REVIEW OF PAYMENT RATES FOR CHILDREN'S RESIDENTIAL TREATMENT SERVICES (PNMI) COVERED BY SECTION 97

PUBLIC COMMENTS AND RESPONSES

– PREPARED FOR –

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PROJECT BACKGROUND

As part of its efforts to ensure compliance with the requirements of the federal Family First Prevention Services Act (FFPSA), the Maine Department of Health and Human Services (DHHS) contracted the national consulting firm Burns & Associates, a division of Health Management and Associates, to conduct a rate study for Children's Residential Treatment Private Non-Medical Institution (PNMI) services covered by Appendix D of Section 97 of the MaineCare Benefits Manual.

The rate review encompassed several tasks, including:

- A detailed review of FFPSA requirements, MaineCare regulations, billing rules, and DHHS' policy objectives
- Meetings with service providers
- Development and administration of a provider survey that was emailed to all providers to collect information regarding service designs and costs
- Review and analysis of provider cost reports
- Identification of other data sources to inform the development of the rate models, including cross-industry wage and benefit standards and rates paid for comparable services in other states
- Analyses of claims data

Based on this work, detailed rate models were developed. The models include the specific assumptions regarding the costs of delivering each service, such as clinicians' wages, benefits, and caseloads; clinical supports; facility expenses; and agency overhead.

The proposed rate models were presented to providers on March 24, 2021 beginning a three week public comment process during which providers could submit written comments on the models. In response to public comments and the availability of updated data from other published sources, a number of changes were made to the rate models:

- More recent Bureau of Labor Statistics wage data and Bureau of Economic Analysis wage inflation data that became available after publication of the proposed rates was incorporated in the rate models
- Increased the assumed wage for direct support staff
- Increased the paid time-off benefit assumption for paraprofessional staff
- Increased the on-call payment costs for nurses and psychologists/ BCBAs
- Increased miles for post discharge supports, but eliminated the productivity adjustment for travel time as travel will be an allowable billable activity
- Reduced the program support rate from 18 percent to 14 percent (which still provides an increase in the dollar value of program support compared to reported levels given overall rate increases)
- Reduced the administrative rate from 12 percent to 11 percent (which still provides an increase in the dollar value of administration compared to reported levels given overall rate increases)
- Increased assumed food costs in the room and board rate model
- Added the service provider tax to the room and board rate model
- Increased accreditation fees

The cumulative effect of these changes is presented in the table below.

Service Description	Current Rate	Proposed Rate (03/24/2021)	Final Rate	Change Compared to Current Rates	
Children's Mental Health Residential Treatment	$330.72 (Lvl. I) $435.40 (Lvl. II)	$532.73	$580.09	$249.37 $144.69	75.4% 33.2%
Intellectual Disabilities and Autism Spectrum Disorder	$396.47 (Lvl. I) $585.60 (Lvl. II)	$665.95	$727.98	$331.51 $142.38	83.6% 24.3%
Post Discharge Supports	New	$66.33	$53.34		
Room and Board	$54.45	$43.17	$46.34	($8.11)	(14.9%)

The remainder of this document provides DHHS' response to each specific comment.

CROSS-SERVICES

1. ***One commenter stated that the rates need to be adjusted over time to account for rising costs.***

   The rate models are designed to reflect estimated costs for fiscal year 2022, incorporating wage inflation data and the projected cost for complying with the Family First Prevention Services Act (FFPSA) including trauma-informed care training, accreditation, and 24-hour on-call nursing availability.

   By detailing the underlying assumptions and data sources, the rate models are constructed to allow for future adjustments to key elements such as wages, employee benefits, travel, etc. This is consistent with the recommendation in the MaineCare Comprehensive Rate System Evaluation to "update rates every 1 to 2 years…to reflect health care cost inflation in Maine." DHHS is in the process of considering this and other recommendations in the Evaluation. Any future rate increases would be subject to the availability of funding.

2. ***One commenter observed that the success of these programs will depend on MaineCare policies, and specifically expressed concern that the policies may mandate some of the assumptions in the rate models.***

   DHHS is in the process of updating policies that will seek to balance the need for clear and consistent expectations to ensure that children's needs are met, federal requirements, and flexibility for providers in the delivery of the service. Once drafted, they will go through the normal rulemaking process, offering stakeholders an opportunity to comment.

3. ***One commenter suggested that the proposed rates will not cover the costs for agencies with fewer than 10 children in their programs and that, as such, the rate models are establishing a policy that a 10-bed model is preferred.***

   The rate models do not represent any policy preference.

The rate models use an assumed 10-bed program to support the understandability of the models. The models, however, are based on assumed staffing ratios such that they are scalable; smaller programs will have fewer staff and larger programs will have more staff. For example, the Mental Health Residential Treatment model assumes a direct support staffing ratio of two children per staff during non-school hours, translating to five staff onsite during these hours. If a program has eight beds, the model will fund four staff at the same 1:2 ratio and if a program has 12 beds, the model will fund six staff. The same is true for other positions built into the rate model.

Assumed costs related to trauma-informed training and accreditation are spread over an assumed program of ten children, but these costs comprise less than one percent of the total rates so assuming a different program size would have a negligible impact on the total rate.

4. ***One commenter noted that staffing shortages and the inability to hire new staff are preventing them from operating at licensed capacity.***

   It is understood that some providers are not able to fully staff their programs. The rate models assume a 92 percent occupancy rate for *staffed* beds. The rate model does not include a provision for unstaffed capacity because the provider is not incurring its single largest expense: direct support staff. It is hoped that the significant increase in rates – 75.4 percent for level I and 33.2 percent for level II for Mental Health Residential Treatment programs and 83.6 percent for level I and24.3 percent for level II for Intellectual Disabilities and Autism Spectrum Disorder programs – will allow providers to increase their staffing as necessary to meet the demand for services.

5. ***Several commenters objected to the assumed wage for direct support staff. Comments included:***

   - ***The rate study relied on data from 2019 cost reports and so does not account for rising costs.***
   - ***The rate models do not account for the new requirement that staff be behavioral health professionals.***
   - ***Alternative suggestions included a wage of $18.00 to $20.50 per hour or the use of a 'living wage'.***

   The wage assumptions in the proposed rate models were based on Maine-specific wage data from the Bureau of Labor Statistics for May 2019 (the most recent data available at the time), inflated to January 2022 based on Maine-specific wage growth data over the past ten years as reported by the Bureau of Economic Analysis. Since the proposed rate models were released, new wage and wage inflation data was published and has been incorporated in the rates.

   In response to these comments, DHHS reconsidered the BLS occupation classifications that were used to benchmark the wage assumptions for behavioral health professionals. Although a bachelor's degree is not a prerequisite for BHPs, it is recognized that programs could benefit from staff with such qualifications so the benchmarks used for direct support staff was expanded to include a BLS classification that typically requires a bachelor's degree.

   With this new data and the change in the benchmark job classifications, the assumed hourly wage has been increased to $20.94 per hour compared to $17.39 in the originally proposed rate models. In comparison, provider cost reports included an average of $17.16 for behavioral health professionals and $15.09 for other qualified mental health professionals.

6. ***Two commenters stated that the wage assumptions are inadequate and do not account for costs associated with vacancies and staff retention. One of these commenters suggested the rate models should set wage assumptions for all positions based on the 75th percentile of the Bureau of Labor Statistics wage data rather than the 50th percentile (median).***

   The rate model wage assumptions are set at the 50th percentile (median) wage from the BLS dataset, which reflects market-based wages across all employers and not only those funded through public programs. DHHS continues to believe that median wages are an appropriate benchmark as this is the wage at which half the individuals in the occupation earn more and half earn less. Further, as noted in response to comment 5, the BLS job classifications used as benchmarks for BHPs have been revised, increasing the assumed hourly wage from $17.39 per hour to $20.94. As with all rate model assumptions, the assumed wage is intended to represent a reasonable average. Thus, it is expected that some staff will earn more than the assumed wage (for example, those with more experience) and others will earn less (for example, new hires).

7. ***Commenters stated that the assumed amount for on-call pay for nursing and psychologist is insufficient.***

   In response to these comments, the on call pay for nurses and psychologists has been increased to $369 per week compared to $50 in the originally proposed rate models) based on the assumption that there will be 123 on-call hours per week (168 hours in the week less 45 hours during which staff are assumed to be on-shift) and a cost of $3.00 per hour based on research of on-call arrangements for nurses, which generally suggested a range of $2 to $4 per hour.

8. ***One commenter suggested time be included to allow staff to complete required recordkeeping as staff cannot be removed in order to complete documentation.***

   Since the rate models pay for the entire shift of direct support staff working in the home, the productivity adjustments are only intended to cover instances when a substitute staff person is needed to cover for the worker performing the task. In the case of documentation, DHHS believes that the rate models include sufficient staffing to allow for documentation during relatively slower periods during the day, through the use of the social worker position to provide temporary coverage, and/or by staggering shift times.

9. ***One commenter suggested that time be included for staff to attend weekly staff meetings.***

   The rate models include one hour per week for employer time such as staff meetings and one-to-one supervision. As noted in the response to comment 8, the rate models only include productivity adjustments for tasks during which it is assumed that substitute staff are needed to cover for the worker performing the task.

10. ***One commenter stated the psychologist ratio of 1:60 and nursing ratio of 1:50 requires that providers either hire part-time or contract staff or requires these positions to cover multiple programs.***

    The staffing ratios reflect what providers report they are currently delivering. For psychologists, the effective average ratio across all providers' cost reports was 1:220 and the average reported through the provider survey was 1:54. For nurses, the average effective ratio across all providers' cost reports was 1:51 and the average reported through the provider survey and 1:35. The commenter did not suggest a specific staffing alternative, but DHHS does not believe that a full-time psychologist and a full-time nurse is needed for every ten participants. The rate model does not presume how the

provider delivers this staffing, but the commenter is correct that it could be achieved through part-time or contract staff or full-times staff that support other programs (that do not necessarily need to be other residential programs).

11. Commenters objected to the difference in benefit packages for professional and paraprofessional staff.

The benefits package in the proposed rate models only varied in the assumed number of days of paid time off for professional and paraprofessional staff, with an assumed 20 days and 15 days, respectively. In response to these comments, the paid time off assumption for paraprofessional staff has been increased from 15 to 20 days.

12. Several commenters indicated costs associated with staff turnover such as recruiting, overtime, and training need to be included in the rate models.

The rate models account for a number of turnover-related expenses:

- The productivity adjustment for training time reflects the fact that every year, due to turnover, some portion of the workforce receives the more intensive first-year training
- Expenses such as recruiting, and advertising are included in the program support and administrative components of the rate model
- The cost of overtime is included in the assumed hourly wages

13. One commenter suggested that travel costs should be paid with a separate grant.

It is understood that travel requirements can vary substantially across the state. Although no changes have been made to the rate model for residential services at this time, it is noted that DHHS is currently considering the recommendations from the MaineCare Comprehensive Rate System Evaluation, including a suggestion that DHHS may wish to consider the impact that differences in travel have on providers' costs.

The response to comment 20 discusses changes to the travel-related assumptions in the rate model for post-discharge services.

14. Several commenters indicated accreditation cost are not sufficient to cover the required costs.

In response to these comments, the accreditation costs have been increased to reflect the highest identified cost of accreditation. In developing the rate models, accreditation-related costs were reviewed for the Council on Accreditation (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF). The proposed rate models assumed the CARF accreditation fees of $7,300 versus COA's fees of $4,750 for a 10-bed facility. After additional research, the rate models have been revised to reflect accreditation from the Joint Commission at a cost of $10,940. Additionally, the model is scalable, so larger programs will receive more funding for accreditation.

15. One commenter asked how the 18 percent program support rate was developed and what costs are included.

The program support component of the rate model is intended to cover program expenses such as program support wages and benefits, program supplies, client activity fees, and insurance. The assumed program support rate primarily considered information reported through provider cost reports, reflecting direct cost expenses less room and board expenses and the cost of direct care staff wages and benefits since these factors are included elsewhere in the rate models. This resulted in a

program support rate across all providers of 18.7 percent equating to a total of approximately $7.7 million in program support expenses. Given the significant increase in the proposed rates, the program support rate has been reduced to 14 percent, equivalent to total funding of $8.4 million, a 9.3 percent increase compared to current funding levels.

16. ***Several commenters stated the 12 percent administrative rate is insufficient to cover providers' costs, noting that a variety of expenses of increased over the years, including liability insurance, workers' compensation, and information technology such as electronic health records.***

    The administrative rate included in the rate models is based on providers' current, actual costs as indicated in the provider cost reports. Data from the cost reports indicates an overall administrative rate across all providers of 15.2 percent equating to total administrative spending of $6.3 million. Given the significant increase in the proposed rates, the administrative rate has been reduced to 11 percent, equivalent to $6.6 million, a 5.7 percent increase compared to the current level.

17. ***One commenter indicated the service provider tax should be calculated based on total revenue.***

    The service provider tax of six percent is correctly calculated in the rate models. Per the Maine Revenue Services Bulletin 55:

    > Sales of services provided to MaineCare residents and paid for by DHHS are taxed based on the number of billing units billed out for the reporting period multiplied by the rate assigned to the provider by DHHS, excluding any amount of tax included in the DHHS payment.

18. ***One commenter objected to rounding to two decimal points in the rate models.***

    The rounding conventions incorporated in these rate models follow the conventions included in previous rate studies: dollars rounded to the nearest penny, percentages rounded to the nearest tenth of a percent, and work hours are rounded to the nearest one-hundredth of an hour (less than a minute). This approach is intended to support transparency by allowing a reader to calculate the value at each step in the rate model. The rounding conventions neither favor nor disfavor the final rate; they may produce a slightly higher or slightly lower final rate, but the difference is generally within one-tenth of one percent.

CHILDREN'S MENTAL HEALTH RESIDENTIAL TREATMENT

19. ***One commenter stated that the non-school hours staff-to-child ratio should be lowered from 1:2 to 1:1:5.***

    The staffing ratios included in the rate models provide 72.7 hours of direct support staffing per child per week, which is consistent with current staffing levels reported by providers. However, if additional staffing is necessary, the provider has the option to request additional staffing through the temporary high intensity service.

POST DISCHARGE SUPPORTS

20. Several commenters suggested that billable hour assumptions of 26 hours per week is too high due to travel distances and non-client-facing supports (such as collateral contacts).

In recognition of low and short-term caseloads that make it difficult to efficiently schedule trips (that is, to schedule visits to multiple children in the same area on the same day) or to build local capacity, DHHS intends to make the time spent traveling to a service encounter billable. Accordingly, the productivity factor for travel time has been removed from the rate model.

ROOM AND BOARD

21. Several commenters stated the rate does not account for all of providers' costs, such as client activity and outing costs, costs to support clients during day trips to visit families, food, costs to meet individual needs related to client care not covered by family or DHHS, and expenses associated with special medical requirements. Commenters further stated that some costs are not reported in the cost reports because they are not allowed.

The room and board rate is only intended to cover costs associated with the facility (that is, the 'room' component, including rent/ depreciation, utilities, maintenance, etc.) and costs for food and personal care items (that is, the 'board' component). Many of the other costs cited by commenters, such as activity fees, would be incorporated in the PNMI service rate models.

22. One commenter stated the assumed food cost of $11.75 per child per day is insufficient, particularly for children with specialized diets.

The assumed daily food cost in the proposed rate model was consistent with the $11.67 reported in the cost reports. In response to this comment, however, the assumed cost has been increased to $12.30 based on the United States Department of Agriculture's liberal food plan (the most expensive plan) cost for a 14-to18 year-old male (the mostly costly age group).

23. One commenter asked how the assumed building cost of $15.50 per square foot was derived and what cost are included.

The cost per square foot was determined based on information contained in the cost reports and includes rent, mortgage interest, utilities, heat, and maintenance expenses. The reported cost was $15.34 per square foot.

24. One commenter asked how household supplies and property insurance costs were included in the rate model.

The household supplies are included in the child supplies cost component of the rate model, which is funded at $4.25 per day based on the $4.22 average from the provider cost reports. Property insurance costs are included in the program support and administrative cost components of the rate models.

25. One commenter stated the services provider tax should be included in the room and board rate.

The commenter is correct; the service provider tax was incorrectly excluded. The room and board rate model has been revised to include the tax.