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A DIVISION OF
HEALTH MANAGEMENT ASSOCIATES

Mobile Crisis Response Overview of Draft Rate Models

- on behalf of -

Maine Department of Health and Human Services

January 11, 2024

Presentation Summary

- In alignment with legislation (P.L. 2022, Ch. 635, Part JJJ), the Department of Health and Human Services conducted 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
  - Due to concurrent changes in policy, the review of rates for Mobile Crisis services was separated from the larger rate study
  - DHHS contracted with the Burns & Associates division of Health Management Associates (HMA-Burns) to assist with both the larger study and the review of Mobile Crisis rates
- HMA-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
  - Using data from multiple sources rather than any single source
  - Incorporating provider and stakeholder input (e.g., provider survey, public comments)
- This presentation summarizes the process and resulting draft recommendations, beginning the request for public comments, which will be considered prior to finalizing the recommendations
  - In addition to payment rates, the recommendations include changes to billing processes
  - Commenters are encouraged to offer feedback on rates, billing processes, and policies

Agenda

+ Project Background
+ Rate Study Process
+ Draft Recommendations
+ Public Comment Process

PROJECT BACKGROUND

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Background on DHHS Rate-Setting

- As part of its commitment to ensuring reasonable payment rates to sustain MaineCare's provider network to support access to Medicaid services, DHHS has conducted a number of rate studies in recent years

- 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 (Title 22, §3173-J)
  - The legislation requires DHHS to collect and respond to comments prior to the rule-making process

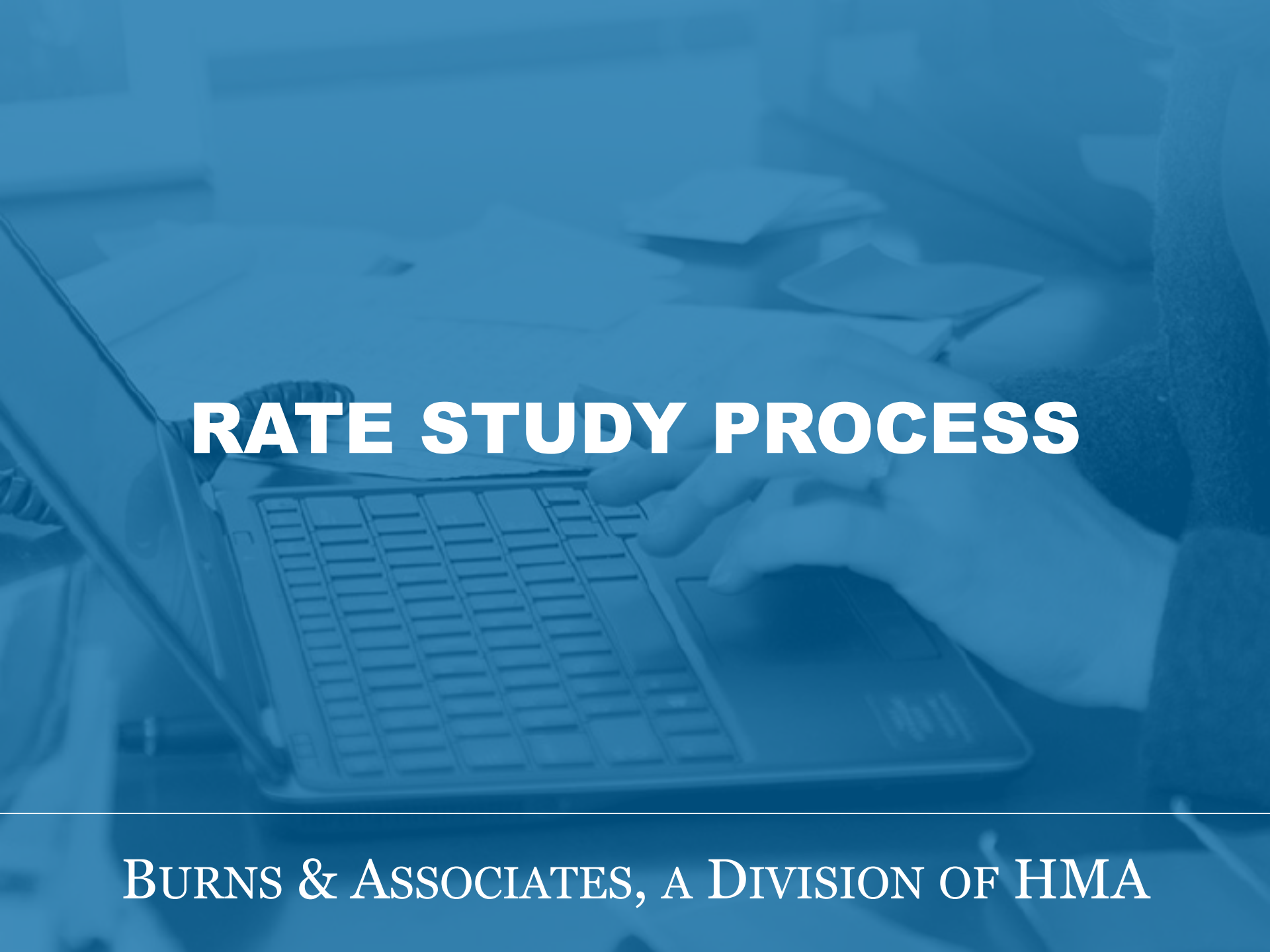
Overview of Burns & Associates

- 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

- 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
- Targeted Case Management and Behavioral Health services (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) in 2019-20 – rates implemented
- Sections 18 / 20 / 21 / 29 (select services) in 2019-20 – rates implemented
- Intensive Outpatient (IOP) services in 2020-21 – select rates implemented
- Private Non-Medical Institutions (App. B and D of Section 97) in 2020-21 – rates implemented
- Targeted Case Management and Behavioral Health services (Sections 13 / 17 / 28 / 65 / 92) in 2021-22 – rates implemented
- Adult Family Care (Section 2) and Day Health (Section 26) services in 2022-23 – rates implemented



RATE STUDY PROCESS

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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., benchmarking rates against other payers)

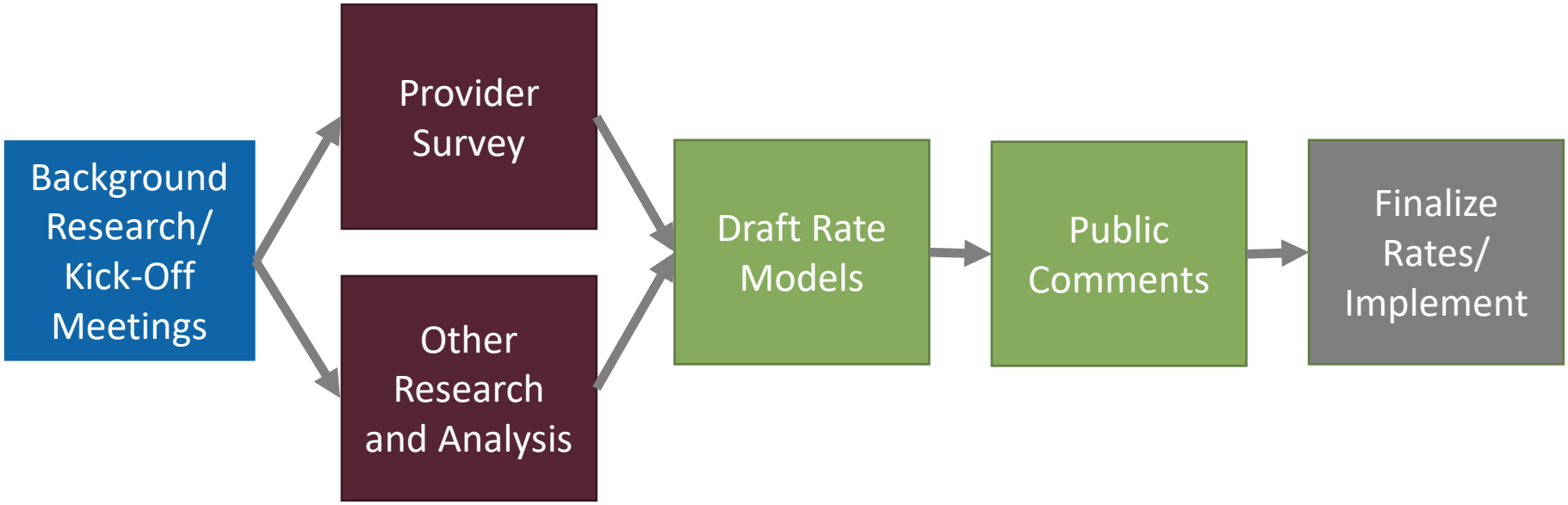
- Rate models should reflect the reasonable costs providers incur to deliver services consistent with the state's requirements and individuals' service plans

- 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

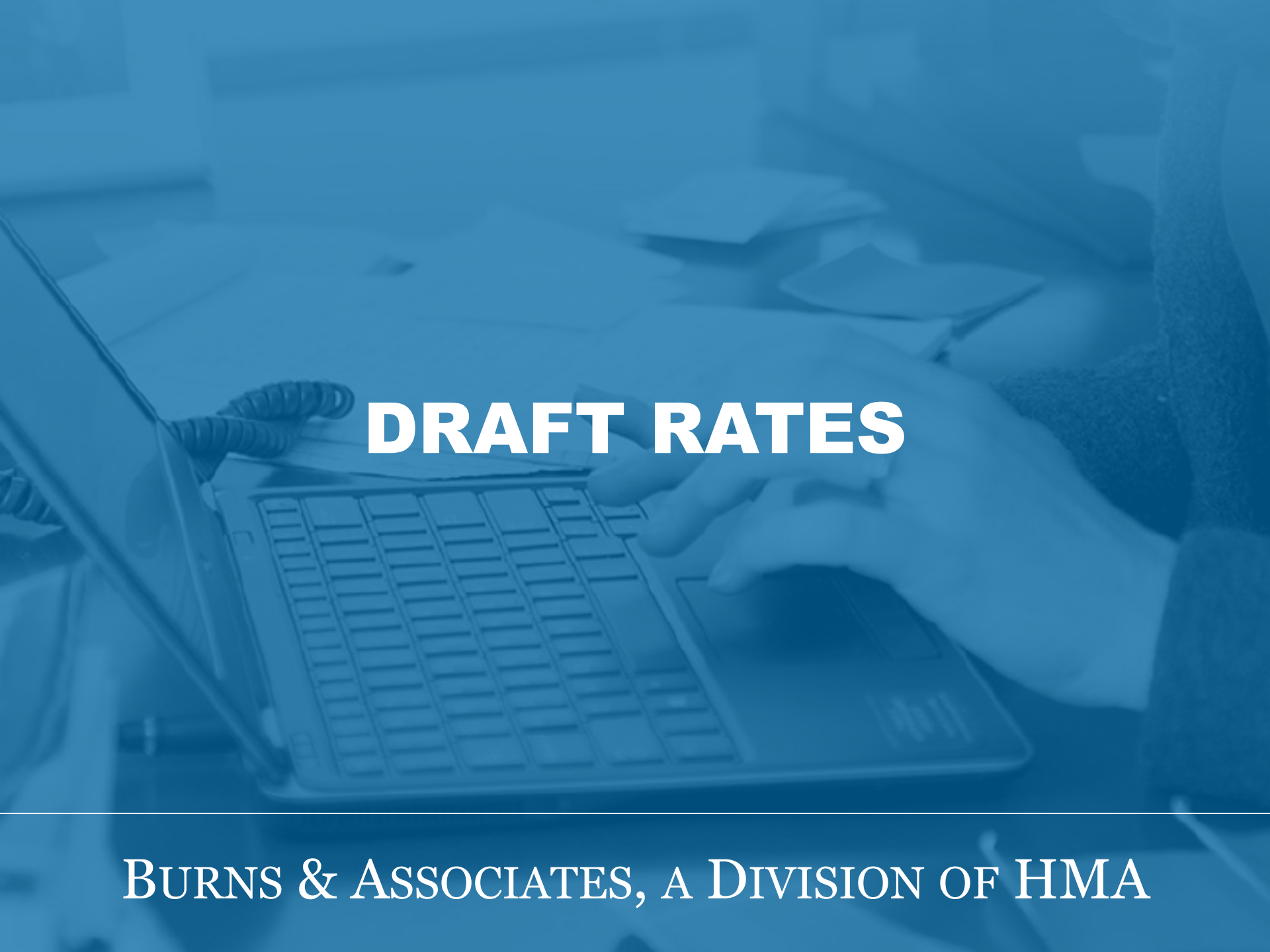
\+ Direct Care 'Productivity' (billable hours)

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

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

\+ Administration

= **Total Rate**



DRAFT RATES

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Draft Billing Framework

- Bundled encounter rate for initial encounters and a 15-minute rate for travel and aftercare supports
- DHHS still developing billing instructions, but seeks feedback on initial structure
  - Encounter rate intended to cover engagement through crisis planning and acute intervention, including initial follow-up on the precipitating crisis event, generally covering the first 24-48 hours after the crisis response
  - Aftercare can include elements of de-escalation and intervention without warranting another encounter billing
  - An individual may subsequently have another crisis event to warrant another billable encounter
- Intent is that all payment from DHHS be based on this model; that is, there would no longer be billing for ancillary activities
  - Rate model intends that all direct care staff time (and indirect costs built into the rates) is captured through the encounter and travel/ aftercare rates, and productivity adjustments
  - State-only funds would be paid via contract for individuals without insurance

Rate Model Overview – General

- Models allocate annual direct care staff hours across encounters and travel/ aftercare based on analysis of claims data and provider data
  - Overall, models allocate 55 percent of annual work hours to encounters, based on the following assumptions
    - Direct support is evenly divided between encounters and aftercare
    - 80 percent of time spent on coordination and collateral contacts, recordkeeping and reporting, and other activities/ downtime is associated with encounters
    - All travel time is incorporated in the aftercare/ travel rate
- Models fund one clinical supervisor for every 5 MHRT/CSPs and peers, and additionally provides on-call funding for each supervisor position
  - It is not expected that a supervisor is in the office 24 hours a day, but that a supervisor is always available

Rate Model Overview – Encounter Rate

- Rate model allocates 1,144 hours per year to the encounter rate (55 percent of an FTE as discussed above)
  - Rate models assumes each direct care staff participates in 150 billable encounters per year (about three per week), which is intended to be an average with some staff participating in more and others in less
- Includes rates for one-person and two-person responses
  - Consistent with updated requirements, it is assumed that most encounters will be a two person response (model assumes an MHRT/CSP with a peer)
  - One person response by an MHRT/CSP accommodates circumstances such as a co-response with law enforcement
- Other supports included in rate model
  - One dispatch coordinator per every 3.3 MHRT/CSPs and peers (position is assumed to meet MHRT/CSP qualifications)
  - Rate model includes funding for psychiatric support
- Draft rate is $1,166.44 per encounter (for a two-person response)

Rate Model Overview – Aftercare/ Travel

- Rate would be used for aftercare supports as well as travel to either a billable encounter or billable aftercare supports
  - Propose to make travel time billable because of unique characteristics of the service (e.g., unpredictable scheduling and generally low volumes)
  - Providers will be expected to take the most efficient route
  - Expect to establish a separate code or modifier for travel time (although the rate will be the same
- Separate rates are provided for and MHRT/CSP and peer specialist
- Rate model allocates 936 hours per year to the aftercare/ travel rate (45 percent of an FTE as discussed above)
  - This includes productivity adjustments so, of these hours, only about 530 hours are assumed to be billable
- Draft rate is $33.92 per 15 minutes for an MHRT/CSP ($27.66 for a peer)

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 2023 reflects May 2022 survey data)
  - *State- (and local-) specific*. Data is published for individual states and sub-state regions ('metropolitan statistical areas')
- BLS wage estimates are inflated to July 2024
  - Based on Maine-specific data from the Bureau of Economic Analysis for net earnings growth
  - Assumes 9.32 percent based on 26 months at 4.2 percent annually

Wage Assumptions – Crosswalking BLS Occupations to Crisis Positions

+ For each position, BLS occupations are chosen based on comparing BLS data on educational requirements and typical responsibilities to service requirements

Rate Model Position	BLS Occupation Benchmark
MHRT/CSP and Dispatch Coordinator	Substance Abuse, Behavioral Disorder, and Mental Health Counselors (21-1018)
Peer Specialists	Psychiatric Aides (31-1133)
Clinician/ Clinical Supervisor	Social and Community Service Managers (11-9151)

+ 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

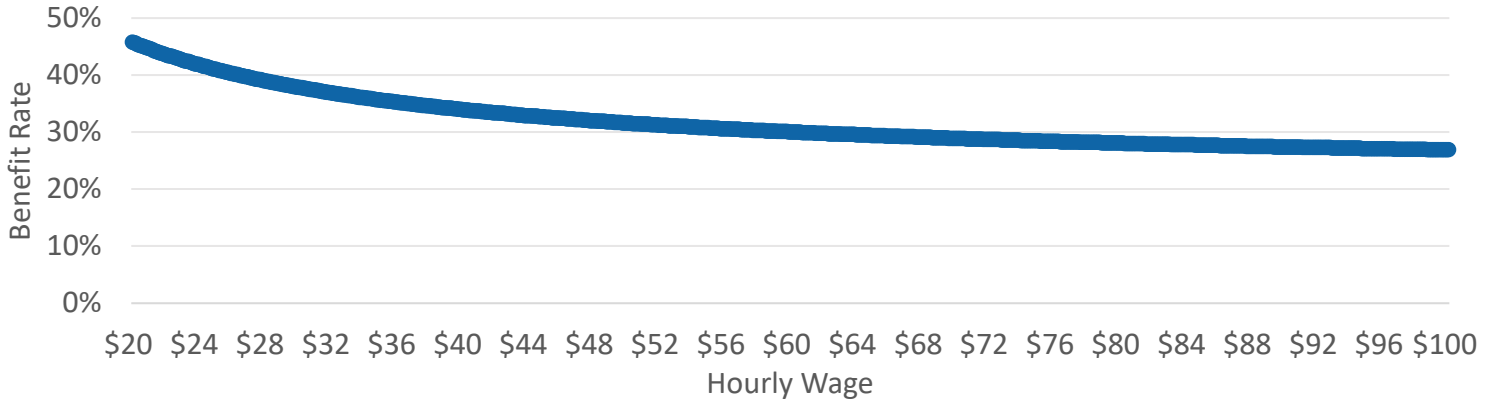
Rate Model Position	Rate Model Assumption	Provider Survey (weighted avg. with # of responses)
MHRT/CSP and Dispatch Coordinator	$28.64	$24.01 (3)
Peer Specialist	$20.46	No responses
Clinician/Clinical Supervisor	$34.27	$31.19 (3)

Payroll Tax and Fringe Benefit Assumptions

- Benefit assumptions for listed position are consistent with the broader behavioral health rate study
  - 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 positions
  - 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 travel/aftercare rate models that are based on 15 minute 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
  - 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
- The crisis intervention encounter rate model is based on the assumption that direct care staff complete 150 assessments per year and all direct and indirect time is included so no productivity adjustments are needed

Productivity Assumptions (cont.)

- Productivity assumptions for work activities (e.g. direct care, recordkeeping, coordination and collateral contacts, etc.) for the travel/aftercare are the same for MHRT/CSPs and peer specialists are detailed in Appendix C of the rate model packet
- Rate models assume 22 hours per week are spent crisis intervention activities and on 18 hours are spent on travel/aftercare activities
- General standards
  - MHRT/CSPs include 240 annual hours for paid time off (30 days) and peer specialist have 200 hours (25 days) as noted in the benefits assumptions section
  - Rate models include 60 annual hours of training for MHRT/CSPs and 65 hours for peer specialists

Administration and Program Support 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
  - 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 is consistent with the larger behavioral health rate study and higher than the 28 percent reported on the provider survey

PUBLIC COMMENTS

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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 January 26th 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

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