REVIEW OF RATES FOR BEHAVIORAL HEALTH AND TARGETED CASE MANAGEMENT SERVICES

(MAINECARE SECTIONS 13, 17, 28, AND 65)

PUBLIC COMMENTS AND RESPONSES –

SUPPLEMENT FOR ADDITIONAL PROVIDER COMMENTS

– PREPARED FOR –

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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BACKGROUND

The Maine Department of Health and Human Services is in the midst of a study of provider payment rates for targeted case management and behavioral health services delivered through Sections 13, 17, 28, and 65 of the MaineCare Benefits Manual. The national consulting firm Burns & Associates, Inc. (B&A) is assisting the Department in this rate study.

Based on a review of service requirements, consideration of provider cost data gathered through a provider survey, and identification and research of other available data, draft proposed rate models were released for public comment in March 2016. Providers and other interested stakeholders were given more than nine weeks to submit comments. The Department considered the comments received from more than 150 organizations and individuals and published responses to each comment in a December 31, 2016 report. In response to these comments, numerous changes were made to the final proposed rate models also published on December 31.

The Department and B&A presented these rates to the Health and Human Services Committee on February 10, 2017. At that hearing, Deputy Commissioner of Finance Alec Porteous committed to continued discussions with providers to understand their concerns and consider additional changes to the rate models.

This document is intended to highlight the broad issues that were raised in regards to the final proposed rate models and the additional adjustments that have been made to the rate models in response.

KEY ISSUES AND RATE MODEL ADJUSTMENTS

Direct Care Staff Wages, Benefits, and Productivity

1. ***Providers expressed concerns regarding wages and qualifications for direct care workers included:***

   - ***The use of the 25th percentile wage for the occupation selected as the benchmark for Targeted Case Management services is inconsistent with the assumptions for other services.***
   - ***The use of separate wage assumptions in Medication Management services delivered by psychiatrists and those delivered by physician assistants and nurse practitioners does not adequately support providers' programs. Further, the assumed wage for physician assistants and nurse practitioners is too low.***
   - ***Providers will not be able to find staff with 60 college hours to deliver Section 28 services.***

   The use of Maine-specific wage data from the Bureau of Labor Statistics to establish the wage assumptions in the rate models is described in the response to comment 1 in the original Public Comments and Responses document. In short, the BLS occupational classifications are compared to the requirements of each service and the occupation or occupations that are the best match are selected. For most services, the median wage for a given occupation was selected although there were exceptions.

   The wage assumption for Targeted Case Management was discussed in the response to comment 24 in the original Public Comments and Responses document. As discussed in that document, the TCM rate model uses the 25th percentile wage for medical and public health social workers was selected. This decision reflects the fact that employees working in the BLS occupation typically possess a master's degree, which is not a requirement for targeted case managers. The Department does not

wish to increase the educational requirement for the service, but believed it is appropriate for the rate model to reflect the lower requirement. The resulting rate model wage assumption is still about 20 percent greater than what providers report paying their staff.

Wage assumptions for the Medication Management rate models were discussed in the responses to comments 112 and 113 in the original Public Comments and Responses document. For the rate model for services provided by physician assistants and nurse practitioners, DHHS changed the assumed wage benchmark from the median to the 75th percentile to reflect the specialized nature of the work and the shortage of these professionals. The resulting wage is approximately $117,000 annually, which exceeds the wages reported by provider survey participants. The difference in wages paid to psychiatrists (to whom provider survey participants paying more than $200,000) remains the basis for the difference in the rates for services delivered by psychiatrists and those delivered by other staff. DHHS considered developing a single, weighted average rate, but that rate would be driven primarily by wages for PAs and NPs who deliver most services, resulting in a rate that would not be adequate for psychiatrists.

The Department's rationale for establishing a 60 credit hour requirement for Section 28 services was discussed in the response to comment 73 in the original Public Comments and Responses document. In response to provider feedback, however, DHHS has withdrawn this proposal, and there will continue to be no college requirement for these staff. The assumed wage in the rate models was reduced consistent with the change in the proposed requirements. The resulting wage is in line with wages reported by provider survey participants.

For all services, the rate models were updated with data from the BLS' May 2016 dataset, which became available March 31, 2017. This resulted in modest increases in the assumed wage for most services.

2. Concerns related to fringe benefits for direct care workers included:

- ***Bureau of Labor Statistics data relies too heavily on private employers, including retail, manufacturing and food service industries, which are not representative of the industry providing the services in the study.***
- ***The assumption for health insurance cost is too low and does not account for family plans.***

Discussion of the fringe benefits for direct care staff was included in comment 2 of the original Public Comments and Responses document. In short, that response noted that, while there were differences in the assumptions related to specific benefits, the overall benefit rate included in the rate models was slightly greater than reported by provider survey participants for full-time staff and much greater than reported for part-time staff. Information from the Bureau of Labor Statistics was provided as a point of reference, but was not a significant factor in the rate model assumptions overall as the benefits incorporated in the rate models are substantially greater than the averages found in the BLS.

In response to the additional provider feedback, several changes were made to the rate model assumptions:

- Separate benefit packages were established for staff with college degrees compared to those without, recognizing that more highly qualified professionals have the ability to command more generous benefits.
- The number of paid days off (holiday, vacation, and sick leave) for staff with college degrees was increased from 25 days per year to 30 days.

- The assumed cost of health insurance for all staff was increased from $400 per month to $425. As noted by a commenter, this is intended to reflect the cost of an individual insurance plan and the rate model does not assume that the employer covers the cost of a family plan. However, the revised assumption is slightly higher than the $410 effective average cost reported by provider survey participants.
- The assumed cost of other, non-delineated benefits for staff with college degrees was increased from $25 per month to $75, which compares to the $36 effective average cost reported by provider survey participants.
- The assumed cost of workers' compensation for all staff was reduced from 3.2 percent of wages to 2.0 percent, which is more in line with the 1.93 percent reported by provider survey participants.
- The assumed cost of workers' compensation for all staff was reduced from 2.2 percent of the taxable wage base to 2.0 percent, which is more in line with the 1.97 percent reported by provider survey participants.

Translated to an overall percentage of wages, compared to the benefit costs reported by provider survey participants, the assumed benefits package for staff with college degrees is now two-to-three percentage points higher and the benefits package for other staff is slightly higher.

3. Objections related to productivity adjustments to account for the non-billable responsibilities of direct care workers included:

- ***The inclusion of paid time off as a productivity adjustment should reduce only billable hours.***
- ***Not enough time was included in the rate models for missed appointments, recordkeeping, supervision and employer time, and training.***
- ***There is no productivity adjustment for collateral contacts in the Home and Community Based Treatment rate models to account for contacts that are not face-to-face and not billable.***
- ***There is no adjustment to account for turnover.***

Treating paid time off as a productivity adjustment was done in response to the informal comment period as discussed in the response to comment 5 of the original Public Comments and Responses document. This resulted in a reduction of time spent on all other tasks rather than billable activities only. That is, when someone takes a week off, that affects all the activities that they would have performed, which would not have been only billable time.

Discussion of productivity assumptions are incorporated throughout the original Public Comments and Responses document. In short, the assumptions are intended to be reasonable averages across all staff. As it relates to turnover, new staff may not be as productive, but there may be lower costs in other areas (for example, they are probably paid less and have lesser benefits than more experienced staff). Conversely, experienced staff may be more productive than assumed in the rate models.

In response to the additional provider feedback, several changes were made to the rate model assumptions:

- The assumption for employer and one-on-one supervision for most services was increased from 1.5 hours per week to 2.25 hours; other services were increased from 1.00 hour to 1.25 hours.

- For Home and Community Based Treatment services provided by bachelor's-level staff, 1.00 hours was added for non-billable collateral contacts; for services provided by master's level staff, 2.00 hours were added.
- Changes associated with paid time off and travel time in certain rate models are outlined elsewhere in this document.

After making these adjustments, the rate models assume that staff providing most services deliver between five and six hours of billable services per eight-hour day.

Travel and Overhead Costs

4. Concerns regarding the overhead assumption primarily related to the inclusion of a fixed $25 per day for program support in most rate models.

Discussion of program support costs was included in the response to comment 11 of the original Public Comments and Responses document. As outlined there, the fixed program support amount was set at $25 per day in order to provide an average of 28 percent for overhead costs (when including the 15 percent administrative factor included in the rate models), consistent with the range of overhead costs incorporated in previous rate studies. Additional, targeted factors were included in certain rate models. Most notably, the Outpatient and Medication Management models included one support staff for every two clinicians such that these models included a total of $102 per day for program support.

In response to the additional provider feedback, the Department reconsidered the program support assumption. In particular, provider survey data was used to calculate daily program support costs specific to each service reviewed. The resulting amounts then informed the rate model assumptions. The program support amounts were set close to these calculations. Additionally, in order to avoid any duplication of costs, the dedicated staff person in the Outpatient and Medication Management models were eliminated. In most cases, this resulted in an increase in the program support assumptions although the daily amount was reduced for some services. The new amounts range from $20 to $200 per day. The total of administration and program support now averages 32 percent across all services.

5. An objection was raised to the inclusion of the service provider tax to home-based Section 28 services.

The service provider tax has been eliminated from the home-based Section 28 rate models.

6. Concerns related to travel included:

- ***More significant travel occurs in the more rural parts of the State.***
- ***A comparison of mileage assumptions to travel time requires "impossible" speeds.***

Travel assumptions were discussed in the responses to several comments in the original Public Comments and Responses document (see, for example, the response to comment 32).

The mileage assumptions included in the rate models were derived primarily from data collected through the provider survey. The mileage that is built into the rate models includes both miles spent traveling to a member as well as miles associated with traveling with a member, which could be an acceptable component of some services and would be billable. Since some of this time will be billable (and, thus, would be reflected as billable hours rather than a productivity adjustment for travel time), comparing the mileage and travel time assumptions is misleading.

In response to the additional provider feedback, however, DHHS did increase the assumed mileage for Community Integration from 175 miles per week to 225 miles and increased the travel time commensurately. The travel time assumption was also increased in the home-based Section 28 rate models.

It was previously acknowledged that, as with all rate model assumptions, some providers' actual costs will be greater than assumed and others will have lower costs. MaineCare does not pay differentiated rates based on region for these services and, while providers serving rural areas may incur higher travel costs, they may have lower costs in other areas.

7. Providers expressed concerns related to the impacts of any rate reductions.

The Department recognizes that there may be challenges associated with implementing rate reductions. For that reason, the rates to be included in the formal rule-making will include a 10 percent stop-loss (that is, no rate will be reduced more than 10 percent). Further, the Department will not institute the new rates until January 1, 2018. The Department believes that the combination of the stop-loss and the long lead time between the publication of the rate models and implementation of the rates will allow providers the time necessary to align their business practices with the new rates.

Similarly, the formal rulemaking will balance the stop-loss with a 10 percent stop-gain that limits any rate increase to 10 percent. Any future changes to the rates (moving beyond the 10 percent stop-loss or stop-gain) would be subject to another formal rulemaking and comment process.