REVIEW OF BEHAVIORAL HEALTH HOME RATES

PUBLIC COMMENTS AND RESPONSES REGARDING PROPOSED RATE MODEL

– PREPARED FOR –

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OCTOBER 15, 2015

PROJECT BACKGROUND

The Maine Department of Health and Human Services (DHHS) is in the process of reviewing provider payment rates for behavioral health home (BHH) services covered by Section 92 of the MaineCare Benefits Manual. The consulting firm Burns & Associates, Inc. (B&A) is assisting in this project.

The rate review encompassed several tasks, including:

- Multiple meetings with service providers
- A detailed review of service requirements, billing rules, and DHHS' policy objectives
- An analysis of cost reports submitted by service providers and development of a provider survey to collect supplemental information
- Identification and research of other available data to inform the development of the rate

Based on this work, a detailed rate model was developed. The model includes assumptions regarding service costs and design, including BHH team composition and caseloads; staff wages and benefits; and agency overhead.

DHHS presented the proposed rate model and related documentation to providers on August 27. Providers were asked to submit their comments in writing to a dedicated email account. The comment period lasted until September 11, but comments submitted after the deadline were also considered.

Comments were received from 3 providers who raised 13 separate issues. In response to comments, DHHS reduced the assumed caseload for peer support specialists/ family or youth support specialists. The remainder of this document provides DHHS' response to each specific comment.

COMMENTS AND RESPONSES

1. ***One commenter expressed support for the proposed rate as well as the process undertaken to develop the rate.***

   The Department of Health and Human Services appreciates the support for the review of the behavioral health home service and the resulting rate model. DHHS intended for this process to be transparent and collaborative. As suggested by several providers, DHHS expects that a more thorough review of BHH standards and goals will be necessary, but believes that the increased rates – an estimated 20 percent for adults and 36 percent for children – is a good interim step in supporting the goals of the program: reducing inefficient healthcare spending, improving chronic disease management, promoting wellness and prevention, supporting recovery and effective management of behavioral health conditions, and promoting an improved experience of care for consumers and families.

2. ***One commenter requested additional clarification regarding proposed changes to the standards for billing the monthly behavioral health home rate, objected to "any additional administrative requirements", and suggested that relaxing the billing standards may increase the "risk of fraud'. Another commenter asked whether there will be a minimum service requirement in order to bill the monthly rate. This commenter also asked what will and will not qualify as a covered service in order to bill the monthly rate.***

   The specific guidelines regarding billing are still under development, but in general, DHHS intends to eliminate the current requirement that a provider deliver at least one hour of at least one covered

service as described in 92.09 (A)(3) of Section 92 of the MaineCare Benefits Manual. Rather, providers will be permitted to bill for a member if they provide any amount of any of the covered services outlined at 92.05.

3. ***One commenter stated that they are unable to transition non-MaineCare-eligible individuals receiving community integration to behavioral health home services because DHHS does not allow the state funding to be used for BHH services and asked whether this policy will be changed.***

   As noted by the commenter, behavioral health home services are currently available only through MaineCare. DHHS is not changing this policy at this time, but will consider it in the future.

4. ***One commenter stated that the cost analysis was significantly based on data reported by current behavioral health home providers, but that this is not a valid basis for determining a reasonable rate because existing service levels have been artificially constrained by the current rates.***

   Provider cost data was only one source of information considered in the development of the rate model for the very reason cited by the commenter – DHHS recognizes that current costs are constrained by the existing rates. Therefore, DHHS also considered other sources of information, including:

   - Input from providers, including suggestions made during the meetings held to discuss the rate review, a portion of the provider survey that asked for recommended caseload levels, and a proposal developed earlier this year by several provider chief financial officers
   - Wage and benefit cost data from the Bureau of Labor Statistics and other sources
   - A review of rates and caseload assumptions for behavioral health home services in other states

   Although provider cost data was one important consideration for certain aspects of the rate models, the sources outlined above were as significant a consideration. As a result of using multiple data sources, the new rate is substantially greater than the current rates and current reported costs. As noted in the response to comment 1, the new rate is an estimated 20 percent greater than the current adult rate and 36 percent higher than the current child rate.

5. ***One commenter stated that the proposed rate was developed from a cost-analysis perspective without taking into account any potential savings for other healthcare costs.***

   The commenter is correct in noting that, as a fee-for-service rate, the behavioral health home rate model is intended to reflect the cost associated with providing the service. The commenter is also correct in noting that BHH services should result in improvements in clients' health and wellness, resulting in reduced healthcare expenditures. As noted in the response to comment 1, these outcomes are among the goals of BHH services. The rate model does not account for these potential savings (the service is not a shared savings model), but any savings will help the State manage overall MaineCare costs.

6. ***One commenter stated that a "suggested caseload" of 26 clients per health home coordinator and 4 "'suggested hours/month" for "low" utilizers and 9.5 hours per month for "high" utilizers implies 175 hours of service per month per coordinator "assuming an equal split between low and high utilizers".***

   The commenter appears to be referring to provider survey results rather than the rate model assumptions. Additionally, the suggested support hours are being misinterpreted.

The provider survey conducted as part of this rate review asked providers to report suggested caseloads for each position included in behavioral health home teams as well as the amount of support that each service recipient receives from each position.

Providers that participated in the survey suggested that the appropriate caseload for a health home coordinator is between 24 and 26 cases (with the former number the weighted average response and the latter number the unweighted average; the median response was 25). The rate model assumes that there is one health home coordinator for every 24 cases, about the same as the current adult rate model (which assumes 24.1 cases) and less than the current child rate model (27.6 cases).

The survey also asked providers to recommend the number of monthly hours of service each recipient should receive. 'Service' was broadly defined to include direct contact as well as 'on behalf of' activities such as case coordination and participating in planning meetings. Providers were asked to offer recommendations for the average case as well as 'high utilizers'.

There was no 'low utilizer' question. Rather, the number cited by the commenter for low utilizers is actually the overall average. By definition, this average include recipients who receive little support and those who receive substantial support. This is the figure that must be used to illustrate work hour assumptions. Thus, a caseload of 24 with four hours of service per case implies that a health home coordinator provides 96 hours service (both direct contact and on behalf of activities) per month, or about 22 hours per week.

As noted, four hours per recipient per month is an average. Some individuals will receive less support and others will receive more, perhaps as much as 9.5 hours for 'high utilizers'. Overall, however, DHHS believes that the caseload and workload assumptions in the rate model are reasonable.

7. One commenter objected to setting the wage assumption for health home coordinators at the 25th percentile wage for healthcare social workers from Bureau of Labor Statistics (BLS) data, noting that the wage assumptions for other staff are set at the median wage for the selected BLS occupation.

In general, the rate model relies on wage data from the Bureau of Labor Statistics for people working in various occupations in Maine. The requirements of each behavioral health home team member were compared to the BLS job descriptions in order to identify the best match. After selecting the appropriation occupation, the rate model generally used the median (50th percentile) wage. The health home coordinator position is an exception, however.

DHHS determined the BLS occupation that best matched the health home coordinators' responsibilities was healthcare social worker (standard occupational classification 21-1022), based on the following description:

> Provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses. Services include advising family care givers, providing patient education and counseling, and making referrals for other services. May also provide care and case management or interventions designed to promote health, prevent disease, and address barriers to access to healthcare.

Though this occupation was determined to be the best match in terms of job responsibilities, DHHS also noted that the typical educational requirement for workers in this occupation is a master's degree. Health home coordinators, however, are not required to have this level of education. The rate model therefore assumes that health home coordinators would generally earn less than the median wage for all workers in this occupation. That is, the median is assumed to reflect the wage paid to someone

with average education and experience in the occupation. Since health home coordinators will generally have less than the average education, a lesser wage level is used.

Specifically, the rate model assumes that health home coordinators are paid at the 25th percentile wage for healthcare social workers. The resulting wage is $20.07 per hour, or almost $42,000 per year. This wage compares favorably to what providers report they currently pay, which is about $17.50 or $18.00 per hour.

8. One commenter stated that the wage assumed for peer support specialists/ family or youth support specialists is too low.

The rate model assumes that peer support specialists/ family or youth support specialists earn a wage of $12 per hour. The rate model also provides for a comprehensive benefits package equal to the benefits assumed for all other behavioral health home team members.

As discussed in the response to comment 7, the rate model generally relies on Bureau of Labor Statistics data to set the wage assumptions. However, the BLS does not have an occupation that is particularly analogous to peer specialists. The wage assumption for this position is therefore derived primarily from current wage levels as noted in provider cost reports. These reports indicate that this position is typically paid between $10.50 and $12.00 per hour. The rate model uses the top of this range, which is equal to the assumption in the Peer Supports rate model that is being added to Section 65 of the MaineCare Benefits Manual. At this time, DHHS does not have other data to suggest the need to increase the wage, but intends to monitor the use and effectiveness of peer supports to determine whether adjustments to rate model assumptions might be necessary.

DHHS did make a separate change related to peer support specialists/ family or youth support specialists. The rate model has been adjusted to assume one specialist for every 100 cases, a reduction from the proposed assumption of one specialist for every 125 cases and half of the 200-case assumption in the current rate model. It is not expected that a specialist will interact with everyone on the BHH team's panel, but the reduced caseload assumption is intended to allow the specialists to increase the supports they provide.

9. One commenter objected to the exclusion of paid time off from the benefit rates used in the rate model, noting that accrued paid time off is paid out when an employee leaves the organization.

As noted by the commenter, the rate model does not include paid time off in its benefit rate calculations because DHHS believes that paid time off is adequately addressed in the model.

The rate model spreads the monthly cost of each behavioral health home team member's wages and benefits across their assumed caseload. Specifically, the model makes assumptions regarding each team member's hourly wage and the cost of their benefits including payroll taxes, unemployment insurance, workers' compensation, health insurance, and other benefits that an employer may offer. Paid time off is not included in this calculation because, generally, this cost is already incorporated in the wage assumption.

For example, consider a staff person earning $41,600 per year. This annual salary translates to an hourly wage of $20 (based on a 2,080-hour work year). If this staff person receives 30 days of paid leave per year, the employer is not paying this staff person an additional $4,800 (30 days multiplied by 8 hours per day multiplied by $20 per hour). Rather, the staff person is still earning $41,600, but is only working 1,840 hours.

If a service is billed on an hourly basis, paid time off must be included in the benefit rate to account for hours that the staff person is paid, but not billable. For a monthly rate like BHH, however, the

$41,600 is fully recouped because this amount is divided by 12 months to establish the monthly cost and then divided by the caseload. The rate model accounts for paid time off in the caseload assumption.

In other words, the caseload assumptions are lower than they otherwise would be due to staff receiving 30 days of annual time off. For example, the rate model assumes that a health home coordinator can manage 24 cases per year even though the coordinator is not working 30 days per year. DHHS believes this assumption, as well as the other caseload assumptions, are reasonable. Since paid time off is already incorporated in the annual salary and this cost is fully allocated across the caseloads, including paid time off in the benefit rate would be 'double-funding' this factor.

It is possible that accrued leave payouts may result in costs not fully accounted for in the rate model. Returning to the example above, it is possible for a staff person to work for an entire year without taking a day off, earn $41,600, resign, and be owed $4,800 for their accrued leave. This specific example is unlikely because paid time off includes holidays that a staff person probably cannot work and an employer may not pay out all accrued leave (for example, many employers do not pay out sick leave), but it is certainly likely that some payouts do occur. However, if a staff person never takes a day off, they should be able to manage a larger caseload. That is, they are actually working 2,080 hours per year rather than 1,840 hours so they could manage a caseload of 27 rather than a caseload of 24. Their employer, in turn, would be able to bill for more cases, generating revenue to cover the cost of an accrued leave payout.

In summary, the rate model already accounts for paid time off. Whether the cost of accrued leave payouts is fully addressed in the model is debatable and DHHS does not have any detailed information about payout costs. Overall, however, the rate model already provides more funding for wages and benefits than reported by providers.

10. One commenter asked whether the rate modes include different travel-related assumptions for city and rural areas or whether such costs were averaged.

As is currently true, the rate for behavioral health home services does not vary based on the region of the State. As such, the assumptions in the rate model are intended to reflect reasonable averages of providers' costs. It is acknowledged that, for a given provider, some costs will likely be greater than assumed in the rate model while other costs will likely be less than assumed.

In the case of travel-related costs, the rate model does not include specific assumptions. Rather, mileage is assumed to be part of agency operating and overhead costs. The commenter cited a specific dollar amount – $9.03 per member per month. This was not a rate model assumption, though, but was the average cost from providers' costs reports. The analysis of the cost report data did not differentiate between rural and more urban providers.

11. One commenter expressed support for the explicit assumption that an administrative support position should be assigned for every 200 cases. However, the commenter suggested that the assumed wage for this position should be higher.

Earlier this year, a group of behavioral health home providers' chief financial officers (CFOs) suggested a number of changes to the BHH rate model. One of these suggestions was the addition of an administrative support staff position to the BHH team. DHHS agreed with that recommendation and added the position to the new rate model at the staffing ratio suggested by the CFO group: one staff person for every 200 cases.

To estimate the cost of the position, DHHS used the Bureau of Labor Statistics job classification for bookkeeping, accounting, and auditing clerks (standard occupational classification 43-3031), based on the following job description:

> Compute, classify, and record numerical data to keep financial records complete. Perform any combination of routine calculating, posting, and verifying duties to obtain primary financial data for use in maintaining accounting records. May also check the accuracy of figures, calculations, and postings pertaining to business transactions recorded by other workers.

The commenter suggested that a better classification would be computer operators (43-9011) whose jobs are described as:

> Monitor and control electronic computer and peripheral electronic data processing equipment to process business, scientific, engineering, and other data according to operating instructions. May enter commands at a computer terminal and set controls on computer and peripheral devices. Monitor and respond to operating and error messages.

DHHS continues to believe that the bookkeeping, accounting, and auditing clerk position appropriately reflects the duties of the administrative staff support position. The corresponding median wage is $16.90 per hour (more than $35,000 per year). The commenter suggested that the wage assumptions should be $19.82 or $24.47 per hour (about $41,000 or $51,000 per year), but DHHS continues to believe the current assumption is reasonable. Although the wage assumption is derived from BLS data, DHHS also notes that the assumption is consistent with the $35,000 salary recommended by the CFO group.

12. One commenter suggested that the rate model continue to reflect the pass-through payment.

The existing behavioral health home rate models include $8 per member per month to account for the administration of the pass-through payments to health homes. This responsibility has been included elsewhere in the new rate model and is no longer detailed as a separate line item.

As noted in the response to comment 13, the rate model includes a total operating and overhead rate of 29.7 percent, including the administrative support staff position for every 200 cases discussed in the response to comment 11. The administrative pass-through payment is assumed to be part of this overhead rate so the specific $8 per member per month assumption has been eliminated.

13. One commenter suggested that the rate model assume a 28 percent operating and overhead rate rather than a 25 percent rate, noting that providers reported an average rate of 28.3 percent.

The commenter is not citing the appropriate figure to compare the rate model assumption to providers' cost reports. The rate model includes a total of 29.7 percent for operating and overhead costs. This is generally consistent with costs reported by providers and DHHS believes the total rate is appropriate.

As discussed in the response to comment 11, the rate model assumes an administrative support staff position for every 200 cases. In addition to that position, the rate model includes another 25 percent of the total rate for other operating and overhead costs. Considering both assumptions, the operating and overhead funding is equal to 29.7 percent of the total rate, or $117.22 per member per month.

On a per member per month basis, provider cost reports for January through June 2015 indicated a weighted average administrative costs of $116.01 and a median of $126.19. On this basis, the $117.22 included in the rate model is in-line with current reported costs.

However, to truly compare the numbers, the billing policy change discussed in the response to comment 2 must be considered. In brief, a change to the billing standard will allow providers to bill for a greater proportion of their caseloads. Specifically, DHHS assumes that providers will be able to bill for an estimated ten percent of their caseloads that is not currently billed. Increasing billable units will reduce the per member per month amounts (because the same overhead costs are being spread across a larger number of billable units). Adjusting for this change in the billing policy would reduce the current per member per month amounts to between $104.40 to $113.57, amounts that are somewhat less than the equivalent rate model assumption.