Overview of Proposed Rate Model for Behavioral Health Home Services

- prepared for –

Maine Department of Health and Human Services

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1

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Introduction

- Purpose of today's discussion is to present proposed rate model for behavioral health home services
  - These materials are *proposals*, not final decisions
- DHHS will continue to engage with providers and other stakeholders as decisions are made
  - All interested parties are invited to offer comments on these proposals

2

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Process

- Burns & Associates, Inc. contracted to assist with review of BHH rates
- Review service definitions and requirements
  - Consider policy goals
  - Review focused primarily on revising the rate based on current requirements, rather than significant changes to policies
- Collect data and input from providers
  - Monthly cost reports
  - Survey regarding staffing, caseloads, and other factors
  - (Forthcoming) public comment period for feedback on proposals
- Conduct research on cost drivers
  - Example: Bureau of Labor Statistics wage and benefit cost data

3

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Process (cont.)

- Develop detailed rate model and supporting documentation outlining assumptions
- Provide opportunity for public comment (see Next Steps)
- Revise rate as appropriate and finalize
- Implementation (see Next Steps)

4

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Process – Provider Survey

- Survey emailed to providers July 17
  - Augmented cost report data
  - Gathered data regarding caseloads and staffing
- Providers given about three weeks to submit surveys
  - Did not formally extend deadline, but accepted all late surveys
  - Also accepted partially-completed surveys (even if a survey was incomplete, any completed sections were included in the analyses)
- Technical assistance offered throughout survey period
  - Training webinar was conducted and a questions and answers document was emailed to providers
  - B&A responded to questions by phone and email
  - B&A reviewed submitted surveys and emailed clarifying questions as necessary

5

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Process – Provider Survey (cont.)

- Participation
  - Of 23 providers that billed BHH services between April 2014 and May 2015, 12 submitted a survey (52 percent)
  - 'Largest' BHH providers (in terms of revenue) were most likely to complete the survey
    - Participating providers accounted for 88 percent of total BHH expenditures
- Survey results were considered in the development of proposed rate model
  - See Provider Survey Analysis packet

6

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Process – Provider Cost Reports

- DHHS collected budget and cost reports between April and December 2014
  - Includes expense information by cost category as well as caseload information
- Provider survey included same cost report worksheet for January through June 2015
  - Intended to identify changes in cost trends in more recent months
- Data was used as reference point for wages and benefits, overhead costs, and caseload ratios
  - See Summary of Cost Reports packet

7

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Process – Independent Rate Model

- Rate model built around the expected caseload and monthly cost of the BHH team
- Model includes assumptions regarding team member wages and benefits, caseloads, and overhead and operating costs
  - Assumptions are based on multiple data sources, including provider cost reports, benchmark data, stakeholder input, and staff expertise
  - Providers do not have to follow the rate model assumptions and have flexibility to design their own programs (within the service definitions and requirements)
- Benefits
  - Transparency – assumptions are clear to everyone
  - Ease of maintenance – DHHS can update the model by making targeted changes to specific factors (for example, to adjust caseload expectations)

8

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Assumptions – Direct Care Worker Wages

- Used federal Bureau of Labor Statistics (BLS) job classifications to identify comparable positions

BHH Position	BLS Job Classification
Health Home Coordinator	Healthcare Social Worker
Clinical Team Leader	Average of Physician Assistant, Registered Nurse, Healthcare Social Worker, Psychologist
Peer	N/A
Nurse Care Manager	Registered Nurse
Medical Consultant	Family and General Practitioner
Psychiatric Consultant	Psychiatrist
Administrative Support	Bookkeeping, Accounting, Auditing Clerk

9

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Assumptions – Direct Care Worker Wages (cont.)

- Median wage used for the selected BLS job classifications with a few exceptions
  - Health Home Coordinators are priced at the 25th percentile of the Healthcare Social Worker occupation because typical qualifications for this position (i.e., a Master's degree) exceed BHH requirements
  - Peers are not pegged to a BLS classification, but are priced at $12.00 per hour, consistent with current reported wages and the Peer Support model developed during the Crisis services rate-setting
  - Psychiatrists are funded at the average (mean) wage because the BLS did not report a median for this occupation
- In general, resulting wage assumptions are greater than or equal to current wages levels reported by providers
- See Appendix A in Proposed Rate Model packet

10

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Assumptions – Direct Care Worker Benefits

- Considered BLS data and other Maine-specific information
- Rate model assumptions
  - $400 per month for health insurance for each worker
  - $25 per month for other benefits for each worker
  - Non-discretionary benefits (FICA, unemployment insurance, workers' compensation)
- Assumptions are translated to benefit rates by wage level
  - Resulting average benefit rate in the rate model (23.4 percent) is consistent with benefit rates reported by providers
- See Appendix B in Proposed Rate Model packet

11

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Assumptions – Direct Care Worker Benefits (cont.)

- Paid time off was not included in the calculated benefit rate
  - Rather, paid time off reduces staff work hours, which are assumed to be incorporated in caseload assumptions
  - Full annual cost of staff is spread across billable caseload
- Example
  - If a staff person has a $40,000 annual salary and receives and takes 30 days of paid time off, the cost to the employer is still $40,000
    - Further, it is not assumed that agencies hire temporary staff to cover for staff on leave; rather, it is assumed that other team members cover for the staff on leave (thus, there is no 'additional' cost)
  - If assumed caseload is 25, annual cost per case is $1,600, or $40,000 total (plus cost of benefits such as FICA, health insurance, etc.)
    - Assumed caseloads are lower than they would be if staff did not have paid time off

12

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Assumptions – Caseloads

- Considered current practices, provider recommendations, and policy goals
- Rate model generally provides for lower caseloads than assumed in the current rates

	Current - Adult	Current - Children	Proposed
HH Coordinator	24.1	27.0	24.0
Clinical Team Leader	267	267	192
Nurse Care Manager	267	400	200
Peer/ Youth Specialist	200	200	125
Psychiatric Consultant	42 hours per 200 cases		
Medical Consultant	42 hours per 200 cases		
Administrative Support	N/A	N/A	200

13

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Assumptions – Operating and Overhead Costs

- Considered providers' cost reports
- Rate model assumes one admin. staff for every 200 clients plus 25 percent of the total rate for other overhead costs
  - Operating and overhead costs account for 29.8 percent of total rate
- Technical notes
  - The rate model presents the overhead rate as a percent of total cost
    - Current rate calculates overhead as a percent of direct costs; in comparable terms, the current rates include a 25 percent overhead rate
  - Overall rate is higher so overhead percentage 'goes farther'
    - Overhead funding in proposed rate model is equivalent to 32 percent of current total rate (rather than current 25 percent)
    - Average current overhead rates reported by providers are about 34 to 36 percent

14

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Assumptions – 'Unbilled' Cases

- Current rates are 'inflated' to account for assumed 7.5 percent of cases that do not meet minimum billing requirement
  - On average, providers report that 8 to 12 percent of enrolled clients cannot be billed in any given month
- DHHS proposes to change the billing requirement, allowing a case to be billed as long as any covered service is provided
  - Thus, the proposed rate model does not include an adjustment for unbilled cases
  - Rather, providers should be able to bill for all (or nearly all) of their enrolled cases

15

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Results

- DHHS proposes a single rate for both adults and children

	Current Rate	Proposed Rate	'Equivalent' Rate
Adults	$365.00	$387.05	$430.06
Children	$322.00		

- 'Equivalent' rate accounts for change in the billing policy
  - Change to billing requirement will result in more billings
  - Without the change, the rate model would have yielded the 'equivalent' rate
- Considering the changes both to the rate and billing policy, the proposal is estimated to have the following impacts:
  - Adults – 18 percent increase
  - Children – 34 percent increase

16

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Next Steps – 'Informal' Comment Period

- Proposed rate model and supporting documentation are being posted online
- Written comments will be accepted at **BHHRates@burnshealthpolicy.com** until September 11
- Comments will be considered and the rate model will be revised as appropriate

17

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Next Steps – Implementation

- After the 'informal' comment period, revisions to the MaineCare Benefits Manual will be promulgated
- DHHS anticipates that the new rates and billing requirement policy will become effective in the first quarter of 2016

18

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Contact Information

Stephen Pawlowski
spawlowski@burnshealthpolicy.com

(602) 241-8520

3030 North 3rd Street
Phoenix, Arizona 85012

www.burnshealthpolicy.com

19

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