BURNS & ASSOCIATES
A DIVISION OF
HEALTH MANAGEMENT ASSOCIATES

Behavioral Health Services Overview of Draft Rate Models

- on behalf of -

Maine Department of Health and Human Services

September 20, 2022

Presentation Summary

- In alignment with legislation (P.L. 2022, Ch. 635, Part JJJ), the Department of Health and Human Services is conducting a rate study for targeted case management and behavioral health services covered by Sections 13, 17, 28, 65, and 92 of the MaineCare Benefits Manual
  - DHHS contracted with Burns & Associates to assist with this study
- Burns is using the same approach as for previous MaineCare rate studies
  - Developing detailed, transparent rate models showing the specific assumptions used to establish the total rates
  - Relies on data from multiple sources rather than any single source
  - Multiple opportunities for stakeholder involvement
- Presentation covers draft rates for comments, which will be considered prior to finalizing the recommendations
  - Overall, the draft rates represent meaningful increases for most services
  - In some cases, recommendations include changes to billing policies and units; in others, changes may be made in the future, but more policy work is needed

Agenda

- Project Background
- Rate Study Process
- Draft Rates
- Service Specific Information
- Public Comment Process

PROJECT BACKGROUND

BURNS & ASSOCIATES, A DIVISION OF HMA

Background on MaineCare Rate-Setting

- As part of its commitment to ensuring reasonable provider payment rates to support MaineCare's provider network, DHHS has conducted a number of rate studies in recent years
  - The Legislature has approved funding to implement many of the recommendations from these rate studies and to otherwise increase rates
- In 2019, DHHS launched a comprehensive rate system analysis to guide rate-setting through benchmarking (as appropriate), conducting regular updates, transitioning from cost settlement, and holding providers accountable for cost and quality
- In 2022, the Legislature established several requirements for rate studies, including regular reviews; benchmarking; and consideration of service standards, provider costs, best practices, and potential alternative payment approaches (P.L. 2022, Ch. 639)
  - The legislation requires DHHS to collect and respond to comments prior to the rule-making process
  - Although this rate study commenced prior to these requirements, it incorporates the Ch. 639 principles
- Separate legislation requires rate models to fund the labor portion of any rate for an "essential support worker" at 125 percent of the state's minimum wage

Scope of Targeted Case Management and Behavioral Health Rate Study

- Case Management and Care Coordination Services
  - Targeted Case Management (Section 13)
  - Community Integration (Section 17)
  - Behavioral Health Homes (Section 92)

- Adult/ Children Outpatient, School Health-Related Services, Specialized Group Services, Evidence-based Services (Section 65)

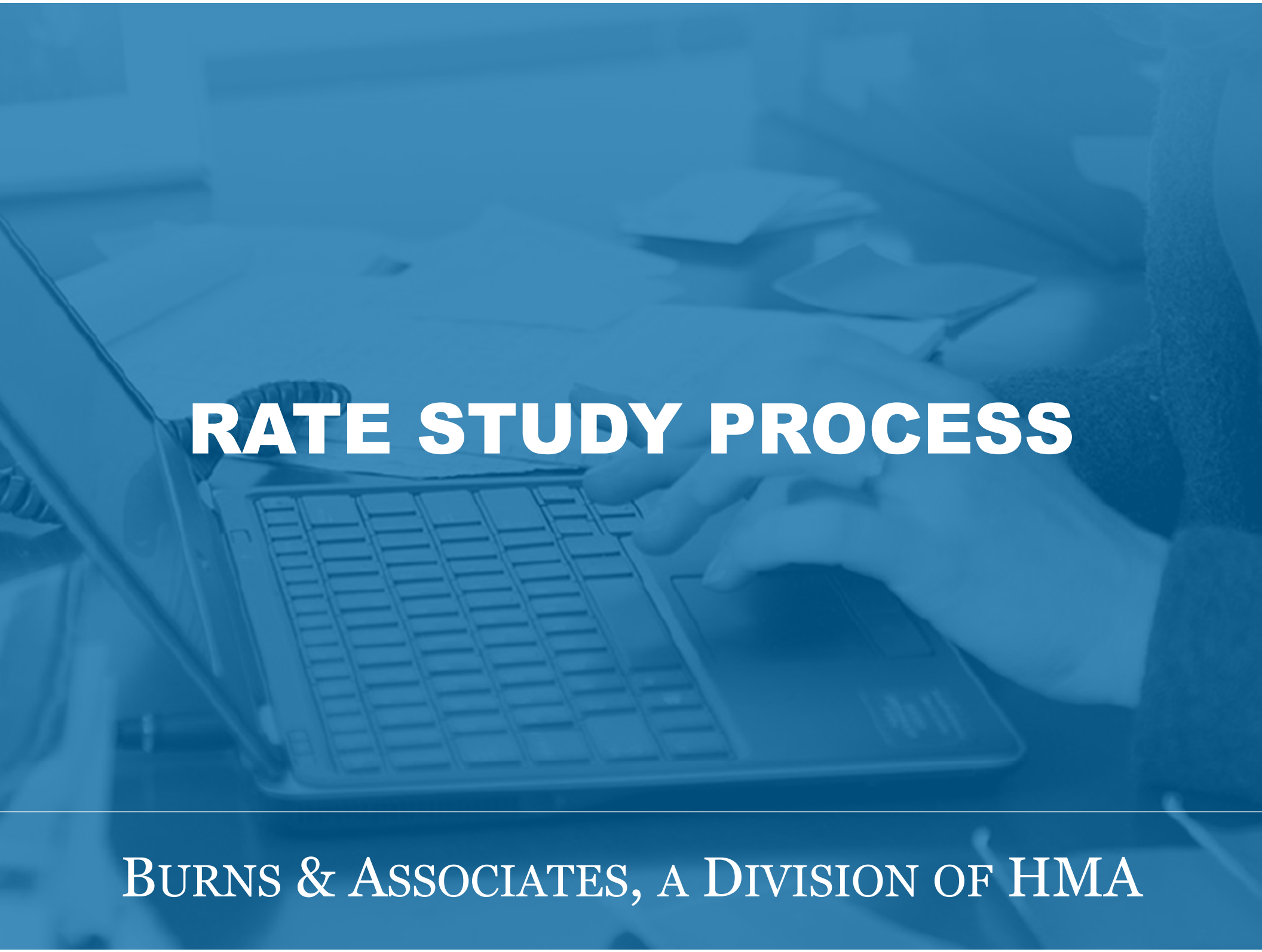
- Community-Based Mental Health and Substance Use Services
  - Community Rehabilitation Services, Daily Living Support Services, Skills Development, Day Support, Adult Assertive Community Treatment (Section 17)
  - Rehabilitation and Community Support for Children with Cognitive Impairments and Functional Limitations (Section 28)
  - Clubhouse, Children's Assertive Community Treatment , Home and Community Based Treatment, Therapies for Disruptive Behavior Disorders (Section 65)

Overview of Burns & Associates

- Health policy consultants specializing in assisting state Medicaid agencies and related departments (developmental disabilities and behavioral health authorities)
  - Consulted in approximately 30 states since its founding in 2006
  - Acquired by Health Management Associates in September 2020
- Have led dozens of providers rate studies across more than 20 states, covering a variety of Medicaid and human services programs
  - Home and community-based services, particularly for 1915(c) waivers
  - Behavioral health services
  - Hospitals and other facilities
  - Child welfare and child care

Burns & Associates' Previous Work in Maine

- Health policy consultants specializing in assisting state Medicaid agencies and related departments (developmental disabilities and behavioral health authorities)
- I/DD HCBS (Sections 21 / 29) in 2014-15 – rates not implemented
- Personal Care (Sections 12 / 19 / 96) in 2015-16 – rates implemented
- **Crisis Services (Section 65) in 2015 – rates not implemented**
- **Behavioral Health Homes (Section 92) in 2015 – rates implemented**
- **TCM/ Behavioral Health (Sections 13 / 17 / 28 / 65) in 2016-17 – Section 28 rates implemented**
- Home Health (Section 40) in 2016-17 – rates not implemented
- **Evidence-Based Treatments (Section 65) 2019-20 – rates implemented**
- Sections 18 / 20 / 21 / 29 (select services) 2019-20 – rates implemented
- Intensive Outpatient (IOP) services – select rates implemented
- Private Non-Medical Institutions (App. B and D of Section 97) – rates implemented



RATE STUDY PROCESS

BURNS & ASSOCIATES, A DIVISION OF HMA

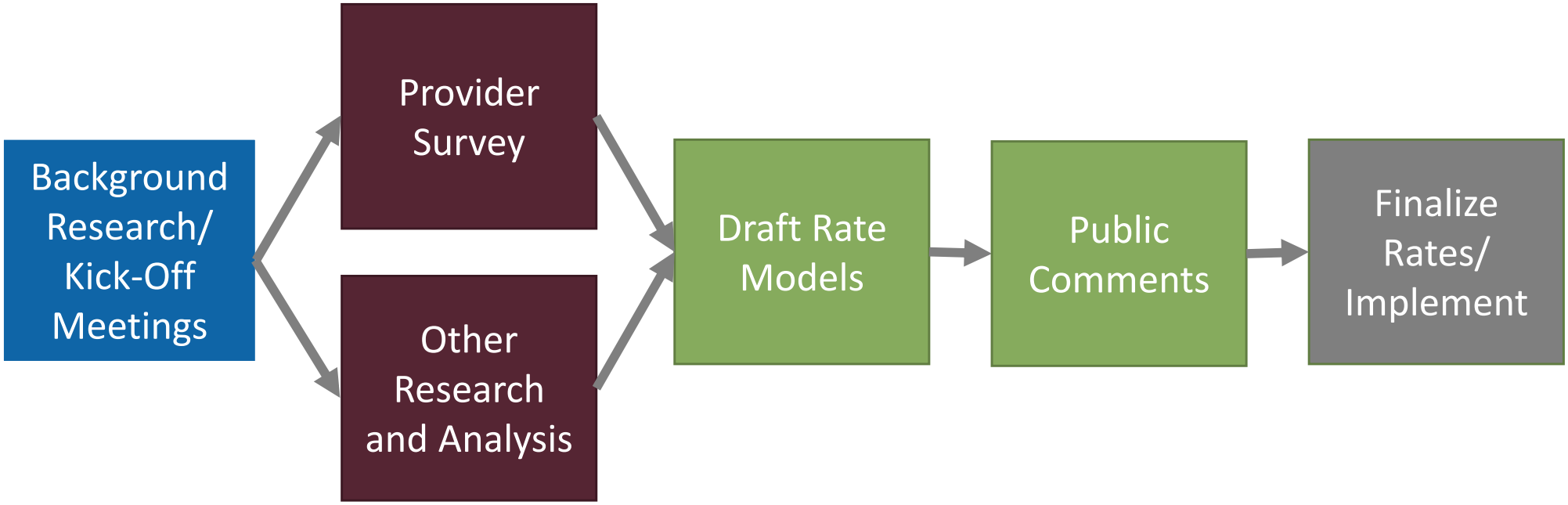
Summary and Goals of Independent Rate Model Approach

- Consider data from multiple sources rather than depending on any single source
  - Policies, rules, and standards
  - Provider and stakeholder input (e.g., provider survey, public comments)
  - Published sources (e.g., BLS wage data, IRS mileage rates)
  - Special studies (e.g., analysis of regional differences in transportation-related costs)
- Rate models should reflect the reasonable costs providers incur to deliver services consistent with the state's requirements and individuals' service plans
- Rates developed independent of budgetary considerations (budgetary impact will be considered as part of implementation planning)

Benefits of Independent Rate Model Approach

- Transparency
  - Models detail the factors, values, and calculations that produce the final rate
- Ability to advance policy goals/objectives
  - For example, improving direct care staff salaries or benefits, reducing staff-to-client ratios, incentivizing community-based services, etc.
- Efficiency in maintaining rates
  - Models can be scaled and adjusted for inflation or specific cost factors (e.g., IRS mileage rate) or to meet budget targets

Rate Study Process



Draft Rate Model Structure

Direct Care Wages

\+ Direct Care Benefits

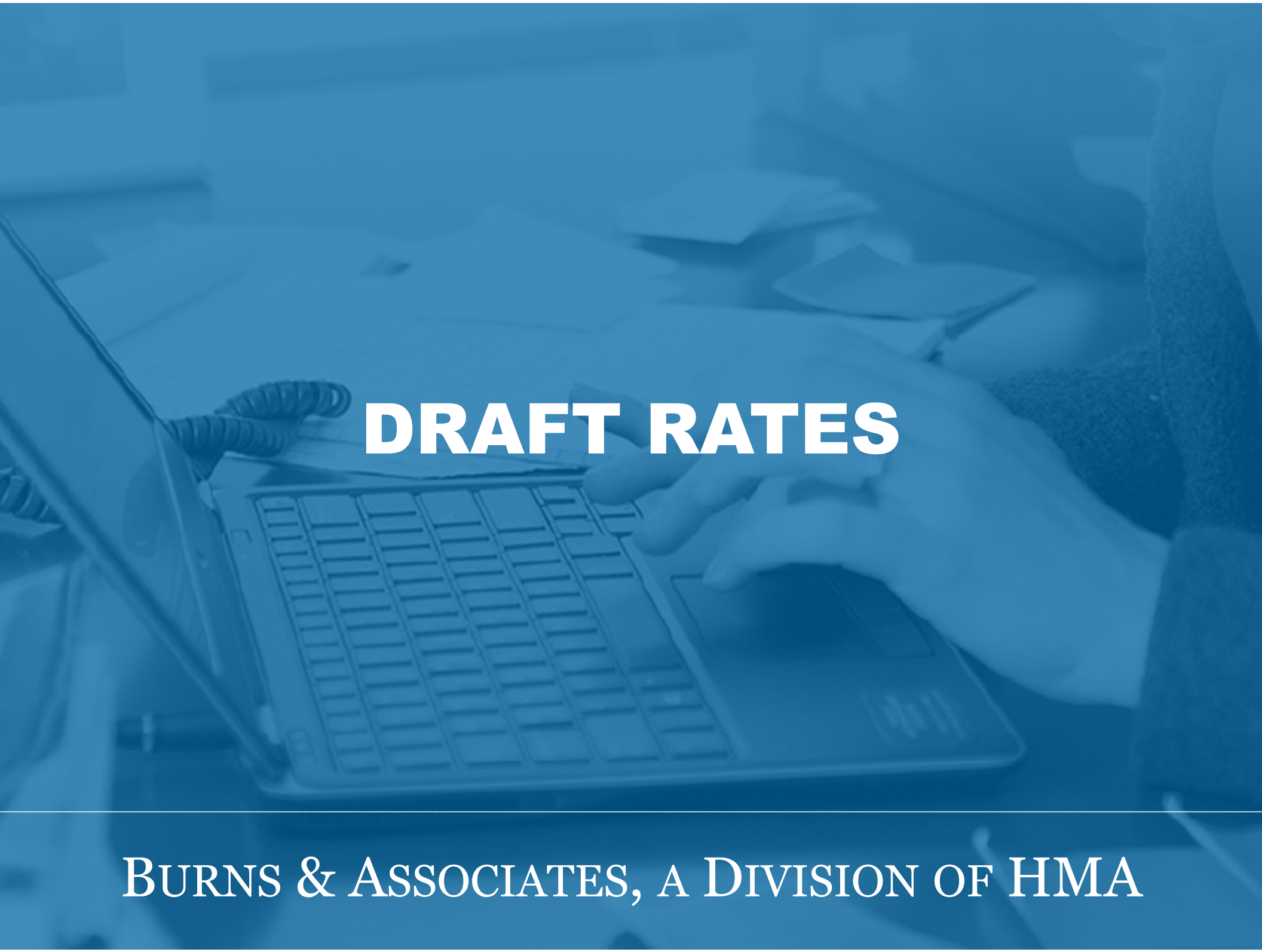
\+ Direct Care 'Productivity' (billable hours)

\+ Program-Specific Factors (e.g., staffing ratio, facility, mileage)

\+ Program Support (e.g., supervision, quality assurance)

\+ Administration

= **Total Rate**


DRAFT RATES
BURNS & ASSOCIATES, A DIVISION OF HMA

Wage Assumptions – Bureau of Labor Statistics Data

- Appendix A of the rate model packet

- Maine wage data published by the Bureau of Labor Statistics used as the starting point for establishing market-based wage assumptions
  - *Comprehensive*. Wage levels are published for more than 800 occupations based on data from 1.2 million establishments representing 57% of the employment in the United States
  - *Cross-industry*. It is not limited to a single industry so estimates for a given occupation are representative of the overall labor market
  - *Regularly updated*. Released once per year – in late March for the previous May (so most recent data published in March 2022 reflects May 2021 survey data)
  - *State- (and local-) specific*. Data is published for individual states and sub-state regions ('metropolitan statistical areas')

Wage Assumptions – Accounting for Wage Growth

- BLS wage data is inflated to July 2023 (the end of the potential first fiscal year of implementation)
  - Based on Maine-specific data from the Bureau of Economic Analysis for net earnings growth
  - Assume 13.59 percent based on 12 months at 9.0 percent (most recent annual figure) and remaining months at 3.6 percent (ten-year average)

- Per legislated requirement, any wage assumption less than 125 percent of the state's minimum wage would be increased to that amount
  - The 2023 minimum wage has not yet been set, but it is assumed the 125 percent requirement will be equal to $17.30 per hour
  - None of the draft rate models include a wage assumption of less than $20 per hour so there is no impact of this requirement

Assumptions – Crosswalking BLS Occupations to Individual Services

- For each service, BLS occupations are chosen based on comparing BLS data on educational requirements and typical responsibilities to service requirements
- For most services, there is a direct match or a single best-fit between the staff providing services and a specific BLS occupation (e.g., the BLS has a classification for registered nurses that can be used for nursing services)
- For other services, there is not a one-to-one match
  - For example, the BLS combines direct support professionals with staff in other industries in the home health and personal care aide classification
  - This classification may not represent the varied roles of DSPs so the rate models construct a weighted average of multiple BLS classifications
- In general, rate models for different services use the same wage assumption when the staffing requirement is the same (e.g., most services provided by MHRT/C's include the same wage assumption)

Assumptions – Crosswalking BLS Occupations to Individual Services (cont.)

- Targeted Case Management – average of child/ family/ school social workers and health education specialists (both bachelor's-level positions)
- Community Integration (MHRT/C) – substance use/ behavioral disorder/ mental health counselor
- Behavioral Health Homes
  - Health home coordinator
    - Adults – substance use/ behavioral disorder/ mental health counselor
    - Children – average of child/ family/ school social workers and health education specialists (both bachelor's-level positions)
  - Clinical team lead – average of clinical and counseling psychologist; healthcare social worker; physician assistant; registered nurse
  - Nurse care manager – registered nurse
  - Peer, family support specialist, and youth support specialist – psychiatric aide
  - Psychiatric consultant – psychiatrist
  - Medical consultant – family medicine physician

Assumptions – Wage Values

- The rate models use the median wage value reported by the BLS for the selected occupation(s) for each service, adjusted for inflation as described

Service	Provider Survey (weighted average with number of responses)	Rate Model Assumption
Targeted Case Management	$20.99 (46)	$29.66
Community Integration	$25.41 (25)	$26.74
Adult BHH Coordinator (MHRT/C)	$18.95 (7)	$26.74
Adult BHH Clinical Lead (LCSW[1])	$28.01 (10)	$45.48
Adult BHH Nurse Care Mgr. (RN)	$30.31 (11)	$40.98
Adult BHH Psychiatrist	$150.80 (2)	$177.06
Adult BHH Physician	$115.38 (1)	$110.42

[1]Rate model includes a mix of occupations in this role, but provider survey suggests LCSW is most common

Assumptions – Wage Values (cont.)

- The rate models use the median wage value reported by the BLS for the selected occupation(s) for each service, adjusted for inflation as described

Service	Provider Survey (weighted average with number of responses)	Rate Model Assumption
Child BHH Coord. (Case Mgr)	$19.54 (9)	$26.74
Child BHH Clinical Lead (LCSW[1])	$30.69 (10)	$45.48
Child BHH Nurse Care Mgr. (RN)	$32.58 (11)	$40.98
Child BHH Psychiatrist	$150.78 (2)	$177.06
Child BHH Physician	$115.38 (1)	$110.42

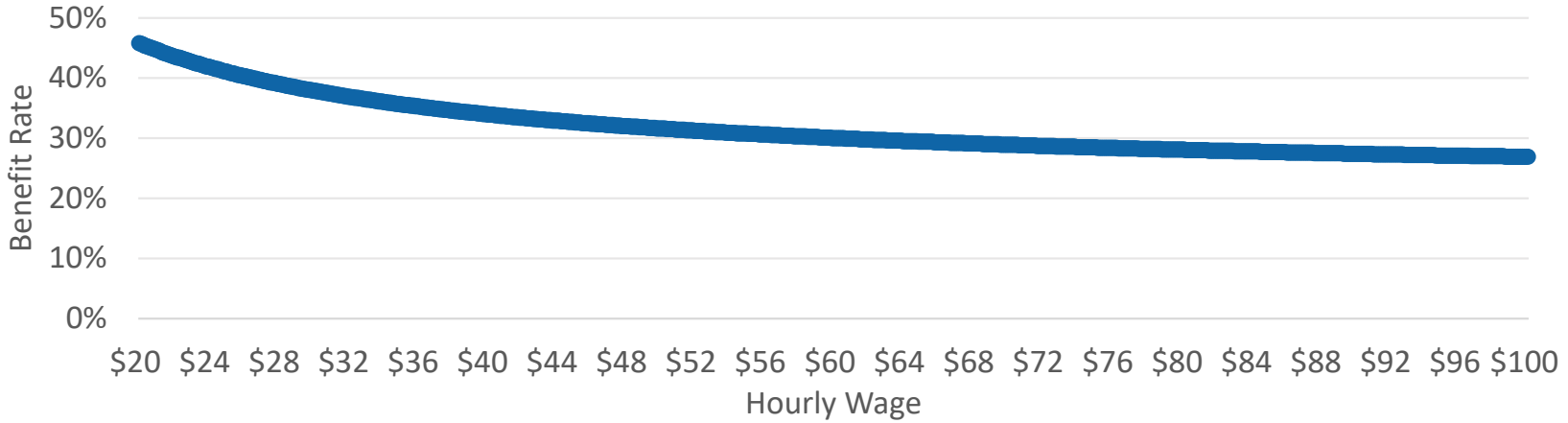
[1]Rate model includes a mix of occupations in this role, but provider survey suggests LCSW is most common

Payroll Tax and Fringe Benefit Assumptions

- Benefit assumptions for direct care staff
  - Paid days off per year (holiday, vacation, and sick leave) – 30 days for "professional" level staff and 25 days for paraprofessionals
  - $591 per month for health insurance for employer share of premiums
    - Based on Maine-specific data from U.S. DHHS' Medical Expenditure Panel Survey for take-up rates and costs for a mix of employee only, employee plus-one, and family coverage options
  - $200 per month for other benefits (e.g., retirement, dental, etc.)
- Payroll taxes
  - 7.65 percent Social Security and Medicare payroll
  - Unemployment Insurance
    - Federal tax at 0.60 percent on first $7,000 in wages
    - State tax at 2.45 percent (new employer rate in 2022) on first $12,000 in wages (inclusive of the 0.07 percent CSSF assessment and the 0.14 percent for the Unemployment Administrative Fund assessment)
- Workers' compensation rate of 3.00 percent

Payroll Tax and Fringe Benefit Assumptions (cont.)

- Benefit assumptions are translated to benefit rates by wage level
  - Rate models include the same benefit assumptions for all direct care staff
  - Paid time off is treated as a productivity adjustment (reduction in billable hours) rather than calculated as part of the benefit rate
  - Since certain benefit assumptions are fixed, the benefit rate declines as the wage increases
    - For example, the $591 assumed for monthly health insurance represents a larger percentage of the wage of someone making $20.00 per hour than for someone earning $50.00 per hour
  - Benefit rate assumed in rate models, by wage level (excludes paid time off)



Productivity Assumptions

- For rate models based on hourly billing, 'productivity adjustments' are intended to recognize costs associated with direct care workers' non-billable responsibilities such as time spent in training or traveling between service encounters
  - Administration funds activities that are not program-specific such as executive management, accounting, human resources
  - Example
    - An employee earning $15 per hour (wages and benefits) and working 40 hours per week earns $600 per week
    - However, if the employer can only bill for 30 hours per week, a productivity adjustment of 1.33 is required (work hours divided by billable hours)
    - Thus, the agency must be able to bill $20 per service hour ($15 multiplied by 1.33) to cover the cost of wages and benefits
- In general, for rate models based on caseload standards, assumptions are intended to reflect a caseload that a staff person can carry based on both direct service and non-service tasks

Productivity Assumptions (cont.)

- Assumptions vary by service as detailed in Appendix C of the rate model packet
- General standards
  - All services include 200/240 annual hours for paid time off (25/30 days as noted in the benefits assumptions section, an average of 3.85/4.62 hours per 40-hour week)
  - All rate models include 50 annual hours for training (an average of 0.96 hours per week)
  - All rate models include 1.50 hour per week for supervision and other employer time
- The other productivity adjustments (e.g., travel time, recordkeeping, etc.) included in the rate models and the assumed amount of time spent on each are more variable across services
- Several rate models assume that direct service staff work fewer than 40 hours per week, on average, based on provider survey results
  - Results in larger productivity adjustment to account for fixed assumptions (e.g., training) being allocated across fewer overall work hours

Administration, Program Support, and Service Provider Tax Assumptions

- Rate models include 15 percent funding for agency administration expenses
  - Administration funds activities that are not program-specific such as executive management, accounting, human resources
- Rate models include 15 percent funding for program operations expenses (group services are funded 20 percent)
  - Program operations funds activities that are program-specific, but not direct support and/or billable such as supervision; training (excluding time of the employee being trained); program development and oversight; quality monitoring; and coordination of care activities
- Total administration and program support of 30 percent (and 35 percent for group services) is higher than the 23 to 25 percent in recent rate studies
  - Generally consistent with provider survey results after accounting for overall rate increases (e.g., 15 percent of $120 is equal to 18 percent of $100)
- Service provider tax calculated as 6 percent of all other costs
  - Applies to all Section 17 services, Section 28 services not provided by schools/ exempt providers, and Section 65 Clubhouse

Targeted Case Management (Section 13)

- No changes to billing units or rules proposed at this time
- Rate model assumes 27.5 billable hours per week before accounting for training and paid time off (23.7 hours after training and PTO adjustments)
  - Provider survey reported 26.8 hours and 27.9 hours after adding in time spent on transporting members and providing after-care, which is outside the scope of services

Service	Billing Unit	Current Rate	Draft Rate	% Change
Targeted Case Management	15 Min.	$23.03	$24.55	6.6%

Community Integration (Section 17)

- No changes to billing units or rules proposed at this time
- Rate model assumes 27.5 billable hours per week before accounting for training and paid time off (23.7 hours after training and PTO adjustments)
  - Provider survey reported 26.8 hours

Service	Billing Unit	Current Rate	Draft Rate	% Change
Community Integration	15 Min.	$22.33	$23.94	7%

Behavioral Health Homes (Section 92)

+ Staffing assumptions reduced from current assumptions based on provider survey results ratio comparison

Position	Current Rate Model	Survey - Adults	Survey - Children	Draft Rate Model
Hlth. Home Coord.	24 cases/FTE	31 cases/FTE	30 cases/FTE	25 cases/FTE
Clinical Team Lead.	192 cases/FTE	284 cases/FTE	208 cases/FTE	200 cases/FTE
Nurse Care Mgr.	200 cases/FTE	425 cases/FTE	604 cases/FTE	300 cases/FTE
Peer Specialist	125 cases/FTE	263 cases/FTE		200 cases/FTE
Family/Youth Spec.[1]	125 cases/FTE		233 cases/FTE	200 cases/FTE
Psychiatric Consult.	42 hours/ 200 cases	101 hours/ 200 cases	114 hours/ 200 cases	100 hours/ 200 cases
Medical Consult.	42 hours/ 200 cases	248 hours/ 200 cases[2]	119 hours/ 200 cases	100 hours/ 200 cases

[1]Children's model now includes separate allowances for family support specialists and youth support specialists; survey figure reports a combined total

[2]Figures are skewed by outliers (e.g., one provider reports seven full-time physicians and physician assistants for 300 members)

Behavioral Health Homes (Section 92) (cont.)

- DHHS proposes to add a High-Fidelity Wraparound model for children
  - More intensive staffing assumptions
    - Health Home Coordinator: 1 FTE per 10 cases (rather than 1:25)
    - Clinical Team Leader: 1 FTE per 6 coordinators (rather than 1:8)
    - Family Support Specialist: 1 FTE per 20 cases (rather than 1:200)
    - Youth Support Specialist: 1 FTE per 20 cases (rather than 1:200)
  - DHHS will be developing policy related to service delivery
- An on-call payment is included in the draft rate
- DHHS will be incorporating a revised pay-for-performance model, equivalent to 4% of new rates and with new performance measures

Service	Billing Unit	Current Rate	Draft Rate	% Change
BHH – Adults	Month	$413.88	$514.46	24.3%
BHH – Children	Month	$413.88	$580.38	40.2%
BHH – Children HFW	Month		$1,425.04	

PUBLIC COMMENTS

BURNS & ASSOCIATES, A DIVISION OF HMA

Public Comment Process

- Rate models and the supporting documentation will be available on the project website: https://www.burnshealthpolicy.com/MaineCareBH/
- Written comments will be accepted until October 14th and should be submitted to kmatzinger@healthmanagement.com
- All comments will be reviewed and summarized
  - Consolidated document of comments and responses will be published
- Revise rate models based on public comments as warranted

Stephen Pawlowski

spawlowski@healthmanagement.com

(602) 466-9840

3030 North 3rd Street, Suite 200

Phoenix, Arizona 85012

www.healthmanagement.com/who-we-are/burns-associates/