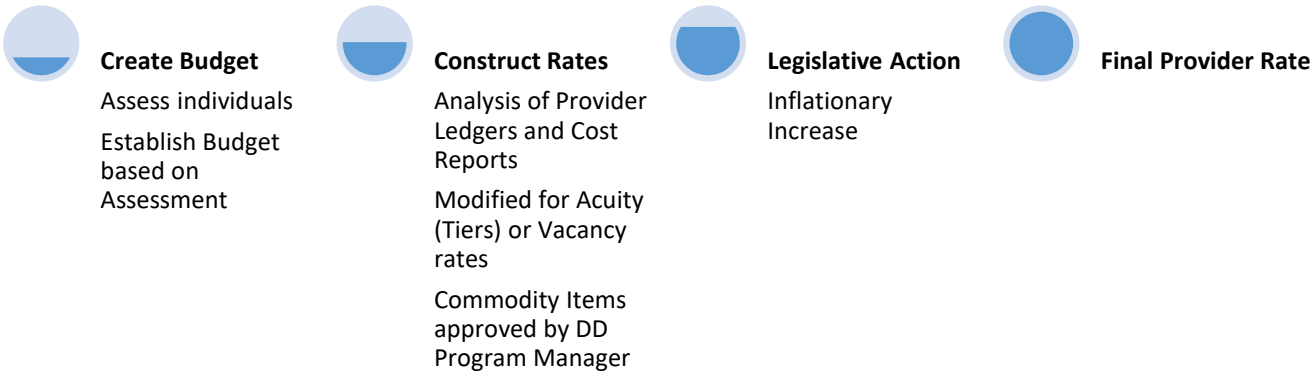
Summary of Methodology

Information related to rate methodologies was derived from the waiver applications available on the CMS website. Rates created for the HCBS, autism, children's hospice, and medically fragile waivers were created by utilizing a benchmark to an existing service either within Medicaid or within a State program. Where a benchmark was not available, an estimate of costs from prior years was utilized. The rate was then increased over time through legislative approval.

Figure 1 Process Flow for Service Rate Settings

Rates in the DD waiver were created by a vendor who analyzed the provider ledgers and cost reports to develop rates that factored in wages and administrative expenses. Those rates can further be modified to reflect vacancy rates or the acuity level of the waiver participant.

Figure 2 Process flow for DD Rate Development



Several waivers provide the option for self-direction. In those waivers, the rate paid to the actual service provider is established by the waiver participant within certain parameters (minimum wage and individual budget maximum). However, the rate paid by Medicaid for the service is at the State maximum. If a waiver participant chooses to pay a rate higher than the established rate for the service, the additional cost cannot be billed to Medicaid.

Waiver-specific details are described in the following section with notes for specific services available under each waiver.

Children's Hospice (0834.R02.00)

Initial rates were established using the following methodologies. However, the waiver application indicated that there was no way to determine if the rates established during the first waiver application would meet the need.

- Case Management – based on the rate within the Human Service Centers (HSC) established for case management.
- Respite – benchmarked to the home health rate.
- Hospice, Skilled Nursing, and Palliative Care – based on the nursing rates/comparative tasks already provided in other Medicaid services.
- Bereavement Counseling – based on rates for comparative services within the HSC.
- Equipment and Supplies – based on comparative rates from the medically fragile approved rates.
- Expressive Therapy – based on the comparable service to the rate of individual therapy through the HSC.

While rates were not increased by the legislature in 2017, the waiver application did note that rates are generally granted inflationary increases through legislative action (estimated at 3% per year).

Autism Spectrum Disorder (ASD) Birth through Fifteen (0842.R02.00)

In 2018, the rates were rebased across all providers. Respite, Service Management, and Assistive Technology rates were determined based on the average expenditure from past years. However, in subsequent years the rates were compared against other similar services (e.g., Respite benchmarked to supervision) and reviewed for reasonableness. Service Management and Assistive Technology rates were increased by 3% through legislative action.

Medicaid Waiver for Home and Community Based Services (0273.R06.00)

In 2020 rates and rate setting methodology for all waiver services were reviewed and discussed with stakeholders prior to Electronic Visit Verification (EVV) and Fair Labor Standards Act (FLSA) implementation. The rates have been increased based on action from the legislature.
Several rates were described in the waiver application with similar but slightly different specific methodologies:

- Non-Medical Transportation (NMT) escort rate is based on the average paid for a driver using their personal vehicle in ND according to the US Bureau of labor and statistics.
- Environmental modification and specialized equipment costs are based on the actual cost of the modification.
- The individual and agency fee-for-service rates for respite care, chore, and supported employment were established using a benchmark year (often 2006 or 2007) and then subsequently inflated by legislatively approved rate increases.
- Adult day care and adult residential services utilized cost reports and have approved administrative expenses that cannot exceed 15% of direct care costs.

- The rate for residential habilitation and community support services was based on the services provided under the North Dakota Traditional ID/DD HCBS waiver.
- The home delivered meals per meal rate was established in 2007 based on the current average cost of providing Older American Act nutrition services.
- The homemaker rate was revised in 2016 and was based on 90% of the current fee schedule.
- The rate for companionship and supervision are based of the updated homemaker rate.
- The rate for Adult Foster Care (AFC), and family personal care are determined based on a formula and factor-based system (which is shown on a worksheet). This system considers the tasks required to care for specific clients. Each allowable task has an identified point factor. The total points are multiplied by a factor, which is unique to AFC. The factor formula then calculates a daily rate. The legislature provided an $8.00 per day plus a 3% increase to the previous limits for these services in 2013.

Medicaid Waiver for Medically Fragile Children (0568.R03.00)

Rates for the medically fragile waiver were rebased in 2021. Program managers or case managers will develop individual budget authorizations based on hours of support needed, as identified in the individual service plan. The initial maximum hourly rate was determined based on nursing facility rates, 2019 MMIS cost utilization data, and existing Family Support Services programs. The maximum allowed in the other budget categories was based on nursing facility rates, Medicaid Management Information System (MMIS) cost utilization data, and information from the existing Family Subsidy program. The following methods were used to develop or rebase the rates:

- Case management, dietary supplements, environmental modifications, equipment and supplies, in-home support, and transportation were rebased in 2021. Institutional respite and individual and family counseling services were reviewed during this time but determined to remain appropriate.
    - Rates were rebased by comparing the last waiver year estimates to paid claims during the past year. When there were no actual costs to be determined, the fee service rates within the department were compared. Adjustments to the estimated rates were then determined based on this review.
- Transportation – based on prior authorization of mileage and transportation-related costs such as lodging and meals.
- Dietary supplements – based on the actual cost of approved supplements.
- Individual and Family Counseling – based on the cost of service established at the Human Service Centers.
- In-home Support and Institutional Respite – families negotiate rates within minimum wage and budget of allotted money.
- Equipment and Supplies – based on the actual cost of the modification or the cost of the equipment.
- Environmental Modifications – costs must be the lower of two bids.
- Case management – based on the rate within the HSC rate setting of case management services.

Rates are adjusted based on allowed increases approved through the legislative budget process. Families can set the rate for their in-home support staff within the limits set by the State (must be the minimum

wage or more and must remain within a personal budget of the $18,966 per year of waivered services, excluding costs for case management).

Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver (0037.R08.00)

Rates for the DD waiver were rebased in 2018. The Department uses an individualized budget system (for residential habilitation, independent habilitation, day habilitation, individual employment support, small group employment support, and prevocational services) wherein the budget for a service is based on the maximum number of hours authorized for that specific client. The rates are determined based on legislative appropriations and only updated when the legislature approves the amount of change.

The initial rates went into effect on April 1, 2018. To develop these rates a vendor reviewed the provider's general ledgers to determine the appropriate cost components for the expenses. The components are direct care staff, employment-related costs, program supports, and general and administrative costs. After these were identified, the history of spending was analyzed using cost reports as well as information taken directly from the provided accounting systems.

For residential habilitation, independent habilitation, day habilitation, prevocational services, individual employment support, and small group employment support, a standardized assessment tool is used to assess participants. Sections of the assessment score are factored into an algorithm to determine the average number of direct care staff hours in 24 hours needed by the individual per day of service. For each service, the client budget is calculated by multiplying the hourly rate from the rate matrix by the direct care staff hours identified through the algorithm utilizing the client's assessment. The hourly rates for these services include: direct care staff wages, employment-related expenses, program support, relief staff, and administrative costs.

- The Residential Habilitation hourly rate also contains a vacancy factor intended to cover costs when a client is no longer in the setting with no intent to return. The vacancy factor was established by reviewing the distribution of vacancy utilization on MMIS claims from January 2016 to April 2019. In residential habilitation, a personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized or otherwise away from the setting to ensure stability and continuity of staffing up to 30 calendar days per year per participant.
- Payment rates for residential habilitation, day habilitation, prevocational services, and small group employment support, may include a component for ongoing nursing support, higher credentialed staff, and increased programmatic oversight. There are three additional medical acuity tiers for the rate.

Other services utilize slightly different methodologies:

- Payment rates for parenting supports, provider-managed in-home supports, family care option, and extended home health care include the following components: administrative costs, program supervision, and direct intervention time (direct support staff salary and fringes). The support hours needed are recommended by interdisciplinary teams and reviewed and approved by the regional DD Program Administrator and the DD Division.

- Adult Foster Care (AFC): provider rates are determined based on a formula and factor-based system (which is shown on a worksheet). This system considers the tasks required to care for specific clients. Each allowable task has an identified point factor. The total points are multiplied by a factor, which is unique to AFC. The factor formula then calculates a daily rate. The legislature provided an $8.00 per day plus a 3% increase to the previous limits for these services in 2013.
- Environmental modifications, equipment and supplies, behavioral consultation, and community transition services: The rates are determined by the individual within an individualized budget developed with the Developmental Disabilities Program Management (DDPM) and reviewed/approved by the regional DD Program Administrator (DDPA) and the DD Division.

Self-directed services in-home supports are available within this waiver. The DDPM develops the client's individualized budget based on the amount and frequency as identified during the person-centered planning process, informal resources available to the client, the client's risk of unwanted out-of-home placement, additional client preferences, the maximum allowable hours for each self-directed service, and the service rate set in by the state legislative body. Clients are responsible for determining staff wages. They are free to choose a wage rate above the wage limits established by the State but may not reallocate funds assigned to each service.

1915(i) Waiver Rate Setting Methodology

Rates were established by comparing services to similar covered Medicaid services. Medicaid pays the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers is also based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers is based on the cost of service delivery as determined by the single state agency from cost data submitted annually by state government providers.

Services using this methodology include:

- Peer Support
- Housing Supports
- Supported Employment
- Training and Supports for Unpaid Caregivers
- Non-Medical Transportation
- Community Transition Services
- Supported Education
- Pre-Vocational Training
- Benefits Planning

Service Payment to the Elderly and Disabled (SPED) and Expanded Service Payment to the Elderly and Disabled (Ex-SPED)

The state determines provider rates for SPED and EX-SPED based on a formula and factor-based system, using the same methodology as previously described for AFC, Family Personal Care, Family Home Care, Personal Care Assisted Living, all of which use a worksheet to generate a daily rate. This system

considers the tasks required to care for specific clients. Each allowable task has an identified point factor. The total points are multiplied by a factor. The factor formula then calculates a daily rate. The legislature provided an $8.00 per day plus a 3% increase to the previous limits for these services in 2013.

The state determines provider rates for respite care, homemaker, chore, emergency response system, case management, SPED personal care, environmental modification, adult day care, non-medical transportation, home delivered meals, extended personal care, and supervision using the same methodology described under the HCBS waiver (aged and disabled) above.

Rural Differential (RD) Rate Setting Methodology

The RD rate is based on the number of miles a QSP travels round trip from their home to provide services at the home of an authorized HCBS client. Rates are based on the distance to each individual's home even if the QSPs serve more than one recipient in the community or in the same home. If the QSP travels to the client's home and remains in that community overnight or for a period of days, they are not eligible to claim the RD rate for those dates of service. The RD rate may only be claimed on the day the QSP travels to and from the client's home. For example, if a QSP travels more than 21 miles round trip to provide care to their parent, and then stays with them for several days, the RD rate would only be claimed on the first and last days they provide the care. The QSP can only use the standard QSP rate for the days they do not travel to and from home.

Case managers are required to verify distance between the HCBS client's home and the QSP's home base. If there is a discrepancy when calculating distance, the final decision will be made by the RD Coordinator overseeing the program. The HCBS case manager must send a written request explaining the issue to the RD Coordinator.

Many of the waivers share a methodology. A summary that compares the methodologies is provided in the table below. Note the SPED and EX-SPED are not included in this table since they are not waivers.

Table 1 Summary of Waiver Rate Methodologies

Waiver	HCBS Waiver (aged and disabled)	Autism	Children's Hospice	Developmental Disability	Medically Fragile
Year Rebased	2020	2018	Unknown	2018	2021
Service Rate Methodology	Established using a benchmark year (2006-2007) for costs or against similar services. Adult day and adult residential through an analysis of cost reports. Administrative expenses are capped at 15%. Homemaker established using actual costs with a rural differential added in 2016.	Initial rates are based on the average cost of expenditures from prior years. Subsequent rates are determined based on a comparison to other similar services.	Initial rates are based on benchmarks to other similar Medicaid or State services (Human Services Centers).	Utilizes individually based budgets determined through assessment. Rates developed through an analysis of provider ledgers and cost reports. Rates include modifiers for individual acuity and vacancy rates.	The initial maximum hourly rate is determined by nursing facility rates, 2019 MMIS cost data, and existing state programs. Family budget of $18,966 per year.
Commodity Rate Methodology	Actual costs.	The average expenditure of prior years.	Comparative rates paid from the Medically Fragile approved rate.	Determined by the person-centered plan with the approval of the DDPM.	Actual costs.
Legislative Approved Increases	Yes	Yes	Yes	Yes	Yes
Self-Directed Services	No	Yes	No	Yes	Yes

Summary of Identified Barriers to Care

During the kickoff and brainstorming meetings for this engagement, State staff identified several barriers. These include:

- Availability of Non-emergency medical Transportation (NEMT)
- Availability of direct support professionals across all waivers and services provided.
- Approximately 30% of adults with physical disability clients have co-occurring behavioral health needs, but most providers do not have the training to successfully address those needs.
- Rates, and by extension, documentation was listed as the largest burden amongst QSPs in a recent statewide study conducted by another consultant.
- Billing processes are complicated.
- Cost reports are submitted by providers, which frequently locks them into a rate established through an estimate of costs that do not cover all of their expenses. However, DD providers are not required to submit cost reports for any of the waiver services.
- Many Medicaid waiver and state plan recipients must pay for a share of their services, leaving providers unpaid if the recipient does not pay. SPED also requires a client cost share depending on recipient income and assets.
- Under the current rate structure, keeping people in their homes may cost more than nursing facilities or intermediate care facilities if an individual needs 24-hour supports.
- Some providers have no email or access to broadband.
- Some providers have a primary language other than English; and
- Providers indicating that they serve a county, but then are unable to find staff and ultimately fail to provide services where indicated.

Next Steps

Summarizing current methodology and understanding process flows for North Dakota's HCBS waivers is the first step in this engagement. With this information, and additional data requested from the state, Optumas can take the next steps in the rate study process. Next steps include developing process maps and drafting a summary of the State's policy goals, ensuring the recommended rate setting methodology supports the goals of the State.