PERSONAL CARE AND RELATED SERVICES RATE REVIEW

PUBLIC COMMENTS AND RESPONSES

– PREPARED FOR –

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PROJECT BACKGROUND

The Maine Department of Health and Human Services (DHHS) is in the process of reviewing provider payment rates for personal care/ personal support services, home health aide/ certified nursing assistant, and nursing services covered by Sections 12, 19, and 96 of the MaineCare Benefits Manual, as well as state-funded services provided through Chapter 5, Section 63 and Part 2, Chapter 11 of the Office of Aging and Disability Services 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
- Development and administration of a provider survey to collect information regarding providers' service designs and costs
- Identification and research of other available data to inform the development of the rate models
- Analyses of claims data

Based on this work, detailed rate models were developed. The models included the specific assumptions regarding the costs that providers face in the delivery of each service, such as direct support workers' wages, benefits, and billable time; staffing ratios; travel; and agency overhead.

DHHS released the proposed rate models and related documentation to providers on September 30. Stakeholders were notified by email and a webinar was conducted to explain the proposals and respond to questions. A recording of the webinar was posted online for those who could not participate.

Interested parties were asked to submit their comments in writing to a dedicated email account. The comment period lasted until October 23, but comments submitted after the deadline were also considered.

In total, comments were received from 11 individuals. Comments were thoughtfully written and constructive, and DHHS appreciates all those who took time to provide feedback. This document provides DHHS' response to each specific comment.

COMMENTS AND RESPONSES

1. ***Several commenters expressed support for the proposed rates as well as the underlying methodology. One commenter requested a list of "OADS policy decisions" that were incorporated in the rate models.***

   The Department of Health and Human Services appreciates the support for the process employed to review the rates for personal care and related services. DHHS, in turn, appreciates the time and effort that providers and other stakeholders devoted to this process. DHHS believes this collaborative approach has yielded rate models that, when coupled with the recently legislated rate increase, should help stabilize the service delivery system by accounting for the costs associated with delivering quality services.

   DHHS identified several principles for the review of these rates, including:

   - Conducting a transparent and collaborative study of the rates personal care and related services in order to construct rates that reflect the cost of providing services
   - Aligning rates across the various MaineCare and state-only programs covering these services

- Establishing rates that provide for competitive wage and benefit packages for personal support specialists and other direct care staff, including access to health insurance and paid time off
- Recognizing higher costs associated with short-duration encounters by creating 'visit' rates

2. One commenter noted that DHHS does not have adequate funding to fully implement the rates and further objected to any increase not occurring until the first half of 2016. Other commenters stated their intent to work with the Department to advocate for additional funding.

Implementing the final rate models would require $18.1 million ($8.1 million in State funds). The Department is in the process of evaluating options for increasing current rates and is making available to policymakers the results of the rate study and the resources that would be necessary to implement the rates.

3. Several commenters suggested that the rate model assumptions be reviewed regularly to ensure the rates remain adequate.

The rate model assumptions have been transparently detailed so that it is clear to everyone precisely how the rate models were derived. This transparency allows DHHS, providers, and other to periodically review the appropriateness of the assumptions over time.

For example, the mileage rates included in the rate models are based on the Internal Revenue Services' 2015 rate for business travel. The IRS adjusts this amount annually so a new mileage rate could be easily inserted into the model, which would adjust the rate model for each service with a mileage component.

Rate models will not be automatically adjusted, however. DHHS may choose to review the rates at any time and providers could similarly suggested revisions, but changes to the rates will be dependent on the availability of funding and the State's priorities (for example, funding rate adjustments or expanding services or reducing waiting lists).

4. One commenter noted that the participation rate in the provider survey was negatively impacted by the lack of participation amongst Medicare-certified agencies as well as providers that no longer exist.

A provider survey was conducted as part of the rate study. The survey was intended to collect data regarding the manner in which services are delivered and the costs of providing these services. Providers were given one month to complete the survey and B&A provided technical assistance throughout the survey period.

Participation in the survey was voluntary and, ultimately, only nine of 103 providers submitted a survey. As the commenter notes, participation was particularly poor amongst Section 40 providers. Even excluding these providers, however, participation was lower than anticipated. In fiscal year 2014, there were 57 providers of Section 19 services and 52 providers of Section 96 services (these totals overlap), but, as noted, only nine surveys were received.

Provider survey results were informative, but, given participation levels, the rate models relied primarily on other sources of information. These considerations included DHHS' programmatic input, feedback from providers, and wage and benefit cost data from the Bureau of Labor Statistics and other sources.

5. Two commenters stated that the rate models may not account for regional factors that affect the cost of providing services, including travel in rural areas and a Portland ordinance establishing a minimum wage greater than the rest of the State.

As is currently true, the new rates do not vary based on the region of the State. As such, the assumptions in the rate models 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 a given rate model while other costs will likely be less than assumed.

The commenters provide examples of potential regional variations. The minimum wage in Portland in 2016 is $10.10 per hour, compared to $7.50 in the rest of the State. The lowest wage assumption in any of the rate models is $10.28, which exceeds the 2016 minimum wage, but is less than the 2017 minimum of $10.68. Agencies in Portland, though, may have lower costs in other areas. For example, travel expenses may be less because of greater population density or they may offer a less robust benefits package to offset the higher wage cost.

Similarly, providers in more rural parts of the State may incur travel expenses that exceed those assumed in the rate models. Again, it is assumed that other costs for these providers, such as wages or overhead, would be less than assumed in the models.

Thus, while some cost assumptions will be less than a given provider's costs in one area, other cost assumptions will likely be greater than actual costs; DHHS believes the overall rates are reasonable.

6. One commenter asked how the establishment of short-term and long-term rates will affect authorizations and the claims management system.

The new rate schedule includes separate rates for the first six hours of service provided to a member in a day and for any units of service after six hours. For example, if a provider delivered eight hours of service to an individual, the first six hours (24 units) would be billed at the 'short-term' rate and the next two hours (8 units) would be billed at the 'long-term' rate. The long-term rates are lower than the short-term rates to recognize certain efficiencies that could be expected for extended services (for example, less travel and less recordkeeping).

Members who receive extended care will need authorizations for both short-term and long-term services. As noted in the response to comment 2, DHHS is in the process of considering options for instituting the new rates. Guidelines for authorizations and claims will be part of these considerations.

7. Several commenters emphasized the importance of personal support specialists. Two of these commenters stated that the wages proposed in the rate models represent a positive step in supporting these staff. Two commenters objected to the wage assumptions. One commenter stated that the Bureau of Labor Statistics' (BLS) job classification for personal care aides should not be the basis for the personal support specialist wage assumption because the description of the job does not match the work that PSS's perform. This commenter suggested that the nursing assistant classification better reflects the responsibilities of PSS's. The other commenter stated that the assumed wage of $10.28 per hour is less than the current average paid by their agency, that the BLS data upon which the assumption is based is artificially low due to stagnant MaineCare rates, and that the wage assumption should be $10.91. Both of these commenters suggested that there should be greater parity between wages for PSS's, direct support professionals, and mental health rehabilitation technicians.

The rate models for personal care/ personal support services assume that the personal support specialists providing the service are paid an average wage of $10.28 per hour. This wage is equal to

the statewide average reported by the Bureau of Labor Statistics for personal care aides (standard occupational classification 39-9021). This wage assumption has not been revised.

As noted by the commenter, there are other BLS job classifications with job descriptions similar to PSS staff, including nursing assistants. However, other elements of these occupations are not consistent with PSS requirements. Notably, the typical educational requirement for nursing assistants is a postsecondary non-degree award, which is not required of PSS's.

There are currently different training and service requirements for PSS's, direct support professionals, and mental health rehabilitation technicians. Data that DHHS has collected as part of recent rate studies has indicated that there are differences between the wages paid to these staff in these occupations. As a result, the rate models have included different wage assumptions for these staff. However, through the Direct Service Worker Training Program (DSWTP) DHHS is collaborating with the University of Southern Maine and the University of Maine in Augusta to develop an integrate curriculum for PSS's, DSPs, and MHRT I's. Among other goals, the initiative is intended to improve the supply and mobility of workers across populations and programs. As the project progresses, DHHS will consider whether wage assumptions in rate models need to be revised.

8. One commenter expressed support for the inclusion of an assumed health insurance benefit for care providers.

DHHS recognizes that a stable, qualified, and motivated workforce is critical to the delivery of high-quality services. The rate models therefore include reasonable wage assumptions and a comprehensive benefits package.

As noted by the commenter, the rate models assume that all direct care staff have access to and participate in health insurance from their employer. There will likely be some staff who will not receive health insurance because they work part-time and are ineligible or decline to participate because they have coverage from another source. DHHS, however, wanted the rate models to reflect the presumption that all staff should have access to health insurance.

Specifically, the rate models include $400 per month for every direct care staff for the cost of single-person health insurance coverage. In addition to health insurance, the rate models include funding for Social Security and Medicare payroll taxes, workers' compensation, unemployment insurance, paid time off, and $25 per employee per month for other benefits.

9. One commenter stated that providers are not fully reimbursed for short-term nursing visits such as venipuncture. This commenter stated that they do not receive payment for the cost of supplies and transporting the sample to a lab. The commenter suggested that visit rates be used rather than 15-minute units.

The new rate schedule does include 'visit' rates to accommodate the types of services referenced by the commenter. The rate models include larger productivity adjustments to reflect the greater amount of travel that is required when delivering short-duration services. Although the visit rate models are built on a presumed 45 minutes of service, the rates may be billed for any direct service encounters of less than one hour (only one visit may be billed per individual per day and a visit cannot be billed for an individual on the same day that 15-minute units are billed). This policy ensures a minimum amount of revenue for providers delivering these services in order to cover the types of ancillary costs noted by the commenter.

10. Two commenters stated that the Registered Nursing rate is not adequate to account for their non-billable responsibilities. One of these commenters suggested that nurses be permitted to bill for these duties performed on behalf of a consumer.

The rate models include productivity adjustments to account for the non-billable activities of direct care staff. Effectively, the adjustments spread the cost of non-billable tasks across billable hours. DHHS believes the rate model productivity assumptions are reasonable and has not made any revisions.

DHHS recognizes that nurses have more non-billable responsibilities than other direct care staff so the nursing rate models assume fewer billable hours. In the 'visit' rate models, nurses are assumed to provide 27.75 billable hours of service per 40-hour week compared to 30.50 hours for personal support specialists. The 15-minute rate models assume 33.75 billable hours for nurses compared to 36.50 hours for PSS staff.

In addition to more generous productivity assumptions, the establishment of visit rates, which are discussed in the response to comment 9, are intended to account for non-billable responsibilities associated with very short encounters. The visit rates guarantee minimum funding for nurses that are responsible for brief encounters in order to recognize many of the ancillary tasks they must perform.

Finally, DHHS notes that nursing responsibilities associated with clinical oversight of services provided by other staff (such as supervising staff or reviewing records for members who are not part of their own direct-care caseloads) are not intended to be part of the nursing rate models. Rather, these 'program support' costs are assumed to be included in the overhead and operating costs built into the rate models for personal care/ personal support services and home health aide/ certified nursing assistant services.

11. One commenter stated that nurses travel between 60 and 120 miles per day [300 to 600 miles per week].

The rate models assume that nurses providing 'visits' (of less than one hour) travel 250 miles per week, on average, and that nurses providing lengthier encounters travel 60 miles per week. These assumptions vary because nurses who spend more time with each individual will, by definition, see fewer members, therefore incurring fewer trips between individuals.

The mileage assumptions were partly derived from provider survey results. As discussed in the response to comment 4, however, survey participation was low. The analysis therefore looked at information across all staff (that is, personal support specialists, home health aides/ certified nursing assistants, and nurses). On this basis, the rate model assumptions are consistent with information reported by responding providers. As a result, the rate models include the same mileage assumptions across all staff types.

It is noted that, when evaluating responses for nurses (from only four provider respondents), the weighted average response regarding nurses' travel was 333 miles per week. However, the average reported travel time was only 2.7 hours per week. The nursing rate models include travel time assumptions (eight hours per week for nurses providing visit services and two hours for those providing other, lengthier encounters) that are consistent with reported information and include mileage assumptions that are in-line with these hours (that is, staff are assumed to average about 30 miles per hour).

The travel-related assumptions are unchanged from the proposed rate models as DHHS does not have sufficient data to reconsider the assumptions. Overall, the Department believes the nursing rates – which are at least 24 percent greater than existing rates (for 15-minute units) – are reasonable.