Montana Rate Studies

Adult Behavioral Health, Children's Mental Health, Developmental Services, and Senior and Long Term Care Services Rate Studies

Professional Services, Medical Transportation and Home Infusion Therapy Rate Reviews

Presented to:

Montana Department of Public Health and Human Services

Presented by:

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A. Executive Summary

In this report, Guidehouse Inc. ("Guidehouse") presents our analysis and recommendations for new rates and rate methodologies for an array of programs and services reimbursed by the Montana Department of Public Health and Human Services (DPHHS). The programs included are Adult Behavioral Health (ABH), Children's Mental Health (CMH), Developmental Disabilities (DD) and Senior and Long Term Care (SLTC) that are operated under the Behavioral Health and Developmental Disabilities (BHDD) Division, which includes the former Addictive and Mental Disorders Division (AMDD) and Developmental Services Division (DSD); the Children's Mental Health Bureau (CMHB), under BHDD; and the Senior and Long-term Care Division (SLTCD). The report also details separate reviews of reimbursement rates for Montana Medicaid's Professional Services, Medical Transportation, and Home Infusion Therapy (HIT) fee schedules, which are administered outside of these divisions.

The Department contracted with Guidehouse to conduct a comprehensive provider rate study of services delivered to these four populations to address legislative requirements issued in 2021 through HB 632 Section 20 Subsection 2B. Guidehouse's work also includes a detailed cost reporting plan to support future rate updates for these services, as required by HB 155 Section 1. Guidehouse performed rate reviews of the three HRD programs to examine the rate adequacy of support services for these populations within the broader Medicaid service array.

HB 632 Rate Study

Central to the rate development process, Guidehouse worked to identify the specific costs of delivering services including Residential Services, In-Home Services, Behavioral Services, Day Services, Case Management, Intensive Behavioral Services, Psychiatric Treatment Residential Facilities (PRTFs), Supported Employment, Non-Medical Transportation, Nursing, Peer Support, and Self-Directed Support Services across all programs. The report provides a detailed view of the rate methodology and benchmark rates for each of these services.

At the inauguration of the rate study, Guidehouse worked with the Department to initiate stakeholder engagement efforts involving the formation of three Rate Workgroups and a Steering Committee. Guidehouse communicated the scope of the engagement and operating norms at the start of the rate study process and clarified the Rate Workgroups and Steering Committee would work to accurately capture the cost of service delivery and to determine the common principles and parameters that would apply to the updated rate setting methodology.

To allow for a holistic rate determination process, Guidehouse conducted a comprehensive cost and wage survey to gather data from providers across programs as the basis for the rate studies. Guidehouse also reviewed the State's Medicaid claims data, and other extensive state, regional, and national benchmark metrics, basing assumptions on industry data when provider-reported data was unavailable or insufficient for rate setting.

The approach used to establish the Department's benchmark rates is an "independent rate build-up" methodology commonly applied by states for setting rates for similar populations. It is an approach recognized as compliant with specific Centers for Medicare and Medicaid (CMS) regulations and guidelines and congruent with Medicaid rate setting principles more generally. In alignment with this independent rate build-up approach, the study identified appropriate cost assumptions for each value component used in the rate models, allowing rates to be built from

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the bottom up and calculated according to the relevant unit of service for each service included in the rate study. This modular approach requires a comprehensive analysis of the types of costs incurred by delivering a service and then representing these costs through a reasonable standard cost assumption, which serve as "building blocks" added together to form a cost-based rate for the service as a whole. The objectives of the study were to determine benchmark rates based on resources required to promote access to quality services going forward. As such, cost assumptions in the report frequently rely on recent costs reported by providers as well as national and regional standards that reflect wider labor markets and costs typical of broader industries to respond to changing wage expectations. We also conducted a rate comparison analysis of Montana's rates relative to seven peer states for cognate services. The analysis revealed Montana's rates fall in within the range of rates offered in other states.

Based on the benchmark rates developed for identified services, Guidehouse conducted a fiscal impact analysis of transitioning from existing service rates to the rate benchmarks proposed as a part of the rate study. The analysis indicates implementation of the benchmark rates would result in a roughly 22 percent funding increase, with additional expenditures of over $82 million needed. The projected impact includes both state and federal funds, with additional dollars needed from the State of Montana representing just under a third of total expenditures. Table 1 provides a projection of the additional State dollars required to fund the benchmark rate structure. The calculation subtracts Medicaid federal financial participation from the additional dollars needed to show the estimated State dollars to finance the Medicaid state share.

Table 1: Total Fiscal Impact, Add-On Payments Included (State Share)

By Population/ Program	Paid at SFY22	Add-On Payments	Total Current Cost	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
Total	**$123,564,452**	**$3,238,893**	**$126,803,345**	**$154,480,678**	**21.8%**	**$27,677,332**	**100.0%**	**100.0%**
ABH	$17,636,581	$4,772	$17,641,354	$20,959,394	18.8%	$3,318,041	13.9%	13.6%
CMH	$28,530,000	$838,554	$29,368,555	$32,601,855	11.0%	$3,233,301	23.2%	21.1%
DD	$46,978,746	$0	$46,978,746	$59,100,347	25.8%	$12,121,601	37.0%	38.3%
SLTC	$30,419,125	$2,395,566	$32,814,691	$41,819,081	27.4%	$9,004,389	25.9%	27.1%

Lastly, Guidehouse identified specific rate and policy recommendations for the Department to consider as it navigates the adoption and implementation of rate recommendations for Montana's programs. We also include methodological considerations which underpin our recommended benchmark rates. These considerations include the following items:

- **Rate Structure Recommendations**
  - Standardize cost component assumptions and rate methodologies across populations and programs where feasible and appropriate.
  - Eliminate the Direct Care Wage program add-on payment for service rates increased to the benchmark rates.
  - Develop a uniform policy across populations and programs for reimbursing

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providers for necessary or expected absences from residents/attendees.
    - Bundle transportation costs into rates for residential and day services where these costs are most frequently incurred. Reserve separate billing for transportation in settings and situations which transportation is allowable, but less frequently utilized.
    - Adopt a common policy for geographic and other demographic adjustments to provider rates.
    - Develop a reimbursement methodology for adjusting residential service rates based on an individual's assessed resource need.
- **Individual Rate Recommendations**
    - Transition reimbursement for Adult Substance Use Disorder (SUD) Intensive services from a daily to weekly rate.
    - Establish rate parity between in-state and out-of-state Psychiatric Residential Treatment Facilities (PRTFs).
- **Service Array Alignment Recommendations**
    - Conduct a detailed review of case management service design and payment policy across populations and programs
    - Consider aligning reimbursement for private duty nursing services across the service array, including EPSDT (Early, Periodic, Screening, Diagnostic, and Treatment) rates.
- **Benchmark Implementation Recommendations**
    - Prioritize rate increases for services where current rates are the least aligned to growing costs.
    - Consider a regular process of administrative rate update, that includes adjusting either wage assumptions or overall rate levels based on applicable inflation indices.

HB 155 Cost Reporting Plan

Consistent with House Bill 155, Guidehouse assisted the Department with developing a plan for cost reporting to collect cost data from providers on a recurring basis. The plan includes programs, services and providers that are required based on the HB 155 parameters, types of recommended cost reports, cost reporting data and supplemental material, as well as administration and operation considerations for the Department to implement cost reporting.

- **Cost Reporting Recommendations**:
    - Consider conducting a cost reporting pilot program and prioritize cost reports spanning multiple programs/populations and high-volume services.
    - Engage providers during the cost reporting implementation process to solicit feedback.
    - Consider developing a comprehensive web-based portal for cost reporting.
    - Establish protocols to protect provider cost reporting data.

Professional Services Rate Review

The report also includes Guidehouse's review of the sufficiency and effectiveness of the Department's current reimbursement for professional services, including an analysis of rate adequacy for physicians and other professional practitioners, as well as recommendations for updating Montana Medicaid's Resource Based Relative Value Scale (RBRVS) professional fee

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schedule.

As the basis for our recommendations, Guidehouse reviewed reimbursement practices used by Medicare and other state Medicaid programs nationwide. We compared reimbursement across individual services in addition to estimated payments for Montana's Medicaid population. We also examined in detail payment levels across physician, allied[1], and mental health provider groups, as well as individual provider types.

Medicare rates are required to be sufficient to promote efficiency, economy, quality, and access, while safeguarding against unnecessary utilization. As a result, Medicare is accepted by the vast majority of physician practices and is used nationwide as a benchmark for commercial and Medicaid payments. In addition to its role as a national standard, Medicare reimbursement furnishes benchmarks that are specifically applicable to professional services in frontier states such as Montana, especially since the Affordable Care Act established increased payment for physician services in frontier states including Montana, Wyoming, and North Dakota, building in an additional premium to address access issues in these states. Benchmarking Medicaid rates to Medicare reimbursement for physician services is the most accurate and defensible method for measuring rate adequacy outside of resource-intensive and administratively cumbersome provider cost studies.

Our analysis shows that prior to significant budget cuts to professional services in 2017-2018, Montana Medicaid's physician rates in 2016 were 9 percent higher than Medicare and at least 11 percent higher than all but one state Medicaid program. The reductions in 2018 temporarily brought Montana Medicaid's physician reimbursement to 101 percent of the Medicare benchmark. However, the gap has widened rapidly again in recent years, largely due to statutorily required minimum increases to the physician conversion factor, but further exacerbated by overall increases to the Medicare Relative Value Units (RVUs) reflected in the RBRVS fee schedule.

In contrast to these trends for physician services, Medicaid rates in 2016 for allied and mental health providers were significantly lower than Medicare and other state Medicaid programs, and these rates have remained steady or slightly decreased as budgetary changes are modeled by DPHHS to account for RVU changes.

Inconsistent legislative requirements for DPHHS rate updates across the range of practitioners reimbursed on the professional fee schedule have contributed to significant reimbursement inequity among different provider types.

Due to the higher rates, payment levels for physician and mid-level practitioner services exceed the reimbursement needed for quality and access to care. In line with these findings, Guidehouse developed several scenarios for modification of the payment rates, ranging from a small decrease in conversion factors to significant changes to both conversion factors and provider rates of reimbursement as well as additional provider rates of reimbursement for several provider types. Guidehouse devised these scenarios to align Medicaid payment levels more closely with the Medicare standard. This report details our methodology for comparing

[1] Allied services apply to the following health care professionals: physical therapists, occupational therapists, speech therapists, optometrists, opticians, audiologists, school-based services, licensed direct-entry midwives, and orientation and mobility specialists for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits.

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payment rates as well as relevant findings from our analysis, which includes fiscal impact projections for the options under consideration.

- **Professional Services Rate Recommendations:**
  - Target reimbursement levels at 105 percent of Medicare rates for anesthesia, physician, and mid-level services.
  - Lower the provider rate of reimbursement for mid-level practitioners to 85 percent for adult services and 95 percent for pediatric services
  - Target reimbursement levels at 90 percent of Medicare for mental health services.
  - Change the provider rate of reimbursement to 123 percent for psychologists.
  - Apply future physician budget increases to reimbursement levels rather than directly to the conversion factors.[2]

To support these recommendations, Guidehouse analyzed the fiscal impact of the fee schedule update broadly by service, as well by provider taxonomy. Our analysis identifies overall changes in reimbursement and physician specialties that are likely to see increases or reductions resulting from the changes.

- Reducing physician reimbursement levels to 105 percent of Medicare and reducing the mid-level adjusters would lower payments by approximately $27.3 million overall, and $6.3 million in state share expenditures.
- Increasing mental health professionals and psychologists rate of reimbursement levels would increase payments by approximately $4 million overall, and roughly $1 million in state share expenditures.

Medical Transportation and HIT Rate Reviews

The final report section details Guidehouse's review of the sufficiency and effectiveness of the Department's current reimbursement for medical transportation and home infusion therapy (HIT) services, including an analysis of rate adequacy and recommendations for updating Montana Medicaid's ambulance and non-emergency medical transportation (NEMT) fee schedules.

As the basis for our recommendations, Guidehouse reviewed reimbursement practices used by Medicare and other state Medicaid programs nationwide. We compared reimbursement across individual services in addition to estimated payments for Montana's Medicaid population.

For ambulance and emergency transportation services, we identified Medicare rates as an appropriate reimbursement standard for assessing rate adequacy. Medicare rates are required to be sufficient to promote efficiency, economy, quality, and access, while safeguarding against unnecessary utilization. As a result, Medicare is used nationwide as a benchmark for a wide variety of commercial and Medicaid payments. Benchmarking Medicaid rates to Medicare reimbursement is the most accurate and defensible method for measuring rate adequacy outside of resource-intensive and administratively cumbersome provider cost studies.

For NEMT and HIT services, Guidehouse considered alternatives to Medicare as comparative standards. In the case of NEMT, Medicare does not offer a standard for comparison, since

[2] Note: This will require a change to the Montana Code Annotated (MCA)

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NEMT is not covered under the federal program. In the case of HIT, Guidehouse determined the reimbursement framework for Montana's HIT payment method and corresponding provider billing practices diverge too substantially from Medicare to yield a meaningful comparison. As an alternative set of benchmarks for NEMT and HIT, we analyzed other state Medicaid programs' payment methods and reimbursement levels to identify appropriate thresholds for payment adequacy.

Our analysis shows payment levels for ambulance and NEMT services may not meet the reimbursement needed for quality and access to care, while HIT rates exceed other states using a similar methodology. In line with these findings, Guidehouse developed several scenarios for adjusting payment rates, ranging from a small increase in fees to significant changes to both fees and the payment method. Guidehouse devised these scenarios in consultation with DPHHS staff either to align Medicaid payment levels more closely with the Medicare standard or to bring payment levels in line with other Medicaid programs.

The report details our methodology for comparing payment rates as well as relevant findings from our analysis, which includes fiscal impact projections for the options under consideration.

- **Medical Transportation and HIT Recommendations:**
    - Raise overall ambulance payment levels to 84 percent of Medicare (not including supplemental payments).
        - Increase payment rates for services covered by Medicare to 80 percent of Medicare.
        - Adopt premium payments for ambulance services in rural localities to achieve a total payment level increase of 5 percent.
    - Discontinue separate payments for life support and supplies.
    - Increase NEMT taxi and van rates to the comparison state average.
    - Increase the NEMT mileage reimbursement rate to the average of the Montana, peer states, and IRS rates.
    - Maintain HIT rates at current levels.

To support these recommendations, Guidehouse analyzed the fiscal impact of the fee schedule update, both overall and by service. Our analysis identifies overall changes in reimbursement as well as the estimated state share resulting from the changes.

- Increasing ambulance reimbursement levels to 84 percent of Medicare will increase payments by approximately $2.3 million total, reflecting $518,401 in Medicaid state share expenditures.
- Increasing NEMT reimbursement levels will increase payments by $936,051 total, representing $214,730 in state share expenditures.

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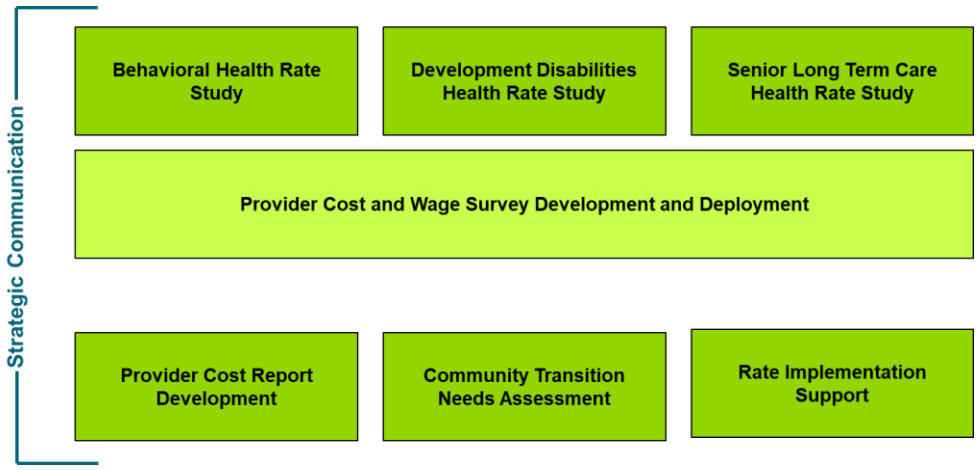
B. HB 632 Provider Rate Study

B.1. Introduction and Background

Montana's Department of Public Health and Human Services (DPHHS) contracted with Guidehouse to conduct a comprehensive rate review of services provided in Adult Behavioral Health (ABH), Children's Mental Health (CMH), Developmental Disabilities (DD) and Senior and Long Term Care (SLTC) programs. The focus of the rate study was to address legislative requirements issued in 2021 through HB 632 Section 20 Subsection 2B. Specifically, HB 632 authorizes a provider rate study to determine the need for adjusting service rates to address the financial and service delivery impacts of COVID-19. In fulfillment of these requirements and as depicted in Figure 1, the engagement scope included the following study elements:

1. Rate Studies: Rebasing of Behavioral Health, Development Disabilities, and Senior and Long Term Care rates to derive benchmark rate recommendations
2. Provider Cost and Wage Survey: Data collection initiative from providers for rate review and rebasing efforts
3. Provider Cost Report Plan Development: A long-term plan for collecting expenditure data from providers.
4. Community Transition Needs Assessment: A study of programmatic and system gaps across vulnerable populations to make actionable recommendations in addition to rate study recommendations.
5. Rate Implementation Support: Considerations and policy guidance to support the implementation of rate recommendations.

Figure 1: Overview of Project Initiatives



In addition to analyzing changes in provider costs generally, the rate study was guided by an additional focus on specific impacts of COVID-19 on service delivery, the costs to sustain high quality services, and workforce implications, including the need to address acute labor shortages. The study utilized a multitude of data sources, survey data collection, and avenues for stakeholder feedback to develop rate structure recommendations more responsive to

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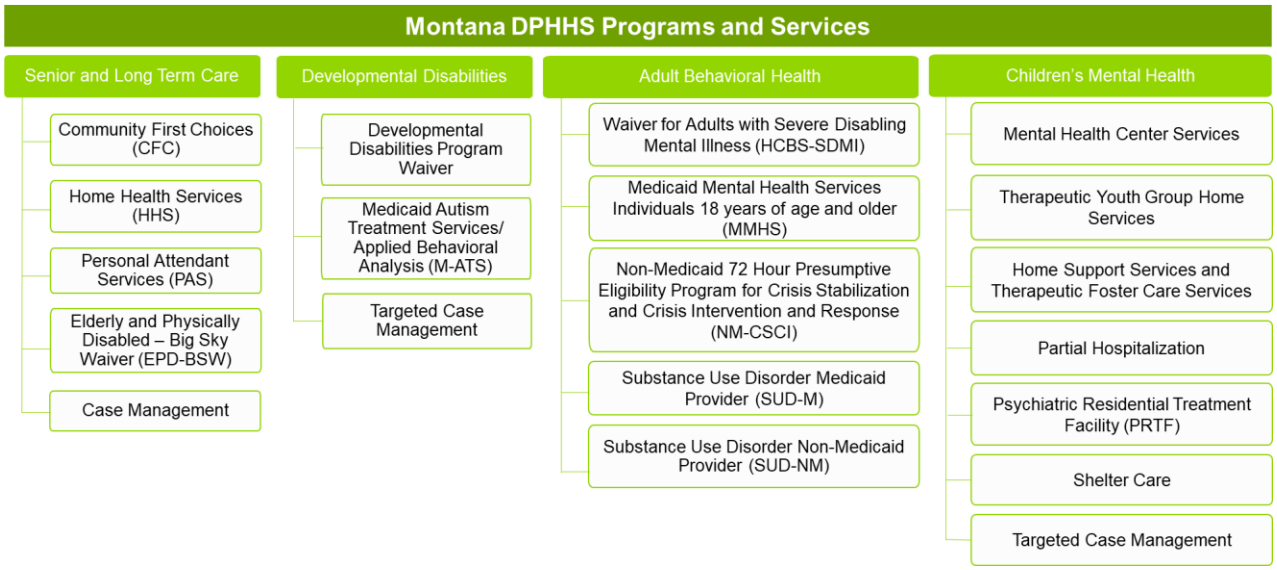
desired and lasting service delivery changes as well as future planning and budgeting needs, as further described in this report. Findings and recommendations from the rate study are compared to existing provider rates to anticipate and analyze the potential implications of implementing Guidehouse's proposed reimbursement benchmarks and rate adjustments.

The programs and services in Figure 2 were reviewed for the rate study.

Figure 2: Overview of Montana DPHHS Programs



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B.2. Stakeholder Engagement

B.2.1. Rate Workgroup and Steering Committee Structure

To support the development of cost-based rates for the State's programs, Guidehouse and DPHHS worked with service providers and other stakeholders in the rate development process. The rate study considered worker wage levels and benefits, providers' administrative costs, and program support costs, among other factors. This effort was informed by a comprehensive provider cost and wage survey soliciting broad provider participation, analysis of provider-submitted financial and service delivery data, as well as ongoing, extensive stakeholder input throughout the rate development process.

DPHHS convened two distinct, recurring stakeholder forums to support the rate study: a workgroup structure utilizing three specialized Rate Workgroups to address detailed technical issues, and a Steering Committee advising the study more broadly across populations and representing a wider array of stakeholder interests. Figure 3 describes the composition of each group, their respective roles, and discussion topics. Appendix C includes member details of each stakeholder group.

Figure 3: Rate Workgroup and Steering Committee Composition and Roles

Rate Workgroups			Steering Committee
Behavior Health (12 members)	**Developmental Services (13 members)**	**Senior and Long-Term Care (11 members)**	**20 members**
Composition: • Membership representative of associations and providers directly impacted by rate changes • Provider representatives who reflect the full range of services included within the rate study scope • Members have a strong understanding of provider finances, reporting capabilities, and service costs			**Composition:** • Caregivers and natural supports • Consumer advocacy representatives • Service providers • Chairperson or designated representative from each Rate Workgroup • Lieutenant Governor • Key legislators overseeing services • DPHHS staff
Role: • Provide subject matter expertise on provider survey and rate methodology development • Review and validate rate model factors and assumptions, including wages, benefits, administration, program support and staffing • Provide recommendations for consideration in the Final Report			**Role:** • Validate decision-making processes • Review rate model and methodology approach and estimated fiscal impacts • Review feedback from Rate Workgroup and make final rate model recommendations • Champion recommended changes in the Final Report

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Rate Workgroups			Steering Committee
Behavior Health (12 members)	**Developmental Services (13 members)**	**Senior and Long-Term Care (11 members)**	**20 members**
Discussion Topics: • Provider Survey design, administration, and results • Peer state selection for comparison • Rate build-up approach and rate components • Benchmark wages and adjustments, including supplemental pay and inflation factor • Staffing levels and supervision ratios • Additional assumptions for rate models, including nursing services provided, occupancy factors, and productivity • Final rate models, current service utilization landscape, and fiscal impact of proposed rates • Considerations for implementation and future analysis			**Discussion Topics:** • Scope of engagement and operating norms • Overall rate build-up approach and • Provider Survey purpose and administration • Final rate models, current service utilization landscape, and fiscal impact of proposed rates • Feedback from Rate Workgroup, and DPHHS's corresponding responses and actions • Considerations for implementation and future analysis

B.2.2. Additional Stakeholder Engagement

Beyond the formal rate workgroup and steering committee structure, Guidehouse coordinated with the Department to conduct additional meetings with key stakeholder groups, including focused sessions for members, providers and provider industry representatives, as well as direct care workers and union representatives.

Specifically for members and their families, caregivers and advocacy communities, Guidehouse conducted four sessions to engage these communities in the rate study work. An initial meeting, held virtually on April 20, 2022, offered an overview of the rate study work on behalf of Montanans. Additionally, three community feedback sessions were held virtually on May 17, and 19-20, to give members further opportunities to share thoughts and ideas about services they receive and how the rate study could impact them and their lives.

Lastly, all stakeholders were provided a chance to share feedback during a public comment meeting on June 15, 2022 following Guidehouse's presentation of our full rate study findings and recommendations. This public comment session was a capstone to the listening sessions that allowed these stakeholders an opportunity to express thoughts, ideas and concerns about the finalized and recommended rates per the final report.

Guidehouse conducted a one-time meeting in April 2022 with representatives of unions that impact one or more of the programs in this rate study. The meeting was focused on discussing the goals of the rate study and the benchmark wages and benefits. A few union members who were registered nurses and social workers confirmed the baseline wages for those job types

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aligned with their expectations.

DPHHS posted agendas and sent out meeting invites to engage community members. Information from these sessions was recorded in meeting notes for review and incorporation into study findings. All meetings were open to the public and receptive to public comment.

As captured in Table 2, Guidehouse worked with the Department to conduct 37 stakeholder meetings over six months between January and June 2022.

Table 2: Types of Meetings with Stakeholders

Type of Meeting	Description of Meeting	Number of Meetings
Rate Workgroup Meetings	Bring together service-specific subject matter experts, drawn from provider communities with detailed understandings of service provision, operational challenges, and provider costs.	21
Steering Committee Meetings	Provides advisory feedback on rate studies, involving the full array of stakeholder perspectives. The Committee will help DPHHS to advance system-wide proposals and holistically consider potential impacts to all stakeholders, especially members.	3
Provider Survey Training Sessions	Guidehouse and DPHHS provides training and assistance to providers during the survey response period.	2
Provider Survey Technical Assistance Session	Guidehouse and DPHHS provides technical assistance to providers during the survey response period.	1
Assisted Living Facility (ALF) Provider Survey Reporting Discussion	Meeting to discuss the rate study specifically for ALF's in the State of MT and to answer questions as it pertained to the ALF industry.	1
Union Meeting	Meeting to discuss the rate study specifically for unionized labor industries in the State of MT and to answer questions as it pertained to their union members	1
General Stakeholder Meeting	Meeting to discuss the purpose of the rate study for stakeholders who were not participating on the Workgroup or Steering Committee	1
Cost Reporting	One-time meeting with provider representatives and volunteers	1

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Type of Meeting	Description of Meeting	Number of Meetings
Provider Focus Group	from the Rate Workgroups to design, discuss, and review a cost reporting plan required under House Bill 155.	
Member Outreach Webinar	Provide members and caregivers an overview of the Rate Study with goals and objectives in a transparent way and allow for feedback in the process.	1
Member Listening Session Meeting	Attended member focused committee workgroups to allow participants an opportunity to share thoughts, concerns and perspectives on the study and overarching program dynamics (e.g., access issues, choice, workforce quality, etc.).	3
Health Care Worker Meeting	Meeting to discuss the rate study specifically for health care workers in the State of Montana and to answer questions as it pertained to their questions and concerns	1
Public Comment Meeting	Provides members and caregivers an opportunity to provide feedback on preliminary rate study findings and recommendations.	1
Total Stakeholder Meetings		**37**

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B.3. Data Sources

B.3.1. Overview of Data Sources

Cost assumptions developed throughout the rate study relied on a wide variety of data sources. Guidehouse drew from both DPHHS provider data as well as national and regional standards to arrive at cost assumptions. Our approach for this study was to establish assumptions based on provider-reported and State-recommended data when available and appropriate, as well as extensive industry data that reflect wider labor markets for similar populations.

Guidehouse conducted a cost and wage survey to obtain the cost of delivering services from providers including employee salaries and wages, administrative costs, program support costs, provider fringe benefits, and additional service-specific costs. The cost and wage survey, in particular, provided valuable and detailed information on baseline hourly wages, wage growth rate, administrative costs, program support costs, provider staffing patterns, and provider fringe benefits, as well as staff productivity for all programs included in the rate study. Guidehouse also analyzed trends in the detailed claims data for services that were in scope for this specific rate study from each of the programs to determine the fiscal impact of implementing the new benchmark rates resulting from the rate rebasing process.

Although a majority of cost assumptions used for rate development were derived from provider-reported survey data, publicly available sources were required for supplemental cost data and for benchmarking purposes to establish a comprehensive rate for some services. Guidehouse also conducted a targeted survey to review the DD program employer-authority, self-direction model. The survey results were used to identify financial differences between traditional agency-based programs and consumer self-direction models and inform recommendations on the self-direction program design within the larger context of the rate study.

We describe the key features of the provider cost and wage survey as well as the other sources used in the rate development process in the section below.

B.3.2. Provider Cost & Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey ("Survey") based on the landscape of services provided in the community to individuals in Montana with adult behavioral health service needs, child mental health service needs, developmental disabilities, and senior and long-term care service needs. The aim of the survey was to collect provider cost data across multiple services and programs that would serve as the basis for the rate studies. Additionally, Guidehouse aimed to utilize the survey to:

- Capture provider cost data to provide cost foundation for rate studies
- Receive uniform inputs across all providers to develop standardized rate model components
- Measure change in direct care worker wages over time
- Establish baseline cost assumptions for comparing and standardizing services operating in different programs and with different state plan and/or waiver authorities

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- Determine cost basis for evaluating rate equity for services
- Gather needed data to understand billable vs. non-billable time and staffing patterns per service
- Investigate differences in costs among frontier/rural/suburban areas
- Solicit general feedback from providers to explore service delivery improvements and efficiencies

The survey was aimed exclusively at collecting information about provider costs incurred in delivering services under the programs included in the rate study. Specifically, the following services and providers were excluded from the survey:

1. Services billed at cost and are not based on a standardized rate were excluded from the survey. The survey did not include specific questions on services such as: Personal Emergency Response System, Environmental Modification Services, Community Transition Services, Specialized Medical Supplies, and Health and Wellness Services.
2. "Private practice" providers who only deliver professional services such as psychotherapy, counseling, and related psychiatric services not specific to programs identified in *Section B.1, Introduction and Background* were excluded from the survey. Private mental health practitioners are reimbursed under a standardized fee schedule used to reimburse all services delivered by practitioners providing professional services, including physicians, nurses, physical and occupational therapists, and mental health professionals. Reimbursement requirements are highly standardized for these services and are reimbursed under a Resource-based Relative Value Scale (RBRVS) methodology. Guidehouse reviewed therapy services reimbursed under Montana's RBRVS system as a part of a separate review of Montana's professional services fee schedule.

B.3.2.1. Survey Design and Development

Guidehouse designed this survey with input from DPHHS staff and Rate Workgroup members, as well as drawing on knowledge gained from conducting similar surveys in other states. Guidehouse and the Department worked with the Rate Workgroups to develop, review, update and release the survey. The survey was designed in Microsoft Excel and included six (6) sections or worksheets on topics outlined in Table 3 below. During the Rate Workgroup meetings in January 2022, Guidehouse provided an overview of the survey including the objectives, topics, and questions on each worksheet within the survey document and solicited feedback from stakeholders. With the aim of collecting annual wage, benefit, and service delivery data from the fourth quarter of 2021 and organizational cost data from State Fiscal Year (SFY) 2019, Guidehouse collected information on the survey components highlighted in Table 3. Guidehouse requested specific financial datasets from different time periods considering impacts of the COVID-19 Public Health Emergency (PHE) and consequent changes in service costs. SFY 2019 data was best suited to capture relationships between different cost components, and it offered a picture of relative overhead and support costs for normal service delivery unaffected by potential temporary COVID-related changes. On the other hand, more recent data from 2021 was best suited for near-term trends likely to impact future rates including responding to rising wage pressures and inflationary costs.

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Table 3: Provider Cost and Wage Survey Organization and Data Elements

Worksheet # - Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
1 – Organizational Information	Provider identification, contact information, organizational details, and organizational revenues	Provider Organization's Fiscal Year 2019, with the exception of one question on fiscal year 2021 revenues
2 – Total Organizational Costs	Employee salaries, taxes and benefits; non-payroll administrative costs and program support costs; and facility, vehicle and equipment costs	Provider Organization's Fiscal Year 2019
3 – Program Areas	Geographic areas where programs are operated	October 1, 2021 – December 31, 2021
4 – Services	Services delivered	October 1, 2021 – December 31, 2021
4a – Staff Time and Wages *(content varies based on service selected in #4)*	Job types, staff types, hourly wages, supplemental pay, bonuses, rate changes, and training time	October 1, 2021 – December 31, 2021
4b – Staffing Patterns and Service Design *(content varies based on service selected in #4)*	Billable vs. Non-Billable, supervisor and staffing patterns; training requirements, and other service design and delivery specifications	October 1, 2021 – December 31, 2021
5 – Provider Benefits	Benefits that organizations offer full-time and part-time employees who deliver services – health, vision and dental insurance; retirement, unemployment benefits and workers' compensation; holiday, sick time, and paid time off	October 1, 2021 – December 31, 2021
6 – Additional Information	Clarifying comments in addition to the information covered in other worksheets or sections	Not Applicable

B.3.2.2. Survey Administration and Support

The survey was released via e-mail on February 2, 2022 to the entire provider community in scope for the rate study. A detailed instruction manual accompanied the survey to assist providers with responding to the survey questionnaire. To conduct a successful and accurate survey, Guidehouse facilitated live provider trainings webinars available to all providers on February 3 and February 4, 2022, following the release of the survey. In the training sessions, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions. One hundred and eighty-three provider representatives attended the training sessions and nearly 80 questions were addressed during the sessions. The trainings were recorded and posted to the Montana website devoted to the rate study. A

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link to the recording of the webinar was shared with providers, and a frequently asked questions (FAQ) document was distributed to address common questions submitted by providers. Guidehouse also developed a temporary survey website to share survey material with providers and offer an additional avenue for distributing content to providers.

Additionally, Guidehouse offered ongoing support and resources in helping providers to complete the survey, through a dedicated electronic e-mail inbox which providers could access to receive answers to their specific questions as well as a live technical assistance webinar held a few weeks prior to the survey deadline. A separate Assisted Living facility instruction document was created after the training to help properly address potential complexities related to these types of facilities. Providers were allowed four weeks to complete the survey and granted an extension option of one week if additional time was needed, with a final survey deadline of March 11, 2022.

B.3.2.3. Provider Cost and Wage Survey Participation

In total, Guidehouse received 97 surveys: 44 surveys for Adult Behavioral Health, 18 surveys for Children's Mental Health, 39 for Developmental Disabilities, and 49 for Senior and Long-Term Care. This response rate demonstrates 23 percent of all providers, or 38 percent of all "large" providers, which are providers whose expenditures total over $150,000, and 9 percent of all "small" providers, or providers whose expenditure total is under $150,000. Tables 4 and 5 below include a detailed view of the survey response rates by providers and provider expenditure perspectives across all rate study populations. Additionally, Tables 6 and 7 provide survey response rates by providers and provider expenditure respectively compared across all populations.

Total survey submissions represent 23 percent of all providers eligible to complete the survey. According to leading experience management firm, Qualtrics, typical survey response rates fall between 20-30 percent, though response rates depend heavily on survey design, medium, and population size[3].

Guidehouse measures "representativeness" by the number of providers, the relative size and scale of providers operations, and total State expenditures represented by surveyed providers. "Large" providers typically have greater capacity than "small" providers to complete cost surveys. Although fewer in number than small providers, large providers tend to receive a substantially higher share of total expenditures. Consequently, their costs are more representative of system costs as a whole. Table 4 includes the percentage of both large and small providers that responded to the survey.

Table 4: Survey Response Rates for all Populations

Provider by Size	Total Providers*	Percentage of Large and Small Providers	Provider Survey Submissions	Percent of Providers Responding
Over $150K	205	48%	78	38%
Under $150K	218	52%	19	9%
Total	**423**	**100%**	**97**	**23%**

[3] Qualtrics, Survey Distribution Methods, How to Increase Survey Response Rates Available online: https://www.qualtrics.com/experience-management/research/tools-increase-response-rate/

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*Note: Schools, MATS/ABA and Medication Assisted Treatment providers currently excluded.

Provider expenditure is a reliable metric to represent the financial impact of the provider on the entire DPHHS system rather than the raw count of providers alone. Therefore, Guidehouse also reviewed the response rates by provider expenditure. As highlighted in Table 5, 69 percent of providers across all populations participated in the survey.

Table 5: Survey Response Rates by Expenditure for all Populations

Provider by Size	Total Expenditures*	Percentage of Large and Small Provider Expenditures	Expenditures Captured in Survey Submission	Percent of Expenditures Captured in Surveys
Over $150K	$315,565,611	97%	$221,621,797	70%
Under $150K	$8,198,291	3%	$1,188,053	14%
Total	**$323,763,901**	**100%**	**$222,809,850**	**69%**

*Note: Schools, MATS/ABA and Medication Assisted Treatment providers currently excluded.

Guidehouse further analyzed survey response rates within each program to derive additional insights. As indicated in Table 6, the survey response rate by number of providers revealed a majority of DD and CMH providers, both small and large providers, responded to the survey. On the other hand, less than a fourth of SLTC and ABH providers submitted survey responses.

Table 6: Survey Response Rates by Population

Provider by Size	Total Providers*	Percentage of Large and Small Providers	Provider Survey Submissions	Percent of Providers Responding
SLTC	**311**	**100%**	**49**	**16%**
Over $150K	137	44%	36	26%
Under $150K	174	56%	13	7%
ABH	**189**	**100%**	**44**	**23%**
Over $150K	98	52%	34	35%
Under $150K	91	48%	10	11%
DD	**69**	**100%**	**39**	**57%**
Over $150K	56	81%	37	66%
Under $150K	13	19%	2	15%
CMH	**25**	**100%**	**18**	**72%**
Over $150K	20	80%	17	85%
Under $150K	5	20%	1	20%

*Note: Schools, MATS/ABA and Medication Assisted Treatment providers currently excluded.

However, the response rates by total expenditure highlighted nearly half of all providers within each program submitted survey responses. The analysis by expenditure also depicts a significantly higher response rate for ABH and SLTC relative to the actual number of providers that submitted responses, therefore indicating the response rate was higher for large providers compared to small providers within the two programs. The provider response rate by expenditure for DD and CMH is consistent with trends in the percentage of providers that responded. Of note, a vast majority of DD and CMH providers are considered large providers relative to the ABH and SLTC programs that have a wide range of provider sizes which also

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explains the variation in response rates across programs. See Table 7.

Table 7: Survey Response Rates by Expenditure per Population

Provider by Size	Total Expenditures*	Percentage of Large and Small Providers	Expenditures Captured in Survey Submission	Percent of Expenditures Captured in Surveys
SLTC	**$104,961,858**	**100%**	**$46,534,037**	**44%**
Over $150K	$99,328,903	95%	$45,791,427	46%
Under $150K	$5,632,955	5%	$742,611	13%
ABH	**$56,362,882**	**100%**	**$38,460,888**	**68%**
Over $150K	$54,703,127	97%	$38,165,649	70%
Under $150K	$1,659,754	3%	$295,238	18%
DD	**$130,421,796**	**100%**	**$106,192,185**	**81%**
Over $150K	$129,583,925	99%	$106,043,683	82%
Under $150K	$837,871	1%	$148,502	18%
CMH	**$32,017,365**	**100%**	**$31,622,740**	**99%**
Over $150K	$31,949,655	100%	$31,621,038	3%
Under $150K	$67,710	0%	$0	99%

*Note: Schools, MATS/ABA and Medication Assisted Treatment providers currently excluded.

B.3.2.4. Provider Cost and Wage Survey Review and Validation

After receiving the survey responses, Guidehouse compiled responses and conducted the following quality checks to prepare the data for analysis:

- Completeness: Checked the completion status in all worksheets within individual survey workbooks to determine whether follow up was required to resolve any issues and missing data. Guidehouse followed up with providers individually within a week of receiving the survey responses if clarification or correction was required.
- Outliers: Reviewed quantitative data points (e.g., wages, productivity, benefits, number of clients and caseloads, staffing patterns) reported across all organizations to identify potential outliers. If any outlier data points were excluded or assumptions were made for rate model inputs, the assumptions were reviewed with the Department and the Rate Workgroup and are documented as such in this report.

It is important to note cost survey processes are not subject to auditing processes, as an established administrative cost reporting process would be. Providers' self-reported data were not audited for accuracy, although outliers were examined and excluded when warranted, and additional quality control checks were conducted to ensure data completeness. The absence of an additional auditing requirement is ultimately a strength rather than a weakness of the cost survey approach, as it allows providers to report their most up-to-date labor costs, a key concern for rate development at a moment of heightened inflation.

The survey data reported by providers was utilized to develop several key rate components including baseline hourly wages, Employee Related Expenses (ERE), and administrative and

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program support cost factors. Section B.5. further outlines how the survey data was utilized for rate setting purposes.

B.3.3. Self-Direction Survey (SDS) and Cost Data

As a part of the rate study, the Department requested Guidehouse to conduct an additional research study to review the Developmental Disability Program's (DD) employer-authority, self-direction model. Study findings are useful not only for identifying financial differences between traditional agency-based programs and consumer self-direction models, but also for informing DD's self-direction program design to support the employer-authority model of waiver service delivery within the larger context of the DPHHS rate study.

As a part of the study, Guidehouse analyzed the following data elements:

- Population information
    - Number of members utilizing employer-authority, self-direction model within the Comprehensive Waiver;
    - Number of employees employed per service, per member within employer authority model of the Comprehensive Waiver;
    - Total number in the Comprehensive Waiver; and
    - Wage analysis of provider pay.
- Data Sources:
    - Montana's Fiscal Management Service (FMS) provider;
    - Self-direction participant survey data;
    - Rate Study Claims data; and
    - Self-direction employer townhall feedback forum.

The data seeks to provide a snapshot comparing the actual reported expenses through the self-direction program, detailed in the fiscal management service provider claims data, with the self-reported costs reported by members self-directing their services.

In order to review the data from the State on reported services utilized, Guidehouse collected time and wage data from Montana's FMS provider. The data collected included a comprehensive time and wage report for the time periods of July 1, 2018 to June 30, 2019, and October 1, 2021 to December 31, 2021. These claims data sets provided a comparative look at hours and wages before the COVID public health emergency and during. Guidehouse also conducted a survey for members who self-direct their services through an employer-authority model to capture expenses and collect qualitative responses on their feedback on the self-direction program. This survey data was used for a comparative analysis of fiscal management service providers reported expenditures. The survey was created based on best practices of self-direction survey data collection methods, and was broken into four sections:

- Unpaid Administrative Costs;
- Unpaid Benefits;
- Qualitative satisfaction questions; and
- SDS services participant utilization.

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The self-direction survey was distributed electronically to 230 self-directing employers who utilize the SDS employer-authority option through the Home and Community-Based Waiver for Individuals with Developmental Disabilities. Participation included 23 members who responded with information, resulting in 14 surveys completed in their entirety and used for analysis.

B.3.4. Claims Data

Guidehouse developed a detailed claims data request to be able to process the Medicaid claims utilization for 5 state fiscal years. This request included all detailed claims for services that were in scope for this specific rate study from each of the programs: Senior and Long-Term Care (SLTC), Adult Behavioral Health (ABH), Developmental Disabilities (DD), and Children's Mental Health (CMH). We requested key fields such as provider detail, payment information, service identifying fields and units of measure. After reviewing claims information, it was recognized that, prior to SFY 2020, the DD program had its data stored outside of the State of Montana's Medicaid Management Information System (MMIS) and in a legacy system called the Agency Wide Accounting and Client System (AWACS). This system presented challenges for combining the data with MMIS and was consequently excluded. However, for the other programs, Guidehouse was able to harness the additional years of data to examine utilization trends over time and determine SFY 2020 was the most complete year of information. We understand the COVID-19 public health emergency potentially had an impact during this time period, however, SFY 2020 experienced only a 2-month impact on utilization in comparison to SFY 2021 claims. Analyzing these trends is an important consideration to determine fiscal impact accurately when the new benchmark rates are applied. We want to ensure we are capturing a normal utilization year to properly project overall fiscal impact.

B.3.5. Other Data Sources

Cost assumptions developed throughout the study rely on a wide variety of data sources. The objectives of the rate study aim to establish benchmark rates based on a combination of publicly available resources as well as understanding the necessary cost requirements required to promote access to quality services going forward. As will be detailed in greater depth in the sections that follow, Guidehouse's provider cost and wage survey furnished the majority of our rate assumptions on employee wages, provider fringe benefit offerings, staff productivity, staff-to-client ratios, and transportation requirements for the array of services.

While cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate in the face of future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the resources required to provide services in the near future or are not comparable to or competitive with the industry as a whole, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the cost assumptions used by Guidehouse frequently draw on national and regional standards, at least for comparison purposes, that reflect wider labor markets as well as median costs typical of broader industries, to benchmark Montana reported information from the provider cost and wage survey. Table 8 summarizes some of the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

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Table 8: Other Data Sources

Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)	Federal wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage geographic and industry wage comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Costs for Employee Compensation Survey (CECS)	Federal data on employee benefits cost, analyzing groups of benefit costs including insurance, retirement benefits, paid time off, and other forms of non-salary compensation. Used for reference in establishing benchmark ERE assumptions.
Bureau of Labor Statistics, Provider Price Index (PPI)	Federal index of inflation across multiple industries for Medicaid populations. Updated monthly and includes data series for Residential Developmental Disability Homes, Home Health Care Services, and Nursing Care Facilities. Used for reference to understand annual inflation for provider costs and for recommendations on recurring rate update.
Bureau of Labor Statistics, Consumer Expenditure Survey	Federal data on annual consumer spending. Provides potential cost assumption for food costs per meal.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)	Federal data on health insurance costs, including Illinois-specific data regarding multiple aspects of health insurance (employer offer, employee take-up, premium and deductible levels, etc.) Used for reference in estimating health care costs for benchmark ERE assumptions.
Other State Medicaid Fee Schedules and Reimbursement Methodologies	Data from other states on reimbursement levels for cognate services as well as overall service design. Used for peer state comparison and well as development of best-practice recommendations for improving supported employment service delivery.
Internal Revenue Service	The Internal Revenue Service is the revenue service for the United States federal government, which is responsible for collecting taxes and administering the Internal Revenue Code, the main body of the federal statutory tax law.
U.S. Department of Agriculture, Food Plans	Federal budgeting tool used to estimate food costs in various settings. Provides potential cost assumption for food costs per meal.

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U.S. Census Bureau, Current Population Survey Food Security Supplement	Federal data on per meal costs indicative of “food-secure” households. Used for establishing benchmark cost assumptions for CILA residential food costs.

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B.4. Peer State Comparisons

B.4.1. Overview

Guidehouse's recommendations for the current study are comprised of existing approaches used in other states, and Guidehouse's experience conducting similar studies and analyses in these states. Guidehouse gathered peer state data sources to assist the development of the rate build-up methodologies for comparable waiver services included in the rate study. Peer state waiver rate services were also used to compare and validate final rate pricing across similar services where applicable. Due to the uniqueness of every state's Medicaid system, no state waiver is exactly comparable to similar waivers for a similar population in another state. However, it is helpful to compare waiver rates to similar waiver rates in other states to understand whether current rates represent an outlier, or whether differences can be explained by distinctive service definitions or economic conditions in the State.

Guidehouse appreciates that Montana is unique among other states geographically, demographically, and culturally. Therefore, we were selective in identifying these peer states and the services within the states. We not only identified comparable states but then reviewed each service definition prior to comparison to help confirm the applicability and adequacy of comparison. As an example, when comparing residential services, it is important to understand the facility size and services offered within the facility to understand where differences could lie resulting in justifiably varied rates. These services also do not normally have an equivalent Medicare or commercial benchmark to use as a fair comparison, which in turn makes finding a Medicaid equivalent even more important.

With the initial review of the peer state comparison, there was not an immediately clear pattern of systematic underfunding across most of the programs. Rather, the apparent overall trend is that Montana's rates usually fall within most other state rates, not usually the highest but also not the lowest. However, SLTC services generally show slightly lower overall rates than the state averages across widely utilized services which aligns with the findings within the cost analysis. Not surprisingly, later analysis will show SLTC requires some of the largest rate increases due to in-home and residential service rates being lower overall.

B.4.2. Comparison Approach

First, Guidehouse identified states that seemed similar to Montana by demographics, geography, Medicaid program design, and scope of services offered for the HCBS population. As seen in the map shown in Figure 4, Guidehouse researched the initial peer states marked in light green. For Colorado, we compared Montana's rates against the "Outside Denver" rates, and for Washington, we compared to the "Outside Seattle" rates to generate a more appropriate comparison, excluding the large metropolitan areas whose service conditions and costs of living are without analogue in Montana:

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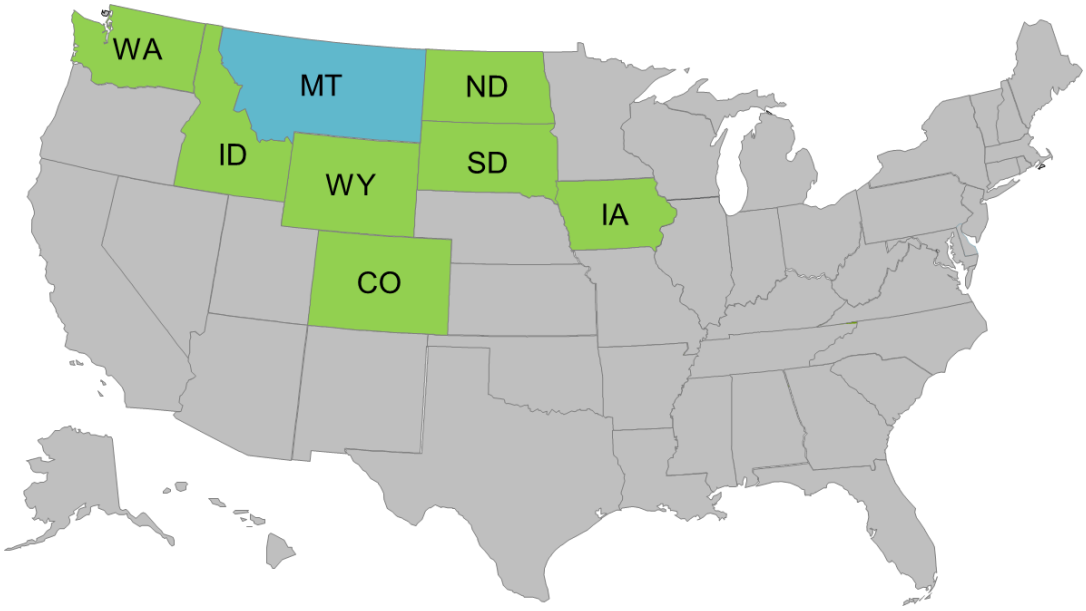
Figure 4: Peer States for Rate Comparison



B.4.3. Adult Behavioral Health Comparisons

When reviewing Montana's behavioral health service array, Guidehouse identified three behavioral health rates that had comparable services in at least two other peer states. See Table 9. Across all three services, Montana's current rate typically falls in the middle of the various state rates, and alternately above or below the other state average, depending on the specific service. For Community Based Psychiatric Rehabilitation & Support-Individual (CBPRS), Montana's rate is $7.29 per 15-minute increment, which is just slightly more than Washington's similar service. However, it falls substantially lower than the corresponding rate for Idaho. Peer Support services, in comparison, show Montana to have the highest rate across all 5 peer states, paying 17.2 percent more than the overall average of the 5 peer states. While for the American Society of Addiction Medicine's (ASAM) Medically Monitored Intensive Inpatient-ASAM 3.7 (Daily Rate) Montana is within a few dollars of the peer state average, falling between the two other peer states whose rates vary by nearly $94.

Table 9: Behavioral Health Peer State Rate Comparison

Behavioral Health									
Service	**MT**	**CO**	**ID**	**IA**	**ND**	**SD**	**WA**	**All Other State Average**	**Percent Difference**
Community Based Psychiatric Rehabilitation &	$7.29	-	$13.63	-	-	-	$7.15	$10.39	**-42.5%**

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Behavioral Health									
Service	**MT**	**CO**	**ID**	**IA**	**ND**	**SD**	**WA**	**All Other State Average**	**Percent Difference**
Support (Individual)									
Peer Support (15 Minutes)	$13.87	-	$13.63	$12.50	$7.53	-	$12.30	$11.49	**17.2%**
SUD Medically Monitored Intensive Inpatient-ASAM 3.7 (Daily Rate)	$246.05	-	-	-	-	$204.78	$298.36	$251.57	**-2.2%**

Despite only showing three rates within the total ABH population mix, we captured mental health and Substance Use Disorder (SUD)-related services in our comparison. The ASAM 3.7 is part of the larger array of ASAM related models which falls under the "Intensive Behavioral Services" category defined by Guidehouse, which also includes the services Medication Assisted Treatment (MAT), Program for Assertive Community Treatment (PACT), Montana Assertive Community Treatment (MACT) and Crisis Stabilization. Unique to the ABH program, this intensive behavioral health category accounts for roughly 30 percent of total ABH spending within the services included in scope for this rate study. Peer Support proves to be a valuable comparison when trying to understand the baseline rates for supporting services. North Dakota has a rate that is almost half the other peer states, which brings down the overall state average. When this rate is removed, Montana's rate is in line with the other states, indicating consistency across the starting wage within the peers. Community Based Psychiatric Rehabilitation & Support (CBPRS) seems low in comparison to the Peer Support service. Washington has a similar trend, in which its Peer Support service is almost double the CBPRS rate. However, in Idaho the rates are the same. This type of variation could be attributed to different staffing expectations for providing this service, which are not clearly outlined in service manuals. The proposed benchmark rate for CBPRS sees roughly a 69 percent increase whereas Peer Support, which appears to be more in line with other states, has a 16 percent increase with the proposed rate. ASAM 3.7 also has an increase that falls in the middle at about 30 percent.

B.4.4. Children's Mental Health Comparisons

When compared to peer states, Montana's rate for psychiatric residential treatment facilities (PRTF) falls within the range seen in the eight states listed in Table 10. However, Montana's out-of-state rate comes in at the upper end of the range. Guidehouse's proposed benchmark rate is $509.81, which would put Montana at the top of the range, with the exception of Colorado's recently updated PRTF rate.

Table 10: PRTF Peer State Rate Comparison

State	Per Diem Effective Date	PRTF (In-state or general)	PRTF (out of state)	Median PRTF Rate
Colorado	7/1/2021	$750.00		$750.00

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State	Per Diem Effective Date	PRTF (In-state or general)	PRTF (out of state)	Median PRTF Rate
South Carolina	4/1/2022	$500.00		$500.00
Minnesota	7/1/2021	$478.52		$478.52
Virginia	7/1/2021	$423.32		$423.32
Montana	7/1/2021	$339.88	$452.04	$395.96
Kentucky	7/1/2020	$365.00		$365.00
Nebraska	7/1/2021	$349.65		$349.65
South Dakota	7/1/2021	$334.56		$334.56
Wyoming	7/1/2021	$327.00	$296.40	$311.70

B.4.5. Developmental Disability Services Comparisons

For Developmental Disability Services, Guidehouse identified four services relevant for comparison across five peer states. See Table 11. Overall, Montana's rates fall within the comparable peer states for all rates listed and in two out of four of the peer states they are also higher than the average of the other states. Supported Employment has a wide range in peer state rates, which pulls up the other state average. Montana's rate comes in right between the two lowest and the two highest rates for this service. Private Duty Nursing-LPN is similar in that Montana falls between the two peer states but comes closer to the top of the range, just below Washington. For Private Duty Nursing-RN, the rates are higher than LPN overall, as expected, and Montana falls within the same range of being in the middle, but closer to the top of the range. Its rates are 12.3 percent higher than the average. Lastly, Residential Habilitation-Supported Living (No Geo Factor) shows a high rate for North Dakota in comparison to Montana and the other peer states, which to some extent skews the "all other state average". Removing North Dakota as an outlier brings Montana's rate within 3 cents of the average.

Table 11: Developmental Services Peer State Rate Comparison

Developmental Services									
Service	**MT**	**CO**	**ID**	**IA**	**ND**	**SD**	**WA**	**All Other State Average**	**Percent Difference**
Supported Employment (Individual: 1 Hour)	$40.48	$59.44	$34.44	$68.48	$42.80	-	-	$51.29	**-26.7%**
Private Nursing Duty (LPN 15 Minutes)	$9.29	-	$5.20	-	-	-	$10.57	$7.89	**15.1%**
Private Nursing Duty (RN 15 Minutes)	$11.70	-	$7.65	$12.87	-	-	-	$10.26	**12.3%**
Residential Habilitation-	$25.59	-	$21.24	-	$37.05	-	$27.00	$28.43	**-11.1%**

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Developmental Services									
Service	**MT**	**CO**	**ID**	**IA**	**ND**	**SD**	**WA**	**All Other State Average**	**Percent Difference**
Supported Living (No Geo Factor)									

Similar to the comparisons illustrated for the other programs, the subset of services for comparison is small, but the types of services vary substantially, capturing a diverse mix of services. These services span three service categories: Supported Employment, Nursing and Residential Services. The nursing category shows Montana falling a fair amount below the other state average, which aligns with findings in Guidehouse's service cost and fiscal impact analysis. Proposed benchmarks for the nursing categories show substantial increases, which follows the peer state indicating these services are currently lower than their peers. Residential services account for roughly 67 percent of total spending, which makes it increasingly beneficial to find a peer state comparison for a residential service. Supported Employment displays a wide range of rates from $34.44 in Idaho to $68.48 in Iowa. Differences here, though, could be related to disparate service designs rather than a measure of rate inadequacy.

B.4.6. Senior and Long Term Care Services Comparisons

In the case of Senior and Long Term Care services, Guidehouse's peer state analysis identified four services for comparison, including personal assistance services, which are highly utilized services that constitute a substantial proportion of overall spending on home and community-based long-term care. For both agency-based and self-directed versions of Personal Assistance, Montana's rates lie near the middle among the comparison states. The agency-based versus the self-directed models have about a 3.5 percent difference between their current rates. When comparing to the other state average, we also observed a 3.5 percent difference, indicating that other states have a similar differential between their agency-based and self-directed rates. For Respite and Homemaker services, Montana's current rate still is within the middle of the range; however, it appears to be on the lower end of the range in comparison to the Developmental Disabilities rates. Montana was also within the middle of the range but was coming in at the top of the range.

Table 12: Senior and Long Term Care Peer State Rate Comparison

Senior and Long-Term Care									
Service	**MT**	**CO**	**ID**	**IA**	**ND**	**SD**	**WA**	**All Other State Average**	**Percent Difference**
Personal Assistance Services (Agency-Based 15 Minutes)	$5.51	$5.16	$4.49	-	$7.46	-	-	$5.70	**-3.5%**

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Senior and Long-Term Care									
Service	**MT**	**CO**	**ID**	**IA**	**ND**	**SD**	**WA**	**All Other State Average**	**Percent Difference**
Personal Assistance Services (Self-Directed 15 Minutes)	$4.59	$4.60	-	-	$5.43	-	$4.21	$4.75	**-3.4%**
Respite (15 Minutes)	$4.53	$5.70	$4.41	-	$5.43	-	-	$5.18	**-14.3%**
Homemaker (15 Minutes)	$4.53	$4.98	$4.16	-	-	$7.26	-	$5.47	**-20.7%**

Personal Assistance is a key service within the SLTC population. In-Home services such as Personal Assistance and Homemaker account for almost 40 percent of total expenditures within the SLTC Medicaid service array for the services within scope of this rate study, making these valuable services when observing peer state comparisons. In contrast to the other programs, each of the selected services shows a lower rate than the other state average, indicating a wider rate disparity. This status becomes clearer when analyzing the fiscal impact, which suggests SLTC services are underfunded relative to services provided by other programs, even when taking add-on payments into account. This condition is largely due to low current rates for in-home services. Guidehouse's proposed benchmark rates would result in Montana having the highest rate out of all peer states presented for each of the services indicated in Table 12.

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B.5. Rate Methodologies and Components

B.5.1. Overview of Rate Methodologies

In this section, we discuss our analysis of the Department's current rate methodologies for each of the service arrays under review. The section describes Guidehouse's "independent rate build-up" approach to rate development and identifies the various components of a general independent rate build-up model. It details the process by which Guidehouse determined appropriate assumptions for each component value as well as how we incorporated the diversity of cost components into the final rate models.

Many of the service rate benchmarks we propose follow a series of general assumptions for the components of each rate, adjusted according to the specific context and goals for providing each service. This rate build-up approach is based on a core set of wage assumptions for direct care staff, supplemented by estimates of the cost of other supporting staff, activities and materials needed to support direct care provision. In this section of the report, we describe in detail the methodology for calculating various components used in the rate models. In addition, we describe the data sources used to determine the component. The section is divided into the following areas:

- Staff Wages
- Employment Related Expenditures (ERE)
- Productivity of Direct Care Staff
- Occupancy and Absences
- Supervision
- Staffing Ratios
- Staff Mileage
- Administrative Expenses
- Program Support Expenses
- Self-Directed Service Adjustments

B.5.2. General Cost Assumptions

The methodology for developing a rate for a unit of service – or a rate model – varies across types of services but generally includes certain key components. A rate model starts with the wage for the primary staff person providing a service—for example, a Direct Support Professional (DSP), Personal Care Aide, Job Coach, or Board-Certified Behavior Analyst (BCBA), depending on the service—and then building upon that wage with fixed or variable cost factors to account for additional program support costs.

Typical components of a rate methodology or rate model include:

- Direct Care Compensation Costs
  - Staff Wage Costs
  - Employment Related Expenditures (ERE)
  - Supervision Costs
- Billing Adjustments to Direct Care Compensation Costs

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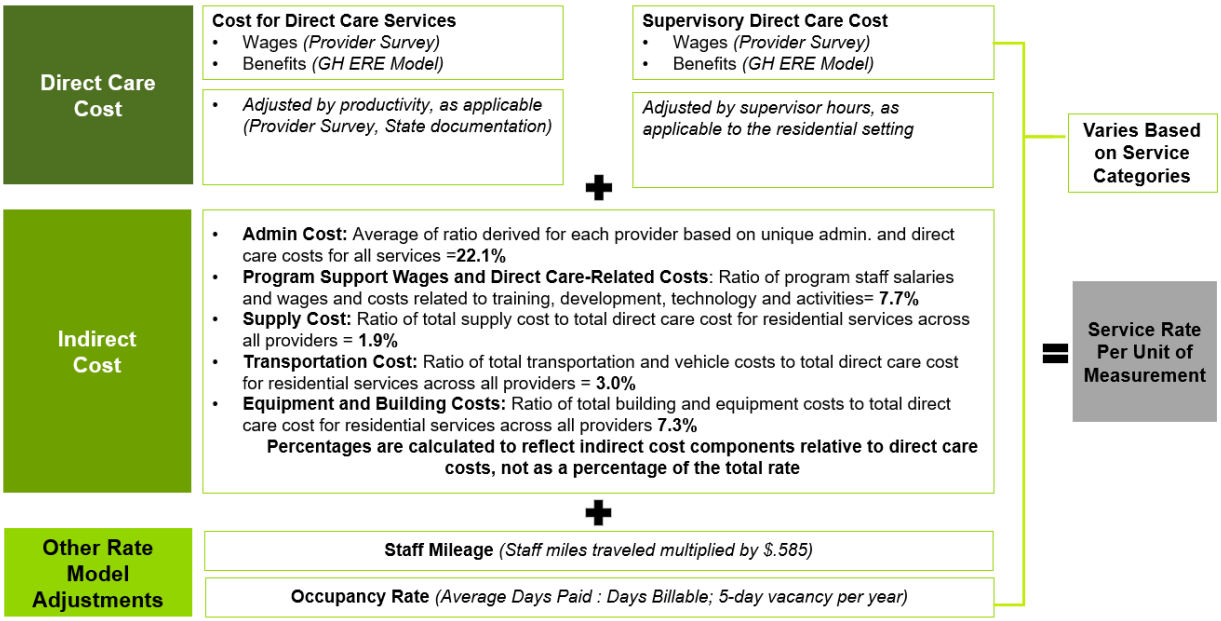
  - Productivity of Direct Service Staff
  - Occupancy and Absences
- Administrative Expenses
- Program Support Expenses

Together, these components sum to a unit rate designed to reimburse a provider organization for all inputs required for quality service delivery. This approach is often called an "independent rate build-up" approach because it involves several distinct rate components whose costs are captured independently through a variety of potential data sources. These costs are essentially "stacked" together into a collective cost per unit that defines the rate needed for cost coverage. Figure 5 illustrates the "building block" structure of Guidehouse's rate development methodology. Although individual rates may incorporate different building blocks, each rate model follows a similar process for identifying the component blocks for inclusion, based on the service requirements and specific adjustments needed to align overall costs with the appropriate billing logic and units of service.

Figure 5: Overview of Rate Components



The different cost components schematized here are discussed in further detail in the following sub-sections of the report.

B.5.2.1. Staff Wages

Wages for direct care staff form the largest component of any rate model, as many of the services for which Guidehouse developed rate models depend substantially on the labor time of the qualified, dedicated staff who care for the four distinct populations. To best understand the landscape of wages in Montana, we used data from the cost and wage survey reported by provider organizations as well as industry-wide data sources.

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As part of the cost and wage survey, each responding provider reported average hourly or "baseline" wages in addition to overtime, shift differential and other forms of supplemental pay, as well as inflationary trends in wages and other wage or salary-related information. The staff types with the highest number of Full-Time Equivalents (FTE) reported in the survey were DSPs and Personal Assistants, with almost 3,000 FTEs between the two job categories. DSPs and similar staff types are often the foundation of direct care in the study population, as evidenced by the number of positions reflected in the survey responses. Considering the fact that wages for DSPs have not tracked as closely to inflation over time as wages for other job types, and that DSP wages are closer to the minimum wage than wages for other job types, DSP wages are typically the most sensitive in the system both to changes in the labor market and to rising consumer costs. For these reasons, the study was focused particularly on wage trends for DSP and similar staff, such as personal assistants and nursing assistants.

Average DSP wages from the calendar year fourth quarter of 2021 across the four service arrays fell into a three-dollar range around $15.30, which was weighted based on the number of FTEs across programs to account for variation in different sizes of providers. Table 13 displays each program, the number of DSP FTEs for each program, and the average hourly wage weighted within and across programs.

Table 13: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs

Job Type	CY2021 Q4 Baseline Wage – Cost and Wage Survey			
	Population Service Array	**Number of FTEs**	**Average Hourly Wage Weighted based on FTEs per program**	**Average Hourly Wage Weighted based on FTEs across programs**
Direct Support Professional	Adult Behavioral Health	409.7	$14.99	**$15.30**
	Children's Mental Health	308.7	$16.30	
	Developmental Services	1,154.9	$15.46	
	Senior and Long-Term Care	194.5	$13.36	

For other direct care staff types, Guidehouse followed a similar practice of weighting reported wages by the number of FTEs, then comparing that wage to benchmark wages reported by the BLS OEWS specific to Montana for mid-2021. For example, a Certified Nursing Assistant in the cost and wage survey mapped to a Nursing Assistant BLS job classification while an Employment Specialist mapped to a Rehabilitation Counselor BLS job classification. This served to justify the validity and representativeness of wages reported through the survey, as weighted average wages fell around the mean BLS-reported wage for many job types.

Analysis revealed no distinct trend in variation in wages between providers primarily serving in

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rural regions of Montana compared to more urban regions.[4] However, this outcome may be due to the fact many of the providers surveyed offer services across the state, so regional cost disparities may not be visible when considering wage costs in aggregate. Our baseline wage assumptions, therefore, did not account for differences in geography, as our analysis did not find a justification to differentiate wages based on the location of the provider. The preliminary wages above also do not yet include inflationary increases or supplemental pay.

B.5.2.1.1. Inflationary Increases in Wages

We also consulted federal data in tandem with survey data to understand how wages and costs have trended over recent years. Table 14 includes the most recent growth rate from each source, which include:

- **BLS Producer Price Index (PPI).** The BLS publishes a PPI for Medicaid populations including residential and developmental disability homes, home health care services, and nursing care facilities are specific to the populations and services in scope for this study. The most recent PPI data from February 2022 produces an annual growth rate between 2.71 percent and 5.37 percent, depending on the Medicaid population under consideration. Specific to residential and developmental disability homes, the most recent data indicates a growth rate of 4.95 percent.
- **BLS Current Employment Statistics (CES).** The BLS also publishes CES data which looks at earnings rather than costs. Across relevant employee categories (e.g., Assisted Living Facilities for Elderly Staff, Elderly and Persons with Disabilities Staff, Home Health Care Staff), 2021 trends document an annual growth rate in earnings of 5.30 percent.
- **Cost and Wage Survey.** Responding provider organizations recorded the average growth rate of earnings between 2018 and 2019, 2019 and 2020, and 2020 and 2021 for their staff; most providers only reported wage changes for the latter year, and the rate for the latter year was relatively high. However, the median growth rate in wages reported in the survey between 2020 and 2021 does align with industry trends such as the BLS PPI and CES, at 5.00 percent.

Table 14: Sources of Growth Rates in Relevant Costs and Wages

Source	Time Period	Growth Rate
Bureau of Labor Statistics (BLS) Producer Price Index (PPI) for Residential and Developmental Disability Homes	2021	4.95%
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for Selected Employee Categories	2021	5.30%
Montana DPHSS Provider Cost and Wage Survey	2021	5.00%

[4] The classification of a county as rural, urban or frontier was based on the definitions from the individual divisions.

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To align potential growth in costs during 2022 and to account for economic and labor conditions that may reflect the future cost of service delivery, our wage assumptions include the growth rate from the survey of **5 percent**.

B.5.2.1.2. Supplemental Pay

Supplemental pay – inclusive of costs such as overtime wages, shift differentials, holiday pay, and non-production bonuses *on top of* compensation from regularly-earned wages – was reported in the cost and wage survey. In analyzing survey results, Guidehouse calculated a supplemental pay percentage of 6.32 percent by dividing total supplemental pay reported by total wages for each provider (excluding outlying providers for which this percentage was over 15 percent). However, only about 30 percent of responding providers indicated they offered supplemental pay for one or more job types, and the supplemental pay reported varied widely.

For this reason, Guidehouse again consulted federal data from the BLS Employer Costs for Employee Compensation (ECEC) quarterly data series for the Nursing and Residential Care industry, which divides costs into hourly wages as well as expense categories related to mandatory taxes and benefits, insurance, retirement, paid time off, supplemental pay, and other benefits. In the fourth calendar year quarter of 2021 (CY2021 Q4) – the same time period as requested in the cost and wage survey – supplemental pay for the selected labor category equaled 3.75 percent of the average hourly wage, which appears relatively stable over the five-year period from 2017 through 2021. Guidehouse uses the five-year average supplemental pay percentage of **3.72 percent** to account for most recent pay rates as well as the impact of COVID-19 on the rates, as supplemental pay information collected through the survey deviates from the most recent historical *and* industry trends and comes from a potentially unrepresentative sample. The BLS ECEC data includes all supplemental cost components integral to overall compensation, and the data provides consistent and periodic trends that can be used to project a future state.

B.5.2.1.3. Final Wage Adjustments

Our benchmark wage assumptions are computed by inflating the CY2021 Q4 weighted average hourly wages to reflect growth in costs and adding supplemental pay as a function of wage and labor costs, as demonstrated in Figure 6.

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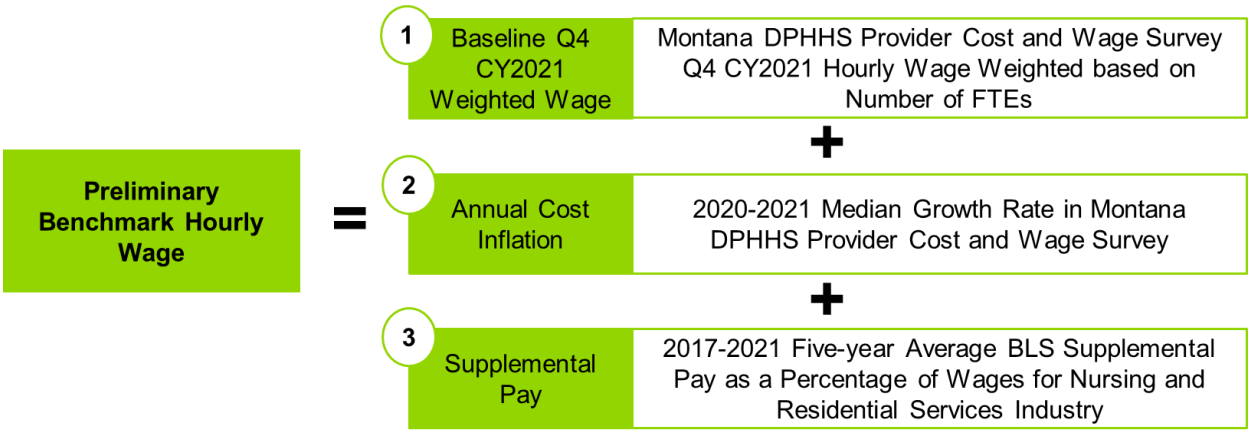
Figure 6: Calculation of Wage Adjustment Factors



For example, using the DSP weighted baseline wage from 2021 of $15.30 (as discussed above), Guidehouse added a 5 percent inflation factor which amounts to $0.76, or a total of $16.06. From the inflated wages – now in 2022, as these represent a growth by one year – we add a 3.72 percent supplemental pay add-on of $0.60, which brings the projected total hourly wage for 2022 to $16.66 for DSPs. Table 15 completes this equation for each job type, and also includes the number of FTEs for each job type as reported in the cost and wage survey. The last four rows of Table 15 below – for job types of Clinical Director, Direct Support Supervisor, Executive Director / Assistant Director, and Residential Director – are supervisory positions while the rows above those are direct care positions.

Table 15: Benchmark Wage Recommendations

Job Type	Direct Care vs. Supervisor Staff	Number of FTEs (Survey)	CY2021 Q4 Survey Baseline Wages or BLS	Projected 2022 Baseline Hourly Wage	Projected 2022 Hourly Wage
			Baseline Wage (CY2021)	2022 Hourly Wages (Baseline + 5% Inflation Factor)	Benchmark Hourly Wage (2022 Hourly Wage + 3.72% Supp. Pay)
Addiction Counselor	Direct Care	29.5	$23.79	$24.98	$25.91
Behavioral Specialist/Technician	Direct Care	86.5	$17.57	$18.44	$19.13
Board Certified Assistant Behavior Analysts	Direct Care	2.0	$31.17 *(BLS)*	$32.73	$33.95
Board Certified Behavior Analyst	Direct Care	13.2	$41.98 *(BLS)*	$44.08	$45.72

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Job Type	Direct Care vs. Supervisor Staff	Number of FTEs (Survey)	CY2021 Q4 Survey Baseline Wages or BLS	Projected 2022 Baseline Hourly Wage	Projected 2022 Hourly Wage
			Baseline Wage (CY2021)	2022 Hourly Wages (Baseline + 5% Inflation Factor)	Benchmark Hourly Wage (2022 Hourly Wage + 3.72% Supp. Pay)
Case Manager	Direct Care	381.3	$18.23	$19.14	$19.85
Certified Nursing Assistant	Direct Care	24.0	$15.33	$16.09	$16.69
Certified Peer Support Specialist	Direct Care	15.5	$16.13	$16.94	$17.57
Direct Support Professional	Direct Care	2,067.8	$15.30	$16.06	$16.66
Employment Specialist/Job Coach	Direct Care	23.1	$17.79	$18.68	$19.38
Licensed Clinical Professional Counselor (LCPC)	Direct Care	75.8	$27.11	$28.47	$29.53
Licensed Clinical Social Worker (LCSW)	Direct Care	70.1	$25.53	$26.81	$27.80
Licensed Practical Nurse (LPN)	Direct Care	47.2	$23.90	$25.10	$26.03
Personal Assistant	Direct Care	869.3	$15.32	$16.09	$16.68
Psychiatrist	Direct Care	2.65	$87.03	$91.38	$94.78
Psychologist	Direct Care	0	$41.98 (BLS)	$44.08	$45.72
Registered Nurse (RN)	Direct Care	78.0	$33.88	$35.58	$36.90
Respite Provider	Direct Care	7.0	$10.29	$10.80	$11.21
Clinical Director	Supervisor	27.5	$35.14	$36.90	$38.27
Direct Support Supervisor	Supervisor	245.0	$22.21	$23.32	$24.19
Executive Director/ Assistant Director	Supervisor	47.2	$42.47	$44.60	$46.26

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Job Type	Direct Care vs. Supervisor Staff	Number of FTEs (Survey)	CY2021 Q4 Survey Baseline Wages or BLS	Projected 2022 Baseline Hourly Wage	Projected 2022 Hourly Wage
			Baseline Wage (CY2021)	2022 Hourly Wages (Baseline + 5% Inflation Factor)	Benchmark Hourly Wage (2022 Hourly Wage + 3.72% Supp. Pay)
Residential Director	Supervisor	21.6	$29.37	$30.84	$31.99

B.5.2.2. Employee-Related Expenses

Total compensation includes wages as well as employment-related expenses (ERE) – for example, DSPs earn not only their wages over the course of the year, but also benefits such as days off, health insurance, and employer retirement contributions. These ERE or fringe benefits include legally required benefits, paid time off, and other benefits such as health insurance. Table 16 lists the components of ERE and calculates an example ERE percentage for a DSP using our wage recommendations.

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation. Employers in Montana pay a federal unemployment tax (FUTA) of 6.00 percent of the first $7,000 in wages and state unemployment tax (SUTA) of a range of 0.13 percent to 6.30 percent of the first $35,300 in 2021 wages.[5] Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.4 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 percent rate of the first $142,800 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act (FICA) contributions. Per the cost and wage survey, employers in Montana pay an average effective tax of 2.96 percent toward workers' compensation insurance.
- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The median aggregate number of paid days off per year, per the cost and wage survey, was 28 days total. As PTO benefits only apply to full-time workers, the daily value of this benefit is multiplied by a **part time adjustment factor**, which represents the proportion of the workforce which works full-time for the provider organizations responding to the cost and wage survey.
- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part time adjustment factor, as well as a **take-up rate** specific to each benefit type which represents the proportion of employees who actually utilize the benefit.

Not all providers who responded to the provider cost and wage survey have historically offered a "full" or competitive benefits package. To determine competitive contributions for benefits

[5] Per the Montana Department of Labor and Industry, the average SUTA rate in the State is 1.12 percent of wages. Available online: https://uid.dli.mt.gov/_docs/contributions-bureau/rate-insert.pdf

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which are not legally required, Guidehouse analyzed paid time off components in aggregate and data on other benefits only from providers *who contribute to their full-time employees' benefits*. Analyzing these contributions and take-up rates for providers offering "other benefits" yielded median annual contributions per employee.

We compared benefits information reported in the survey to the publicly available Medical Expenditure Panel Survey (MEPS). MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage. During this comparison we found the average monthly premium reported in the State of Montana was $712 after applying an inflation factor. This came in slightly higher than the average of $657 reported in the survey. Guidehouse ultimately decided to use the MEPS information over the survey data, both because this source is grounded in a wider response base, and because it provides a more representative standard for determining competitive insurance offerings for Montana employers overall. However, reported information in the survey was largely in line with costs identified in the MEPS data, corroborating the accuracy of the benefits data submitted by providers and confirming the applicability of the MEPS data as an appropriate benchmark for identifying health insurance costs. Our preference for the MEPS data was mostly due to the fact providers reporting in the cost and wage survey did not always clearly differentiate between costs for individual and family insurance plans, leading to average amounts that were more similar than expected, but close to overall MEPS costs when considered in aggregate. Therefore, while data for our assumptions of vision insurance, dental insurance, and other benefits come from information reported through the cost and wage survey, we use data from Medical Expenditure Panel Survey (MEPS) for determining a take-up rate and monthly premium assumption for health insurance.

Calculating each ERE component as a percentage of the annual wage assumption for DSPs, or $31,824 per year, yielded a competitive fringe benefit package of **32.3 percent** of wages as outlined in Table 16.

Table 16: Components of ERE for a Direct Support Professional

Component	Value / Calculation	
Annual Wage	$31,824 ($15.30 x 2080 hours)	
FUTA	0.60% of up to $7,000	$42 (0.12%)
SUTA	1.12% of up to $35,300	$356 (1.12%)
FICA	7.65% of up to $118,500	$2,435 (7.65%)
Workers' Compensation	2.96%	$942 (2.96%)
Legally Required Benefits	**-**	**$3,775 (11.9%)**
Daily Wage	$15.30 x 8 hours	$122.40

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Component	Value / Calculation	
Part-Time Adjustment Factor	72.22%	
Paid Time Off	28 days	
Paid Time Off	**$122.40 x 72.22% x 28 days**	**$2,475 (7.8%)**
Part-Time Adjustment Factor	72.22%	
Insurance Take-up Rate	53% – 83%	
Retirement	4.43%	$348 (1.1%)
Health Ins.	$712/mo.	$3,398 (10.7%)
Dental Ins.	$335/yr.	$133 (0.4%)
Vision Ins.	$107/yr.	$41 (0.1%)
Other Benefits	$200/yr.	$120 (0.4%)
Other Benefits	**-**	**$4,040 (12.7%)**
Total ERE per DSP	**Legally Required Benefits + Paid Time Off + Other Benefits**	**$10,289 (32.3% of Annual Wage Assumption)**

Providers who participate in the Healthcare for Healthcare Workers program reported considerably higher benefit costs related to health insurance. Our benefit assumptions are not designed to meet participation criteria for this program or replace the additional funding received through participation.

Under the employment structure for many provider organizations, DSPs represent baseline staff. However, as wages rise, costs of contributing to certain legally required benefits and other benefits do not necessarily become more expensive. As wages increase, the proportion of ERE to wages decreases; therefore, we developed individual ERE percentages based on job type.

As an example of how the ERE percentage decreases with a higher wage within Table 17 we display the numbers for the following job types:

- Direct Support Professional
- Direct Support Supervisor
- Licensed Clinical Professional Counselor
- Registered Nurse
- Executive Director / Assistant Director

Similarly, the ERE percentage was calculated for other job types utilizing the benchmark hourly

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wages.

Table 17: Examples of Employee-Related Expenses across Job Types

Component	Direct Support Professional	Direct Support Supervisor	Licensed Clinical Professional Counselor (LCPC)	Registered Nurse (RN)	Executive Director/ Assistant Director
Hourly Wage	$15.30	$22.21	$27.11	$33.88	$42.47
Annual Wages – FY2022	$31,824	$46,197	$56,389	$70,470	$88,338
Legally Required Benefits	$3,774 (11.9%)	$5,338 (11.6%)	$6,419 (11.4%)	$7,913 (11.2%)	$9,808 (11.1%)
Paid Time Off Benefits	$2,475 (7.8%)	$3,593 (7.8%)	$4,386 (7.8%)	$5,481 (7.8%)	$6,870 (7.8%)
Other Benefits	$4,040 (12.7%)	$4,197 (9.1%)	$4,309 (7.6%)	$4,463 (6.3%)	$4,658 (5.3%)
Total ERE per DSP	**$10,289 (32.3%)**	**$13,128 (28.4%)**	**$15,113 (26.8%)**	**$17,856 (25.3%)**	**$21,336 (24.2%)**
Hourly Wage with ERE	**$20.25**	**$28.52**	**$34.38**	**$42.46**	**$52.73**

B.5.2.3. Productivity of Direct Care Staff

While direct care staff can only bill for the time during which they are delivering services, they perform other tasks as part of their workday. Productivity factors account for this “non-billable” time, like travel time to a member’s home to deliver services or time spent keeping records or in training, by upwardly adjusting compensation (wages and ERE) to cover the full workday.

Consider a simple example to illustrate this process:

> A direct care staff person is paid $16 per hour and works an 8-hour day. The cost to the agency for the day is $128 ($16 * 8 hours). However, if half of the staff member’s 8-hour day (4 hours) was spent on activities that are non-billable, the agency would only be able to bill for 4 hours of the staff member’s time. Therefore, a productivity adjustment would have to be made to allow the agency to recoup the full $128 for the staff cost. The adjusted wage rate per billable hour would need to be $32 in this example. This means the productivity adjustment needs to be 2.0.

While this is an exaggerated example (a typical productivity adjustment is around 1.4 for many of the services in scope for this study), it demonstrates the importance of including a productivity factor to fully reimburse for direct support time.

Provider organizations reported the average number of billable hours (out of an assumed 8-hour workday) through the cost and wage survey, which then translated into a productivity factor for staff delivering each service. For example, for Day Services, providers reported an average of 6.04 billable hours per each direct care staff member’s 8-hour day, meaning 75.5 percent of their day is typically spent on client-facing, billable activities. Dividing 8 by 6.04 (or equivalent, 1 divided by 75.5 percent or .755) yields a productivity adjustment of 1.32, which is then multiplied by ERE-adjusted wages to get productivity-adjusted compensation.

B.5.2.4. Occupancy and Absences

For some services, such as day programs, an “occupancy rate” is used to further adjust the cost

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assumptions behind the rate. These adjustments are made for many of the same reasons as staff time is adjusted for "productivity". Namely, if provider costs are divided over all billable units, the rate must account for the fact that not all time which is hypothetically billable when determining the rate can actually be billed by providers. Program absences or unoccupied days occur for a variety of reasons including non-attendance to a day program due to sickness, absences from a residence due to clients visiting their families, or short vacancies in a home before a new resident replaces a former resident. In order to cover a provider's incurred costs across the year, rates will typically include some combination of an occupancy factor and/or retainer days policy (also known as a "bed hold") to allow reimbursement otherwise lost to absences. A retainer days policy addresses this issue by allowing providers to bill under a limited number of days and conditions even when the service was not provided. Conversely, with an occupancy adjustment approach, providers are allowed to bill only when the service is actually provided. However, an occupancy adjustment is added to the rate models to build in the anticipated amount of average lost annual revenue due to bed absences. So long as vacancies or absences are reasonably low and reflect efficient operations, a rate So long as vacancies or absences are reasonably low and reflect efficient operations, a rate that includes an occupancy factor is more responsive to the actual relationship between provider revenue and costs.

B.5.2.5. Supervision

While direct care staff deliver services, other staff are often present to supervise, usually multiple staff at one time. Wages for supervisors are often higher, but proportionate, to the wages of the direct care staff they supervise and are therefore included in independent rate models as a separate component or add-on to the primary staff wage. The supervision cost component captures the cost of supervising direct care staff. It should be noted that supervision costs are distinct from administrative costs related to higher-level management of personnel. Supervision is time spent in direct oversight of and assistance with care provision and is frequently conducted by staff who are themselves providing direct care as a part of their role.

The cost and wage survey includes questions regarding the number of direct care staff supervised by one supervisor and the total number of hours a supervisor spends, on average, directly supervising staff; for most service groups, the average number of staff supervised by one supervisor ranged from two to five, except for community-based services for which the supervisor "span of control" was higher. For example, for Day Services the supervisor span of control was 4.9 staff to one supervisor, on average. Developing this add-on accounts for the costs of employing supervisors to help assure appropriate delivery of services.

B.5.2.6. Staffing Ratios

Just as one supervisor may oversee the work of multiple direct care staff simultaneously, one DSP may deliver a service to multiple clients simultaneously. As services are reimbursed per-client, this means the costs associated with direct service can be split across multiple units of service in cases when the ratio of staff to clients ("staffing ratio") is more than one-to-one.

Staffing needs of each service typically vary and require examination to assign the appropriate staff wage rate assumptions. The cost and wage survey asks for the average staffing ratios of each service, and analysis of survey results across provider organizations as well as careful readings of service definitions informed assumptions of staffing ratios. And while some services genuinely call for individualized or 1:1 (meaning one staff member to one client) staffing ratios,

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many allow for appropriate delivery of services to small groups, ranging from two to five clients per staff member, on average.

B.5.2.7. Administrative Expenses

Administrative expenses reflect costs associated with operating a provider organization, such as costs for administrative employees' salaries and wages along with non-payroll administration expenses, such as licenses, property taxes, liability and other insurance. Rate models typically add a component for administrative expenses so as to spread costs across the reimbursements for all services an organization may deliver; our recommended rates reflect this methodology by establishing a percentage add-on for each service rate.

To determine an administrative add-on, Guidehouse calculated the ratio of administrative costs to direct care wages and benefits by summing administrative costs reported in the cost and wage survey, then dividing by total direct care wages and benefits inflated according to new wage and fringe assumptions for DSPs and other direct care workers for the time period captured in the survey.[6] Administrative costs include several categories:

- ***Payroll Administrative Expenses:*** *Employees and contracted employees who perform administrative activities or maintenance activities earn salaries and benefits, which count toward payroll expenses in the calculation of total administrative costs.*
- ***Non-Payroll Administrative Expenses:*** *Costs including office equipment and overheard comprise non-payroll administrative expenses, net of bad debt and costs related to advertising or marketing.*
- ***Facility and Utilities for Administrative Use:*** *Rent, mortgage, and depreciation for administrative space factors into total administrative costs, as do utilities and telecommunication expenses relating to administrative use.*

Direct care costs include the salaries, wages, taxes. and benefits for direct care employees. After dividing administrative costs by direct care costs for each provider, Guidehouse calculated an average and median ratio of 20.8 percent and 22.1 percent, respectively. Our recommended rate models incorporate the higher ratio of 22.1 percent, which adds a dollar amount to a unit rate by multiplying the rate components of productivity-adjusted direct care staff and supervisor compensation by the median administrative percentage.

B.5.2.8. Program Support Expenses

Program support expenses reflect costs associated with delivering services, but which are not related to either direct care or administration, but still have an impact on the quality of care. These costs are specific to the program but are not billable, and may include:

- **Program Support Wages and Direct Care-Related Costs**: Employees and contracted employees who perform program support activities earn salaries and benefits, which count toward direct care-related expenses in the calculation of total program support costs. These may also include costs for staff training and development, activities costs,

[6] The calculation to determine median and average administrative expense ratios excluded providers that did not report administrative or direct care costs or reported costs such the ratio of administrative costs to direct care costs was above 40 percent.

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and expenses for devices and technology, all of which are related to the quality of care but not specifically billable.

- **Supplies**: This includes the costs of program supplies used by client in, for example, day programs.
- **Client Transportation**: When client transportation is "bundled" into a service, this means the service definition includes transportation of the client to and from the location of service delivery. These costs may include costs relating to actually transporting the client (e.g., mileage); vehicle licensing, acquisition, registration, leasing, and insurance; vehicle maintenance and repair; and vehicle depreciation.
- **Staff Transportation**: Staff transportation is not reimbursed in the same manner as client transportation, which may be bundled into a specific service or its own standalone service (e.g., Non-Medical Transportation). To incorporate reimbursement for staff transportation into a service rate, Guidehouse developed assumptions of the miles traveled by staff using the reported travel time from the cost and wage survey. Distances traveled per week were averaged across comparable services and reconciled to reported time spent traveling between client sites. This assumption could vary from service to service, so we leaned on the survey reported mileage heavily to understand the total time spent traveling between client sites to determine the average number of miles traveled. The Internal Revenue Service (IRS) standard mileage reimbursement for 2022 is 58.5 cents, which we then multiplied by the estimated distances traveled for certain services to arrive at a service-specific staff transportation add-on.[7]
- **Building and Equipment**: When services are delivered in a facility, certain costs for the direct care facility may be included such as: utilities and telecommunications; building maintenance and repairs; facility janitorial, landscaping, and other costs not part of rent; and non-administrative equipment costs and depreciation.

Similar to the calculation for administrative costs, the program support percentage is calculated based on cost data reported in the provider survey. Program support costs reported by providers were calculated in relation to direct care costs reported in the provider survey. The largest components of this add-on are program support wages and direct care-related costs, which comprise 7.7 percent of the direct care costs, and building and equipment costs at 7.3 percent of direct care costs. Supplies accounted for 1.9 percent and client transportation accounted for an additional 3 percent. The combination of these 4 program support numbers, Guidehouse arrived at an overall program support add-on of 19.9 percent, however this depends on the service – a service which does not include transportation would not include the transportation component just as a service which is delivered in the member's home would not include the building and equipment component.

B.5.2.9. Self-Directed Service Adjustments

Self-directed waiver services give participants utilizing waiver services more choice and flexibility in managing their waiver services and individual budgets. Self-direction allows the person maximum control over his or her HCBS including the amount, duration, and scope of

[7] IRS Standard Mileage Rates for 2022. Available online: https://www.irs.gov/newsroom/irs-issues-standard-mileage-rates-for-2022

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services and supports, as well as choice of providers, which may include family or friends. Self-direction of services requires more responsibility and greater expectations of the participants in services and their designated representatives. The fiscal management service assists with the financial and administrative oversight of being a self-direction employer. Participants can also hire a Support Broker to assist with service management. The individual, and their designated representative(s) are responsible for all aspects of hiring, training, and managing of staff. They must also oversee individual goals documentation of service delivery, timekeeping, and payroll.

Montana's authority for its self-direction program comes from its Medicaid 1915(c) Home and Community-Based Waiver for Individuals with Developmental Disabilities, which is designed to provide participants with developmental disabilities a choice of receiving services in a community setting. This waiver is currently serving 2,880 participants with developmental disabilities as of August 2021.

The 2018-2019 report included 47,598 unduplicated claim entries totaling $3,516,836.47 and 258,277 hours of service utilization. The 2021 data included 14,143 unduplicated claim entries totaling $1,914,346.84 and 75,561 hours of service utilization. See Tables 18 and 19 for a summary of utilization.

Table 18: 2018-2019 Fiscal Management Service Provider Data for Employer-Authority Self-Direction Participants in the Home and Community-Based Waiver for Individuals with Developmental Disabilities

Service	Hours Recorded	Total Aggregate Wages	Average Pay per Hour	Percent of Total Hours	Percent of Total Spending	Total Staff	Total Clients	Staff per Client
Respite Services	142,838	$1,688,703	$11.82	55.3%	48.0%	257	159	1.6
Follow Along Support	537	$16,891	$31.46	0.2%	0.5%	1	1	1.0
Personal Supports Services	113,455	$1,785,294	$15.74	43.9%	50.8%	162	85	1.9
Co-Worker Support Flat Day Rate	0	$0	$0	0.0%	0.0%	0	0	0.0
Supports Broker Services	127	$3,106	$24.42	0.0%	0.1%	3	3	1.0
Individual Employment Support	1,320	$22,843	$17.30	0.5%	0.6%	6	3	2.0

Table 19: 2021 Fiscal Management Service Provider Data for Employer-Authority Self-Direction Participants in the Home and Community-Based Waiver for Individuals with

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Developmental Disabilities

Service	Hours Recorded	Total Aggregate Wages	Average Pay per Hour	Percent of Total Hours	Percent of Total Spending	Total Employees	Total Clients	Employees per Client
Respite Services	40,940	$532,300	$13.00	54.2%	27.8%	168	128	1.3
Follow Along Support	257	$8,683	$33.79	0.3%	0.5%	2	4	0.5
Personal Supports Services	34,363	$598,254	$17.41	45.5%	31.3%	132	90	1.5
Co-Worker Support Flat Day Rate	0	$0	$0	0.0%	0.0%	0	0	0.0
Supports Broker Services	1	$23	$23.00	0.0%	0.0%	1	1	1.0
Individual Employment Support	0	$0	$0	0.0%	0.0%	0	0	0.0
Other	0	$775,087	$0	0.0%	40.5%	330	0	0.0

Table 20 through Table 23 list results of the Comprehensive waiver survey of self-direction employers. Questions in the self-direction survey asked self-direction employers about four areas including uncompensated administrative costs, uncompensated program support costs, uncompensated benefits, and services utilized within the waiver associated with the self-direction employer-authority model of service delivery. In Table 20 through Table 23, the percentages in 'Yes' and 'No' responses in section indicate the percentage of self-direction employers who indicated whether or not they have experienced uncompensated costs.

Table 20: Uncompensated Administrative Costs Self-Direction Survey Results

Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Office Supplies and Services (e.g., office supplies / postage / shipping / printing)	36%	64%
Dues, Memberships and Subscriptions	29%	71%
Advertising	21%	79%
Other Administrative Expenses (e.g., meeting expenses, etc.)	15%	85%
Bank Service Charges / Fee / Interest	14%	86%

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Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Information Technology Expenses	8%	92%
Fundraising Activities	8%	92%
Legal and professional services	0%	100%
Training	0%	100%

Table 21: Uncompensated Program Support Costs Self-Direction Survey Results

Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Personal Protective Equipment (e.g., general use)	31%	69%
Personal Protective Equipment (e.g., pandemic related)	31%	69%
Rental Property	14%	86%
Utilities	14%	86%
Maintenance/ Repairs	8%	92%
Depreciation/Amortization	0%	100%

Table 22: Uncompensated Benefits Self-Direction Survey Results

Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Employee Wages	62%	38%
Worker's Compensation	38%	62%

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Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Staff Fringe Benefits	23%	77%
Bonuses/ Retention Costs	17%	83%
Covid-19 related expenses	15%	85%
Health Insurance	0%	100%
Vision Insurance	0%	100%
Dental Insurance	0%	100%
Life insurance (Term/whole)	0%	100%
Short-term Disability	0%	100%
Long-term Disability	0%	100%
Other Staff/ Employee Insurance	0%	100%
Retirement	0%	100%

Table 23: Comprehensive Waiver Self-Direction Services Used in the Last 12 to 18 Months from Self-Direction Employer Survey Results

Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Personal Supports	77%	23%
Transportation	69%	31%
Respite	64%	36%
Supported Employment - Follow Along Support	23%	77%
Supported Employment - Individual Employment Support	23%	77%
Supported Employment - Co-Worker Support	15%	85%

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Expense Type	Percentage of Self-Direction Employers Indicated Experiencing Uncompensated Costs in Survey Responses	
	Yes	No
Personal Emergency Response System (PERS)	8%	92%
Supports Brokerage	0%	100%

As a part of the larger rate study, Guidehouse used the data collected from the self-directed program's fiscal administrator and the self-directed survey responses on uncompensated costs to determine where there are gaps between reported and accrued expenses within the self-direction program. Further, the analysis allowed us to identify trends in spending by comparing the 2019 and 2021 fiscal administrator data and identifying the potential impacts of COVID, including supplemental payments made to providers. Guidehouse found from our survey results that within the employer-authority, self-direction model there is currently an unmet need to improve and/or enhance the training of employees hired to deliver services through the employer-authority model. Guidehouse was also able to identify the following additional key trends and themes:

- The most commonly uncompensated expenses reported incurred by those self-directing their services included office supplies, COVID and Personal Protective Equipment (PPE), and internet service for administrative duties as a self-direction employer.
- Through the qualitative response portion in our self-direction survey, respondents indicated they would like to "*Continue to provide training resources*," "*…would like to pay [their employees] more per hour*," and "*…would like to hire more workers.*"
- Personal Supports Services and Respite Services made up the majority of total recorded service hours in both 2018 and 2021 at a combined 99.2 percent and 99.7 percent of total hours, respectively. Those services were also reported as the most reported utilized services in our survey data.
- All other services showed a decrease in proportion of hours between the 2018 and 2021 fiscal administrator data, with individual employment supports not recorded in 2021. Further, 69 percent of survey respondents recorded transportation service utilization and it did not appear in the analysis of fiscal administrator data.
- The inclusion of "Other" payments in the 2021 data skewed the proportion of expenditures for all services, representing 40.5 percent of total expenditures. It was reported by DD these are likely attributed to supplemental payments to providers as a result of additional COVID funding, but Guidehouse was unable to obtain confirmation from DD or the fiscal administrator.
- Average wages increased between 2019 and 2021 for almost all reported services.
- There is a significant discrepancy between self-directing survey respondents that accrued transportation expenditures compared to what is recorded in the fiscal administrator data, which was $0 in both claims data reports.

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In terms of rate development, this data also served as the basis for estimating cost differences between agency-based and self-directed services when analyzing in-home service rates with established rate differentials in the current fee schedule. We determined the main basis for a rate differential lies in the relative administrative costs of the two types of service delivery. Guidehouse found self-directed services typically incur only 20% of the administrative costs observed in agency-based services. Although the self-directed service survey showed self-directed staff lack many of the benefit costs associated with agency-based staff, in the interest of providing comparable direct care resources for both versions of the service, rate models for self-directed services included benefit assumptions equivalent to these cost components for agency rates. For those SLTC in-home services in which Guidehouse developed a rate differential for self-directed services, the lower rate reflects significantly reduced administrative and supervisory cost assumptions, while applying the same direct care and program support cost assumptions across both service modalities.

B.5.3. Non-Residential Service Methodologies

Guidehouse organized all services across all divisions and programs into a common set of service categories to review and evaluate the diverse array of services. These service categories were developed to group similar services together in the provider cost and wage survey to support efficient and standardized reporting that would support the rate development process, as well as to identify similar service designs and rate model structures for closely related services. However, the rate development process also considered the distinct specifications and nuances of complex services that demonstrated differences from other services within a service category. Figure 7 captures the 10 service categories included in the rate study.

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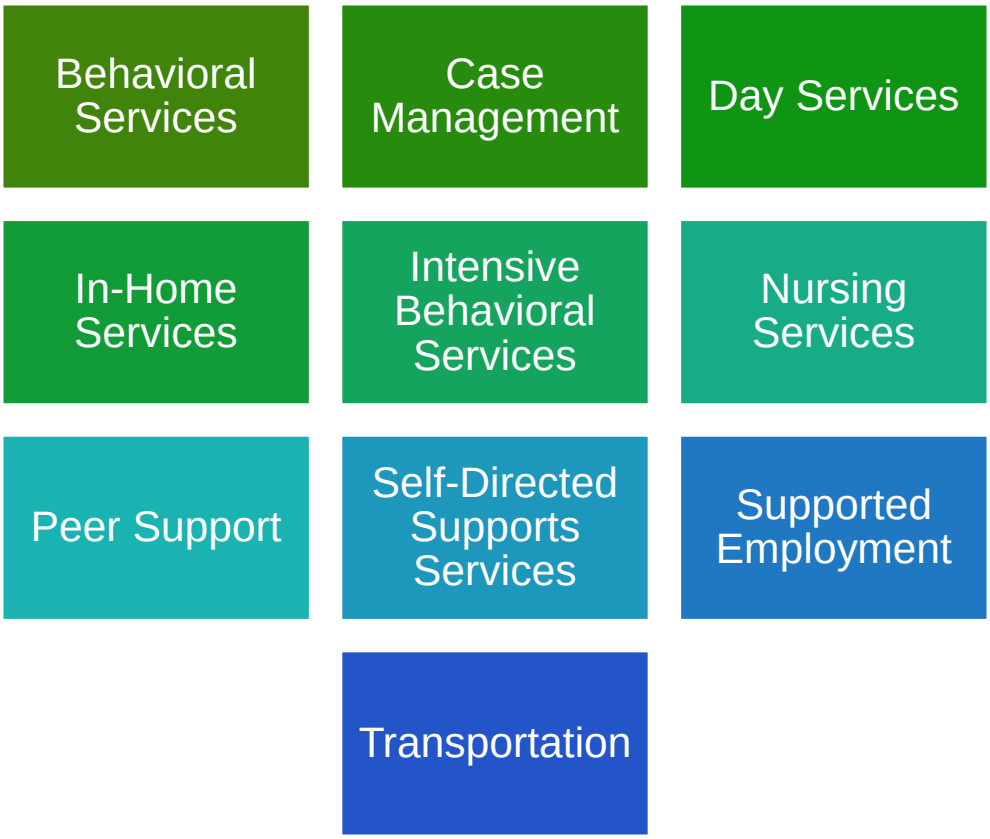
Figure 7: Non-Residential Service Array



B.5.3.1. In-Home Services

The In-Home Services category represents services that take place in a home-based setting. The following cost component factors were considered for these services: productivity (billable vs. non-billable time), staff transportation, additional supplies, and supervisory time. We relied on the provider cost and wage survey results to provide differentiation between the services and well as the specific staff types that perform these services. The following services are included in the In-Home Services category:

- Caregiver Training and Support (DD)
- Companion (DD)
- Community Supports Services (SLTC - CFC/PAS)
- Community Supports Services (SLTC - CFC/PAS) - U9
- Community Supports Services (SLTC)
- Family Training and Support (SLTC)
- Homemaker (DD)
- Homemaker (SLTC)
- Homemaker Chores (SLTC)
- Homemaker Chores (ABH)
- Home Health Aide (SLTC)
- Home Support Services Frontier Differential (CMH)
- Home Support Services (CMH)
- Medical Escort (SLTC - CFC/PAS)
- Medical Escort (SLTC - CFC/PAS)-U9
- Personal Assistance Attendant (ABH)
- Personal Assistance Attendant - Agency-Based (SLTC)
- Personal Assistance Services (SLTC - CFC/PAS)
- Personal Care (DD)
- Personal Assistance Attendant - Self-Directed (ABH)
- Personal Assistance Attendant - Self-Directed (SLTC)

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- Self-Directed Personal Assistance Services (SLTC - CFC/PAS)
- Personal Assistance Oversight - Self-Directed (SLTC)
- Personal Assistance Oversight - Self-Directed (ABH)
- Personal Supports (DD)
- Personal Assistance Nurse Supervision - Agency-Based (SLTC)
- Personal Assistance Attendant - Per Day (SLTC)
- Non-Medicaid Respite Care - Youth (CMH)
- Nutrition Classes, Nutritionist (SLTC)
- Nutritional Counseling, Dietician (SLTC)
- Nutritionist Services - Medicaid State Plan (DD)
- Respite (DD)
- Respite Care (SLTC)
- Respite Care (ABH)
- Respite Care - Assisted Living (ABH)
- Respite Care - Assisted Living and Adult Foster Care (SLTC)
- Senior Companion (SLTC)
- Specially Trained Attendant (SLTC)
- Specially Trained Attendant (SLTC - CFC/PAS)
- Specially Trained Attendant - U9 (SLTC - CFC/PAS)
- Special Child Care for Children (SLTC)

Standardization: Rate models and rates were made to ensure rate equity for services that have the same service design and are provided within multiple programs. In particular, when determining the personal assistance rates, a consistent rate of $7.35 for the self-directed version and $8.92 for the agency-based version was developed. However, these rates vary across the programs in the current rate structure. Respite is another example of service rates and rate models that were standardized. Table 24 below includes benchmark rates for the Respite services – the services have different units of measurement; however, all the rates start with the baseline of $6.02 per 15 minutes.

Service Team: Even though the provider cost and wage survey results were primarily used for individual rate model inputs, documentation in the provider manuals and feedback from the Rate Workgroups on the general structure of services also informed the rate setting process. In the instance of the Home Supports service, the models most often incorporated a team structure of a Behavioral Specialist/Technician and Licensed Clinical Social Worker (LCSW). On the other hand, the remaining in-home services all included a single practitioner.

Rate Components: As referenced in the previous section, we used the provider cost and wage survey to determine individual inputs based on service. When the survey provided robust individual service components, we utilized the information provided however we also created averages for the components to be able to build in additional standardization and consistency. The rate components obtained through this approach included wages, productivity, supervision span of control, program support, administrative support, and staff mileage. For example, although all respites services within the Respite category included the basic rate component elements including wages, productivity, supervision, administration, and program support, the variability in this rate in comparison to the other 1:1 service delivery model is in the high productivity, lower wages, and removal of staff transportation and program support for program staff salaries and wages to account for any additional supplies. See Table 24.

Table 24: In-Home Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
DD	Caregiver Training & Support	$56.08	$59.08	Hour
SLTC	Community Supports Services	$5.84	$9.52	15 min
SLTC	Community Supports Services- Self Directed	$4.63	$7.90	15 min
SLTC	Community Supports Services	$5.80	$9.52	15 min

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Program	Service	Current Rate	Benchmark Rate	Unit
DD	Companion	$23.10	$36.48	Hour
SLTC	Family Training & Support	$8.76	$11.98	15 min
CMH	Home Support Services	$18.69	$29.98	15 min
CMH	Home Support Services Frontier Differential*	$21.49	$32.23	15 min
DD	Homemaker	$21.92	$30.43	Hour
SLTC	Homemaker	$4.53	$7.61	15 min
ABH	Homemaker Chores	$259.47	$331.04	Per Diem
SLTC	Homemaker Chores	$257.67	$331.04	Unit
SLTC	Home Health Aid	$35.17	$40.86	Visit
SLTC	Medical Escort	$5.84	$9.60	15 min
SLTC	Medical Escort- Self Directed	$4.63	$8.03	15 min
ABH	Nutrition (Meals)	$5.88	$8.97	Meal
SLTC	Nutrition (Meals)	$5.84	$8.97	Meal
DD	Nutritionist Services (Medicaid State Plan)	$92.08	$74.92	Hour
ABH	Personal Assistance Attendant	$5.88	$8.92	15 min
SLTC	Personal Assistance Attendant - Agency-Based	$5.51	$8.92	15 min
SLTC	Personal Assistance Attendant – Self Directed	$4.59	$7.35	15 min
SLTC	Personal Assistance Attendant - Agency-Based	$5.51	$8.92	15 min
SLTC	Personal Assistance Attendant - Self-Directed	$4.49	$7.35	15 min
ABH	Personal Assistance Attendant - Self-Directed	$4.67	$7.35	15 min
SLTC	Personal Assistance Nurse Supervision – Agency Based	$5.51	$9.10	15 min
SLTC	Personal Assistance Oversight - Self-Directed	$4.49	$7.35	15 min
SLTC	Personal Assistance Services - 15 minutes	$5.84	$8.92	15 min
DD	Personal Care	$23.10	$35.68	Hour
CMH	Non-Medicaid Respite Care – Youth	$2.76	$4.06	15 min
DD	Respite	$17.96	$24.08	Hour
DD	Respite - (Both Self Direct Options)	$17.96	$24.08	Hour
ABH	Respite Care	$4.57	$6.02	15 min
SLTC	Respite Care	$4.53	$6.02	15 min
ABH	Respite Care - Assisted Living	$177.73	$192.64	Day
SLTC	Respite Care - Assisted Living & Adult Foster Care	$176.50	$192.64	Day
DD	Personal Supports (both self-direct options)	$23.10	$29.40	Hour
SLTC	Self-Directed Personal Assistance Services - 15 minutes	$4.63	$7.35	15 min
SLTC	Senior Companion	$1.38	$1.94	15 min
SLTC	Special Child Care for Children	$5.81	$6.70	15 min
SLTC	Specially Trained Attendant	$5.84	$8.92	15 min
SLTC	Specially Trained Attendant	$5.80	$8.92	15 min
SLTC	Specially Trained Attendant – Self Directed	$4.63	$7.35	15 min
SLTC	Specially Trained Attendant - LPN	$9.23	$15.40	15 min
SLTC	Specially Trained Attendant - RN	$11.62	$21.22	15 min

B.5.3.2. Case Management

The Case Management service category encompasses all case management, targeted case management, as well as care coordination services. The current structures for case management services vary substantially across programs. Although Guidehouse did not

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standardize these services and service rates, we are recommending a more robust and detailed program evaluation to build consistency across the programs as outlined further in Section B.8. We have included the targeted case management services for Children and Youth with Special Health Care Needs, High-Risk Pregnant Women- Services provided by the Nutritionist, High-Risk Pregnant Women - Services provided by the Nurse, and High-Risk Pregnant Women - Services provided by the Social Worker even though these services are provided within other programs.

The following services are included in the Case Management service category:

- Care Coordination (ABH)
- Case Management (ABH)
- Case Management (SLTC)
- Case Management plus Supported Living Coordination (SLTC)
- Targeted Case Management for Children and Youth with Special Health Care Needs (TCM-OTHER)
- Targeted Case Management for High-Risk Pregnant Women - Services provided by the Nurse (TCM-OTHER)
- Targeted Case Management for High-Risk Pregnant Women - Services provided by the Nutritionist (TCM-OTHER)
- Targeted Case Management for High-Risk Pregnant Women - Services provided by the Social Worker (TCM-OTHER)
- Targeted Case Management -Adult (ABH)
- Targeted Case Management - Substance Use Disorders (ABH)
- Targeted Case Management - Youth (CMH)
- Targeted Case Management - Youth Frontier Differential (CMH)
- Targeted Case Management (DD)

Caseload: We asked for specific information within the provider cost and wage survey to understand the caseload for each individual service. This value had a widespread range from 20 to 50 members depending on the provider and program. These caseload numbers are the largest factor, in addition to wages, that dictate the variation in the benchmarked rates.

Unit of Measure: The current reimbursement structure across various models includes 15-minute, daily, as well as monthly rates. Therefore, the rate models are adjusted to calculate rates for appropriate reimbursement units.

Service Team: While all Case Management services include a standard case manager as the primary provider, the Case Management (ABH) and Case Management (SLTC) services both include additional registered nursing support. Similarly, the Case Management plus Supported Living Coordination (SLTC) service accounts for additional Service Coordinator time to work within the supported living environment. See Table 25.

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Table 25: Case Management Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Care Coordination	$13.47	$14.09	15 min
ABH	Case Management	$12.92	$14.70	Day
SLTC	Case Management	$11.35	$11.45	Day
SLTC	Case Management	$16.08	$16.17	15 min
SLTC	Case Management plus Supported Living Coordination	$19.08	$25.81	Day
DD	Targeted Case Management – Developmental Disabilities	$137.38	$141.03	Month
Other	Targeted Case Management for Children and Youth with Special Health Care Needs	$7.09	$7.30	15 min
Other	Targeted Case Management for High-Risk Pregnant Women - Services provided by the Nurse (TCM-OTHER)	$7.09	$8.03	15 min
Other	Targeted Case Management for High-Risk Pregnant Women - Services provided by the Nutritionist (TCM-OTHER)	$7.09	$8.43	15 min
Other	Targeted Case Management for High-Risk Pregnant Women - Services provided by the Social Worker (TCM-OTHER)	$7.09	$8.49	15 min
ABH	Targeted Case Management-Adult Mental Health	$13.70	$16.17	15 min
ABH	Targeted Case Management-Substance Use Disorders	$13.70	$16.06	15 min
CMH	Targeted Case Management-Youth Mental Health	$16.35	$16.17	15 min
CMH	Targeted Case Management-Youth Mental Health Frontier Differential*	$18.80	$17.38	15 min

B.5.3.3. Day Services

The Day Service category has services that take place in a facility-based setting which provides a place outside the home during the day for members with all types of disabilities to be active in the community, socialize with their peers, and receive necessary health and personal care services. Day Services includes the following:

- Adult Day Care (SLTC)
- Adult Day Care (ABH)
- Day Habilitation (SLTC)
- Day Supports and Activities (DD)
- Day Supports Tier Basis (DD)
- Day Treatment - Adult Half Day (ABH)
- Retirement Services (DD)
- Youth Day Treatment (CMH)

Program Support: Day Services include the full program support rate of 19 percent including allocations for supplies, client transportation, as well as building and equipment costs due to the

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extent and nature of the support require for these services taking place in a facility instead of a member's home.

Staffing Ratios: Unlike many of the in-home services that are usually a 1:1 staffing ratio, the day services have group settings that account for more than one client being served at the same time by a single staff member. There was wide variability in the staffing ratios reported within the provider cost and wage survey, so the staffing ratios vary for the individual services. Table 26 captures staffing patterns built into the Day Service rate models.

Table 26: Day Service Staffing Patterns

Service	Staffing Ratio
Adult Day Care (SLTC) Adult Day Care (ABH) Day Habilitation (SLTC) Day Treatment - Adult Half Day (ABH)	Average staffing ratio: 3.7 clients
Day Supports (DD) Retirement Services (DD)	1:1
Youth Day Treatment (CMH)	Provider manual recommended: 6 clients

Occupancy Adjustment: To account for clients that are unable to make their appointments we include an occupancy adjustment for most of the Day Services. This occupancy adjustment factor is 1.08 or 260 as a fraction of 240. This factor accounts for the 260 working business days within a calendar year a program could be open for billing, accepting up to 20 days of reasonable absences across the year.

Rate Components: All Day Services have the same direct care staff wages, supervision, productivity, administrative add-on, full program support costs, an additional occupancy adjustment factor, and the removal of the staff transportation. The wages are consistent between these services since primarily a Direct Support Professional (DSP) with a Direct Support Supervisor (DSS) provide these services. Youth Day Treatment and Day Treatment - Adult Half Day require Licensed Clinical Professional Counselor's (LCPC) to provide the direct care that result in increased rates due to the higher wage for this job type. Additionally, while most of the Day Services account for a productivity of around 75 percent based on provider survey results, the Youth Day Treatment has a slightly lower productivity of 63.4 percent that was confirmed with the Department since some of the children's services require more training time.

Tiered Rates: The number of tiers in the current tiering structure was retained as is for Day Supports and Activities as well as Retirement Services; however, the underlying assumptions related to wages, supervision, program support, and administrative add-ons were updated. A starting hourly rate was estimated based on the hourly cost of the provider's time, operating in continuous 1-to-1 interaction over the course of an 8-hour day, and then the portion of time required for each tier was applied. The percentage caps currently in effect for the various tier level were removed to support achieving rate equity among the tiers. At the same time, the rate models also assumed the average amount of daily hours for each tier should be used when setting tier cost instead of the maximum. Lastly, the time ranges specified for Tiers 1 and 2 were updated to align with the rest of the tiers more closely within each service.

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These updates resulted in roughly 17-24 percent for day supports tiers and 11-18 percent for retirement services tiers. Within the rate tiers for each service, variances in changes are due largely to different percentage caps applied to each of the current rates. Differences in retirement services and day supports increases are due to our assumption around lower program support costs for retirement services than day supports, while the current rate structure assumes approximately the same operations costs between the two service types. See Table 27.

Table 27: Day Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Adult Day Care	$2.28	$3.16	15 min
SLTC	Adult Day Care	$2.27	$3.16	15 min
SLTC	Day Habilitation	$82.58	$111.01	Day
DD	Day Supports and Activities Hourly (over 8 ave hrs/day)	$27.63	$33.10	Hour
DD	Day Supports and Activities Tier 1 (.1-.5 ave hrs/day)	$11.74	$14.07	Hour
DD	Day Supports and Activities Tier 2 (.5-1.0 ave hrs/day)	$24.04	$28.96	Hour
DD	Day Supports and Activities Tier 3 (1.01-1.25 ave hrs/day)	$30.22	$37.24	Hour
DD	Day Supports and Activities Tier 4 (1.26-1.75 ave hrs/day)	$42.31	$49.65	Hour
DD	Day Supports and Activities Tier 5 (1.76-2.25 ave hrs/day)	$54.71	$66.20	Hour
DD	Day Supports and Activities Tier 6 (2.26-2.75 ave hrs/day)	$66.86	$82.75	Hour
DD	Day Supports and Activities Tier 7 (2.76-3.25 ave hrs/day)	$79.47	$99.30	Hour
DD	Day Supports and Activities Tier 8 (3.26-4.0 ave hrs/day)	$97.81	$119.99	Hour
DD	Day Supports and Activities Tier 9 (4.01-4.75 ave hrs/day)	$116.81	$144.81	Hour
DD	Day Supports and Activities Tier 10 (4.76-5.5 ave hrs/day)	$136.77	$169.64	Hour
DD	Day Supports and Activities Tier 11 (5.51-6.25 ave hrs/day)	$157.15	$194.46	Hour
DD	Day Supports and Activities Tier 12 (6.26-6.99 ave hrs/day)	$177.68	$219.29	Hour
DD	Day Supports and Activities Tier 13 (7.0-7.99 ave hrs/day)	$204.21	$248.25	Hour
ABH	Day treatment –Adult Half Day	$13.91	$21.33	Hour
DD	Retirement Services Hourly (over 8 ave hours per day)	$27.63	$31.40	Hour
DD	Retirement Services Tier 1 (.1-.5 ave hrs/day)	$11.74	$13.35	Hour
DD	Retirement Services Tier 2 (.5-1.0 ave hrs/day)	$24.04	$27.48	Hour
DD	Retirement Services Tier 3 (1.01-1.25 ave hrs/day)	$30.22	$35.33	Hour
DD	Retirement Services Tier 4 (1.26-1.75 ave hrs/day)	$42.31	$47.10	Hour
DD	Retirement Services Tier 5 (1.76-2.25 ave hrs/day)	$54.71	$62.80	Hour
DD	Retirement Services Tier 6 (2.26-2.75 ave hrs/day)	$66.86	$78.50	Hour
DD	Retirement Services Tier 7 (2.76-3.25 ave hrs/day)	$79.47	$94.20	Hour
DD	Retirement Services Tier 8 (3.26-4.0 ave hrs/day)	$97.81	$113.83	Hour
DD	Retirement Services Tier 9 (4.01-4.75 ave hrs/day)	$116.81	$137.38	Hour
DD	Retirement Services Tier 10 (4.76-5.5 ave hrs/day)	$136.77	$160.93	Hour
DD	Retirement Services Tier 11 (5.51-6.25 ave hrs/day)	$157.15	$184.48	Hour

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Program	Service	Current Rate	Benchmark Rate	Unit
DD	Retirement Services Tier 12 (6.26-6.99 ave hrs/day)	$177.68	$208.03	Hour
DD	Retirement Services Tier 13 (7.0-7.99 ave hrs/day)	$204.21	$235.50	Hour
CMH	Youth Day Treatment	$11.71	$15.49	Hour

B.5.3.4. Supported Employment

The Supported Employment service category includes all supported employment services, prevocational services, and services that have a job coaching element to help members obtain or maintain paid employment or self-employment.

Supported Employment services reimbursed by DPHHS currently include:

- Life Coach (ABH)
- Prevocational Services (SLTC)
- Supported Employment (SLTC)
- Supported Employment (ABH)
- Supported Employment - Individual Employment Support (DD)
- Supported Employment Follow Along (DD)
- Supported Employment Small Group Hourly (DD)
- Supported Employment Small Group Tiers (DD)

Rate Components: The supported employment services had some variability in the core rate components. In discussion with the Rate Workgroups, members raised the concern of high staff mileage to travel between client sites due to the rural nature of Montana. Therefore, the provider cost and wage survey results were used to ensure this nuance was captured in the rate assumptions. Due to increased staff transportation, productivity was slightly lower for some services. This results in productivity percentages ranging from an average of 63.4 percent to around 75 percent.

The standard administration add-on of 22.1 percent was included as well as an additional 9.6 percent for program support to account for baseline program support with additional supplies. Prevocational Services is an exception and takes place in a group setting with five clients, therefore the program support was increased to 19.9 percent to account for the additional costs associated the place of service delivery.

Staff Transportation: As mentioned above, staff transportation was a key topic discussed with the Rate Workgroups since the rural nature of Montana could require some workers to travel long distances to reach their clients. Since a relatively small number of providers reported this information within the survey for individual services, we created an average cost across all services that amounted to a $2.89 dollar add-on to an hourly rate. For services reimbursed at 15-minute units, a fourth of the hourly add-on amount was included in the service rate.

Tier Rates: The tiering structure described in detail in Section B.5.3.3 for Day Services also applies to Supported Employment rates. The updated tier benchmark rates result in 36-45 percent increases for Supported Employment. These increases are larger than the Day Supports and Retirement services due the difference in wage benchmarks for job coaches over the DSP. See Table 28.

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Table 28: Employment Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Life Coach	$12.45	$12.75	15 min
SLTC	Prevocational Services	$8.04	$11.78	Hour
ABH	Supported Employment	$13.58	$14.37	15 min
SLTC	Supported Employment	$13.49	$14.37	15 min
DD	Supported Employment - Individual Employment Support	$40.48	$49.61	Hour
DD	Supported Employment - Individual Employment Support - both Self Direct options	$40.48	$49.61	Hour
DD	Supported Employment Follow Along	$40.48	$49.94	Hour
DD	Supported Employment Follow Along - both self direct options	$40.48	$49.94	Hour
DD	Supported Employment Small Group Hourly - AwC Self Direct	$27.63	$38.56	Hour
DD	Supported Employment Small Group Hourly (over 8 ave hours per day)	$27.63	$38.56	Hour
DD	Supported Employment Small Group Tier 1 (0-.5 ave hrs/day)	$11.74	$16.39	Daily
DD	Supported Employment Small Group Tier 2 (.5-1 ave hrs/day)	$24.04	$33.74	Daily
DD	Supported Employment Small Group Tier 3 (1.01-1.25 ave hrs/day)	$30.22	$43.38	Daily
DD	Supported Employment Small Group Tier 4 (1.26-1.75 ave hrs/day)	$42.31	$57.84	Daily
DD	Supported Employment Small Group Tier 5 (1.76-2.25 ave hrs/day)	$54.71	$77.12	Daily
DD	Supported Employment Small Group Tier 6 (2.26-2.75 ave hrs/day)	$66.86	$96.40	Daily
DD	Supported Employment Small Group Tier 7 (2.76-3.25 ave hrs/day)	$79.47	$115.68	Daily
DD	Supported Employment Small Group Tier 8 (3.26-4.0 ave hrs/day)	$97.81	$139.78	Daily
DD	Supported Employment Small Group Tier 9 (4.01-4.75 ave hrs/day)	$116.81	$168.70	Daily
DD	Supported Employment Small Group Tier 10 (4.76-5.5 ave hrs/day)	$136.77	$197.62	Daily
DD	Supported Employment Small Group Tier 11 (5.51-6.25 ave hrs/day)	$157.15	$226.54	Daily
DD	Supported Employment Small Group Tier 12 (6.26-6.99 ave hrs/day)	$177.68	$255.46	Daily
DD	Supported Employment Small Group Tier 13 (7.0-7.99 ave hrs/day)	$204.21	$289.20	Daily

B.5.3.5. Peer Supports

The Peer Supports category is for all services that have a certified peer support specialist as the primary provider of the service. The following services are included in this category:

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- Peer Support (Certified) – Group (ABH)
- Peer Support (Certified) – Individual (ABH)
- Peer Support (Certified) – Individual (ABH)
- Peer Support (Certified) – Individual (ABH)
- Peer Support (Certified) Co Occurring - Individual (ABH)
- Peer Support (Certified) Co Occurring – Individual (ABH)
- Peer Support (Certified) Co-Occurring – Individual (ABH)

Rate Components: These services include wages for a certified peer support specialist, supervision time, increased staffing ratio for the group setting, administration add-on, program support costs that include supplies and staff transportation. To keep the rates consistent, the models include components that are calculated as an average across all Peer Support service costs reported in provider cost and wage survey.

Supervision Hours: The rate models account for increased supervision time per week to oversee the individual Certified Peer Support Specialists, each service includes 10 hours per week of supervision time with the direction of the program based on previous legislation. See Table 29.

Table 29: Peer Support Services Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Peer Support (Certified) Group – (Up to eight members per group.)	$2.78	$3.14	15 min
ABH	Peer Support (Certified) Individual	$13.87	$16.06	15 min
ABH	Peer Support (Certified) Individual (co-occurring)	$13.87	$16.06	15 min

B.5.3.6. Behavioral Services

The Behavioral Services category includes services that support members in improving or maintaining mental or behavioral health. These services most often have the primary service provider as a Behavioral Specialist/Technician, LCPC, LCSW, Board Certified Assistant Behavior Analysts and Board-Certified Behavior Analyst. Behavioral Services include the following services:

- Behavioral Intervention Assistant (ABH)
- Behavioral Support Services (DD)
- Psychological Services (DD)
- Dialectical Behavior Therapy – Skill Development - Group (ABS)
- Dialectical Behavior Therapy – Skill Development – Individual (ABS)
- Extraordinary Needs Aide Services (ABH)
- Comprehensive School and Community Treatment (CMH)
- Consultative Clinic and Therapeutic Services (SLTC)
- Consultative Clinic and Therapeutic Services (ABH)
- Intensive Individual DBT Psychotherapy Services (ABS)
- Illness Management and Recovery – Group (ABS)
- Illness Management and Recovery – Individual (ABS)
- Community-Based Psychiatric Rehabilitation and Support - Group (CMH)
- Community-Based Psychiatric Rehabilitation and Support – Group (ABS)
- Community-Based Psychiatric Rehabilitation and Support – Individual (CMH)
- Community-Based Psychiatric Rehabilitation and Support – Individual (ABS)

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- Community-Based Psychiatric Rehabilitation and Support – Individual (Non-Medicaid-CSCI)

Job Types and Service Team: The provider cost and wage survey, as well the provider manuals and input from the Department were referenced to identify the expected staff type and level for each service.

Rate Components: There is wide variability in the rate components that are included for program support and staff transportation for these services. The productivity numbers are low relative to other service categories, ranging from about 63 percent to 70 percent for these services to account for the additional time required for charting for mental health services and the staff travel time. We also noticed differences in the staff transportation reported across the variety of services, in particular for the CBPRS services. The program support numbers vary due to where the service takes place and the level of program support required to administer the service. The program support numbers included for each service are reflected in Table 30 below.

Table 30: Program Support Percentages for Behavioral Services

Program	Service	Program Support Percentage	Program Support Categories Included
SLTC	Behavioral Intervention Assistant (ABH)	15.0%	Baseline and Building & Equipment
DD	Behavioral Support Services (DD)	7.7%	Baseline
DD	Psychological Services (DD)	15.0%	Baseline and Building & Equipment
ABH	Psychosocial Rehabilitation (ABH)	7.7%	Baseline
ABH	Dialectical Behavior Therapy – Skill Development – Group (ABS)	9.6%	Baseline and Supplies
ABH	Dialectical Behavior Therapy – Skill Development - Individual (ABS)	9.6%	Baseline and Supplies
ABH	Intensive Individual DBT Psychotherapy Services (ABS)	9.6%	Baseline and Supplies
ABH	Illness Management and Recovery – Group (ABS)	9.6%	Baseline and Supplies
ABH	Illness Management and Recovery – Individual (ABS)	9.6%	Baseline and Supplies
CMH	Community-Based Psychiatric Rehabilitation and Support - Group (CMH)	1.9%	Supplies
ABH	Community-Based Psychiatric Rehabilitation and Support - Group (ABS)	1.9%	Supplies
CMH	Community-Based Psychiatric Rehabilitation and Support – Individual (CMH)	1.9%	Supplies
ABH	Community-Based Psychiatric Rehabilitation and Support – Individual (ABS)	1.9%	Supplies
ABH	Community-Based Psychiatric Rehabilitation and Support – Individual (ABH)	1.9%	Supplies
ABH	Extraordinary Needs Aide Services (ABH)	1.9%	Supplies

Standardization: After discussion with the programs and confirmation from the Rate Workgroups, Guidehouse recommends standardizing the Extraordinary Needs Aide Services with the Community-Based Psychiatric Rehabilitation and Support (CPBRS)– Individual service. To incentivize the use of the ENA service, we have increased the rate to $12.32 to align with CPBRS, which is a 203 percent increase from the original $4.07 rate. Based on discussion with

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the Department, we determined that resource needs for ENA would be comparable CPBRS if the service is to be delivered as intended. See Table 31.

Table 31: Behavioral Health Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Behavioral Intervention Assistant	$7.88	$12.54	15 min
DD	Behavioral Support Services	$62.57	$92.39	Hour
ABH	Community-based psychiatric rehabilitation & support – group	$2.18	$3.08	15 min
CMH	Community-based psychiatric rehabilitation & support – group	$2.17	$3.08	15 min
ABH	Community-based psychiatric rehabilitation & support – individual	$7.29	$12.32	15 min
CMH	Community-based psychiatric rehabilitation & support – individual	$7.25	$12.32	15 min
CMH	Comprehensive School and Community Treatment (CSCT)	$96.00	$97.44	15 min
SLTC	Consultative Clinic and Therapeutic Services	$381.89	$507.00	Unit
ABH	Consultative Clinical and Therapeutic Services	$384.56	$507.00	Unit
CMH	CSCT Intervention, Assessment and Referral (IAR)	$96.00	$97.44	15 min
ABH	Dialectical Behavior Therapy – Skill Development – Group	$11.79	$10.41	15 min
ABH	Dialectical Behavior Therapy – Skill Development – Individual	$18.04	$20.81	15 min
CMH	Extraordinary Needs Aide Services	$4.07	$12.32	15 min
ABH	Illness Management and Recovery – Group	$6.97	$8.79	15 min
ABH	Illness Management and Recovery – Individual	$12.50	$17.58	15 min
ABH	Intensive Individual DBT Psychotherapy Services	$60.38	$62.44	45-50 min
DD	Psychological Services	$182.89	$204.65	Hour

B.5.3.7. Nursing Services

The Nursing category includes the following Private Duty Nursing services for members who require continuous in-home nursing care.

- Private Duty Nursing (SLTC)
- Private Duty Nursing - LPN (SLTC)
- Private Duty Nursing - LPN (ABH)
- Private Duty Nursing - RN (SLTC)
- Private Duty Nursing - RN (ABH)
- Private Duty Nursing (Medicaid State Plan) - LPN (DD)
- Private Duty Nursing (Medicaid State Plan) - RN (DD)
- Registered Nurse Supervision (SLTC)

Standardization: Within this category Guidehouse recommends creating standardized rates across programs to ensure rate equity especially since the service is identical across programs. This approach is nearly identical to the current nursing rates that vary across programs by a few

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cents. As highlighted in Table 32, the service rate is $19.30 when a Registered Nurse (RN) is expected to be the service provider and $14.12 for a Licensed Practical Nurse (LPN).

Rate Components: These services are similar in structure to the larger in-home service category, since both categories of services take place in a client's home. We included the applicable wage, productivity, administrative add-on, program support for supplies, and staff transportation to travel between client sites obtained as average values from the cost and wage survey. Other than differences in the type of direct care staff assumed, nursing services vary from in-home services primarily because the service rate does not include additional supervision time. Since staff transportation can be a large cost portion of the service delivery, $3.57 was identified as an add-on for each hour of service. Since these services are reimbursed at 15-minute increments, we added a fourth of the $3.57 hourly amount to the benchmark rate.

Table 32: Nursing Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
SLTC	Private Duty Nursing	$11.62	$19.30	15 min
ABH	Private Duty Nursing - LPN	$9.29	$14.12	15 min
SLTC	Private Duty Nursing - LPN	$9.23	$14.12	15 min
ABH	Private Duty Nursing - RN	$11.71	$19.30	15 min
SLTC	Private Duty Nursing - RN	$11.62	$19.30	15 min
DD	Private Duty Nursing (Medicaid State Plan) LPN	$9.29	$14.12	15 min
DD	Private Duty Nursing (Medicaid State Plan) RN	$11.70	$19.30	15 min
SLTC	Registered Nurse Supervision	$15.78	$20.97	15 min

B.5.3.8. Self-Directed Support Services

As listed below, the Self-Directed Support Services category includes three services, two of which relate to helping the client manage their finances, while the third supports a person in self-directed services and supports. These rate models follow a similar pattern to other service categories in identifying the appropriate job type to incorporate the correct hourly wage into the models. Rates also include supervision, program support and administrative cost components.

- Financial Manager (SLTC)
- Independence Advisor (SLTC)
- Supports Broker (DD)

Financial Manager and Independence Advisor: These two service rates are developed using a Financial Manager base wage. The rate accounts for the 22.1 percent administrative add-on as we do for the rest of the services, and a program support of 9.6 percent to account for the baseline program support and additional supplies. Once the total costs for wages, supervision, program support, and administrative support are included for an entire year, the cost is divided by 38.5 members served each month to determine the monthly per diem amount per client.

Supports Broker: Supports Broker serves in the same capacity as a case manager and the hourly wage assumption for the two job types are comparable. This rate model includes rate components similar to the "In-Home" service models but features slightly lower program support to account for the self-directed aspect of the service. The rate includes the 22.1 percent

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administrative add-on but a program support of 1.9 percent to allow for additional supply costs. In addition to the administrative and program support costs, an 80 percent productivity factor, minimal amount of supervision time for general oversight, and a staff mileage add-on are built into the rate. There is a 41 mile per week mileage assumption that is multiplied by the standard IRS mileage rate of 58.5 cents to determine the applicable transportation dollar add-on per member. See Table 33.

Table 33: Self-Directed Support Service Rate

Program	Service	Current Rate	Benchmark Rate	Unit
SLTC	Financial Manager	$177.97	$181.92	Month
SLTC	Independence Advisor	$177.97	$181.92	Month
DD	Supports Broker (both self-direct options)	$31.31	$41.34	Hour

B.5.3.9. Transportation

Rate development for transportation assumes standardized mileage and trip rates across all programs. Currently, there is a mileage cost assumption that ranges between $0.33 and $0.41 per mile. For mileage-based transportation reimbursement, Guidehouse recommends updating the mileage rate based on federal Internal Revenue Service (IRS) mileage allowances current for 2022. The IRS mileage rate accounts for fuel and insurance costs as well as vehicle maintenance and depreciation.

Per trip rates were developed based on cost information reported in the provider cost and wage survey and are based on total vehicle operation and maintenance costs reported. Rates were derived by calculating the average cost per trip per provider. Providers who deliver and bill for distinct transportation services reported their total costs associated with transportation as well as total trips taken during the reporting period. The transportation rate per trip per provider is obtained by dividing each provider's transportation costs by the trips the provider reported. This operation yields a cost per trip for each provider. The rate benchmark reflects the average trip cost among all reporting providers. The benchmark transportation rates exhibit increases between 15-18 percent from the current rates, depending on the target population.

For residential and day services, client transportation costs are bundled into the service rates, which means transportation for these services should not be billed separately. We expect this will have significant impact on utilization of these services and claim volume. Therefore, to project an appropriate fiscal impact under the benchmark rates, we estimate utilization under that revised policy would be approximately 33 percent of what it is currently, since the majority of its utilization would already be covered in typical residential and day service transport. The 33 percent figure is based on an analysis of the proportion of current expenditures in the BSW and SDMI waivers for transport versus combined residential and day services, considering services in these waivers already bundle transportation. Guidehouse also recommends updating the underlying mileage assumptions in the developmental services transportation toolbox to reflect the current $0.585 IRS mileage rate. See Table 34.

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Table 34: Transportation Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
DD	Transportation - Mileage Reimbursement	$0.41	$0.59	Mile
DD	Transportation - Mileage Reimbursement - both Self Direct options	$0.41	$0.59	Mile
ABH	Transportation - Miles	$0.34	$0.59	Mile
SLTC	Transportation - Miles	$0.33	$0.59	Mile
DD	Transportation - Residential Integration Wheelchair Van (each unit is regular unit rate times 20%)	$40.77	$58.18	Unit
ABH	Transportation - Trip	$12.87	$14.90	Trip
SLTC	Transportation - Trip	$12.78	$14.90	Trip
DD	Transportation - Work/Day Integration (12 max/yr)	$12.55	$14.90	Trip

B.5.3.10: Intensive Behavioral Services

The Intensive Behavioral services category encompasses a range of the higher intensity SUD and behavioral related services. All these services, except for Medication Assisted Treatment, require multidisciplinary teams to deliver the set of services. This category includes the following services:

- American Society of Addiction Medicine (ASAM) Levels of Care (2.1, 2.5, 3.1, 3.2, 3.3, 3.5, 3.7)
- Program of Assertive Community Treatment (PACT)
- Intensive Program of Assertive Community Treatment (inPACT)
- PACT Community Maintenance Program (CMP)
- Montana Assertive Community Treatment (MACT)
- Crisis Stabilization
- Medication Assisted Treatment (MAT)

The sub-sections below detail the methodological assumptions informing each of the services within the Intensive Behavioral Services category.

B.5.3.10.1. ASAM and Partial Hospitalization Services:

The ASAM rate models represent the following services:

- ASAM 2.1 - SUD Intensive Outpatient
- ASAM 2.5 - SUD Partial Hospitalization
- ASAM 3.1 - SUD Low Intensity Residential (Single Gender)
- ASAM 3.1 - SUD Low Intensity Residential (Parent/Child)
- ASAM 3.2WM - SUD Clinically Managed Residential Withdrawal Management
- ASAM 3.3 - SUD Population Specific High Intensity Residential
- ASAM 3.5 - SUD High Intensity Residential
- ASAM 3.7 - SUD Medically Monitored Inpatient

The Partial Hospitalization services include the following:

- Acute Partial Hospitalization
- Sub-Acute Partial Hospitalization

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Guidehouse separated the ASAM models into two rate model styles to account for a set of these services being in a residential setting whereas the 2.1 and 2.5 services are in an outpatient or partial hospitalization setting. All intensive behavioral residential models assumed a 95 percent occupancy adjustment factor to account for potential turnover rates. This is slightly lower than the 98 percent recommended for the non-ASAM residential models to allow for additional flexibility in accounting for turnover due to short-term stays. The variability in service location requires additional considerations for staffing. The program's provider manual, the ASAM continuum of care, and the Medicaid website identify rigorous service criteria that we leveraged to appropriately capture the specifics of each individual level of service[8]. The ASAM levels are intended to be built on top of each other with higher intensity-based services as the service tiers increase. Figure 8 represents the American Society of Addiction Medicine (ASAM) continuum of care that was referenced when calculating service rates.

[8] Medicaid Innovation Accelerator Program, Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms (*April 2017*). Available online: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf

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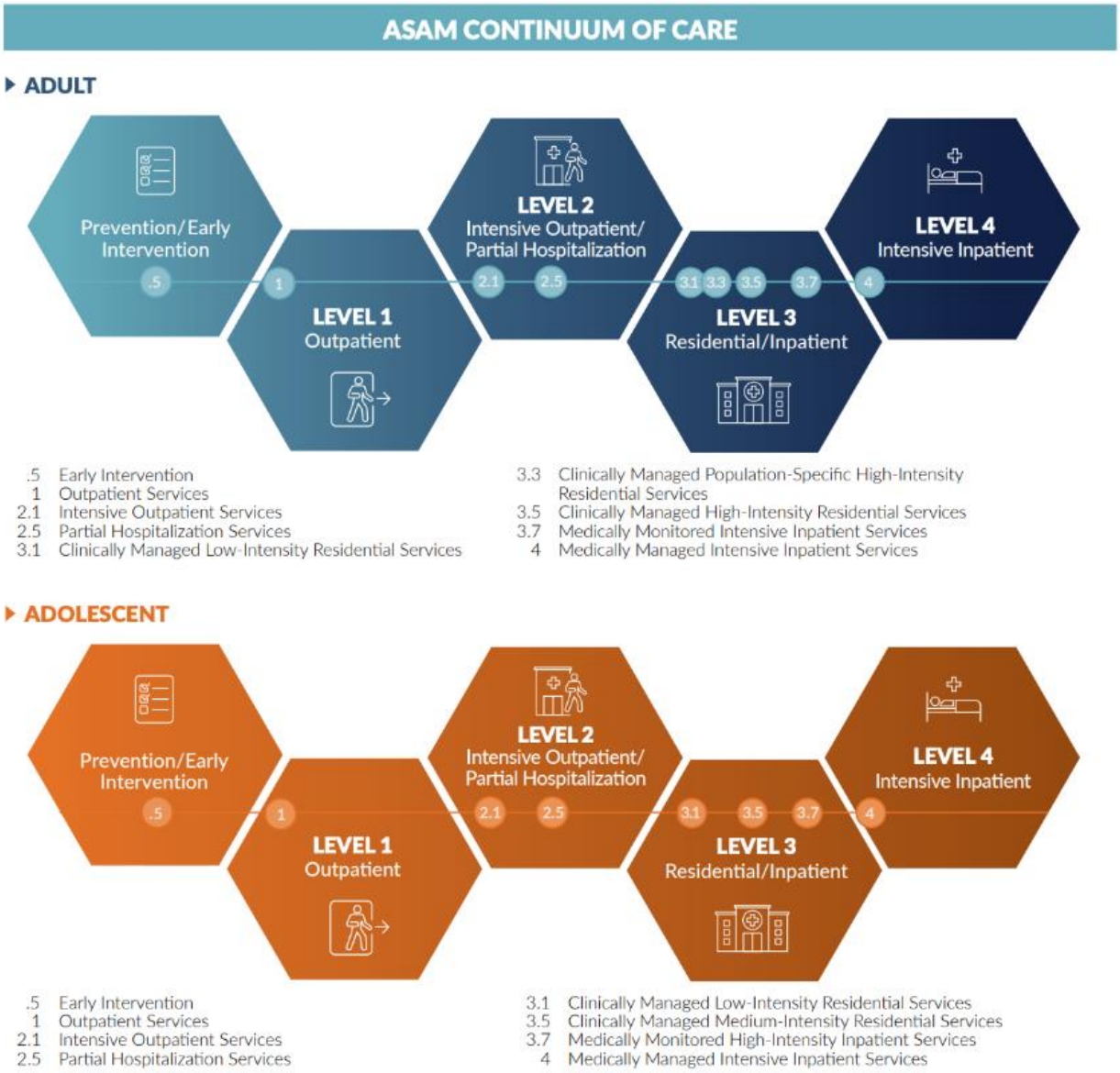
Figure 8: ASAM Continuum of Care[9]



For this mix of services Guidehouse updated existing ASAM models, created new service models and altered the unit of measure for reimbursement.

ASAM 2.1 and ASAM 2.5

For the ASAM 2.1 intensive behavioral services and ASAM 2.5 partial hospitalization

[9] ASAM Criteria. Available online: https://www.asam.org/asam-criteria/about-the-asam-criteria

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services, the reimbursement unit was modified based on input from the program to better align with the ASAM model definitions. The unit was updated from a daily to a weekly rate to accurately reflect the ASAM requirement of ">=9 Hours/weekly for adults, >=6 hours/weekly for adolescents" for ASAM 2.1 and ">= 20 hours/weekly" for ASAM 2.5. This weekly rate also required the removal of the high tier and low tier distinction in the current rate model. This unit change is intended to create accurate billing to account for the weekly nature of these services. This will also help providers in cases where members may only attend services twice a week and therefore can only bill the daily rate twice.

Acute partial hospitalization and sub-acute partial hospitalization were developed in the same fashion as the ASAM 2.5 Partial Hospitalization model. This model varies slightly from ASAM 2.5 by having an LPN instead of an Addiction Counselor and accounting for the increased time the certified nursing assistant spends with the client. For the Sub-Acute service, the FTEs were adjusted for half time for all direct care staff except for the certified nursing assistant.

ASAM 3.1

ASAM 3.1 is currently a room-and-board-only rate whereas the modified service will be a 24-hour low intensity residential service that has a single gender and family split. The program currently does not have a low intensity residential SUD model – these models are intended to be intermediate steps before the high intensity settings.

ASAM 3.1: This model assumes a 24-hour service environment with eight beds. Since this is a lower intensity "clinically managed" model, the service does not need to be staffed with medical personnel. ASAM defines clinically managed as "services that are directed by nonphysician addiction specialists rather than medical personnel". Therefore, this model includes a DSP/CNA, Case Manager and Addition Counselor. The ASAM 3.1-Family model is similar however the facility size has only six beds and there is an additional Peer/Family Support Specialist.

ASAM 3.2WM and ASAM 3.3

These two ASAM levels are new services proposed by the program.

ASAM 3.2WM: Similar in structure to ASAM 3.1, this model is a 24-hour environment residential setting. However, since this service is "medically monitored" there needs to be additional medical personnel to oversee medication. The job types included are a DSP/CNA, Licensed Clinical Social Worker (LCSW), Case Manager, Addiction Counselor and Registered Nurse (RN). In addition to the added RN hours there is also some increased DSP/CNA hours to account for a slightly higher need than 3.1.

ASAM 3.3: Building on top of 3.2 is ASAM 3.3 that is a high intensity residential setting. The multidisciplinary team is the same structure as 3.2, however there is additional staff required during the daytime hours to account for the high intensity need of the residents which results in a higher per diem rate.

ASAM 3.5 and ASAM 3.7

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ASAM 3.5: This high intensity residential setting service structure is almost identical to ASAM 3.3 since it is intended to serve high intensity residents. However, the ASAM 3.5 definition designates the need for 24-hour trained counselors so instead of a DSP/CNA being fully staffed we model the costs using a Behavioral Specialist/Technician. All other hourly and staffing assumptions are consistent with ASAM 3.3 which results in a small rate variation.

ASAM 3.7: In comparison to ASAM 3.5, this next level adds the need for 24 hour "medically monitored" service. Therefore, the staffing assumptions in the rate model is adjusted to account for 24 hours of registered nurse time to monitor medication and provide increased care for this higher intensity setting. Even though the rate model accounts for increased nursing hours, a 1:8 staffing ratio is assumed around the clock in comparison to ASAM 3.5 with increased staffing of 1:4 during the daytime hours.

All residential ASAM models include the 22.1 percent administrative percentage applied to the direct care costs of each service as well as 4.9 percent program support for any additional client transportation and supplies required. See Table 35.

Table 35: ASAM Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	ASAM 2.1- SUD Intensive Outpatient*	New Payment Structure	$389.37	Weekly
ABH	ASAM 2.5- SUD Partial Hospitalization*	New Payment Structure	$449.24	Weekly
ABH	Partial Hospitalization – Acute*	New Payment Structure	$419.38	Weekly
CMH	Partial Hospitalization – Acute*	New Payment Structure	$419.38	Weekly
CMH	Partial Hospitalization- Sub Acute*	New Payment Structure	$332.63	Weekly
ABH	ASAM 3.1 - SUD Low Intensity Residential (Single Gender)**	New Payment Structure	$143.49	Day
ABH	ASAM 3.1 - SUD Low Intensity Residential (Parent/Child)**	New Payment Structure	$210.13	Day
ABH	ASAM 3.2WM - SUD Clinically Managed Residential Withdrawal Management**	NEW	$254.69	Day
ABH	ASAM 3.3 - SUD Population Specific High Intensity Residential**	NEW	$274.51	Day
ABH	ASAM 3.5 - SUD High Intensity Residential	$246.05	$277.99	Day

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Program	Service	Current Rate	Benchmark Rate	Unit
ABH	ASAM 3.7 - SUD Medically Monitored Inpatient	$246.05	$321.79	Day

* Currently these are daily rates, will be converted to weekly rates.
** New payment structure, no current comparable rate.

B.5.3.10.2. Program of Assertive Community Treatment (PACT)/Montana Assertive Community Treatment (MACT)

For both the MACT and PACT models, the rate models are based on calculating the total costs required for the entire multidisciplinary team within a year and then determining the cost for each member within the team caseload. These costs are further distributed into weekly rates for MACT and PACT, and daily rates for CMP and InPACT. See Table 37.

MACT

Guidehouse referenced the program provider manuals to determine the staffing requirements for the service. Based on the provider manual we included the following staffing:

- Prescriber, .375 FTE
- Physician/Psychiatrist Supervision; two hours per month
- Team Lead, one FTE
- Nursing staff, one FTE
- Professional staff, one FTE
- Care Coordinators, one FTE
- Paraprofessionals, one FTE
- Certified Peer Support Specialists, two FTE
- Administrative Assistant, 1 FTE

After determining the total cost for the wages for each of the staff types listed above, the cost per member was calculated by assuming a caseload of 45, which is 90 percent of the suggested listed in the provider manual.

PACT (PACT, InPACT and CMP):

Similar in structure to MACT, the provider manuals were used to determine the staffing requirements for PACT. The staffing requirements listed below were used in the rate modeling assumptions.

- Prescriber: 1 FTE
- Physician/Psychiatrist Supervision: 2 hours per month
- Team Lead: 1 FTE
- Nursing Staff: 2 FTE
- Professional Staff: 2 FTE
- Care Coordinators: 3 FTE
- Paraprofessionals: 2 FTE
- Licensed Addiction Counselor: 1 FTE

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- Vocational Specialist: 1 FTE
- Certified Peer Support Specialists: 2 FTE
- Administrative Assistant: 2 FTE
- Tenancy Specialist

After determining total costs for the staff, including wages of the staff, administrative percentage of 22.1 percent and a program support of 7.7 percent to help with team coordination and management, we determined the proportion of costs that would be allocated to the PACT program versus InPACT program. Since the number of contacts is different for these services, rate development was designed to distribute adequate resources were being distributed appropriately for each service. Assuming roughly 80 percent of the provider manual suggested caseload, an estimated 64 PACT members and 12.8 InPACT members would be served by the staff within the year. The PACT members receive three contacts per week, whereas InPACT members receive five contacts per week, resulting in a total 9,984 PACT contacts per year and 3,328 InPACT contacts per year. Consequently, roughly 75 percent of the program costs are allocated to PACT, with the remaining 25 percent allocated to InPACT. See Table 36.

Table 36: Final Benchmark Rate Components (PACT and InPACT)

Total Annual Cost	$1,583,916.83	
Clients Served	64.0	12.8
Contacts in Year	9,984	3,328
Proportion of Cost Based on Contacts	$1,187,937.62	$395,979.21
Total Annual Cost/Member	$18,561.53	$30,935.88

Table 37: PACT and MACT Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Program Assertive Community Treatment (PACT)	$346.75	$356.95	Weekly
ABH	Intensive Program Assertive Community Treatment (InPACT)	$118.17	$118.98	Day
ABH	Montana Assertive Community Treatment- (MACT)	$264.32	$286.48	Week

For the additional CMP portion of the program that is intended to provide medication and community support, we included an additional FTE for peer support and a quarter FTE of psychiatry time for medication management to provide support for this additional caseload of members. Using a peer support and psychiatrist wage, total costs were determined and divided by the total contacts per member within a year for 80 members. See Table 38.

Table 38: PACT Community Maintenance Program (CMP)

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	PACT Community Maintenance Program (CMP)	$49.54	$64.28	Day

B.5.3.10.3. Crisis Stabilization

The crisis stabilization service was modeled based on a 24-hour multidisciplinary team that is

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prepared to manage and service high intensity crisis situations at any point within the day. This multidisciplinary team includes:

- Clinical Director
- Registered Nurse
- Licensed Clinical Social Worker (LCSW)
- Certified Peer Support Specialist
- Psychiatrist

This team is intended to be on staff 24 hours a day with additional substitute hours included to account for paid time off, sick days and holidays. Additional administrative costs of 22.1 percent and program support of 9.6 percent to account for baseline program support and supplies included in the total costs. Once the total costs were developed, we divided by 365 days within the year to determine the per diem. This per diem rate represents crisis stays over 24 hours. However, we also developed a new hourly rate for any stays less than 24 hours. The team staffing remains the same; however, we assumed an occupancy of 75 percent to account for instances in which beds may be empty for a majority of the day, but receive a rush in the evening hours. See Table 39.

Table 39: Crisis Stabilization Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Crisis Stabilization	$363.95	$400.88	Day
ABH	Crisis Stabilization – Hourly (New – services less than 24 hours)	N/A	$21.16	Hour

B.5.3.10.4. Medication Assisted Treatment

Medication assisted treatment is different from other intensive behavioral services in that there is not a multidisciplinary team structure. Guidehouse utilized cost and wage information directly from providers to properly reflect the cost of the staff. We assumed this service is primarily administered by a mid-level practitioner with a small amount of MD level supervision. We then adjusted by an 80 percent productivity factor to allow for additional time for charting and determining treatment plans for patients. The standard administrative percentage of 22.1 percent and a 1.9 percent program support for supplies were then applied to the direct care costs to determine the hourly add-on. The combination of the ERE-adjusted hourly wage, supervision time and administrative and program support add-ons determined an hourly rate. For established weeks of care, we assumed a visit would require an hour of time. However, for an intake week we determined 2.5 hours of time would be required to account for the following additional services needed: an in-person assessment by a physician or mid-level practitioner, an integrated behavioral health assessment, tobacco screening (if clinically appropriate), screening for alcohol misuse / abuse (AUDIT/CRAFFT), presumptive drug screening, urine pregnancy test (if clinically appropriate) and induction of medication. See Table 40.

Table 40: Medication-Assisted Therapy (MAT)

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Medication-Assisted Therapy (MAT) Established	$128.56	$146.20	Week

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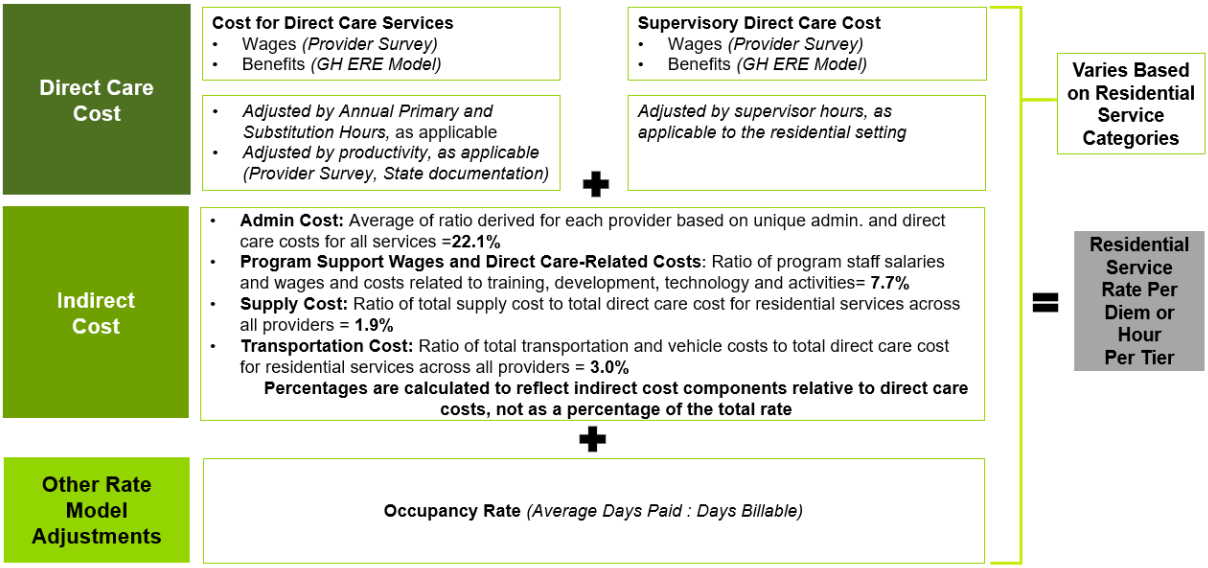
Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Medication-Assisted Therapy (MAT) Intake	$359.97	$365.50	Week

B.5.4. Community Residential Service Methodologies

Community residential services follow a similar structure as the non-residential models with wages for direct care staff, supervision cost, administrative add-on, applicable program support and additional adjustments for extra staff and occupancy adjustments. The information in Figure 9, even though similar to the methodological overview in the non-residential section, illustrates specific components to address the hours required to staff residential homes, taking into account substitute hours for paid time off as well as program support costs related to supplies, client transportation and staff training, development, and activities, as well as clinical support staff compensation.

Figure 9: Residential Rate Model Components



Residential services take place in a residential setting outside an individual's family home. The intensity and staffing can vary between the services. These services include:

- Adult Foster Care (ABH)
- Adult Foster Support (DD)
- Assisted Living (DD)
- Behavioral Health Group Home (ABH)
- Congregate Living (DD)
- Permanency Therapeutic Foster Care (CMH)
- Residential Habilitation
    - Assisted Living Facilities and Adult Foster Homes (SLTC)
    - Group Home (SLTC)

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  - TBI-AR (SLTC)
  - Supported Living (DD)
  - Intensive Mental Health Group Home (ABH)
  - Mental Health Group Home (ABH)
- Residential Training Supports (DD)
- Therapeutic Foster Care (CMH)
- Therapeutic Youth Group Home (CMH)

Hours Calculations: A key rate component of the residential models is the calculation of the primary and substitute hours required to staff the residential setting. Total hours required for daytime, nighttime and day program/school hours all need to be considered to ensure there is adequate staffing for the number of residents. The annual DSP primary hours represent the total number of staffed service delivery hours. Substitution hours represent the hours needed to cover non-productive hours due to staff training, paid time off, and resident absences from day programs. The training hour assumptions assume a staff turnover rate of 50 percent and required annual training hours per staff as 30 hours. The *PTO-Related Substitution* assumes 28 days of paid time off, consistent with the 28-day average paid time off reported by providers in the Provider Survey.

The calculation for the hour requirement follows the same pattern; however, staffing levels vary by setting. Table 41 provides an example of a facility that needs a daytime staffing ratio of 1:4, but a nighttime staffing of 1:8 with no variation in day staffing based on day program or school attendance. To determine the number of staff needed for a home, we take the home size divided by the staffing ratio. In the example below, since the home size is for eight or more members, we identify the need for two daytime staff and one nighttime staff. We also assume most residential settings need to be staffed 24 hours a day, 365 days in a year, resulting in 8,760 total yearly hours per staff. If the setting has higher intensity residents, increased hours would be required to account for multiple staff working simultaneously.

Table 41: Residential Service Staff Calculation

Home Size: 8+		
Time	**Staffing Ratio**	**Actual Staff Needed**
Day	1:4	2
Night	1:8	1
Day Program/School	N/A	N/A

In the case of the example residential setting with a 1:4 daytime staffing and 1:8 nighttime staffing, the DSP hours are split amongst the residents differently depending on the time of day. We take the total daytime hours divided by the four residents and the total nighttime hours, divided by the eight residents, resulting in 1,825 total hours per resident in a year. See Table 42.

Table 42: Residential Service Staffing Hours

Residential 8+ Home Staffing Hours			
Time Type	**DSP Hours**		**Total Daily Hours**
	Day	**Night**	
Sun	16	8	24

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Residential 8+ Home Staffing Hours			
Time Type	DSP Hours		Total Daily Hours
	Day	Night	
Mon	16	8	24
Tue	16	8	24
Wed	16	8	24
Thu	16	8	24
Fri	16	8	24
Sat	16	8	24
Total Weekly Hours	112	56	168
Annual DSP Total	5,840	2,920	8,760
Staffing Ratio	1:4	1:8	-
Hours Per Resident	1,460	365	1,825

Substitution hours required for the current staffing levels are then calculated in Table 43 as follows:

Table 43: Residential Service Substitution Hours Calculation

Home Size	Staffed Hours	FTE = Staffed Hours ÷ 2080	Substitute Training Hours	Substitute PTO Hours	Total Substitution Staff Hours
1	8,760	4.21	189.5	1,179	1,525
2	4,380	2.11	94.8	590	762
3	2,920	1.4	63.2	393	508
4	2,190	1.05	47.4	295	381
5	2,044	0.98	44.2	275	351
6	1,947	0.94	42.1	262	330
7	1,877	0.9	40.6	253	316
8+	**1,825**	**0.88**	**39.5**	**246**	**305**

These hourly calculations feed into each of the residential models based on setting and variation in resource need intensity defined by that setting. Detailed staffing ratios, hour assumptions and additional staffing resources for each service are included within Appendix A.

Tier Development: For congregate living, the nine tiers established by the program were maintained in line with the other tiered daily rates. We adjusted the underlying cost assumptions based on information provided by the provider cost and wage survey for wage and the total number of required hours within the service description. We used the annual hourly assumptions within each tier to determine the effective annual hours required to provide the

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service based on the intensity of the tier. As the tiers increase so do the hours required. The DSP wage, supervision time per staff, administrative and program support factors all stay the same regardless of tier.

Geographic Variation: Guidehouse maintained the program's definitions of medium, high, and rural. The additional factor was maintained on the current rates that have this differentiation, but we did not generalize geographical differentials to other services. The increases for each increment of geographic differential was standardized to 2.5 percent.

Program Support and Administrative Add-Ons: As with the other services within the rate study these residential services also received a 22.1 percent administrative add on. The program support varies depending on the residential service. The residential program support varied from 4.9 percent, which includes supplies and client transportation, and 12.6 percent, which also adds baseline program support of 7.7 percent to include costs related to program support staff, training, and activities. See Table 44.

Table 44: Residential Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
ABH	Adult Foster Care	$89.68	$103.85	Day
ABH	Adult Foster Care-Therapeutic Leave	$89.68	$103.85	Day
DD	Adult Foster Support (low supervision)	$816.87	$3,323.91	Month
DD	Adult Foster Support (moderate supervision)	$1,435.05	$3,786.55	Month
DD	Adult Foster Support (enhanced supervision)	$2,453.93	$4,249.18	Month
DD	Adult Foster Support (intensive supervision)	$5,075.56	$4,711.82	Month
DD	Assisted Living Enhanced	$256.02	$287.48	Day
DD	Assisted Living Moderate	$192.02	$215.61	Day
ABH	Behavioral Health Group Home	$171.65	$185.51	Day
DD	Congregate Living Children's	$27.48	$33.17	Hour
DD	Congregate Living Medical	$32.00	$35.34	Hour
DD	Congregate Living Hourly (more than 10.95 ave hrs/day)	$25.32	$30.52	Hour
DD	Congregate Living Tier 1 (1-4.8 ave hrs/day. 0-1735.99 annual hrs)	$103.31	$136.22	Hour
DD	Congregate Living Tier 2 (4.9-5.47 ave hrs/day. 1754-2005.99 annual hours)	$120.50	$160.61	Hour
DD	Congregate Living Tier 3 (5.48-6.14 ave hrs/day. 2006-2235.99 annual hours)	$136.81	$181.02	Hour
DD	Congregate Living Tier 4 (6.15-7.14 ave hrs/day. 2236-2605.99 annual hours)	$160.90	$206.98	Hour
DD	Congregate Living Tier 5 (7.15-7.7 ave hrs/day. 2606-2845.99 annual hours)	$175.47	$232.47	Hour

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Program	Service	Current Rate	Benchmark Rate	Unit
DD	Congregate Living Tier 6 (7.8-8.43 ave hrs/day. 2846-3075.99 annual hours)	$194.24	$252.40	Hour
DD	Congregate Living Tier 7 (8.44-8.75 ave hrs/day. 3076-3194.99 annual hours)	$203.83	$266.86	Hour
DD	Congregate Living Tier 8 (8.76-9.9 ave hrs/day. 3195-3613.99 annual hours)	$231.87	$290.73	Hour
DD	Congregate Living Tier 9 (10-10.95 ave hrs/day. 3614-3999.99 annual hours)	$256.46	$324.82	Hour
CMH	Permanency Therapeutic Foster Care	$140.90	$172.61	Day
SLTC	Res Hab - Assisted Living Facilities and Adult Foster Homes	$104.00	$124.75	Day
SLTC	Res Hab - Group Home	$206.58	$224.51	Day
SLTC	Res Hab - TBI-AR	$165.77	$189.72	Day
DD	Res. Hab. Supported Living – Base	$767.70	$978.30	Month
DD	Res. Hab. Supported Living – Flex	$1,151.55	$1,467.45	Month
DD	Res. Hab. Supported Living (Small agency) High geo factor	$34.81	$44.51	Hour
DD	Res. Hab. Supported Living (Small agency) Medium geo factor	$33.97	$43.45	Hour
DD	Res. Hab. Supported Living (Small agency) no geo factor	$33.37	$42.39	Hour
DD	Res. Hab. Supported Living High geographic factor	$26.68	$34.24	Hour
DD	Res. Hab. Supported Living Medium geographic factor	$26.03	$33.43	Hour
DD	Res. Hab. Supported Living no geographic factor	$25.59	$32.61	Hour
DD	Res. Hab. Supported Living rural remote	$27.66	$35.06	Hour
ABH	Residential Habilitation – Adult Group Home	$163.49	$167.22	Day
ABH	Residential Habilitation - Assisted Living Facilities and Adult Foster Homes	$104.00	$124.75	Day
ABH	Residential Habilitation – Intensive Mental Health Group Home	$296.24	$334.26	Day
ABH	Residential Habilitation – Mental Health Group Home	$206.21	$258.58	Day
DD	Residential Training Support (high geographical factor)	$26.52	$34.24	Hour
DD	Residential Training Support (medium geographical factor)	$25.88	$33.43	Hour
DD	Residential Training Support (no geographical factor)	$25.44	$32.61	Hour
DD	Residential Training Support (small agency / high geographical factor)	$34.62	$44.51	Hour
DD	Residential Training Support (small agency / medium geographical factor)	$33.77	$43.45	Hour
DD	Residential Training Support (small agency / no geographical factor)	$33.18	$42.39	Hour
SLTC	Supported Living	$232.64	$284.14	Day

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Program	Service	Current Rate	Benchmark Rate	Unit
CMH	Therapeutic Foster Care	$50.91	$64.64	Day
CMH	Therapeutic Youth Group Home	$201.82	$224.47	Day
CMH	Therapeutic Youth Group Home Therapeutic home leave	$201.82	$224.47	Day

B.5.5. PRTF Service Methodology

Psychiatric Residential Treatment Facilities (PRTFs) submitted provider cost and wage survey information for the specific costs associated with their residential treatment services rendered. Guidehouse analyzed cost information as well as bed capacity and member counts reported within the survey. To increase the rigor in validation, we compared the total days reported within the survey to the Medicaid claims data provided from the State. We also were able to leverage longitudinal trend data to understand the member counts within each month for the various facilities within the State.

The first step within the process was to calculate the total costs reported. The survey asked for Medicaid costs to be split apart from the total costs within the facility to accurately reflect the Medicaid portion of the facility cost to set a Medicaid per diem rate. Within the total costs tab of the survey, we asked for costs to be split by Total Employee Salaries and Wages, Total Employee Taxes and Benefits, Total Non-Payroll Administrative Costs, Total Non-Payroll Program Support Expenses and Total Facility, Vehicle and Equipment Related Expenses. We summed all costs within the Expenses Allocated to Medicaid column of the survey, however we removed the costs associated with Professional Services to align with the language in the State Plan Amendment (SPA) that indicates not to include these services since they should be paid outside the institutional cost of a facility. Once total costs we calculated we applied a 7 percent inflation factor to account for two years of trend from SFY19 to the current SFY21 period.

After costs were calculated, we assessed longitudinal trends provided by the State that represented the total number of Medicaid occupied beds within the facilities for SFY21. We created an average across SFY21 to determine the average number of occupied beds within the year and then multiplied this value by 365 total days within the year to determine the total number of occupied Medicaid days. The total inflated costs from the survey were then divided by the total SFY21 days to determine a statewide Medicaid per diem.

The Guidehouse recommendation is to use this single state-wide rate and apply it to out of state providers as well as in state. It is our understanding after discussions with the Department that in-state PRTF's receive an additional $20 per day as a component of the Direct Care Wage (DCW) add-on payment. Therefore, the percentage increase when comparing to the benchmark rate is smaller than currently being presented. The proposed benchmark rates within the rate study are intended to create rates that would eliminate the need for the additional DCW add on payment. Table 45 below captures the benchmark rates for both in-state and out-of-state PRTFs.

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Table 45: Psychiatric Treatment Residential Facility (PRTF) Service Rates

Program	Service	Current Rate	Benchmark Rate	Unit
CMH	Psychiatric Residential Treatment Facility (PRTF)- In State	$336.51	$509.81	Day
CMH	Psychiatric Residential Treatment Facility (PRTF)- Out of State	$447.56	$509.81	Day

B.5.6. Excluded Services

Certain services listed on the State's fee schedules were excluded from the rate study for several reasons. The most common services excluded from the rate study are services reimbursed at provider cost and are not based on a standardized rate. A few other services were excluded for reasons including the services being reimbursed under the RBRVS methodology and not provider cost, the service has an additional Temporary Service Increase (TSI) that varies in reimbursement, and removal of services. Rather, for these services, it would be more appropriate for the programs to reimburse at cost, up to a predetermined authorization limit, or refer to RBRVS to determine an applicable rate based on RVUs. Table 46 includes a list of the excluded services and the reasons for exclusion.

Table 46: Other Services Excluded from Rate Study

Program	DPHHS Program	Description	Reason for Exclusion
ABH	SDMI Waiver	Acupuncture	Varies by case
ABH	SDMI Waiver	Adaptive Recreational Therapy	Varies by case
ABH	SDMI Waiver	Chiropractic	Varies by case
ABH	SDMI Waiver	Community Transition Services	Varies by case
ABH	SDMI Waiver	Craniosacral Therapy	Varies by case
ABH	SDMI Waiver	Environmental Accessibility Adaptations - Home Modifications	Varies by case
ABH	SDMI Waiver	Exercise Classes	Varies by case
ABH	SDMI Waiver	Health and Wellness	Varies by case
ABH	SDMI Waiver	Health Club Membership	Varies by case
ABH	SDMI Waiver	Hippotherapy	Varies by case
ABH	SDMI Waiver	Hyperbaric Oxygen Therapy	Varies by case
ABH	SDMI Waiver	Massage Therapy	Varies by case
ABH	SDMI Waiver	Mind-Body Therapies	Varies by case
ABH	SDMI Waiver	Pain and Symptom Management	Varies by case
ABH	SDMI Waiver	Pain Mitigation Counseling/Coaching	Varies by case
ABH	SDMI Waiver	Personal Emergency Response - Rental	Varies by case
ABH	SDMI Waiver	Reflexology	Varies by case

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Program	DPHHS Program	Description	Reason for Exclusion
ABH	SDMI Waiver	Respite Care - Nursing Facility	Varies by case
ABH	SDMI Waiver	Respite Care - Hospital	Non-utilized service
ABH	SDMI Waiver	Specialized Medical Equipment	Varies by case
ABH	SDMI Waiver	Specialized Medical Supplies	Varies by case
ABH	SDMI Waiver	Specialized Nursing Services	Varies by case
ABH	SDMI Waiver	Wellness Classes	Varies by case
ABH	Medicaid Substance Use Disorder Services	Dip Strip or Saliva Collection, Handling, and Testing	Varies by case
ABH	SUD Non-Medicaid 0-138% of Poverty Procedure Codes and Rates for Individuals	CLIA Laboratory Performed Blood or Urine Test	Varies by case
ABH	SUD Non-Medicaid 0-138% of Poverty Procedure Codes and Rates for Individuals	SUD Clinically Managed Low Intensity (ASAM 3.1) (room & board)	Payment Structure Changed
ABH	SUD Non-Medicaid 0-200% of Poverty Pharmacy	Methadone, oral, 5 mg	Pharmacy
ABH	SUD Non-Medicaid 139-200% of Poverty Procedure Codes and Rates for Individuals	CLIA Laboratory Performed Blood or Urine Test	Varies by case
ABH	SUD Non-Medicaid 139-200% of Poverty Procedure Codes and Rates for Individuals	Dip Strip or Saliva Collection, Handling, and Testing	Varies by case
ABH	SUD Non-Medicaid 139-200% of Poverty Procedure Codes and Rates for Individuals	SUD Clinically Managed Low Intensity (ASAM 3.1) (room & board)	Payment Structure Changed
DD	DDP Waiver	Assisted Living OTHER	Varies by case
DD	DDP Waiver	Caregiver Training & Support OTHER	Varies by case
DD	DDP Waiver	Community Transition Services	Varies by case

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Program	DPHHS Program	Description	Reason for Exclusion
DD	DDP Waiver	Community Transition Services - Empl Auth Self Direct	Varies by case
DD	DDP Waiver	Environmental Modifications	Varies by case
DD	DDP Waiver	Environmental Modifications - Empl Auth Self Direct	Varies by case
DD	DDP Waiver	Fiscal Agent Admin Fee	Varies by case
DD	DDP Waiver	Homemaker Other	Varies by case
DD	DDP Waiver	Individual Goods and Services	Varies by case
DD	DDP Waiver	Individual Goods and Services - Empl Auth Self Direct	Varies by case
DD	DDP Waiver	Personal Emergency Response (Monthly Service)	Varies by case
DD	DDP Waiver	Personal Emergency Response (Monthly Service) - both Self Direct options	Varies by case
DD	DDP Waiver	Personal Emergency Response System (Installation & Testing)	Varies by case
DD	DDP Waiver	Personal Emergency Response System (Installation & Testing) - both Self Direct options	Varies by case
DD	DDP Waiver	Remote Monitoring	Varies by case
DD	DDP Waiver	Respite (Other)	Varies by case
DD	DDP Waiver	Specialized Medical Equipment	Varies by case
DD	DDP Waiver	Specialized Medical Equipment - Empl Auth Self Direct	Varies by case
DD	DDP Waiver	Specialized Medical Supplies	Varies by case
DD	DDP Waiver	Specialized Medical Supplies - Empl Auth Self Direct	Varies by case
DD	DDP Waiver	Trans OTHER - both Self Direct options	Varies by case
DD	DDP Waiver	Transportation - Commute Individual	Dependent on Transportation Toolbox – mileage assumptions updated
DD	DDP Waiver	Transportation - Commute Individual Wheelchair Van	Dependent on Transportation Toolbox – mileage assumptions updated
DD	DDP Waiver	Transportation - Commute Individual AwC self direct	Dependent on Transportation Toolbox – mileage assumptions updated
DD	DDP Waiver	Transportation - Commute Shared	Dependent on Transportation Toolbox –

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Program	DPHHS Program	Description	Reason for Exclusion
			mileage assumptions updated
DD	DDP Waiver	Transportation - Commute Shared Wheelchair Van	Dependent on Transportation Toolbox – mileage assumptions updated
DD	DDP Waiver	Transportation - Res Integration AwC self direct	Dependent on Transportation Toolbox – mileage assumptions updated
DD	DDP Waiver	Transportation OTHER (taxi, bus pass, misc)	Dependent on Transportation Toolbox – mileage assumptions updated
DD	DDP Waiver	TSI Adult Foster	Varies by case
DD	DDP Waiver	TSI Assisted Living	Varies by case
DD	DDP Waiver	TSI Behavioral Support Services	Varies by case
DD	DDP Waiver	TSI Congregate Living	Varies by case
DD	DDP Waiver	TSI Day Supports and Activities	Varies by case
DD	DDP Waiver	TSI Retirement Services	Varies by case
DD	DDP Waiver	TSI SE Small Group Empl	Varies by case
DD	DDP Waiver	TSI Supported Employment Follow Along	Varies by case
DD	DDP Waiver	TSI Supported Living	Varies by case
DD	MATS	Implementation Guidance by BCBA	RBRVS
DD	MATS	Implementation Guidance by Intermediate Professional	RBRVS
DD	MATS	Treatment Plan by BCBA	RBRVS
DD	MATS	Treatment Plan by Intermediate Professional	RBRVS
DD	MATS	Intensive Treatment	RBRVS
SLTC	Big Sky Waiver	Acupuncture	Varies by case
SLTC	Big Sky Waiver	Adaptive Recreational Therapy	Varies by case
SLTC	Big Sky Waiver	Chiropractic	Varies by case
SLTC	Big Sky Waiver	Community Transition Services	Varies by case
SLTC	Big Sky Waiver	Craniosacral Therapy	Varies by case
SLTC	Big Sky Waiver	Environmental Accessibility Adaptations - Home Modification	Varies by case
SLTC	Big Sky Waiver	Environmental Accessibility Adaptations - Vehicle Modification	Varies by case
SLTC	Big Sky Waiver	Exercise Classes	Varies by case
SLTC	Big Sky Waiver	Goods and Services (other than supplies)	Varies by case

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Program	DPHHS Program	Description	Reason for Exclusion
SLTC	Big Sky Waiver	Goods and Services (supplies)	Varies by case
SLTC	Big Sky Waiver	Health and Wellness	Varies by case
SLTC	Big Sky Waiver	Health Club Membership	Varies by case
SLTC	Big Sky Waiver	Hippotherapy	Varies by case
SLTC	Big Sky Waiver	Hyperbaric Oxygen Therapy	Varies by case
SLTC	Big Sky Waiver	Massage Therapy	Varies by case
SLTC	Big Sky Waiver	Mind-Body Therapies (Such as Hypnosis and Biofeedback)	Varies by case
SLTC	Big Sky Waiver	Pain and Symptom Management - Negotiated with Upper Limit	Varies by case
SLTC	Big Sky Waiver	Pain Mitigation Counseling/Coaching	Varies by case
SLTC	Big Sky Waiver	Personal Emergency Response - Rental	Varies by case
SLTC	Big Sky Waiver	Personal Emergency Response System - Installation and Testing	Varies by case
SLTC	Big Sky Waiver	Personal Emergency Response System – Purchase	Varies by case
SLTC	Big Sky Waiver	Reflexology	Varies by case
SLTC	Big Sky Waiver	Res Hab - Child Foster Care	Non-utilized service
SLTC	Big Sky Waiver	Respiratory Therapeutic Procedures	RBRVS
SLTC	Big Sky Waiver	Respite Care – Nursing Facility	Varies by case
SLTC	Big Sky Waiver	Respite Care - Hospital	Non-utilized service
SLTC	Big Sky Waiver	Specialized Medical Equipment	Varies by case
SLTC	Big Sky Waiver	Specialized Medical Supplies	Varies by case
SLTC	Big Sky Waiver	Wellness Classes	Varies by case
SLTC	Community First Choice	Personal Emergency Response - Rental	Varies by case
SLTC	Community First Choice	Personal Emergency Response - Rental	Varies by case
SLTC	Community First Choice	Personal Emergency Response System - Installation and Testing	Varies by case
SLTC	Community First Choice	Personal Emergency Response System - Installation and Testing	Varies by case
SLTC	Home Health	General Class Medical/Surgical Supplies	Varies by case
SLTC	Home Health	Occupational Therapy - Visit Charge	RBRVS
SLTC	Home Health	Physical Therapy - Visit Charge	RBRVS
SLTC	Home Health	Skilled Nursing - Visit Charge	RBRVS

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Program	DPHHS Program	Description	Reason for Exclusion
SLTC	Home Health	Speech Therapy - Visit Charge	RBRVS

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B.6. Benchmark Rates and Final Recommendations

B.6.1. Rate Recommendations by Population and Program

Benchmark rates for each service across all programs, outlined in Tables 47 through 65, were developed using the rate build-up approach. Appendix A includes the rate models for individual services along with the appropriate sources and calculations for each rate component that contributes to the benchmark service rate.

B.6.2. Adult Behavioral Health Service Rates

The dialectical behavior therapy services fall under the Adult Behavioral Health (ABH) program for members 18 years of age and older. These services are delivered by a licensed mental health professional that is trained and certified in Dialectical Behavior Therapy. Dialectical Behavior Therapy Skill Development may be reimbursed to mental health center and/or mental health provider types as part of the state plan..

Table 47: Dialectical Behavior Therapy (DBT) Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Dialectical Behavior Therapy – Skill Development – Group	15 min	$11.79	$10.41	-11.7%
Dialectical Behavior Therapy – Skill Development – Individual	15 min	$18.04	$20.81	15.4%
Intensive Individual DBT Psychotherapy Services	45-50 min	$60.38	$62.44	3.4%

Adult mental health services for members 18 years of age and older are found in the Other Rehabilitation Services state plan. These services are available through licensed mental health centers. See Table 48.

Table 48: Mental Health Services for Members 18 years of Age and Older Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Adult Foster Care	Day	$89.68	$103.85	15.8%
Adult Foster Care-Therapeutic Leave	Day	$89.68	$103.85	15.8%
Behavioral Health Group Home	Day	$171.65	$185.51	8.1%
Community-based psychiatric rehabilitation & support – group	15 min	$2.18	$3.14	43.9%
Community-based psychiatric rehabilitation & support – individual	15 min	$7.29	$12.36	69.5%
Crisis Stabilization Program	Day	$363.95	$400.88	10.1%
Day treatment –Adult Half Day	Hour	$13.91	$21.33	53.3%
Illness Management and Recovery – Group	15 min	$6.97	$8.79	26.1%
Illness Management and Recovery – Individual	15 min	$12.50	$17.58	40.6%

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
InPACT	Day	$118.17	$118.98	0.7%
Montana Assertive Community Treatment-(MACT)	Week	$264.32	$286.48	8.4%
PACT	Week	$346.75	$356.95	2.9%
PACT Community Maintenance Program (CMP)	Day	$49.54	$64.28	29.8%
Peer Support (Certified) Individual	15 min	$13.87	$16.06	15.8%
Peer Support (Certified) Individual (co-occurring)	15 min	$13.86	$16.06	15.9%

The partial hospitalization rates are a part of the Adult Behavioral Health Services for members 18 years of age and older through the state plan.. These rates were previously daily rates but have been adjusted as weekly rates to align with the SUD partial hospitalization rate. Therefore, there is only one rate for weekly instead of a half day and full day. See Table 49.

Table 49: Partial Hospitalization Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Acute Partial Hospitalization – Full Day	Day	New Payment Structure	$419.38	Unit Change
Acute Partial Hospitalization – Half Day	Day	New Payment Structure	$419.38	Unit Change

The following home and community-based services are for adults under the Severe Disabling Mental Illness (SDMI) waiver. These services have a wide range with some being reimbursed on a case-by-case basis at cost. Services within this program permit the State to provide an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. See Table 50.

Table 50: Home and Community Based Services (HCBS) for Adults with Severe Disabling Mental Illness (SDMI) Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Acupuncture	Session	$72.65	Varies by case	
Adaptive Recreational Therapy	Session	$57.09	Varies by case	
Adult Day Care	15 min	$2.28	$3.16	38.5%
Behavioral Intervention Assistant	15 min	$7.88	$12.54	59.1%
Case Management	Day	$12.92	$14.70	13.8%
Chiropractic	Session	$77.83	Varies by case	
Community Transition Services	Service	$2,075.68	Varies by case	
Consultative Clinical and Therapeutic Services	Unit	$384.56	$507.00	31.8%
Craniosacral Therapy	Session	$72.65	Varies by case	

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Environmental Accessibility Adaptations - Home Modifications	Service	$4,151.37	Varies by case	
Exercise Classes	Class	$67.46	Varies by case	
Health and Wellness	Session	$181.62	Varies by case	
Health Club Membership	Month	$67.46	Varies by case	
Hippotherapy	Session	$46.70	Varies by case	
Homemaker Chores	Per Diem	$259.47	$331.04	27.6%
Hyperbaric Oxygen Therapy	Session	Negotiated	Varies by case	
Life Coach	15 min	$12.45	$12.75	2.4%
Massage Therapy	Session	$72.65	Varies by case	
Mind-Body Therapies	Session	$129.73	Varies by case	
Nutrition (Meals)	Meal	$5.88	$8.97	52.6%
Pain and Symptom Management	Session	$674.60	Varies by case	
Pain Mitigation Counseling/Coaching	Treatment	$674.60	Varies by case	
Personal Assistance Attendant	15 min	$5.88	$8.92	51.7%
Personal Assistance Attendant - Self-Directed	15 min	$4.67	$7.35	57.4%
Personal Assistance Oversight - Self-Directed	15 min	$4.67	$7.35	57.4%
Personal Emergency Response - Rental	Month	$71.61	Varies by case	
Private Duty Nursing - LPN	15 min	$9.29	$14.12	52.0%
Private Duty Nursing - RN	15 min	$11.71	$19.30	64.8%
Reflexology	Session	$72.65	Varies by case	
Residential Habilitation – Adult Group Home	Per Diem	$163.49	$167.22	2.3%
Residential Habilitation - Assisted Living Facilities and Adult Foster Homes	Day	$104.00	$124.75	20.0%
Residential Habilitation – Intensive Mental Health Group Home	Per Diem	$296.24	$334.26	12.8%
Residential Habilitation – Mental Health Group Home	Per Diem	$206.21	$258.58	25.4%
Respite Care	15 min	$4.57	$6.02	31.7%
Respite Care - Assisted Living	Per Diem	$177.73	$192.64	8.4%
Respite Care - Nursing Facility	Day	Medicaid Rate	Varies by case	
Specialized Medical Equipment	Item	$2,075.68	Varies by case	
Specialized Medical Supplies	Item	$2,075.68	Varies by case	
Specialized Nursing Services	Session	$72.65	Varies by case	
Supported Employment	15 min	$13.58	$14.37	5.8%
Transportation - Miles	Mile	$0.34	$0.59	72.1%
Transportation - Trip	Trip	$12.87	$14.90	15.8%
Wellness Classes	Session	$181.62	Varies by case	

The substance use disorder (SUD) services encompass various treatment services for both Medicaid and Non-Medicaid services. Non-Medicaid services address those individuals who are

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not eligible for Medicaid or for those under 200 percent of poverty, with the exclusion of any procedures billed under RBRVS methodology. This category also includes medication-assisted therapy and services on the SUD Medicaid provider fee schedule. See Table 51.

Table 51: Substance Use Disorder (SUD) Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
ASAM 2.1 - Intensive Outpatient*	Day	New Payment Structure	$389.37	New Payment Structure
ASAM 2.5 - SUD Partial Hospitalization	Day	New Payment Structure	$449.24	Unit Change
ASAM 3.1 - SUD Clinically Managed Low Intensity (Single Gender)	Day	New Payment Structure	$143.49	New Payment Structure
ASAM 3.1 - SUD Low Intensity Residential (Parent/Child)	Day	New Payment Structure	$210.13	New Payment Structure
ASAM 3.2WM - SUD Clinically Managed Residential Withdrawal Management	Day	NEW	$254.69	New Service
ASAM 3.3 - SUD Population Specific High Intensity Residential	Day	NEW	$274.51	New Service
ASAM 3.5 - SUD Clinically Managed High-Intensity (Adult)/ Medium-Intensity (Adolescent) Residential	Day	$246.05	$277.99	13.0%
ASAM 3.7 - SUD Medically Monitored Intensive Inpatient	Day	$246.05	$321.79	30.8%
CLIA Laboratory Performed Blood or Urine Test	Per Test	Up to $23.98	Varies by case	
Dip Strip or Saliva Collection, Handling, and Testing	Per Test	$8.46	Varies by case	
Medication-Assisted Therapy (MAT)	Week	$128.56	$146.20	13.7%
Medication-Assisted Therapy (MAT) Intake	Week	$359.97	$365.50	1.5%
Methadone, oral, 5 mg	5 mg	Medicaid Pharmacy Rate	Pharmacy Not in Scope	
Peer Support (Certified) Co-occurring Individual	15 min	$13.87	$16.06	15.8%
Peer Support (Certified) Group – (Up to eight members per group.)	15 min	$2.78	$3.14	13.0%
Peer Support (Certified) Individual	15 min	$13.87	$16.06	15.8%
Peer Support (Certified) Individual (co-occurring)	15 min	$13.87	$16.06	15.8%

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Psychosocial Rehabilitation	15 min	$12.53	$14.31	14.2%
SUD Clinically Managed Low Intensity (ASAM 3.1) (room & board)	Day	$38.47	New Payment Structure	
SUD Clinically Managed Low Intensity (ASAM 3.1) (Women/children room & board)	Day	$140.42	New Payment Structure	

Table 52 summarizes Behavioral Health Targeted Case Management (TCM) Services available through the Medicaid program. TCM services listed must be provided by a licensed mental health center or a state-approved substance use disorder (SUD) program with the appropriate licensure to be reimbursed for services. These mental rates are for the adult population. SUD rates are for both youth and adults.

Table 52: Targeted Case Management Services Rates for Behavioral Health.

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Targeted Case Management-Adult	15 min	$13.70	$16.17	18.0%
Targeted Case Management-Substance Use Disorders	15 min	$13.70	$16.06	17.2%

The services in Table 53 are additional types of targeted case management services provided by DPHHS. However, these services are intended for non-mental health related conditions for children and youth with special needs and high-risk pregnant women.

Table 53: Targeted Case Management (Non-Mental Health) Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Targeted Case Management for Children and Youth with Special Health Care Needs	15 min	$7.09	$7.30	3.0%
Targeted Case Management for High-Risk Pregnant Women - Services provided by the Nurse	15 min	$7.09	$8.03	13.3%
Targeted Case Management for High-Risk Pregnant Women - Services provided by the Nutritionist	15 min	$7.09	$8.43	18.9%
Targeted Case Management for High-Risk Pregnant Women - Services provided by the Social Worker	15 min	$7.09	$8.49	19.7%

Services in Table 54 are listed under the Non-Medicaid 72 Hour Presumptive Eligibility Program for Crisis Stabilization & Crisis Intervention and Response for members 18 years of age and older. Members in receipt of Medicaid are not eligible.

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Table 54: Crisis Stabilization and Intervention State Plan

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Care Coordination	15 min	$13.47	$14.09	4.6%
Community-based psychiatric rehabilitation & support – individual	15 min	$7.29	$12.32	69.0%
Crisis Management Mental Health Center Day One	Hour	$18.60	Service Removed	
Crisis Management Mental Health Center Day Three	Hour	$7.02	Service Removed	
Crisis Management Mental Health Center Day Two	Hour	$11.70	Service Removed	

B.6.3. Children's Mental Health Service Rates

Table 55 summarizes youth Behavioral Health Targeted Case Management (TCM) Services available through the Medicaid program. TCM services listed must be provided by a licensed mental health center with the appropriate licensure or endorsement to be reimbursed for services. These specific rates are for the children's population.

Table 55: Targeted Case Management Services Rates for Children's Mental Health

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Targeted Case Management-MH Youth	15 min	$16.35	$16.17	-1.1%
Targeted Case Management- MH Youth Frontier Differential*	15 min	$18.80	$17.38	-7.5%

Services in Table 56 are intended for youth in the State of Montana, which can be found on the Children's Mental Health fee schedule. These services are available through licensed mental health centers, group homes, in-home, foster care, and partial hospitalization. Services paid under the RBRVS methodology are not included.

Table 56: Medicaid Youth Mental Health Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Acute Partial Hospitalization-Full Day	Day	New Payment Structure	$419.38	Unit Change
Acute Partial Hospitalization-Half Day	Day	New Payment Structure	$419.38	Unit Change

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Community-based psychiatric rehabilitation & support – group	15 min	$2.17	$3.08	41.9%
Community-based psychiatric rehabilitation & support – individual	15 min	$7.25	$12.32	69.9%
Comprehensive School and Community Treatment (CSCT)	15 min	$96.00	$97.44	1.5%
CSCT Intervention, Assessment and Referral (IAR)	15 min	$96.00	$97.44	1.5%
Extraordinary Needs Aide Services	15 min	$4.07	$12.32	202.6%
Home Support Services	15 min	$18.69	$29.98	60.4%
Home Support Services Frontier Differential*	15 min	$21.49	$32.23	50.0%
Non-Medicaid Respite Care – Youth	15 min	$2.76	$4.06	46.9%
Permanency Therapeutic Foster Care	Day	$140.90	$172.61	22.5%
Sub-acute Partial Hospitalization-Full Day	Day	New Payment Structure	$332.63	Unit Change
Sub-acute Partial Hospitalization-Half Day	Day	New Payment Structure	$332.63	Unit Change
Therapeutic Foster Care	Day	$50.91	$64.64	27.0%
Therapeutic Youth Group Home	Day	$201.82	$224.47	11.2%
Therapeutic Youth Group Home Therapeutic home leave	Day	$201.82	$224.47	11.2%
Youth Day Treatment	Hour	$11.71	$15.49	32.3%

Services in Table 57 are intended for youth in the State of Montana, which can be found on the Medicaid Youth Mental Health fee schedule. In state and out of state facilities are listed with the same proposed benchmark rate.

Table 57: Psychiatric Residential Treatment Facility Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
PRTF In State	Day	$336.51	$509.81	51.5%
PRTF out of State	Day	$447.56	$509.81	13.9%

The services listed in Table 58 have been included in the children's services array for the purposes of the rate study. These services are provided to children who are abused, neglected or abandoned. Shelter Care was incorporated into the rate study, since the service is similar to many of the other children's residential services included.

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Table 58: Non-Medicaid Shelter Care Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Shelter Care – Level 4	Day	$88.93	$106.91	20.2%
Shelter Care – Level 5	Day	$150.70	$195.04	29.4%

B.6.4. Developmental Services

The following services found in Table 59 are under the developmental disabilities HCBS waiver program intended to support Medicaid members with developmental disabilities. These waiver services are long-term services and supports that may be provided by a contracted DDP provider or self-directed by the member with provider choice or employer authority.

Table 59: Developmental Disabilities Program

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Adult Foster Support (enhanced supervision)	Month	$2,453.93	$4,249.18	73.2%
Adult Foster Support (intensive supervision)	Month	$5,075.56	$4,711.82	-7.2%
Adult Foster Support (low supervision)	Month	$816.87	$3,323.91	306.9%
Adult Foster Support (moderate supervision)	Month	$1,435.05	$3,786.55	163.9%
Assisted Living enhanced	Day	$256.02	$287.48	12.3%
Assisted Living moderate	Day	$192.02	$215.61	12.3%
Assisted Living OTHER	Day	Varies	Varies by case	
Behavioral Support Services	Hour	$62.57	$92.39	47.7%
Caregiver Training & Support	Hour	$56.08	$59.08	5.3%
Caregiver Training & Support - AwC Self Direct	Hour	$56.08	$59.08	5.3%
Caregiver Training & Support OTHER	Cost	varies	Varies by case	
Community Transition Services	Item	varies	Varies by case	
Community Transition Services - Empl Auth Self Direct	Item	Varies	Varies by case	
Companion	Hour	$23.10	$36.48	57.9%
Congregate Living Children's	Hour	$27.48	$33.17	20.7%
Congregate Living Hourly (more than 10.95 ave hrs/day, over 4000 annual hrs)	Hour	$25.32	$30.52	20.5%
Congregate Living Medical	Hour	$32.00	$35.34	10.4%
Congregate Living Tier 1 (1-4.8 ave hrs/day. 0-1735.99 annual hrs)	Day	$103.31	$136.22	31.9%
Congregate Living Tier 2 (4.9-5.47 ave hrs/day. 1754-2005.99 annual hours)	Day	$120.50	$160.61	33.3%

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Congregate Living Tier 3 (5.48-6.14 ave hrs/day. 2006-2235.99 annual hours)	Day	$136.81	$181.02	32.3%
Congregate Living Tier 4 (6.15-7.14 ave hrs/day. 2236-2605.99 annual hours)	Day	$160.90	$206.98	28.6%
Congregate Living Tier 5 (7.15-7.7 ave hrs/day. 2606-2845.99 annual hours)	Day	$175.47	$232.47	32.5%
Congregate Living Tier 6 (7.8-8.43 ave hrs/day. 2846-3075.99 annual hours)	Day	$194.24	$252.40	29.9%
Congregate Living Tier 7 (8.44-8.75 ave hrs/day. 3076-3194.99 annual hours)	Day	$203.83	$266.86	30.9%
Congregate Living Tier 8 (8.76-9.9 ave hrs/day. 3195-3613.99 annual hours)	Day	$231.87	$290.73	25.4%
Congregate Living Tier 9 (10-10.95 ave hrs/day. 3614-3999.99 annual hours)	Day	$256.46	$324.82	26.7%
Day Supports and Activities Hourly (over 8 ave hours per day)	Hour	$27.63	$33.10	19.8%
Day Supports and Activities Tier 1 (.1-.5 ave hrs/day)	Day	$11.74	$14.07	19.8%
Day Supports and Activities Tier 10 (4.76-5.5 ave hrs/day)	Day	$136.77	$169.64	24.0%
Day Supports and Activities Tier 11 (5.51-6.25 ave hrs/day)	Day	$157.15	$194.46	23.7%
Day Supports and Activities Tier 12 (6.26-6.99 ave hrs/day)	Day	$177.68	$219.29	23.4%
Day Supports and Activities Tier 13 (7.0-7.99 ave hrs/day)	Day	$204.21	$248.25	21.6%
Day Supports and Activities Tier 2 (.5-1.0 ave hrs/day)	Day	$24.04	$28.96	20.5%
Day Supports and Activities Tier 3 (1.01-1.25 ave hrs/day)	Day	$30.22	$37.24	23.2%
Day Supports and Activities Tier 4 (1.26-1.75 ave hrs/day)	Day	$42.31	$49.65	17.3%
Day Supports and Activities Tier 5 (1.76-2.25 ave hrs/day)	Day	$54.71	$66.20	21.0%
Day Supports and Activities Tier 6 (2.26-2.75 ave hrs/day)	Day	$66.86	$82.75	23.8%
Day Supports and Activities Tier 7 (2.76-3.25 ave hrs/day)	Day	$79.47	$99.30	25.0%
Day Supports and Activities Tier 8 (3.26-4.0 ave hrs/day)	Day	$97.81	$119.99	22.7%
Day Supports and Activities Tier 9 (4.01-4.75 ave hrs/day)	Day	$116.81	$144.81	24.0%
Environmental Modifications	Item	Varies	Varies by case	

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Environmental Modifications - Empl Auth Self Direct	Item	Varies	Varies by case	
Fiscal Agent Admin Fee	Cost	Varies	Varies by case	
Homemaker	Hour	$21.92	$30.43	38.8%
Homemaker Other	Cost	Varies	Varies by case	
Individual Goods and Services	Item	Varies	Varies by case	
Individual Goods and Services - Empl Auth Self Direct	Item	Varies	Varies by case	
Meal Services	Meal	$6.13	$8.97	46.4%
Meal Services - Empl Auth Self Direct	Meal	$6.13	$8.97	46.4%
Nutritionist Services (Medicaid State Plan)	Hour	$92.08	$74.92	-18.6%
Personal Care	Hour	$23.10	$35.68	54.5%
Personal Emergency Response (Monthly Service)	Month	Varies	Varies by case	
Personal Emergency Response (Monthly Service) - both Self Direct options	Month	Varies	Varies by case	
Personal Emergency Response System (Installation & Testing)	Item	Varies	Varies by case	
Personal Emergency Response System (Installation & Testing) - both Self Direct options	Item	Varies	Varies by case	
Personal Supports (both self direct options)	Hour	$23.10	$29.40	27.3%
Private Duty Nursing (Medicaid State Plan) LPN	15 min	$9.29	$14.12	52.0%
Private Duty Nursing (Medicaid State Plan) RN	15 min	$11.70	$19.30	65.0%
Psychological Services	Hour	$182.89	$204.65	11.9%
Remote Monitoring	Hour	$8.67	Varies by case	
Res. Hab. Supported Living – Base	Month	$767.70	$978.30	27.4%
Res. Hab. Supported Living – Flex	Month	$1,151.55	$1,467.45	27.4%
Res. Hab. Supported Living (Small agency) High geo factor	Hour	$34.81	$44.51	27.9%
Res. Hab. Supported Living (Small agency) Medium geo factor	Hour	$33.97	$43.45	27.9%
Res. Hab. Supported Living (Small agency) no geo factor	Hour	$33.37	$42.39	27.1%
Res. Hab. Supported Living High geographic factor	Hour	$26.68	$34.24	28.3%
Res. Hab. Supported Living Medium geographic factor	Hour	$26.03	$33.43	28.4%
Res. Hab. Supported Living no geographic factor	Hour	$25.59	$32.61	27.4%
Residential Training Support (high geographical factor)	Hour	$26.52	$34.24	29.1%
Residential Training Support (medium geographical factor)	Hour	$25.88	$33.43	29.2%

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Residential Training Support (no geographical factor)	Hour	$25.44	$32.61	28.2%
Residential Training Support (small agency / high geographical factor)	Hour	$34.62	$44.51	28.6%
Residential Training Support (small agency / medium geographical factor)	Hour	$33.77	$43.45	28.7%
Residential Training Support (small agency / no geographical factor)	Hour	$33.18	$42.39	27.8%
Respite	Hour	$17.96	$24.08	34.1%
Respite - (both self direct options)	Hour	$17.96	$24.08	34.1%
Respite (Other)	Cost	Varies	Varies by case	
Retirement Services Hourly (over 8 ave hours per day)	Hour	$27.63	$31.40	13.6%
Retirement Services Tier 1 (.1-.5 ave hrs/day)	Day	$11.74	$13.35	13.7%
Retirement Services Tier 10 (4.76-5.5 ave hrs/day)	Day	$136.77	$160.93	17.7%
Retirement Services Tier 11 (5.51-6.25 ave hrs/day)	Day	$157.15	$184.48	17.4%
Retirement Services Tier 12 (6.26-6.99 ave hrs/day)	Day	$177.68	$208.03	17.1%
Retirement Services Tier 13 (7.0-7.99 ave hrs/day)	Day	$204.21	$235.50	15.3%
Retirement Services Tier 2 (.5-1.0 ave hrs/day)	Day	$24.04	$27.48	14.3%
Retirement Services Tier 3 (1.01-1.25 ave hrs/day)	Day	$30.22	$35.33	16.9%
Retirement Services Tier 4 (1.26-1.75 ave hrs/day)	Day	$42.31	$47.10	11.3%
Retirement Services Tier 5 (1.76-2.25 ave hrs/day)	Day	$54.71	$62.80	14.8%
Retirement Services Tier 6 (2.26-2.75 ave hrs/day)	Day	$66.86	$78.50	17.4%
Retirement Services Tier 7 (2.76-3.25 ave hrs/day)	Day	$79.47	$94.20	18.5%
Retirement Services Tier 8 (3.26-4.0 ave hrs/day)	Day	$97.81	$113.83	16.4%
Retirement Services Tier 9 (4.01-4.75 ave hrs/day)	Day	$116.81	$137.38	17.6%
Specialized Medical Equipment	Item	Varies	Varies by case	
Specialized Medical Equipment - Empl Auth Self Direct	Item	Varies	Varies by case	
Specialized Medical Supplies	Item	Varies	Varies by case	
Specialized Medical Supplies - Empl Auth Self Direct	Item	Varies	Varies by case	
Supported Employment - Co Worker Support	Day	$11.18	$6.29	-43.7%
Supported Employment - Co Worker Support - both Self Direct options	Day	$11.18	$6.29	-43.7%

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Supported Employment - Individual Employment Support	Hour	$40.48	$57.49	42.0%
Supported Employment - Individual Employment Support - both Self Direct options	Hour	$40.48	$57.49	42.0%
Supported Employment Follow Along	Hour	$40.48	$57.49	42.0%
Supported Employment Follow Along – BASE	Month	$425.04	$520.91	22.6%
Supported Employment Follow Along - both self direct options	Hour	$40.48	$57.49	42.0%
Supported Employment Follow Along - TIER #1	Month	$850.08	$1,041.81	22.6%
Supported Employment Follow Along - TIER #2	Month	$1,254.88	$1,537.91	22.6%
Supported Employment Small Group Hourly - AwC Self Direct	Hour	$27.63	$38.56	39.6%
Supported Employment Small Group Hourly (over 8 ave hours per day)	Hour	$27.63	$38.56	39.6%
Supported Employment Small Group Tier 1 (0-.5 ave hrs/day)	Day	$11.74	$16.39	39.6%
Supported Employment Small Group Tier 10 (4.76-5.5 ave hrs/day)	Day	$136.77	$197.62	44.5%
Supported Employment Small Group Tier 11 (5.51-6.25 ave hrs/day)	Day	$157.15	$226.54	44.2%
Supported Employment Small Group Tier 12 (6.26-6.99 ave hrs/day)	Day	$177.68	$255.46	43.8%
Supported Employment Small Group Tier 13 (7.0-7.99 ave hrs/day)	Day	$204.21	$289.20	41.6%
Supported Employment Small Group Tier 2 (.5-1 ave hrs/day)	Day	$24.04	$33.74	40.3%
Supported Employment Small Group Tier 3 (1.01-1.25 ave hrs/day)	Day	$30.22	$43.38	43.5%
Supported Employment Small Group Tier 4 (1.26-1.75 ave hrs/day)	Day	$42.31	$57.84	36.7%
Supported Employment Small Group Tier 5 (1.76-2.25 ave hrs/day)	Day	$54.71	$77.12	41.0%
Supported Employment Small Group Tier 6 (2.26-2.75 ave hrs/day)	Day	$66.86	$96.40	44.2%
Supported Employment Small Group Tier 7 (2.76-3.25 ave hrs/day)	Day	$79.47	$115.68	45.6%
Supported Employment Small Group Tier 8 (3.26-4.0 ave hrs/day)	Day	$97.81	$139.78	42.9%
Supported Employment Small Group Tier 9 (4.01-4.75 ave hrs/day)	Day	$116.81	$168.70	44.4%
Supports Broker (both self direct options)	Hour	$31.31	$41.34	32.0%
Trans OTHER - both Self Direct options	Cost	Varies	Varies by case	
Transportation - Commute Individual	Month	Varies	Dependent on Transportation Toolbox –	

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
			mileage assumptions updated	
Transportation - Commute Individual Wheelchair Van	Month	Varies	Dependent on Transportation Toolbox – mileage assumptions updated	
Transportation - Commute Individual AwC self direct	Month	Varies	Dependent on Transportation Toolbox – mileage assumptions updated	
Transportation - Commute Shared	Month	Varies	Dependent on Transportation Toolbox – mileage assumptions updated	
Transportation - Commute Shared Wheelchair Van	Month	Varies	Dependent on Transportation Toolbox – mileage assumptions updated	
Transportation - Mileage Reimbursement	Mile	$0.41	$0.59	42.7%
Transportation - Mileage Reimbursement - both Self Direct options	Mile	$0.41	$0.59	42.7%
Transportation - Res Integration AwC self direct	Unit	$40.77/$48.92	$58.18/$69.81	42.7%
Transportation - Residential Integration (each unit is 99.45 miles)	Unit	$40.77	$58.18	42.7%
Transportation - Residential Integration Wheelchair Van (each unit is regular unit rate times 20%)	Unit	$48.92	$69.81	42.7%
Transportation - Work/Day Integration (12 max/yr)	Trip	$12.55	$14.90	18.7%
Transportation - Work/Day Integration Wheelchair Van (regular unit rate times 20%) 12 max/yr	Trip	$15.06	$17.88	18.7%
Transportation OTHER (taxi, bus pass, misc)	Trip	Varies	Dependent on Transportation Toolbox – mileage assumptions updated	
TSI Adult Foster	Month	Varies	Varies by case	
TSI Assisted Living	Day	Varies	Varies by case	
TSI Behavioral Support Services	Hour	$62.57	Varies by case	
TSI Congregate Living	Daily/Hourly	Varies	Varies by case	
TSI Day Supports and Activities	Daily/Monthly	Varies	Varies by case	
TSI Priv Nursing LPN	15 mins	$9.29	Varies by case	
TSI Priv Nursing RN	15 mins	$11.70	Varies by case	
TSI Psychological Services	15 mins	$182.89	Varies by case	
TSI Retirement Services	Daily/Hourly	Varies	Varies by case	

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
TSI SE Small Group Empl	Daily/Hourly	Varies	Varies by case	
TSI Supported Employment Follow Along	Hour	Varies	Varies by case	
TSI Supported Living	Hourly/Monthly	Varies	Varies by case	

Under the developmental disabilities waiver there are additional services for those Medicaid members with autism spectrum disorder (ASD) that are not older than 20 years of age, serious emotional disturbance (SED) no older than 17 years of age or the member is no older than 20 years of age and enrolled in an accredited secondary school and Intellectual Developmental Disability and no older than 20 years of age. These services are all reimbursed under the RBRVS payment methodology. See Table 60.

Table 60: Autism Treatment Services and Applied Behavior Analysis Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Implementation Guidance by BCBA	15 min	$18.20	RBRVS	
Implementation Guidance by Intermediate Professional	15 min	$13.48	RBRVS	
Intensive Treatment	15 min	$10.11	RBRVS	
Treatment Plan by BCBA	15 min	$35.96	RBRVS	
Treatment Plan by Intermediate Professional	15 min	$26.61	RBRVS	

In addition to the developmental disabilities program there is targeted case management for Medicaid members with developmental disabilities presented in Table 561

Table 61: Targeted Case Management Service Rates for Developmental Disabilities

Description	Unit	Current Rate	Rounded Benchmark	Percent Change
Targeted Case Management	Month	$137.38	$141.03	2.7%

B.6.5. Senior and Long Term Care Service Rates

The Big Sky HCBS Waiver services are intended for Medicaid members who are elderly, over 65, or are physically disabled. These services are intended to allow elderly and physically disabled members who require nursing home level care to receive that care in their home or community rather than in a nursing home. See Table 62.

Table 62: Big Sky Waiver Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Acupuncture	Session	$72.15	Varies by case	

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Adaptive Recreational Therapy	Session	$56.69	Varies by case	
Adult Day Care	15 min	$2.27	$3.16	39.1%
Case Management	15 min	$16.08	$16.17	0.6%
Case Management	Day	$11.35	$11.45	0.9%
Case Management plus Supported Living Coordination	Day	$19.08	$25.81	35.3%
Chiropractic	Session	$77.29	Varies by case	
Community Supports Services	15 min	$5.80	$9.52	64.2%
Community Transition Services	Session	$2,061.30	Varies by case	
Consultative Clinical and Therapeutic Services	Unit	$381.89	$507.00	32.8%
CrainioSacral Therapy	Session	$72.15	Varies by case	
Day Habilitation	Day	$82.58	$111.01	34.4%
Environmental Accessibility Adaptations - Home Modification	Service	$4,122.60	Varies by case	
Environmental Accessibility Adaptations - Vehicle Modification	Service	$4,122.60	Varies by case	
Exercise Classes	Class	$66.99	Varies by case	
Family Training & Support	15 min	$8.76	$11.98	36.7%
Financial Manager	Month	$177.97	$181.92	2.2%
Financial Manager (do not use with U9 modifier)	Month	$177.97	$181.92	2.2%
Goods and Services (other than supplies)	Service	$515.32	Varies by case	
Goods and Services (supplies)	Item	$515.32	Varies by case	
Health and Wellness	Session	$180.36	Varies by case	
Health Club Membership	Month	$66.99	Varies by case	
Hippotherapy	Session	$46.38	Varies by case	
Homemaker	15 min	$4.53	$7.61	67.9%
Homemaker Chores	Unit	$257.67	$331.04	28.5%
Hyperbaric Oxygen Therapy	Session	Negotiated	Varies by case	
Independence Advisor	Month	$177.97	$181.92	2.2%
Massage Therapy	session	$72.15	Varies by case	
Mind-Body Therapies (Such as Hypnosis and Biofeedback)	session	$72.15	Varies by case	
Nutrition (Meals)	meal	$5.84	$8.97	53.7%
Nutrition Classes, Nutritionist	15 min	$15.73	$18.73	19.1%
Nutritional Counseling, Dietician	15 min	$15.73	$18.73	19.1%
Pain and Symptom Management - Negotiated with Upper Limit	session	$669.92	Varies by case	
Pain Mitigation Counseling/Coaching	treatment	$669.92	Varies by case	
Personal Assistance Attendant - Agency-Based	15 min	$5.51	$8.92	61.9%
Personal Assistance Attendant - Per Day	Day	$10.83	$15.34	41.6%
Personal Assistance Attendant -Self-Directed	15 min	$4.59	$7.35	60.1%

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Description	Unit	Current Rate	Benchmark Rate	Percent Change
Personal Assistance Nurse Supervision - Agency-Based	15 min	$5.51	$9.10	65.1%
Personal Assistance Oversight - Self-Directed	15 min	$4.59	$7.35	60.1%
Personal Emergency Response - Rental	Month	$71.11	Varies by case	
Personal Emergency Response System - Installation and Testing	Item	$103.07	Varies by case	
Personal Emergency Response System - Purchase	Item	$824.52	Varies by case	
Prevocational Services	Hour	$8.04	$11.78	46.5%
Private Duty Nursing	15 min	$11.62	$19.30	66.1%
Private Duty Nursing - LPN	15 min	$9.23	$14.12	53.0%
Private Duty Nursing - RN	15 min	$11.62	$19.30	66.1%
Reflexology	Session	$72.15	Varies by case	
Registered Nurse Supervision	15 min	$15.78	$20.97	32.9%
Res Hab - Assisted Living Facilities and Adult Foster Homes	Day	$104.00	$124.75	20.5%
Res Hab - Child Foster Care	Day	$112.13	Non-utilized service	
Res Hab - Group Home	Day	$206.58	$224.51	8.7%
Res Hab - TBI-AR	Day	$165.77	$189.72	14.4%
Respiratory Therapeutic Procedures	15 min	$11.79	RBRVS	
Respite Care	15 min	$4.53	$6.02	32.9%
Respite Care - Assisted Living & Adult Foster Care	Day	$176.50	$192.64	9.1%
Respite Care - Hospital	Day	$371.04	$192.64	-48.1%
Respite Care - Nursing Facility	Day	Medicaid Rate	Non-utilized service	
Senior Companion	15 min	$1.38	$1.94	40.4%
Special Child Care for Children	15 min	$5.81	$6.70	15.3%
Specialized Medical Equipment	item	$2,061.30	Varies by case	
Specialized Medical Supplies	item	$2,061.30	Varies by case	
Specialized Nursing Services	Unit	$72.15	$84.88	17.6%
Specially Trained Attendant	15 min	$5.80	$8.92	53.8%
Specially Trained Attendant - LPN	15 min	$9.23	$15.40	66.8%
Specially Trained Attendant - RN	15 min	$11.62	$21.22	82.6%
Supported Employment	15 min	$13.49	$14.37	6.5%
Supported Living	Day	$232.64	$284.14	22.1%
Transportation - Miles	Mile	$0.33	$0.59	77.3%
Transportation - Trip	Trip	$12.78	$14.90	16.6%
Wellness Classes	Class	$180.36	Varies by case	

The Community First Choice (CFC) program state plan provides home and community-based attendant services and supports to eligible Medicaid enrollees who are either elderly or have a disability. There are self-directed and agency-based rates for various services within the program. Under the CFC program additional time is available for community integration, yard hazard removal for the purpose of providing safe access and entry to the home, correspondence assistance and personal emergency response system. See Table 63.

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Table 63: Community First Choice Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Community Supports Services	15 min	$5.84	$9.52	63.1%
Community Supports Services	15 min	$4.63	$7.90	70.5%
Medical Escort	15 min	$5.84	$9.60	64.4%
Medical Escort	15 min	$4.63	$8.03	73.5%
Personal Assistance Services - 15 minutes	15 min	$5.84	$8.92	52.7%
Personal Emergency Response – Rental	Item	$71.11	Varies by case	
Personal Emergency Response – Rental	Item	$71.11	Varies by case	
Personal Emergency Response System - Installation and Testing	Item	$103.07	Varies by case	
Personal Emergency Response System - Installation and Testing	Item	$103.07	Varies by case	
Self-Directed Personal Assistance Services - 15 minutes	15 min	$4.63	$7.35	58.7%
Specially Trained Attendant	15 min	$5.84	$8.92	52.7%
Specially Trained Attendant	15 min	$4.63	$7.35	58.7%

In addition to the CFC program there are Personal Assistance Services (PAS) services designed to provide long term supportive care in a home setting for elderly and disabled Medicaid members. Under the PAS program there is additional time for limited grocery shopping, housekeeping and laundry. The PAS program has a self-directed and agency-based option for each of the services represented in Table 64.

Table 64: Personal Assistance Services (PAS) Service Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Community Supports Services	15 min	$5.84	$9.52	63.1%
Community Supports Services	15 min	$4.63	$7.90	70.5%
Community Supports Services	15 min	$4.63	$7.90	70.5%
Medical Escort	15 min	$5.84	$9.60	64.4%
Medical Escort	15 min	$4.63	$8.03	73.5%
Personal Assistance Services - 15 minutes	15 min	$5.84	$8.92	52.7%
Self-Directed Personal Assistance Services - 15 minutes	15 min	$4.63	$7.35	58.7%

For the Senior and Long Term Care population, specific home health services are offered with the goal of avoiding unnecessary institutionalization or hospitalization by providing skilled nursing, therapy services, home health aide services and medical supplies, equipment, and appliances. Services found in Table 65 may be provided in the member's residence, saving health care costs.

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Table 65: Home Health Service (SLTC) Rates

Description	Unit	Current Rate	Benchmark Rate	Percent Change
Home Health Aide - Visit Charge	Visit	$35.17	$40.86	16.2%
General Class Medical/Surgical Supplies	Item	90% of billed charges	Varies by case	
Occupational Therapy - Visit Charge	Visit	$78.76	RBRVS	
Physical Therapy - Visit Charge	Visit	$78.76	RBRVS	
Skilled Nursing - Visit Charge	Visit	$78.76	RBRVS	
Speech Therapy - Visit Charge	Visit	$78.76	RBRVS	

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B.7. Fiscal Impact Estimates

B.7.1. Fiscal Impact Overview

As a part of determining final rate recommendations, Guidehouse analyzed how proposed rate benchmarks would affect projected expenditures in an effort to estimate the fiscal impact of increased rates for the State of Montana as well as providers delivering services across the State. This analysis was conducted exclusively for the purposes of the rate study, to assess the implications of increasing funding for services to the levels identified by study rate benchmarks. However, as we note in the sub-sections below, our analysis includes several simplifying assumptions that, while warranted for projection purposes, may not reflect eventual service utilization or future Medicaid federal financial participation. Moreover, these assumptions represent Guidehouse's best judgment based on the utilization data available, but do not necessarily reflect State legislative or executive decision-making, nor do they indicate additional commitments to future financing.

In the following sub-sections, Guidehouse describes the data sources for our utilization assumptions, including the service periods reflected in the data as well as any service exclusions or other limitations that frame the data set. The analysis also considers factors that influenced utilization assumptions and our approach to addressing these factors, including COVID-19 service impacts, utilization patterns sensitive to reimbursement increase, or adjustments to utilization stemming from proposed changes to service definition. With these caveats in mind, the report presents the fiscal impact to the service overall as well as by each DPHHS program, detailing projected total and "state share" expenditures. The analysis also breaks down expenditure comparisons by service category to shed additional insight into some of the key service rate resulting in higher and lower financial impacts.

B.7.2. Baseline Data and Service Periods

While rate studies typically rely on expenditure data and utilization assumptions based on the most recently completed year of payments, data concerns or service delivery anomalies sometimes warrant exception to this general preference for more recent utilization data. In the case of the present study, the public health emergency prompted by COVID-19 led to a systemic disruption of service delivery that significantly altered patterns of utilization, resulting in claims data unrepresentative of prior service volume as well as likely utilization in the future. Although Guidehouse collected data from SFY 2017 through 2021, we ruled out the SFY 2021 service period as a base period for projection due to reduced utilization evident, as well as other distortions in the mix of service provision due to the emergency.

The service period reflected in SFY 2019 is the only annual period entirely free of COVID-19 impacts. However, in comparing each of the three annual periods against one another, Guidehouse determined SFY 2020 was also relatively free of negative PHE utilization impacts, which occur late in the final quarter of the fiscal year. In fact, SFY 2020 appears to be the most comprehensive data set available, considering not all program services had migrated from

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legacy systems to MMIS (Montana Medicaid Management Information System) as the primary data repository by 2019. Data for developmental services, in particular, revealed critical gaps in SFY 20219 service utilization due to the fact that much of this data was not yet transitioned from AWACS. The merit of the SFY 2020 service period is that it is both largely reflective of the pre-COVID SFY 2019 data (where claims from that period are complete), and more comprehensive than the SFY 2019 data in representing the full range of service utilization across the system. For these reasons, Guidehouse chose to use the SFY 2020 period as the baseline for fiscal projection.

The only exception to the SFY 2020 source data period is the utilization assumption used for projected targeted case management expenditures for developmental services. This data set did not begin to be captured in MMIS until SFY 2021, with only a partial picture of annual utilization and spend available during this period. Guidehouse addressed this gap by developing projections based on the most recent 12 months of TCM utilization for that population. This alternative is feasible because TCM is a routine service that would typically remain stable from month to month, fluctuating with enrollment but at relatively little risk of significant utilization impact due to COVID-related disruption.

Since State expenditures during SFY 2020 were not paid at current rates, Guidehouse adjusted the expenditure baseline grounded in SFY 2020 by repricing this utilization to reflect current rates. This adjustment is noted in fiscal impact tables in the “Paid at SFY22” columns, which indicates what the Department *would have paid* in SFY 2020 if reimbursing claims at the rates currently effective. For reference, actual SFY 2020 payments are also included in the fiscal impact tables to show not only the effect of recent rate increases since SFY 2020, but also differences in the application of billing rules. To establish the payment baseline, Guidehouse priced each unit of service included in the data at the current rate without mimicking all the claims adjudication nuances that can yield a final payment amount below the Medicaid allowed amount, such as reductions due to third party liability or other determinations. Expenditures calculated at Guidehouse’s benchmark rates follow suit, allowing proportionate comparison for assessing financial impact.

It is important to note, too, the underlying data captures only Medicaid services and does not incorporate those services included in the rate study that are either not Medicaid services (for example, Shelter Care) or were reimbursed by the State for individuals who were not enrolled in or not eligible for Medicaid (for example, TCM). These expenditures are a disproportionately tiny fraction of Medicaid spending, and their inclusion would likely have a negligible impact on the impact statement overall.

Finally, the projections presented later in this section should not be taken as a representation of the total budget for the multitude of programs involved in the study. Services such as Specialized Medical Equipment are not billed at standard rates, but at the specific cost to the provider and reimbursed on a case-by-case basis. These types of services exemplify “pass-through” costs to the provider that would not change under the benchmark projection. The list of services excluded from rate development is documented in Section F.6. and collectively constitute approximately $3.3 million of expenditures across all service populations. Expenditures associated with these services have been bracketed off from the analysis.

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B.7.3. Other Projection Assumptions

For the most part, the analysis' utilization assumptions reflect historical service volume, and Guidehouse did not attempt to adjust utilization patterns based on anticipated changes stemming from rate increases or post-COVID shifts in service provision. While we expect utilization will increase over usage levels observed in SFY 2021 and 2022, expected increases in volume are already captured, to some extent, in the SFY 2020 baseline data, in which growth in utilization is modeled as a return to "normal" pre-COVID service delivery.

While it is possible some services experiencing substantial rate increases may see higher utilization due to new revenue incentives to deliver these services, it is too soon to predict whether rate adequacy alone is sufficient to address workforce shortages that may have contributed previously to depressed utilization or challenges to access to care. Given the uncertain economic climate, the complexity of the dynamics operating in the current labor market, and the difficulty in gauging consumer and provider behavior post-COVID, Guidehouse declined to make rate-influenced adjustments to utilization based on our own speculative trending assumptions.

Guidehouse did include utilization adjustments, however, for services in which benchmark recommendations presume substantial changes in service design or payment methodology that would be likely to impact utilization. On the one hand, our recommendations regarding bundling client transportation costs across residential and day service provision would result in a precipitous decline in utilization of distinct developmental disability transportation services, since providers would no longer be able to bill their transportation costs separately. On the other hand, proposed changes to the units of service for several intensive SUD interventions are likely to affect utilization as these services move to a new daily rate that differs from previous assumptions in the typical daily hours needed for service provision. In both cases, the fiscal impact analysis reflects utilization based on recommended service design rather than merely historical trends.

The analysis identifies fiscal impact in terms of both total expenditure increases and the additional state share dollars needed to fund services at the proposed benchmark rate. Projected state share impacts are also subject to simplified federal participation assumptions that may deviate from actual Federal Medical Assistance Percentage (FMAP) levels depending on several factors, including time of implementation and the persistence of the federal emergency declaration, as well as the relative proportion of Medicaid expansion and non-expansion beneficiaries receiving services.

In SFY 2023, Montana's Medicaid FMAP will be 64.12 percent, which means the federal government will cover 64.12 percent of expenditures for standard Medicaid services, with Montana's state share covering the remaining 35.88 percent of reimbursement costs. While these ratios hold true for the vast majority of services and Medicaid members included in the rate study, there are several exceptions to this relationship, in which federal reimbursement may be substantially higher than the standard FMAP. These exceptions include:

- Services covered under the Community First Choice program, which are funded at an enhanced federal participation rate 6 percentage points higher than the standard FMAP

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(70.12 percent in SFY 2023);
- Services delivered to the Medicaid expansion population, which are subject to a 90 percent FMAP; and
- HCBS services approved by CMS for enhanced American Rescue Plan Act (ARPA) funding at an additional 10 percent above the standard FMAP (74.12 percent) and 5 percent above the expansion FMAP (90 percent).

In addition to these FMAP variations by service and member, all Medicaid expenditures are currently subject to an enhanced 6.2 percent FMAP authorized by the Families First Coronavirus Response Act (FFCRA) for the duration of the federal public health emergency, which remains in effect but is re-evaluated and renewed quarter-to-quarter.

Each of these enhanced FMAP conditions potentially exerts an influence on the ultimate state share of total expenditures. Our fiscal impact accounts for the enhanced FMAP for services delivered under the Community First Choice program as well as services delivered to the Medicaid expansion population, but it does not attempt to model other potential enhancements. For COVID-related FMAP enhancements from FFCRA and ARPA, it remains unclear which services will continue to be subject to enhanced FMAP approvals, as well as whether enhancements contingent on the PHE declaration will remain in effect during the rate implementation effective period projected in the analysis. For these reasons, Guidehouse chose to apply conservative federal participation assumptions, opting to err on the side of *overstating* rather than *understating* the financial implications for decision-makers of fully funding these benchmarks.

B.7.4. Fiscal Impact across All Service and Programs

Comparisons between current rates and the benchmarks developed by Guidehouse included only the reimbursement rate included in DPHHS' effective fee schedules, without considering other payments the Department may make to providers as a part of total reimbursement. For a select number of services in the reviewed service array, the Department has also authorized a separate, "add-on" payment program designed to supplement the rate by addressing specific provider costs, such as increased direct care worker wage assumptions or more expensive, DPHHS-subsidized provider health insurance offerings to their employees.

The first of these "add-on" programs is known as the Direct Care Wage (DCW) add-on payment, and it pertains to a range of services delivered to each of the four populations included in the rate study. The payment is not applied to all services, but only to a subset of in-home services delivered to the senior and long-term care and adult behavioral health populations, as well as several children's mental health center services and residential settings. The DCW add-on is also authorized for several developmental services, but it has been established through a series of rate increases paid through the published fee schedule rate rather than as a separate payment. The impact of the DCW add-on for DD services is already accounted for, then, in the comparison of current rates to Guidehouse's proposed benchmarks.

The second major payment program is called the Health Care for Health Care Workers (HCHCW) add-on payment. This payment is designed to cover the additional cost of

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participating providers whose health insurance offerings fulfill the higher standard required for the program, leading to benefit costs substantially higher than the benefit plans typically offered within the industry. Unlike the DCW add-on, which is tied to the provision of specific services and consequent service volume, the HCHCW is an opt-in program with additional reporting required from those providers choosing to participate.

Because Guidehouse's benchmark recommendations are designed to identify adequate direct care wages, they are intended to replace the current DCW add-ons, since they presuppose that no additional funds would be needed for provider cost coverage beyond those costs already contemplated in the standard rate. For this reason, it is important to include Department expenditures reflected in the DCW program to facilitate a true "apples-to-apples" comparison between current and benchmark rates.

The costs of the HCHCW program, however, are not incorporated into the fiscal impact analysis, since this program are not absorbed into and supplanted by the benchmark rates. Although Guidehouse's health insurance recommendations are established to be competitive in the current labor market and commensurate with industry practice, assumptions for these benefit costs were not developed to fund benefit levels equivalent to the standard of participation in the HCHCW program. In other words, even supposing full implementation of Guidehouse's benchmark recommendations, the HCHCW program would still be needed to cover the additional health insurance costs incurred by HCHCW providers beyond the benefit costs paid through the standard rate.

Table 66 shows the fiscal impact of funding rate changes to the full rate benchmark for all services included in the rate study, and also analyzed by program. The table includes a projection of expenditures if service utilization were to be paid at benchmark rates (the column labeled "Benchmark Cost"), which is compared to a set of baseline current expenditures ("Total Current Expenditures") to identify the overall fiscal impact, a figure that reflects new expenditures needed to finance benchmark rates (representing the "Difference" between benchmark and current spending). Total Current Cost represents a combination of claims paid at current fee schedule rates as well as the DCW add-on payment paid separately. Total DCW add-on payments come to $9.6 million across all programs; this figure does not reflect DD add-ons that are paid through claims, or CMH add-ons for in-state PRTF services, which are also included in the "Paid at SFY22" amount.

Table 66: Total Fiscal Impact, Add-On Payments Included (Federal + State Share)

By Population	Paid at SFY22	Add-On Payments	Total Current Cost	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
Total	**$365,844,127**	**$9,670,123**	**$375,514,250**	**$457,954,972**	**22.0%**	**$82,440,723**	**100.0%**	**100.0%**
ABH	$63,582,882	$17,000	$63,599,882	$74,660,009	17.4%	$11,060,127	16.9%	16.3%
CMH	$79,515,051	$2,337,108	$81,852,159	$90,863,588	11.0%	$9,011,429	21.8%	19.8%

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By Population	Paid at SFY22	Add-On Payments	Total Current Cost	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
DD	$130,932,959	$0	$130,932,959	$164,716,686	25.8%	$33,783,727	34.9%	36.0%
SLTC	$91,813,235	$7,316,015	$99,129,250	$127,714,690	28.8%	$28,585,439	26.4%	27.9%

Analysis suggests the system would require an additional $82.4 million—which includes not just state but also federal dollars—to reimburse providers at the benchmark rates recommended by Guidehouse. While the analysis indicated service arrays for all four populations warrant some level of rate increase, the need for additional funding is not proportionate across all populations. It will be immediately apparent when viewing Table 66 that most of the add-on payments are currently directed at SLTC in-home services. This is not surprising, considering current SLTC rates are generally lower than rates paid for services to the other populations in the rate study. The DCW add-on represents a critical supplement to the lower reimbursement historically paid for the SLTC population. The table also suggests, however, that even when including the DCW add-on subsidy, the SLTC rates still have the farthest to go in achieving rate adequacy, with a funding increase needed of roughly 29 percent, in comparison to the 22 percent increase needed for services as a whole.

While the fiscal impact analysis indicates the system would require $82.4 million annually to increase reimbursement to the benchmark rates, the additional dollars the State of Montana would need to raise represents a substantially lower proportion of those total funds. Given the basic 64.12/35.88 percentage split in federal and state contributions, the state share constitutes just a third of the total additional funding needed, particularly when taking account of the various opportunities for enhanced FMAP. Table 67 notes the effective state share for the mix of services included in the study is 33.73 percent, with children's mental health and state developmental services reimbursed at the standard FMAP, while SLTC services are subject to an enhanced FMAP for in-home services delivered under the Community First Choice program. The sizeable Medicaid expansion population represented among members receiving adult behavioral services further reduces the state share for these services, down to 28.07 percent of the total dollars needed.

Table 67: Effective State Share

Population/Program	Effective State Share
Total	**33.73%**
ABH	28.07%
CMH	35.88%
DD	35.88%
SLTC	32.74%

The collective impact of these state share reductions is a price tag of $27.7 million for the State of Montana, assuming full funding of the benchmark rates. For most of the populations, the percentage increase in expenditure is roughly the same for the state share and for total

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expenditures, but it should be noted the growth in state share expenditures is slightly higher for adult behavioral health services than the expenditure increase for these services as a whole. This result is due to the fact the behavioral health services subject to the highest rate increases are in-home, residential, and day services with relatively low rates of participation from the expansion population. Table 68 details the state fiscal impact across all services, with expenditure breakdowns by population.

Table 68: Total Fiscal Impact, Add-On Payments Included (State Share)

By Population	Paid at SFY22	Add-On Payments	Total Current Cost	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
Total	**$123,564,452**	**$3,238,893**	**$126,803,345**	**$154,480,678**	**21.8%**	**$27,677,332**	**100.0%**	**100.0%**
ABH	$17,636,581	$4,772	$17,641,354	$20,959,394	18.8%	$3,318,041	13.9%	13.6%
CMH	$28,530,000	$838,554	$29,368,555	$32,601,855	11.0%	$3,233,301	23.2%	21.1%
DD	$46,978,746	$0	$46,978,746	$59,100,347	25.8%	$12,121,601	37.0%	38.3%
SLTC	$30,419,125	$2,395,566	$32,814,691	$41,819,081	27.4%	$9,004,389	25.9%	27.1%

While the Table 68 represents the most precise estimate of actual impact to state spending, it may also be beneficial to examine fiscal impact with add-on payments excluded to facilitate better comparison between the proposed benchmark rates and current rates. See Table 69. From this vantage point, it is easier to see the historical rate inequities that have developed among the different populations, with SLTC service rates lagging behind provider costs much more significantly than the rates in effect for the other programs. In the absence of DCW add-on payments, SLTC services would require an additional 39.1 percent in additional funding to bridge the gap between provider costs and reimbursement.

Table 69: Total Fiscal Impact, Add-On Payments Excluded (Federal + State Share)

By Population	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
Total	**$339,205,457**	**$365,844,127**	**$457,954,972**	**25.2%**	**$92,110,846**	**100.0%**	**100.0%**
ABH	$57,560,816	$63,582,882	$74,660,009	17.4%	$11,077,127	17.4%	16.3%
CMH	$76,950,314	$79,515,051	$90,863,588	14.3%	$11,348,537	21.7%	19.8%
DD	$124,042,776	$130,932,959	$164,716,686	25.8%	$33,783,727	35.8%	36.0%
SLTC	$80,651,551	$91,813,235	$127,714,690	39.1%	$35,901,454	25.1%	27.9%

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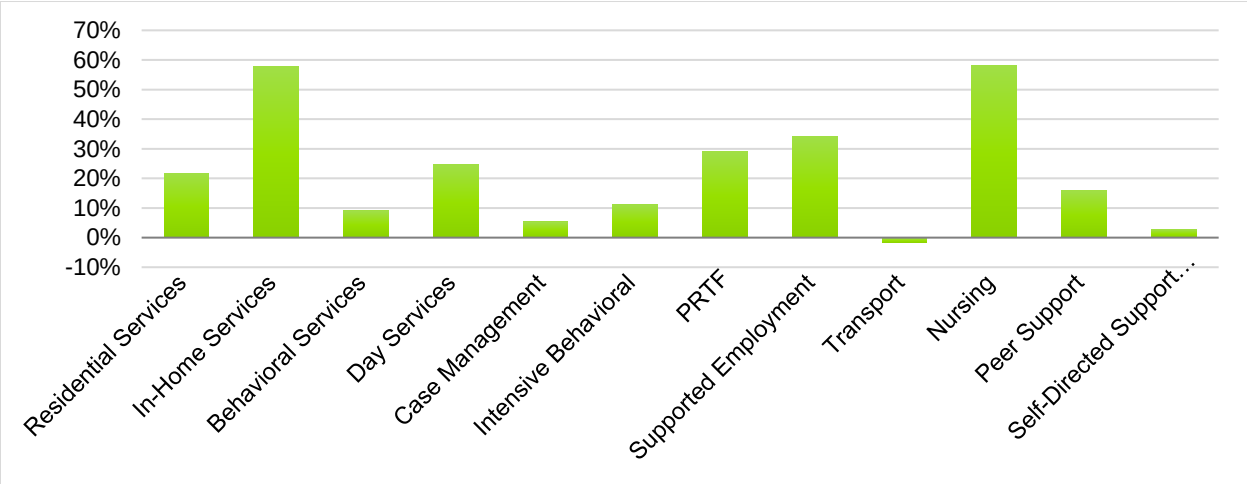
Beyond the historical underfunding evident for SLTC services, there are significant differences in the funding needs projected for each of the programs. There are unique cost drivers impacting the four different service arrays that deserve further exploration. Some of the large increases projected for these services reflect major rate differences between current and benchmark rates, while some increases are muted or amplified by differences in service volume. The most abrupt increases, as seen in the case of SLTC services, are due to a combination of substantial rate increases for services delivered at high volume.

Abstracting for the moment from utilization, one can easily identify the service categories experiencing the most significant rate changes. In-home and nursing services, for example, rise precipitously across the board, regardless of population, at levels reaching almost 60 percent in terms of the total increase in expenditures for these groups of services. However, the magnitude of the increase is perhaps more evident for in-home services than for nursing services, since in-home services make up a large proportion of total service delivery and expenditures across all populations, while nursing services constitute just a small fragment of expenditures within the system. The relative change in expenditures for each category is illustrated in Figure 10.

Figure 10: Percentage Change in Expenditures by Service Category



To evaluate the ultimate impact of these relative changes in spending per service category, it is necessary to understand the proportion of the wider service mix each of these categories represents. In our comparison of the two service categories seeing the largest relative spending increases, in-home and nursing services, we noted in-home services are high-volume while nursing services are not. The overall service mix is evident in Figure 11, where it shows in-home services represent the second-largest service category in the system as measured by total spend, behind only residential services. Nursing services, on the other hand, represent such a small percentage of total expenditures that they are grouped in the “other” category of services reflecting less than 3 percent of all spending.

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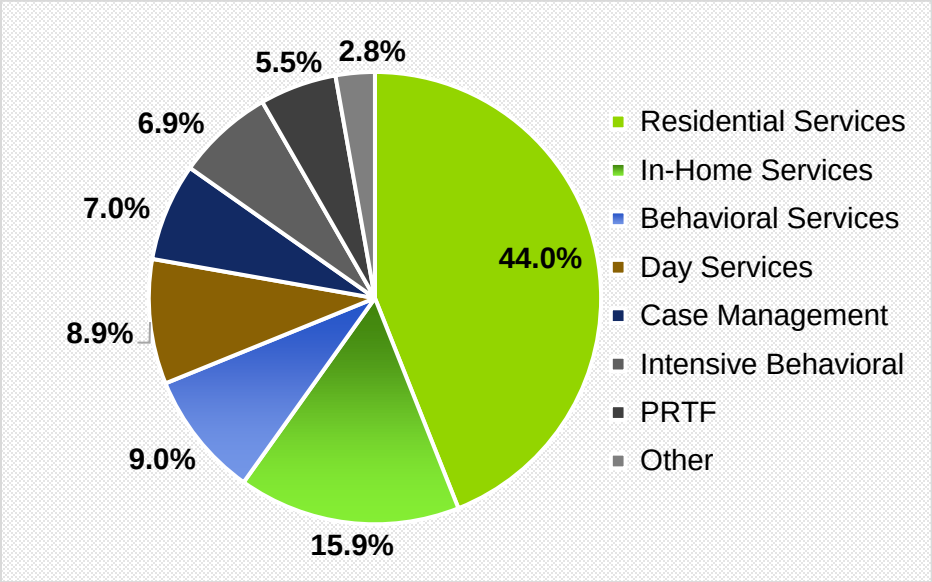
Figure 11: Service Mix by Expenditures across Programs and Populations



As illustrated in the Figure 11, residential and in-home services together constitute the majority of system expenditures, making up just under 60 percent of total expenditures. Figure 12 illustrates the extent to which these two service categories drive increased spending overall. Although growing at a lower rate than in-home services, residential service costs are nevertheless projected to increase by greater than 20 percent, constituting the single largest category of additional funding needed. Figure 12 is particularly apt for showing the relative growth of in-home services, where a significant stretch in this service layer is evident when comparing the bar on the right reflecting benchmark spend to current spend on the left. Projected rate increases would shift spending for in-home services from 14.8 percent of total spending to 18.7 percent.

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Figure 12: Cross Section of All Expenditures by Service Category

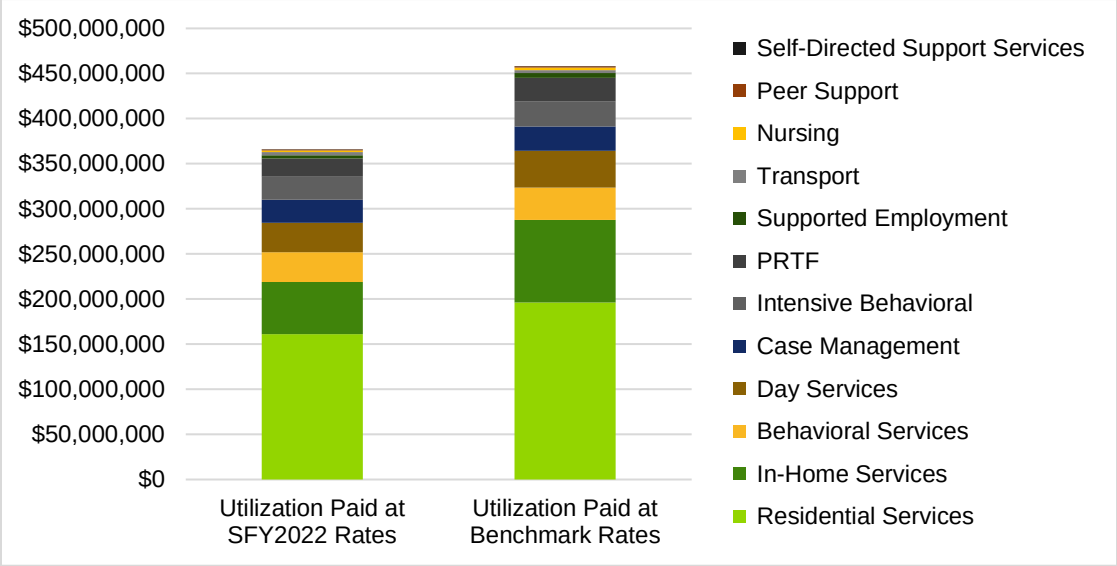

Table 70 provides detailed information on relative changes among different service categories in the system, along with projected fiscal impact per category. The amounts below reflect state share dollars only, and they do not include additional current spending via DCW add-on payments. The purpose of the comparison numbers is to highlight the differences in overall fiscal impact due to the combination of rate change and relative service volume.

Table 70: Summary of Total Fiscal Impact by Service Category (State Share)

Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
All Services	**$114,337,293**	**$123,564,452**	**$154,480,678**	**25.0%**	**$30,916,225**	**100.0%**	**100.0%**
Residential Services	$50,840,672	$57,183,479	$69,727,419	21.9%	$12,543,940	46.3%	45.1%
In-Home Services	$17,992,075	$18,324,123	$28,844,673	57.4%	$10,520,550	14.8%	18.7%
Behavioral Services	$11,384,996	$11,761,913	$12,829,210	9.1%	$1,067,296	9.5%	8.3%
Day Services	$11,322,884	$11,660,521	$14,509,311	24.4%	$2,848,791	9.4%	9.4%
Case Management	$7,662,850	$8,763,276	$9,183,050	4.8%	$419,774	7.1%	5.9%
Intensive Behavioral	$5,077,560	$5,221,574	$5,800,177	11.1%	$578,602	4.2%	3.8%
PRTF	$6,860,825	$7,215,507	$9,303,668	28.9%	$2,088,162	5.8%	6.0%

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Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
Supported Employment	$1,347,365	$1,350,883	$1,814,205	34.3%	$463,321	1.1%	1.2%
Transport	$998,645	$1,205,934	$1,184,887	-1.7%	-$21,047	1.0%	0.8%
Nursing	$618,261	$638,642	$1,010,656	58.3%	$372,013	0.5%	0.7%
Peer Support	$209,698	$216,532	$250,722	15.8%	$34,189	0.2%	0.2%
Self-Directed Support Services	$21,461	$22,066	$22,700	2.9%	$634	0.0%	0.0%

The fiscal impact dynamics observed as a whole across the four service arrays are not necessarily reflective of the particular cost drivers influencing projected spending in each of the programs. The remaining discussion involves an in-depth examination of the specific factors impacting projected expenditures increases for each of the distinct DPHHS programs and service populations.

B.7.5. Fiscal Impact to Adult Behavioral Health Programs

Unlike the fiscal impact projected for the other three study populations, where spending increases are driven by substantial rate increases for a few key services, estimated expenditure increases for the Adult Behavioral Health programs are characterized by more even growth across the behavioral health service array. The behavioral health service array is distinctive in several important ways when compared to the profile of services overall. For instance, although residential services are a major component of the behavioral health service continuum, their role is less dominant for the adult behavioral health population than for other populations, making up a little under 32 percent of expenditures, in contrast to proportions of 37 to 68 percent observed for the other populations studied. Unique to adult behavioral health populations are the “intensive behavioral” interventions specific to behavioral health, without analog for the other service populations. These services constitute 40 percent of adult behavioral health expenditures. The service mix specific to this population is illustrated in Figure 13:

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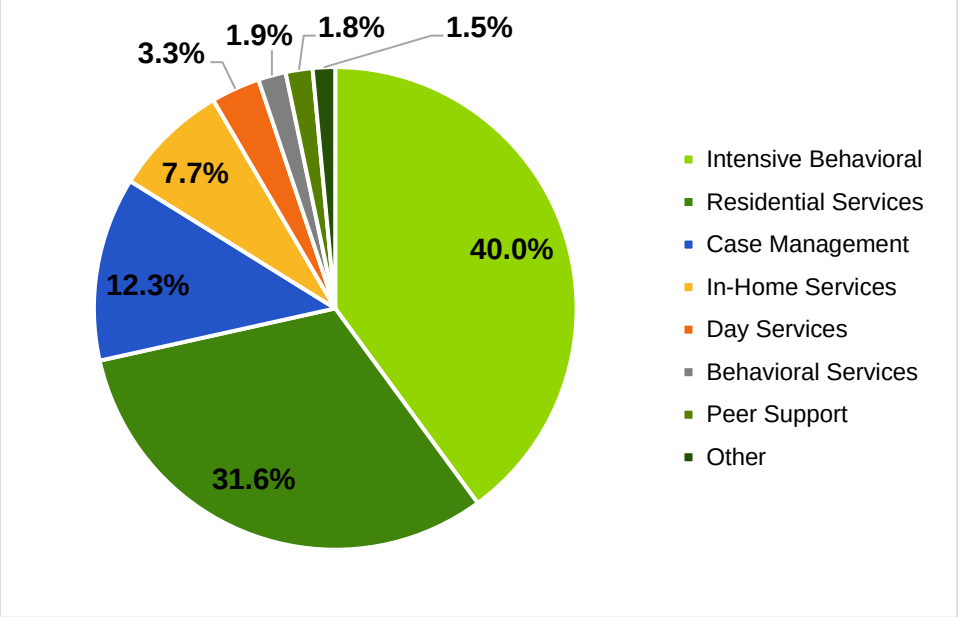
Figure 13: ABH Service Mix by Current Expenditures



There are several service categories projected to see expenditure increases of over 50 percent; these include in-home services, behavioral services, day services, transportation, and nursing services. With the exception of in-home services, however, many of these services constitute a small fraction of total spending. More prominent is the incremental expenditure growth seen for intensive behavioral and residential services, each of which is projected to see increases of less than 12 percent. As Figure 14 suggests, no single service category appears exclusively to drive the bulk of the additional $11 million dollars needed to fund the proposed benchmark rates.

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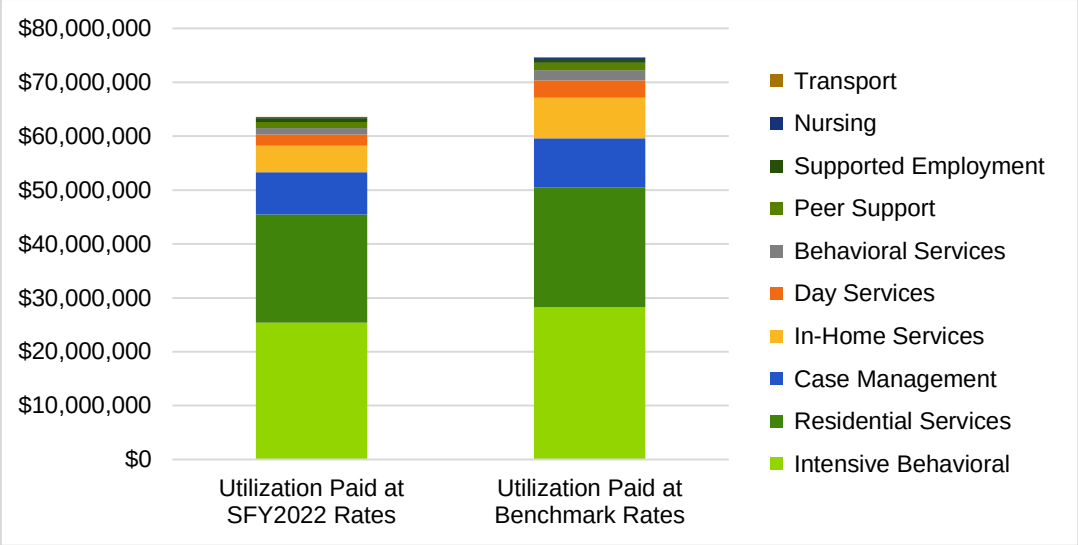
Figure 14: Cross Section of ABH Expenditures by Service Category



Projected state share fiscal impact is indicated in Table 71. For purposes of highlighting the differences in overall fiscal impact due to rate changes and relative service volume, the amounts do not include additional current spending via DCW add-on payments.

Table 71: Summary of ABH Fiscal Impact by Service Category (State Share)

Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
All ABH Services	**$15,737,178**	**$17,636,581**	**$20,959,394**	**18.8%**	**$3,322,813**	**100.0%**	**100.0%**
Residential Services	$5,090,811	$6,636,859	$7,343,858	10.7%	$706,999	37.6%	35.0%
In-Home Services	$1,675,005	$1,763,047	$2,714,860	54.0%	$951,813	10.0%	13.0%
Behavioral Services	$368,140	$379,570	$618,942	63.1%	$239,372	2.2%	3.0%
Day Services	$667,036	$686,448	$1,051,625	53.2%	$365,177	3.9%	5.0%
Case Management	$2,328,497	$2,398,587	$2,795,249	16.5%	$396,663	13.6%	13.3%
Intensive Behavioral	$5,077,560	$5,221,574	$5,800,177	11.1%	$578,602	29.6%	27.7%
Supported Employment	$245,264	$253,424	$259,599	2.4%	$6,175	1.4%	1.2%

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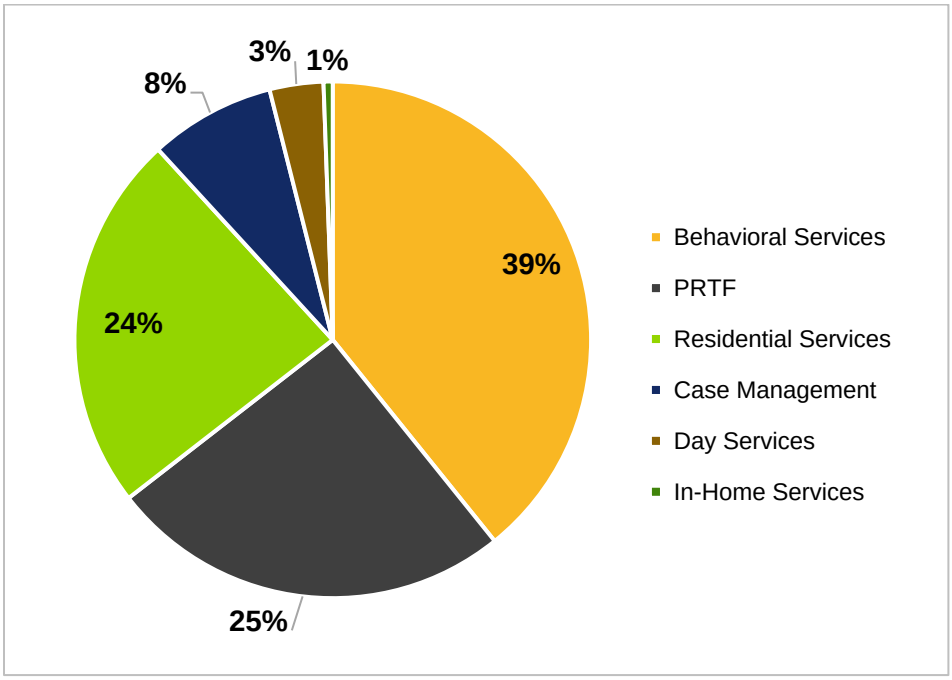
Transport	$24,565	$28,191	$42,816	51.9%	$14,624	0.2%	0.2%
Nursing	$50,602	$52,349	$81,546	55.8%	$29,198	0.3%	0.4%
Peer Support	$209,698	$216,532	$250,722	15.8%	$34,189	1.2%	1.2%

B.7.6. Fiscal Impact to Children's Mental Health Programs

Like adult behavioral health services, the Children's Mental Health program features service categories such as psychiatric residential treatment facility (PRTF) services unique to the children's and youth population, resulting in a distinctive service array and spending projections that do not necessarily align with expenditure trends for the system as a whole. Roughly 88 percent of current spending consists of PRTF, community residential services and behavioral services specific to this population, such as Comprehensive School and Community Treatment. Many of the minor community supports seen in other service arrays, such as nursing and non-medical transportation, are absent from the children's mental health service array. Figure 15 below shows the distribution of service categories for this population.

Figure 15: CMH Service Mix by Current Expenditures



Among the categories represented in the continuum of children's mental health services, sharpest growth is observed for day services and in-home services. However, these categories are relatively minor components of service delivery, and rate increases do not have sizeable impacts on overall spending for this population. More pronounced are the rate increases for

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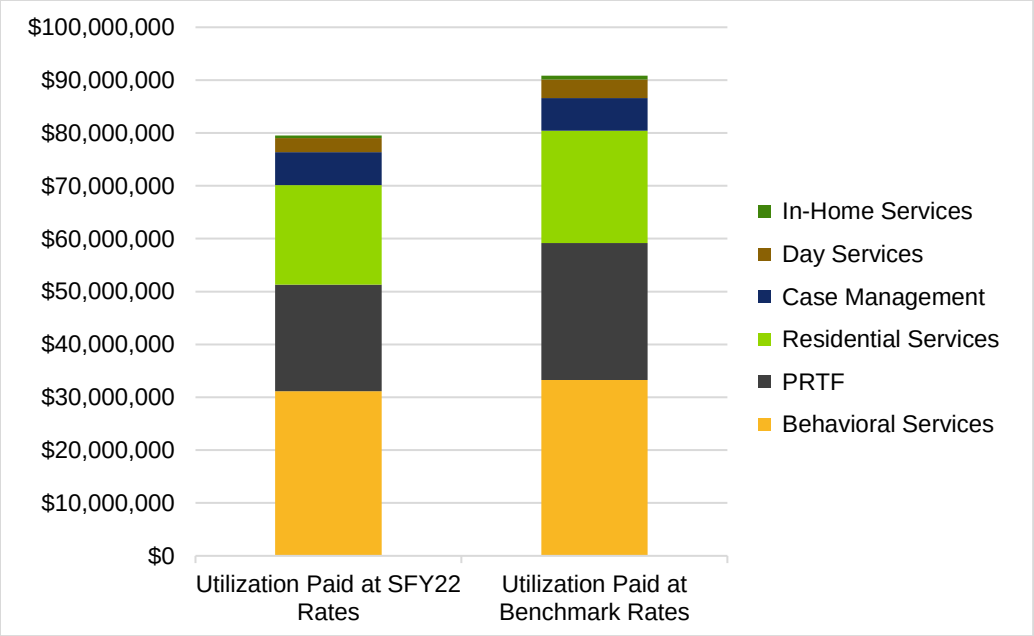
PRTF services, which grow by nearly 29 percent overall for in-state and out-of-state facilities. Most of the relative growth in spending is attributable to PRTFs, since spending for the largest service category, behavioral services, is projected to increase by less than 7 percent. See Figure 16.

Figure 16: Cross Section of CMH Expenditures by Service Category



Projected state share fiscal impact for children's services can be found in Table 72. As with the other populations surveyed, amounts do not include DCW add-on payments in order to highlight the differences in overall fiscal impact due to rate changes and relative service volume.

Table 72: Summary of CMH Fiscal Impact by Service Category (State Share)

Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
All CMH Services	**$27,609,773**	**$28,530,000**	**$32,601,855**	**14.3%**	**$4,071,855**	**100.0%**	**100.0%**
Residential Services	$6,567,742	$6,755,966	$7,619,978	12.8%	$864,012	23.7%	23.4%
In-Home Services	$421,297	$163,512	$261,334	59.8%	$97,823	0.6%	0.8%
Behavioral Services	$10,837,414	$11,188,116	$11,939,597	6.7%	$751,481	39.2%	36.6%
Day Services	$933,389	$960,390	$1,270,405	32.3%	$310,015	3.4%	3.9%

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Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
Case Management	$1,989,105	$2,246,510	$2,206,873	-1.8%	-$39,637	7.9%	6.8%
PRTF	$6,860,825	$7,215,507	$9,303,668	28.9%	$2,088,162	25.3%	28.5%

B.7.7. Fiscal Impact to Developmental Disabilities Programs

The most striking feature of the continuum of developmental services is the relative dominance of the residential services category, at least as measured by expenditures. As seen in Figure 17 residential service payments make up just under 68 percent of all spending for the Developmental Disabilities Programs. In contrast to the community residential settings of other populations, where expenditures are expected to increase between 11 and 19 percent, DD residential services would see over 27 percent growth in spending, suggesting that most of the expenditure growth reflects additional dollars needed to fund residential services. In fact, residential services compose $24 million of the $33 million total needed to fully fund developmental service benchmark rates.

Beyond residential services, day services make up the other major category in the developmental services array. These services are also seeing substantial rate growth of over 21 percent, constituting most of the remaining additional funding needed. In-home, supported employment, nursing and behavioral services are also seeing substantial growth due to rate increases, but these services make up a small proportion of the expenditure profile. Figure 17 shows the service mix specific to developmental services:

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Figure 17: DD Service Mix by Current Expenditures

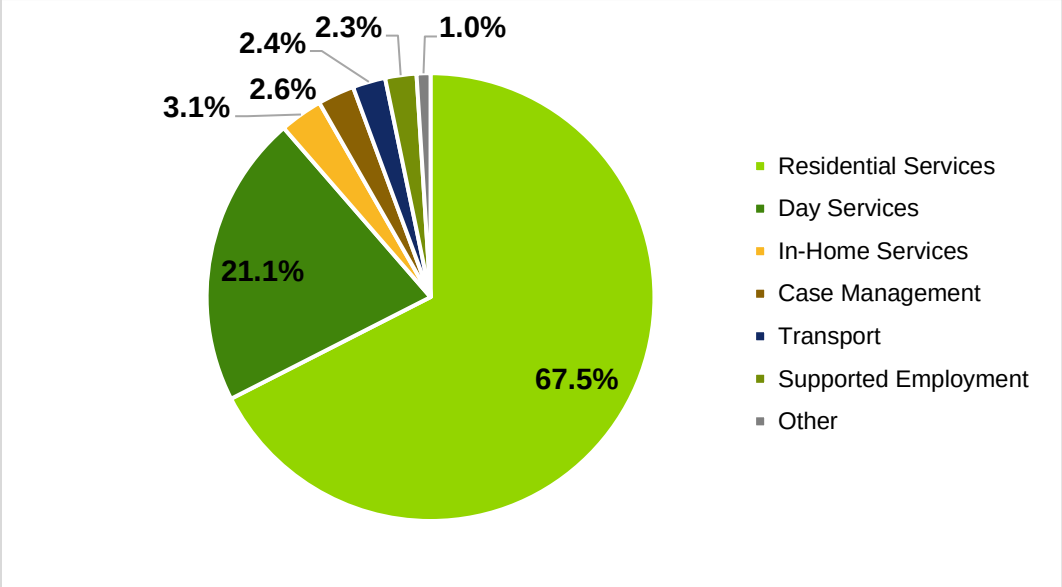
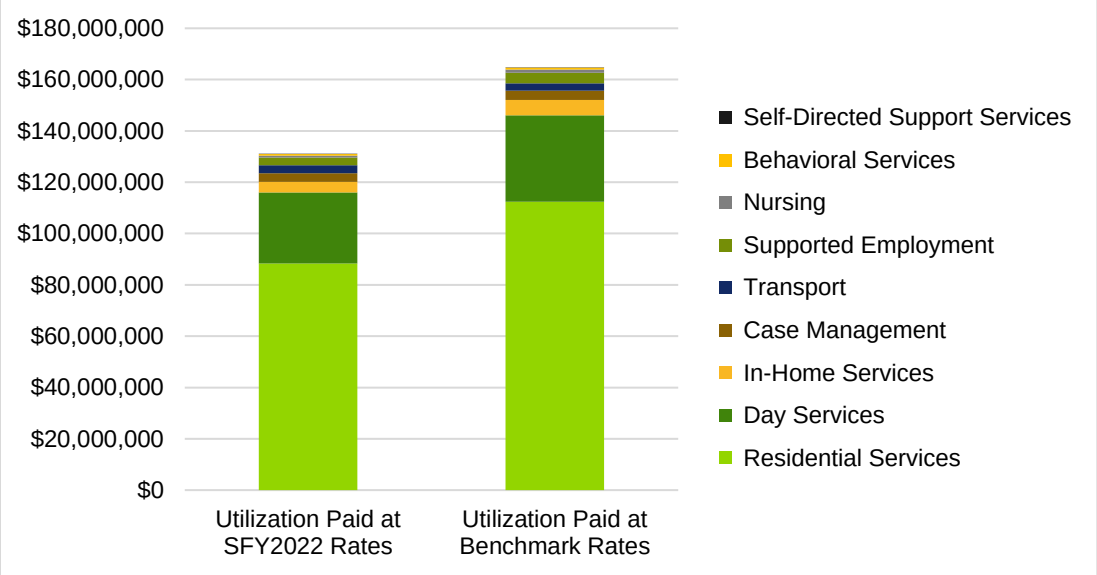


Figure 18 makes the expenditure increases attributable to the growth in residential and day service spending distinctly visible. Together these services compose 89 percent of the additional dollars needed.

Figure 18: Cross Section of DD Expenditures by Service Category



Projected state share fiscal impact for developmental services is detailed in the Table 73. DCW add-on payments are already included in the rates for these services, so differences noted

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reflect the full fiscal impact. All DD services fall under the standard FMAP of 64.12 percent.

Table 73: Summary of DD Fiscal Impact by Service Category (State Share)

Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
All DD Services	**$44,506,548**	**$46,978,746**	**$59,100,347**	**25.8%**	**$12,121,601**	**100.0%**	**100.0%**
Residential Services	$30,523,974	$31,705,819	$40,344,278	27.2%	$8,638,459	67.5%	68.3%
In-Home Services	$1,369,381	$1,459,873	$2,161,104	48.0%	$701,231	3.1%	3.7%
Behavioral Services	$178,456	$192,857	$268,851	39.4%	$75,994	0.4%	0.5%
Day Services	$9,649,273	$9,922,663	$12,063,535	21.6%	$2,140,872	21.1%	20.4%
Case Management	$527,560	$1,242,058	$1,275,058	2.7%	$33,000	2.6%	2.2%
Supported Employment	$1,066,336	$1,060,664	$1,504,653	41.9%	$443,989	2.3%	2.5%
Transport	$919,132	$1,112,140	$1,040,848	-6.4%	-$71,292	2.4%	1.8%
Nursing	$272,081	$282,189	$441,382	56.4%	$159,193	0.6%	0.7%
Self-Directed Support Services	$356	$483	$638	32.0%	$155	0.0%	0.0%

B.7.8. Fiscal Impact to Senior and Long Term Care Programs

As noted in the fiscal impact analysis for services as a whole, the programs administered by the Senior and Long Term Care Programs are the most impacted by the dramatic increases in rates for in-home services and, thus, are expected to have the highest need for additional funding. Figure 19 below illustrates the prominent role in-home services such as personal assistance, homemaker, and companion services play in the SLTC service continuum. These services make up over 53 percent of total spending for this population, in contrast to 16 percent for the four populations collectively. In-home service expenditures are expected to grow by nearly 58 percent. The need for additional funding for SLTC residential services, the second largest category in the service array, is just over 19 percent, which also drives significant growth in expenditures required for full funding.

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Figure 19: SLTC Service Mix by Current Expenditures

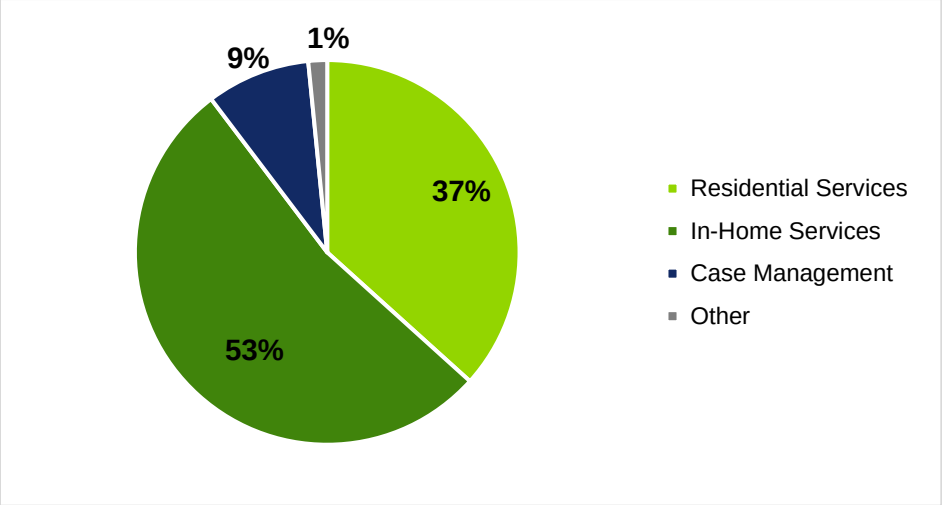
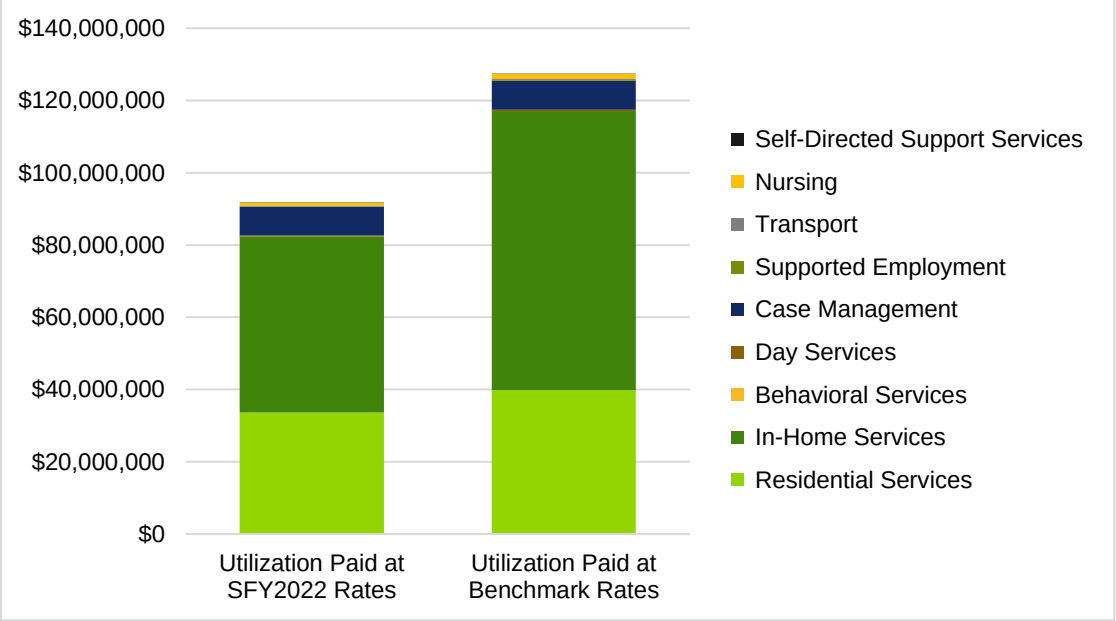


Figure 20 emphasizes the expansive growth of in-home service costs, which have a dramatic effect on overall expenditure patterns. Compared merely from the perspective of differences in the current rates versus benchmark rate payments, SLTC services would need an additional 39 percent of current spending. However, it is important to note that DCW add-on payments offset this increase to some extent, with an additional $7.3 million paid for in-home service provision, reducing the need for further expenditures to just under an additional 29 percent over current spending.

Figure 20: Cross Section of SLTC Expenditures by Service Category



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Projected state share fiscal impact for SLTC services are detailed in Table 74. As with the other populations surveyed, amounts do not include DCW add-on payments, in an effort to highlight the differences in overall fiscal impact due to rate changes and relative service volume. Especially for SLTC services, add-on payments have a significant effect on final fiscal impact, particularly for in-home services, but the effect of the DCW add-on is not included here.

Table 74: Summary of SLTC Fiscal Impact by Service Category (State Share)

Service Category	Paid in SFY20	Paid at SFY22	Benchmark Cost	Change	Difference	SFY22 Percent of Total	Benchmark Percent of Total
All SLTC Services	**$26,483,794**	**$30,419,125**	**$41,819,081**	**37.5%**	**$11,399,956**	**100.0%**	**100.0%**
Residential Services	$8,658,145	$12,084,835	$14,419,304	19.3%	$2,334,469	39.7%	34.5%
In-Home Services	$14,526,393	$14,937,692	$23,707,375	58.7%	$8,769,683	49.1%	56.7%
Behavioral Services	$985	$1,370	$1,819	32.8%	$449	0.0%	0.0%
Day Services	$73,185	$91,020	$123,746	36.0%	$32,726	0.3%	0.3%
Case Management	$2,817,688	$2,876,121	$2,905,870	1.0%	$29,748	9.5%	6.9%
Supported Employment	$35,765	$36,796	$49,953	35.8%	$13,158	0.1%	0.1%
Transport	$54,949	$65,603	$101,224	54.3%	$35,621	0.2%	0.2%
Nursing	$295,579	$304,105	$487,727	60.4%	$183,623	1.0%	1.2%
Self-Directed Support Services	$21,105	$21,583	$22,062	2.2%	$479	0.0%	0.0%

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B.8. Summary of Rate Study Recommendations

B.8.1. Overview

Based on the rate study process and results, Guidehouse identified the rate recommendations and policy considerations highlighted in this section for the Department to consider as it navigates the adoption and implementation of our proposed benchmark rates for the programs under review. Guidehouse also considered input provided by stakeholders throughout the rate development process in arriving at these recommendations for the Department.

This section culminates in a prioritization of our rate and policy recommendations for implementation to help steer investments by the Department in the most sensible, efficient, and quality-oriented manner as possible.

B.8.2. Rate Structure Recommendations

The following recommendations identify systematic changes to the current rate structure designed to promote rate equity among comparable services, optimize resources available for members and providers, and improve payment efficiency.

B.8.2.1. Standardize cost component assumptions and rate methodologies across populations and programs where feasible and appropriate.

Guidehouse recommends identifying equivalent services across programs and creating standard rates to promote rate equity. To achieve an equitable system, it is important not to look at services within the siloes of each population, but to view the rate structure across the system as a whole. Cognate services, regardless of program, require the same resources and therefore should receive the same rate for equivalent work. However, differences in authorized program budgets over the years have frequently created small discrepancies in rates between similar services that, over time, can lead to larger disparities in some cases. For example, “In-Home” services such as personal assistance, medical escort, community support services, and specially trained attendant currently have varied rates for different populations and programs. Nursing services represent another area where current rates have rate differentials without service differences to justify them. For services already aligned, Guidehouse did not find evidence of differences that would call for distinct rates.

Guidehouse recommends implementing standardized wage and benefit assumptions for direct care and supervisor positions that are identical across all populations and programs. Similarly, Guidehouse recommends rates include the costs of the standard, benchmark benefits package we developed to identify the reasonable cost of benefits. Although all providers may not currently offer all benefits, the inclusion of benefits reported by a majority of providers in the Montana DPHHS Cost and Wage survey allows providers to offer them in the future. The wages and benefits are key components in developing service rates and the benchmark metrics have a significant impact on the final rates. Guidehouse identifies the standardized benchmark wages and benefits used in developing the rates to be competitive based on comparison to industry

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data and feedback from stakeholders in the Rate Workgroups and union meetings. Additionally, the due diligence conducted to arrive at the benchmark wages reveals the recommended wages align with industry wages both within Montana as well as nationally for all populations.

Specific examples of standardization can be found in Section B.5., which examines rates by service category across all four service populations.

B.8.2.2. Eliminate the Direct Care Wage Program add-on payment for service rates increased to the benchmark.

As discussed in Guidehouse's fiscal impact analysis presented in Section B.7., several services receive a supplemental payment in addition to the fee schedule rate paid through provider service claiming. In particular, the Direct Care Wage Program is a payment "add-on" designed to supplement the standard rate in order to keep up with rising wage costs. While this program has addressed a real need in ensuring rate sufficiency, it is administratively burdensome to track provider wage costs and maintain a system of parallel payments outside the claims process. Guidehouse's benchmark rates encompass anticipated wage costs, rendering the add-on payment redundant. If the Department is able to finance rate increases up to the level of our proposed benchmark rates, the Direct Care Wage Program would become unnecessary and could be eliminated without harm to providers who currently depend on this supplement to deliver services.

B.8.2.3. Develop a uniform policy across populations and programs for reimbursing providers for necessary or expected absences from residents/attendees.

Department policies concerning reimbursement for absences from residential and day services currently vary across different populations and programs. Some residential services are subject to strict limitations on use of retainer days, while other residential services do not have established bed hold policies but employ a small occupancy adjustment within the rate.

At the time of writing, Guidehouse understands DPHHS intends to institute a consistent retainer days policy of 30 days across residential services for all of the populations under review. Guidehouse supports these efforts, and the residential service rate benchmarks we established assume this policy change would be in effect.

In addition to the retainer days, we have included a 98 percent residential occupancy adjustment for each of the residential services to account for small amounts of annual resident turnover that would not be covered through the retainer days policy.

B.8.2.4. Bundle client transportation costs into the rates for residential and day services where these costs are most frequently incurred. Reserve separate billing for transportation for settings and situations in which transportation is allowable, but less frequently utilized.

Guidehouse's transportation recommendations assume normal residential transportation costs and costs associated with delivering clients to and from their day program will be covered within the rates for these services and will not be reimbursed separately from the daily program rate. Client transportation is included in these services as a program support factor that represents an additional 3 percent of total direct care costs.

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For most populations, these services are already subject to bundled rates. Developmental Services are a notable exception, however, and all client transportation for this population is billed separately from residential and day service delivery. Our detailed recommendations for developmental services transportation can be found Section B.5.3.9.

B.8.2.5. Adopt a common policy for geographic and other demographic adjustments to provider rates.

The current rate structure has different rates for "medium" and "high" urban settings, along with a higher rural/frontier rate for a subset of services across programs. These services include Residential Habilitation Supported Living, Residential Training Supports, Home Supports and Targeted Case Management-Youth. The information reported by providers in Montana DPHHS Cost and Wage survey did not reveal substantial and consistent wage differences. However, the Rate Workgroups and Steering Committee noted that providers typically serve a blend of regions and therefore the wage differential may not be easy to decipher. Based on feedback from the stakeholders, we concluded that rate differentials would be substantiated due to:

- Differences in cost of living between urban and rural areas
- Challenges in attracting a qualified and sufficient provider pool in frontier areas which may warrant a higher rate in rural regions

To account for potential variations, we maintained the existing distinction between medium and high geographic factors. Guidehouse recommends a "high" geographic factor of 105 percent of the standard rate, and a "medium" factor of 102.5 percent. We recommend reimbursement at 107.5 percent of the standard rate for services that recognize a premium for frontier or "rural remote" areas. In addition, enhanced rates established for small providers have been set at 130 percent of the standard rate. Table 75 includes the recommended geographic and demographic adjustment factors.

Table 75: Geographic Adjustment Factors

Geographic Region	Additional Percentage	Cumulative Percentage
Medium	2.5%	2.5%
High	2.5%	5.0%
Rural/Frontier	2.5%	7.5%

B.8.2.6. Develop a reimbursement methodology for adjusting residential service rates based on an individual's assessed resource need.

For each of the service populations included in the rate study, there can be significant variation in the level of support or resource need required for each member, with some members being relatively self-sufficient in many aspects of their lives, and others requiring high levels of staff supervision or other frequent and intensive interventions. In such cases, a single rate for a service may be misaligned with a members' needs in specific cases, ending up too low or too

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high in meeting the need supported by the service. The need for appropriate calibration is particularly high in regularly delivered residential and day services.

This challenge is addressed in part by the development of tiered rates that vary reimbursement based on intensity of resource need, and the Department has established tiered rates in its developmental services programs, especially, to account for substantial differences in members' needs.

In Guidehouse's view, these tiered rates can be further "fine-tuned" through the development of a reimbursement adjustment framework that relies on variation in individual scores from an objective assessment tool, with scores aligned to different levels of reimbursement based on the assessed need. This form of "acuity adjustment" is a common practice in other state Medicaid programs, especially for residential developmental services, where reimbursement frameworks have been built around assessment tools such as the Supports Intensity Scale (SIS), the Inventory for Client and Agency Planning (ICAP), and interRAI instruments.

We encourage the Department to conduct additional study into the feasibility of a rate structure adjusted by individual resource need, with the policy goal of aligning reimbursement more closely with actual support requirements, and better incentivizing providers to serve members with more resource-intensive needs.

B.8.3. Individual Rate Recommendations

The following recommendations are aimed at specific services included within the study, involving significant changes in payment structure or service delivery assumptions.

B.8.3.1. Transition reimbursement unit for Adult SUD Intensive service from daily to weekly units of service.

Guidehouse recommends, with guidance from the Department, to move ASAM 2.1 and ASAM 2.5 from a daily rate to a weekly rate. This change is intended to improve alignment with the ASAM definitions that require specified hours over the course of a week, not a day. The modification in the unit of service would allow providers more flexibility in the total hours spent per day while also reflecting more accurate billing practices to ensure members are receiving the minimum hours within a week.

B.8.3.2. Establish rate parity between in-state and out-of-state PRTFs.

The recommended PRTF benchmark rate is $509.81 for both in-state and out-of-state facilities. This is a change to the current policy where out-of-state PRTFs receive a 33 percent premium on top of the current in-state rate. The recommended benchmark rate would result in a substantially larger increase for the in-state providers over out-of-state, which is an expected and desired outcome. Although the intention of the higher out-of-state rate may have been to promote access to PRTF services when in-state capacity is unavailable, it is possible the higher rate has the effect of actually disincentivizing provision of this care within Montana. Guidehouse's view is the Department would be better positioned by paying a higher, more equitable rate for both in-state and out-of-state facilities. While the benchmark rate would result

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in smaller increases for out-of-state facilities, increases are still significant, with out-of-state providers seeing a roughly 13.9 percent increase. This policy is intended to help incentivize in-state providers to be able to accept children to keep them as close as possible to their families and home community.

B.8.4. Service Array Alignment Recommendations

B.8.4.1. Conduct a detailed review of case management service design and payment policy across populations and programs.

Case management is a service area in which Guidehouse has not recommended standardization due to varieties in the case management service design among each program and across different populations. However, Guidehouse observed large variances in the caseloads, service standards and expectations, and staffing assumptions informing service provision. We recommend the Department conduct a more in-depth review of these services across programs to improve attunement and alignment of case management models with their specific populations and the broader service array to support equitable services for each population.

B.8.4.2. Consider aligning reimbursement for private duty nursing services across the service array, including EPSDT rates.

While private duty nursing services offered under Montana's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program were not within the scope of the Guidehouse rate study, rates paid under this program are equivalent to current rates for the populations and services included within the study. If private duty nursing service delivery under EPSDT is comparable to the services included within our review, which Guidehouse believes to be the case, then our analysis of the labor market for RN and LPN practitioners would suggest that current EPSDT rates for private duty nursing are equally inadequate for covering labor costs, and the Department should consider increasing these rates to a level commensurate with our benchmark recommendations.

Since EPSDT services were not under review, Guidehouse did not examine utilization of these services and did not analyze the fiscal impact of increasing these rates for the EPSDT program.

B.8.5. Benchmark Implementation Recommendations

B.8.5.1. Prioritize rate increases for services where current rates are the least aligned to growing costs.

Rate analysis suggests in-home services such as personal assistance/personal care and homemaker services, along with nursing and a few other services, would require 50-70 percent rate increases in order to keep up with growing labor costs. These services should be prioritized for reimbursement to sustain supports for care delivered in home settings.

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While some residential services appear to require comparatively modest rate increases to keep up with growing costs, Guidehouse identified Congregate Living developmental services and institutional PRTF services as in need of substantial additional investment.

B.8.5.2. Consider a regular process of administrative rate update, that includes adjusting either wage assumptions or overall rate levels based on applicable inflation indices.

The Department should consider a regular process of administrative rate update, that includes adjusting either wage assumptions or overall rate levels based on applicable inflation indices. If the Department were to implement the benchmark rate methodologies recommended by Guidehouse, it would be possible to review rate assumptions annually or bi-annually to assess the need for administrative update of specific types of costs—such as wages—without requiring comprehensive rate rebasing. The independent rate build-up approach for developing the rates would allow the Department to consider specific components of rate (e.g., administrative costs, program support costs, transportation) for further review and updates.

Prior to rate implementation, the Department is encouraged to review the annual growth trend basis to account for the changing economic environment (e.g., inflation, economic growth trends, etc.). Guidehouse recommends monitoring inflationary changes in the Bureau of Labor Statistics' (BLS) Provider Price Index (PPI) data series for Residential Developmental Disability Homes, Home Health Care Services, and Nursing Care Facilities. The BLS has collected data on changes in Medicaid developmental disability home providers' costs on a monthly basis and measured it with a unique inflation index since 2014. There are several advantages to using this index over potential alternatives:

1) The BLS updates the index monthly, providing a point-in-time indicator of cost growth for any current and future rate setting period,
2) The cost index is specific to Medicaid providers making it more responsive to unique and evolving costs in developmental disability programs than other general health care inflation metrics.

Additionally, DPHHS should track BLS Current Employment Statistics (CES) data that produces monthly earnings of workers comparable to providers in DPHHS's programs. Specifically, DPHHS may consider tracking CES data that spans all programs for Assisted Living Facilities for Elderly Staff, Elderly and Persons with Disabilities Staff, Home Health Care Staff, Residential Mental Health and Substance Abuse Facilities Staff, Outpatient Mental Health Center Staff, Office of Mental Health Practitioners Staff, Child and Youth Service Staff, Residential Intellectual Developmental Disability Staff, Vocational Rehabilitation Services, and Individual and Family Services. These BLS data sources are often used by similar programs in other states. Monitoring these indices would also address Steering Committee members' request for information on metrics that would allow for DPHHS to review changes in inflation both continuously and periodically.

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C. HB 155 Cost Reporting Plan

C.1. Introduction and Background

A cost report is a tool used by states in which providers are tasked with reporting the costs involved with rendering services.[10] As identified by the Centers for Medicare and Medicaid Services (CMS), "cost reports are most often used to gauge rate sufficiency by determining whether existing payment rates are sufficient to cover provider costs, establish payment rates, and identify unallowable costs."

Additionally, CMS's 2019 training on cost factors and rate assumptions emphasizes that states are required to explain the details of rate setting methods for each service. Some of the Federal guidance for rate setting methodologies include:

- §1902(a)(30)(A) of the Social Security Act: "Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."
- 1915(c) waiver program Technical Guide pages 252–254 CMS Review Criteria: States must describe "methods" that are employed to "establish provider payment rates" for "each" waiver service.
- 42 CFR 441.303(b) requires the state Medicaid Agency furnish CMS with sufficient information that includes: "A description of the records and information that will be maintained to support financial accountability."

During the 67th Montana State Legislative Session, **House Bill (HB) 155 Section 1** directed the Department, in collaboration with providers, consumers, and other stakeholders, to develop a plan for collecting expenditure data from Medicaid-dependent providers of services with the goal of completing the following objectives:

1. Assist and support the elderly and persons with mental illness, physical disabilities, and developmental disabilities;
2. Ensure services are administered by the Department divisions responsible for overseeing services for the elderly and persons with mental illness, physical disabilities, or developmental disabilities.
3. Enable DPHHS and the legislature to:
    a. analyze the data;
    b. determine the cost of providing services;
    c. make sound judgments about whether the rates being paid for each service are

[10] Centers for Medicare and Medicaid Services, Preventing Unallowable Costs (December 2019) Available online: https://www.medicaid.gov/sites/default/files/2019-12/preventing-unallowable-costs.pdf

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too high, too low, or appropriate; and

d. make decisions about rates that are based on sound data and analysis.

Additionally, HB 155 ensures the cost reporting plan includes the following components:

1. Identify Medicaid-dependent providers;
2. Identify high-volume services based on the units of service and costs;
3. Identify smaller providers who should be exempt from data reporting requirements;
4. Determine a base year for data collection and identify the types of expenditures and the providers who are required to report data in order to make it possible to analyze data and make determinations about rate adequacy;
5. Ensure that expenditure data reporting requirements are consistent across divisions of the Department to the extent possible;
6. Identify how often data should be collected for the purpose of updating the base year expenditures; and
7. Create a schedule prioritizing the order in which data is collected from various providers in order to transition to a point at which the information will be available regarding all applicable providers and will be updated on a regular basis.

In meeting the stakeholder engagement requirements of the legislation, the Department convened three rate study workgroups composed of provider financial and service delivery experts and stakeholders, as well as an overarching Steering Committee comprised of members, caregivers, advocates, providers, state agency staff, the Lieutenant Governor, and other executive and legislative stakeholders to provide additional subject-matter expertise and offer input throughout the study. Feedback received from these groups were vital to the development of rates consistent with the efficiency, accessibility, and quality of care standards federally required by federal Medicaid regulations, specifically, U.S.C. Section 1396(a)(30)(A)[11].

Montana's House Bill 155 requires a plan for ensuring rate adequacy and collecting cost data as well as the purpose and requirements of cost report planning.[12] Of note, these requirements are consistent with Federal requirements for cost surveying. The goal is to develop a cost reporting plan no later than July 2022 that can be delivered to the 2023 legislature. The details under House Bill 155 are outlined below.

C.1.1. Plan for Collecting Expenditure Data

- DPHHS, in collaboration with providers, consumers, and other stakeholders, shall

[11] Title 42, The Public Health and Welfare Available online: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396a%20edition:prelim)
[12] Montana House Bill 155, Plan for Collection of Cost Data Available online: https://leg.mt.gov/bills/2021/billpdf/HB0155.pdf

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develop a plan for collecting expenditure data from Medicaid-dependent providers of services that:
  - Assist and support the elderly and persons with mental illness, physical disabilities, and developmental disabilities;
  - Are administered by the Department divisions responsible for overseeing services for the elderly and persons with mental illness, physical disabilities, or developmental disabilities.
- "Medicaid-dependent providers" means providers with more than half of their clients receiving services through the Medicaid program.

C.1.2. Purpose of Plan

The purpose of the Provider Rate Cost Reporting Plan is to enable DPHHS and the legislature to:

- Analyze the data;
- Determine the cost of providing services;
- Make sound judgments about whether the rates being paid for each service are too high, too low, or appropriate; and
- Make decisions about rates that are based on sound data and analysis.

C.1.3. Plan Requirements

The Provider Rate Cost Reporting Plan must:

- Identify Medicaid-dependent providers;
- Identify high-volume services based on the units of service and costs;
- Identify smaller providers who should be exempt from data reporting requirements;
- Determine a base year for data collection and identify the types of expenditures and the providers who are required to report data in order to make it possible to analyze data and make determinations about rate adequacy;
- Ensure that expenditure data reporting requirements are consistent across divisions of the Department to the extent possible;
- Identify how often data should be collected for purposes of updating the base year expenditures; and
- Create a schedule prioritizing the order in which data is collected from various providers in order to transition to a point at which all applicable provider information will be available and updated regularly.

In response to requirements under House Bill 155, Guidehouse worked with DPHHS to develop a Cost Reporting Plan and collaborate with a focus group of provider representations to solicit their feedback on the plan. Section C.2., Cost Reporting Provider Focus Group highlights information regarding the Provider Focus Group and Section C.3., Cost Reporting Plan includes details on the methodology, plan, and recommendations for cost reporting.

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C.2. Cost Reporting Provider Focus Group

Guidehouse and DPHHS collaborated with volunteers from the Rate Workgroup to form the Cost Reporting Provider Focus Group ("focus group"). The purpose of the focus group was to discuss the development and planning of a cost reporting program and solicit feedback from provider representatives on implementing a program for DPHHS programs. Figure 21 includes the composition, role, and discussion topics for the focus group.

Figure 21: Cost Reporting Provider Focus Group

Cost Reporting Provider Focus Group (43 members)		
Behavior Health	**Developmental Services**	**Senior and Long-Term Care**
Composition: • Volunteers from the Rate Workgroups • DPHHS staff		
Role: • Assess cost reporting data points and provide feedback on the feasibility of reporting data. • Provide advisory feedback on potential impacts of cost reporting on broader provider base including potential operational challenges. • Participate in one focus group meeting for an open discussion on the cost reporting program.		
Discussion Topics: • Background on cost reporting and federal requirements • Review potential revenue, cost, and wage components included reporting • Discuss considerations on administering and operating a cost reporting program, and common practices in other states • Discuss feedback from providers on developing multiple cost reports and combining cost components		

C.3. Cost Reporting Plan Details

The Cost Reporting Plan includes details that would assist DPHHS with designing and implementing a cost reporting program. The plan specifies the programs, services, and providers that should be included as well as excluded from cost reporting based on guidance in House Bill 155 and the guardrails of the rate study. This plan also includes information on suggested content for the cost reports, supplemental material to support cost reporting, and considerations to administer and operate cost reporting.

Guidehouse conducted a review of 10 peer states and other states with established cost

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reporting programs for Medicaid populations to provide additional insights into common and promising practices that may be considered by DPHHS. States reviewed for cost reporting include California, Iowa, Minnesota, Missouri, Kentucky, Louisiana, Maryland, North Dakota, South Dakota, Wisconsin, and Wyoming. Additionally, Guidehouse reviewed federal guidance provided by CMS through recently published trainings for Medicaid HCBS programs and the State's guidance under House Bill 155 for cost surveying, rate setting, and reporting unallowable costs to assist with the cost reporting plan development.

C.3.1. Program Scope

Per House Bill 155, Medicaid programs are within scope for cost reporting. Therefore, provider organizations should be included in scope for cost reporting if they fall under one or more of the following programs.

1. Adult Behavioral Health Programs
    - HCBS for Adults with Severe Disabling Mental Illness
    - SUD Medicaid Providers
    - Medicaid Mental Health Services
    - Targeted Case Management
2. Children's Mental Health
    - Mental Health Center Services
    - Therapeutic Youth Group Home Services
    - Home Support Services and Therapeutic Foster Care Services
    - Partial Hospitalization
    - Psychiatric Residential Treatment Facility (PRTF)
    - Targeted Case Management
3. Developmental Disabilities
    - Developmental Disabilities Program Waiver
    - Targeted Case Management
4. Senior and Long Term Care
    - Community First Choices
    - Personal Attendant Services
    - Elderly and Physically Disabled - Big Sky Waiver
    - Home Health Services

The following programs were deemed out of scope for cost reporting either because the programs are non-Medicaid, or because they are provided by individual practitioners:

- Autism Treatment Services or Applied Behavior Analysis
- SUD Non-Medicaid and Non-Medicaid for Crisis Stabilization & Crisis Intervention and Response
- Out-of-State PRTFs

Additionally, the following service providers are not included for the cost reporting plan:

- Services maintained under the RBRVS are excluded (e.g., Physical Therapy, Occupational therapy services under the HHS program)

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- Schools and individual practitioners are excluded (e.g., Board Certified Business Analysts, Medication-Assisted Treatment practitioners)

C.3.2. Service and Provider Scope

This section includes services and providers that should be included and prioritized for cost reporting.

C.3.2.1. Providers and Services

Overall, 65 percent of providers receiving Medicaid reimbursement are included in the Cost Reporting Plan. Additional information on specific providers and services that are recommended to be included or excluded from the plan is highlighted below.

1. Medicaid-Dependent Providers: Nearly all providers within the programs in scope are identified as Medicaid-Dependent providers, as defined by House Bill 155, with the exception of Assisted Living Facilities (ALFs) and Private Duty Nursing providers. These providers were identified as providers primarily drawing funds outside Medicaid based on the revenue reported by providers that responded to the Montana DPHHS Cost and Wage Survey.

   Although most of these service providers are not Medicaid-dependent, DPHHS should consider encouraging providers to submit cost reports. For example, ALFs are high volume services that represent nearly a fourth of all Medicaid claims for the programs in scope, and the data collected from ALFs may assist the State with future rate review processes.

2. Small Provider Exemption Criteria: Providers with individual Medicaid reimbursement less than $120k or 0.03 percent of total system reimbursement are “small” providers that may be exempt from cost reporting. These providers collectively represent 2.5 percent of total system reimbursement and 35 percent of total number of providers across programs. All services are represented in the remaining 97.5 percent of claims are “large” providers with the following exceptions incorporated.

   - Nutrition (Meals) providers are included although rendered entirely by small providers to account for the service in cost reporting.
   - Consultative Clinic and Therapeutic Services (CCTS) under the Big Sky waiver is excluded since the service is utilized only by one provider and total reimbursement is minimal at $275.

3. Other Service Exclusions: Additionally, the following services are recommended to be excluded from cost reporting.
   - Standalone transportation services (mileage and trip) can be excluded from cost reporting since providers would account for transportation costs associated with service delivery as part of reporting program support costs for services.

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- Services billed and reimbursed at the actual cost to the individual provider and are not based on a standardized rate. These services represent under 0.8 percent of total Medicaid system reimbursement.
    - Specialized Medical Equipment and Supplies; Personal Emergency Response System (PERS); Environmental Accessibility Adaptations and Home Modification; Goods and Services; Dip Strip or Saliva Collection, Handling, and Testing; Health and Wellness.

Appendix B includes a detailed list of services excluded for cost reporting.

C.3.2.2. Service Prioritization

DPHHS should consider prioritizing a subset of cost reports for initial implementation, as highlighted further in Section C.4.1. This section includes high volume services based on the SFY2021 Medicaid claims that DPHHS may prioritize in tandem with the cost reports proposed in Section C.3.3 for a pilot implementation. High volume services spanning all programs (greater than 5 percent of total reimbursement) highlighted below are included for cost reporting.

- Congregate Living
- Personal Assistance Services (Personal Care, Medical Escort, Homemaker, Companion)
- Assisted Living Facilities (ALFs)
- Day Services
- Supported Living
- Psychiatric Treatment Residential Facilities (PRTFs)
- Case Management
- Comprehensive School and Community Treatment (CSCT)
- Youth Group Homes (Therapeutic and Foster Care)
- Adult Group Homes (Behavioral, Adult Group, Mental, Intensive Mental)

C.3.3. Cost Reporting Data Reporting and Standardization

CMS provides guidance on cost surveying processes for HCBS rate setting applicable to DPHHS programs. Typically, cost surveys and reports include basic provider data (e.g., name, contact information, address, number of individuals served, area served, total revenue and expenditures) and fiscal year for the data reported. Cost surveys may also include cost data grouped by specific theme or category dependent on the state's goals and catered to match those goals accordingly. In some cases, states also require providers to submit Audited Financial Statement (AFS) from an independent Certified Public Accountant (CPA).

Table 76 below includes examples of cost reporting areas and data points captured in other states' Medicaid cost reports that are common to varied programs and populations.

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Table 76: Example Cost Reporting Information

Cost Reporting Area	Example Data Points	State Examples
Salaries and Wages for Direct Care and Administrative Staff	Staff Numbers, Direct Care Hours, Administrative Hours, Wages, Total Hours, Gross Salaries/Wages	IA, LA, SD, ND
Administrative Costs	Supplies, Legal Fees, Accounting Fees, Telephone and Communications, Seminars, Subscriptions	IA, LA, SD, ND, MO, CA
Program Support Costs	Program Supplies, Activity Costs, Staff Training	IA, SD
Property, Equipment, and Rental Expenses	Equipment Repair or Purchase, Auto Rental, Rent, Start-Up	IA, LA, SD, ND
Assets, Liabilities, and Equity	Investments and Other Assets, Accrued Taxes, Capital Stock, Insurance, Other Liabilities	IA, SD, MO
Fringe Benefits	Social Security Contributions, Health Insurance, Workers Compensation, Unemployment Insurance, Retirement/Pension	MD, ND, SD
Transportation and Vehicle Costs	Public Transportation, Private Driver Services, Natural Supports (transportation from family, friends, etc.), Vehicles, Vehicle Maintenance, Vehicle Depreciation, Vehicle Insurance	MD, ND
Revenue	Medicaid Program Revenue, Private Pay, Consumer Fees, Grants, Contributions, Rental Assistance, SUD Revenue (e.g., Substance Abuse Prevention and Treatment Block Grant)	CA, IA, LA, ND, SD
Census Data / Other Metrics	ALFs: Occupancy data; Case Management: Caseload metrics; PRTFs: Number of beds	CA, MN, SD
Certification of Cost Report	Agency information, audit details, accounting basis, signature of administrator and preparer	IA, LA, SD, ND, MO, CA

DPHHS cost reports may include one or more of the following reporting areas. Appendix B provides a detailed view of the data that can be captured under each of these areas including feedback provided by the Cost Reporting Provider Focus Group and information gathered from other states.

1. **Revenue**: Total revenue of the provider organization.
    a. Revenue would be helpful is understanding if providers are getting their costs covered and whether there may be any duplicating payments which would be unallowable.
2. **Expenses**: Total costs of the provider organization for services provided under each program.

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a. Cost per Service: Costs components tend to vary from service to service. For example, the place of service delivery would impact the total cost of delivering services. Services that are provided in a facility may have different costs from those provided in the community. Therefore, capturing costs by each service would assist with developing rate assumptions in future rate setting efforts.
b. Unallowable Costs: Unallowable costs are costs submitted for federal Medicaid reimbursement that do not comply with HCBS waiver program federal requirements. Sometimes, these costs are inappropriately included in the rate determination process or may fail to be identified in the billing validation process, resulting in unallowable Medicaid reimbursement. Common unallowable costs include room and board costs, thirty party liable costs or costs supported by external organization, and costs that are unrelated to member care. Therefore, it is imperative to design the cost report to capture unallowable costs separately. Appendix B highlights how DPHHS may isolate unallowable costs.

3. **Wages and Supplemental Pay**: Wages and supplemental pay for each direct care, direct care supervisor, and direct care contractor position in the provider organization.
4. **Other Service Data**: A few cost reports may include additional information like census data and other statistics pertinent to individual services
5. **Audit and Certification Statement**: Each template should include a certification page that requires a chief decision maker (e.g., CEO/CFO/Accounting Manager) to verify or acknowledge the submitted cost report does not contain any unallowable costs and the data is accurate.

DPHHS should consider designing and implementing the six cost report templates outlined below. These distinct reports group similar services and providers for standardization yet allow for customization of cost reporting areas based on the nature of services, providers, and rate models. The Cost Reporting Provider Focus Group also provided feedback on developing exclusive cost reports for a few providers like Assisted Living Facilities (ALFs). Under this plan, while a vast majority of providers will submit only one cost report, a few providers will be required to submit 2-3 cost reports because of the wide array of services delivered.

1. **Assisted Living Facilities (ALFs):** This cost report will be exclusively for ALFs providers for the services listed below.

   Services:
   - Assisted Living Facilities and Adult Foster Care (SLTC)
   - Assisted Living (DD)
   - Assisted Living Facilities and Adult Foster Care (ABH)

   Report Details:

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- ALFs that receive reimbursement for other services in a waiver program including case management, meals, and respite services must include all associated costs within the ALF cost report and will not be required to submit other cost reports.
- This report should include revenue, expense, and wage components in Appendix B.

2. **Case Management:** This report will include Case Management services and programs across all populations. An exclusive report would allow providers that provide only Case Management or Targeted Case Management services to fill only the Case Management report instead of other broader reports that apply to waiver programs or state plan services. Additionally, capturing this information in a distinct report will be helpful for future analysis if DPHHS considers standardizing case management service delivery and potentially rates across programs.

   Services:
   - Targeted Case Management – Adult Behavioral Health
   - Targeted Case Management – Development Disability
   - Targeted Case Management – Youth Mental Health
   - Case Management (ABH)
   - Case Management (SLTC)

   Report Details:
   - The data in this report would include revenue, cost, and wage components similar to the data points captured in Appendix B.

3. **Nutrition (Meals):** This report will be applicable to Meal service providers across the SLTC and DD programs. Most meal providers for the programs in scope provide meal services exclusively. The cost reporting areas would be specific to meals and much simpler than other cost reports including cost of packing, operating, and providing meals services, staff salaries, and additional statistics on the number of meals provided.

   Services:
   - Nutrition – Meals (SLTC)
   - Nutrition – Meals (SLTC)
   - Meals (DD)

   Report Details:
   - Types of Costs: Personnel salaries, fringe benefits, bulk meal transportation costs, packaging costs, supplies, utilities, communications, building costs, building space, professional services, raw food caterer, equipment, insurance, mileage reimbursement, subcontracting expenses (e.g., caterer), volunteer programs

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- Number of Meals: Number of Medicaid home delivered meals, number of Medicaid congregate meals, and number of all other meals.

4. **Mental Health and Substance Use Disorder:** This cost report will cover all adult and children's mental health programs as well as substance use disorder treatment services.

   Services:
   - Mental Health: PACT, Community Based Psychiatric Rehabilitation and Support (CBPRS), Day Treatment, Peer Support, Adult Foster, Adult Group Homes (Behavioral, Adult Group, Mental, Intensive Mental), Youth Group Homes (Therapeutic and Foster Care), Youth Day Treatment, Comprehensive School and Community Treatment (CSCT), Home Support Services, Peer Support
   - Substance Use Disorder (excluding Medication-Assisted Treatment Services): SUD Intensive Outpatient, SUD Clinically Managed (ASAM 3.5), SUD Medically Monitored (ASAM 3.7), SUD Partial Hospitalization (ASAM 2.5), Peer Support

   Report Details:
   - This report should include revenue and expense components capture in Appendix B.
   - Additional data for youth therapeutic group homes and adult group homes may be requested in this report since the nuances for these residential differ from the other services.

5. **Psychiatric Residential Treatment Facility (PRTF):** This report should capture costs and census data for PRTFs.

   Services:
   - In-State PRTF Service

   Report Details:
   - Revenue: Revenue components identified in Appendix B should be included in this report.
   - Costs: Expenses should include total Medicaid costs, costs attributable to the Department of Education, and other costs allowed under the PRTF State Plan Amendment.
   - Number of Beds: The total number of facility licensed beds, number of Medicaid-specific licensed beds and number of Medicaid occupied beds within the year.

6. **Waiver and Home Health Providers:** This report will include cost reporting for all waiver and home health provider services under the BigSky, SDMI, and DDP waivers as well as the CFC, PAS, and HHS programs. Providers that are ALFs or exclusively provide Meals and Case Management services under these programs are not required to submit this cost report in addition to reports 1, 2, or 3.

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Services:

- Big Sky Waiver: Supported Employment, In-Home and Personal Assistance Service, Private Duty Nursing, Respite
- Development Disability Waiver: Supported Employment, In-Home and Personal Assistance Services, Private Duty Nursing, Respite
- Severe Disabling Mental Illness Waiver: Supported Employment, In-Home and Personal Assistance Services, Private Duty Nursing, Respite
- Community First Choice: Personal Assistance, Nursing services
- Personal Attendant Services: Personal Assistance and Nursing services
- Home Health Services: Home Health Aide, Specially Trained Attendant

Report Details:

- This report should include revenue, expense, and wage components captured in Appendix B.
- ALFs, Meals, and Case Management service providers are excluded from this report.
- CFC and PAS services should be distinguished as agency-directed and self-directed services to allow providers to report costs between the two types of services.

C.3.4. Supplemental Material and Support

In a recent training on Medicaid HCBS unallowable costs, CMS highlights unclear cost reporting guidance for providers as a frequent issue states face with including unallowable costs in the cost surveying and rate setting processes[13]. Developing robust cost reporting instructions is integral to assisting providers with cost reporting, especially since this will be a new initiative undertaken by DPHHS and its provider organizations. DPHHS can consider developing the following supplemental material to support providers during the cost reporting process.

1. **Checklist for Cost Reporting**: Several states develop checklists which include high-level topics and requirements that must be met my providers to consider a cost report complete. A checklist document can serve as check the box exercise for providers to ensure all requirements for cost reporting a met during the reporting and submission process.

2. **Instructions for Cost Reports**: An instruction manual would include detailed instructions on all cost reporting topics and data points providers can follow while populating a cost report. The State should specify which costs are unallowable and provide clear guidance as to how these costs should be reported. DPHHS should take precautionary measures to ensure there are not interpretive issues and providers do not

[13] Centers for Medicare and Medicaid Services, Preventing Unallowable Costs (December 2019) Available online: https://www.medicaid.gov/sites/default/files/2019-12/preventing-unallowable-costs.pdf

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unknowingly include unallowable costs. For example, room and board costs are excluded from most Medicaid HCBS waiver program reimbursement as mandated by the Federal government. Similarly, certain education costs and teachers' salaries for PRTFs may be incurred by the Department of Education and are not attributable to Medicaid programs. Instructions for cost reporting should clearly indicate how to capture and separate these unallowable costs. Additionally, the instructions should also include accounting requirements, uniform accounting rules, and other generally accepted principles to complete reports.

3. **Provider Training and Informational Sessions**: DPHHS may consider conducting cost reporting training for providers both initially while implementing a cost reporting program and on a recurring basis. Initial training would benefit all providers for first-time reporting. Recurring trainings would allow education for new providers as well as sharing of updates in policy or cost reporting guidelines with existing providers. DPHHS may also use training as an avenue to address questions from providers.

C.3.5. Administration and Operation Considerations

C.3.5.1. Frequency of Data Collection

Frequency of data collection defines how frequently data should be collected from provider organizations. A national scan of states' cost reporting programs revealed most states collect cost reporting data from Medicaid providers once a year. DPHHS should consider implementing an annual cost reporting process which would be beneficial for reviewing, rebasing, or rate setting purposes. An annual basis would also allow the flexibility in deriving the most recent snapshot of providers' costs for future analysis.

C.3.5.2. Time Period for Data Collection

Time period for data collection defines the period for which data should be collected and submitted. DPHHS should consider requiring providers to submit cost reporting data for their organization's 12-month fiscal year. Additionally, there would a lag of one year in the data to allow collection of audited financials after a provider's fiscal year ends. Most states operating similar programs collected data either based on the state's fiscal year or the provider organization's fiscal year. The Montana DPHHS Cost and Wage survey results revealed nearly 50 percent of participating providers across all programs follow the State's fiscal year cycle (July-June), nearly 40 percent of participating providers reported following the calendar year (January-December), and the remaining providers follow other time periods including the federal fiscal year cycle. Since organizations follow varying monitoring, auditing, and reporting periods, mandating the provider organization's fiscal year would allow providers the flexibility in completing and submitting cost reporting data. Varied reporting periods would also require the State to establish and prepare for appropriate administrative processes. This topic is discussed further in the subsequent sections.

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C.3.5.3. Base Year for Data Collection

A base year for data collection represents the first year for which cost reporting data will be submitted by providers to DPHHS. Since this is a new program to both the State and providers, DPHHS should consider conducting a pilot program for services that span multiple programs, before implementing cost reporting for all providers in scope. A pilot program has several benefits in allowing the State to implement cost reporting in a staggered cadence and allowing the opportunity to learn from the experience to scale it to the other programs after the first year. This would also give providers the opportunity to learn about cost reporting and prepare for the administrative efforts that would be involved in submitting required data to the State. For example, DPHHS may consider the Waiver Program and Home Health provider as well as the Case Management provider cost reports for the pilot implementation since these providers collectively span all programs and a wide range of common services.

The start of the State's fiscal year after the Cost Reporting Plan is approved can serve as the first year for implementation. For example, provider organization's FY2023 can be considered as the base year for data collection for the pilot program in July 2023, if the cost reporting plan is approved by the 2023 legislature. After the pilot is implemented in the first year, cost reporting can be extended to all providers and services in scope during the following year. For example, if the pilot program is completed for provider organization's FY2023, provider organization's FY2024 would be the base year for collecting data from all providers.

C.3.5.4. Cost Report Management and Staffing

A review of peer states' programs revealed cost reports are typically managed by state departments and staff responsible for auditing, budgeting, finance, and/or provider reimbursement. These staff manage the cost reporting program and serve as a liaison to providers. To initiate the process, DPHHS will benefit from identifying the appropriate staff to manage the program. The staff will benefit from establishing a formal communication plan for the state and providers during the cost reporting period. States typically communicate with providers to launch the process, request for clarification, and complete reporting. Providers may also need to communicate with the state to address questions during the cost reporting period. Additionally, as indicated by stakeholders, the Department may also consider establishing a process to report and track providers' administrative efforts involved in cost reporting.

Guidehouse estimated 4.25 FTEs as the number of employees that may be required to manage the six cost reporting programs outlined in Section C.3 of this report. The estimate assumes each type of cost report would require approximately 0.7 FTEs to review, audit, and manage the provider cost reports. For example, in one peer state that manages programs of similar magnitude and serving similar populations, 4.25 FTEs are required year round to manage six cost reporting programs. The team is comprised of 3 auditor FTEs, 1 supervisor FTE who provides subject matter expertise and oversees the work of the three auditors, and 0.25 SME supervisor FTE who serves as a liaison between the auditors and the State. Given the similarities in the programs, a similar staffing plan may work for DPHHS in Montana. This staffing proposal assumes there is no existing infrastructure for DPHHS to leverage for implementing and managing the proposed programs. For example, if DPHHS can leverage the

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0.25 FTE that already assists with nursing facility cost reporting, the staffing requirements for the new programs may be adjusted to account for existing staff.

C.3.5.5. Schedule for Cost Reporting and Monitoring

DPHHS should establish an annual schedule both for the State staff as well as provider organizations to streamline the cost reporting process and set expectations with all stakeholders involved in the process. DPHHS may put in place the following considerations:

- **Submission Period:** Providers may be required to submit cost reports within 4 months after the end of the provider organization's fiscal year. DPHHS may permit two cycles for submissions – one from January through May and the second from July through November – that would align with most provider organizations' fiscal year ending in December and June respectively to initiate and complete their cost reports. The sixth month of each half of the year could be used by the State to wrap up the auditing process for the respective cycles. For example, if a provider's fiscal year ends June 30th, the cost report and audit should be due December 1st. If the fiscal year ends December 31st, the cost report and audit should be due June 1st. In peer states, provider organizations typically initiate the process internally two months prior to the end of the fiscal year and submit their cost reports within six months after the reporting period ends.

  DPHHS should establish with providers that all incomplete or incorrect reports will be returned to the provider for corrections. Corrections and appeals to the cost report are to be made by the provider and resubmitted to the department within 30 calendar days of the initial inquiry from the State. Other states typically allow between 30 to 180 calendar days for the appeals process but given the flexibility in the time for submitting costs, the State should consider allowing no more than 30 days. Additionally, DPHHS should encourage providers to work closely with the State during the cost reporting period to address questions and receive guidance, and to avoid the appeals process altogether.

- **Auditing Schedule**: To continuously review and audit provider cost reports as and when they are submitted, DPHHS should conduct audits year around from January through December. As mentioned in the previous section, DPHHS could consider completing audits within a month after the last set of cost reports are submitted, i.e., June and December depending on the reporting cycle.

  The State may choose to audit a representative subset of all providers every year and target covering all providers within three years. Most states audit each provider's cost report once every 2-5 years. During the Cost Reporting Provider Focus Group meeting, one provider representative expressed that DPHHS may also consider following the State's legislature cycle of a biennium. Given this is a new cost reporting program, DPHHS should consider additional flexibility in targeting an audit schedule of once every three years for each provider. Therefore, DPHHS would audit approximately 100 providers' cost reports every year with the aim to complete the entire provider base over

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three years. Eventually, DPHHS may target a more rigorous review schedule based on initial experience to build additional efficiencies into the process if necessary.

- **Maintaining Records:** Most states require providers maintain on their premises the required service records and financial information sufficient to provide for a proper audit or review, including documentation to support the rationale for allocation of costs. Sufficient data must be available as of the audit date to fully support any item being claimed on the cost report. For example, some states require providers and the state's responsible department to maintain records supporting cost reporting for up to 6-10 years following the submission of the cost reports. Records are typically made available upon reasonable request to representatives within the state.

  DPHHS should consider implementing similar recordkeeping requirements consistent with requirements under the Montana Public Records Act[14]. The Montana Public Records Act states that citizens are entitled to public records and documents in the State. However, the Montana Supreme Court has recognized an entity's property right is confidential or proprietary information such that the information should be shielded from public disclosure. Therefore, if the cost report data is disclosed by the Department, the Department must consider de-identifying provider information before it is made public.

C.4. Cost Reporting Recommendations

The recommendations below are related to the Cost Reporting Plan outlined in Section C.1-C.3.

C.4.1. Conduct a pilot cost reporting program that prioritizes services and programs that span all programs.

Since cost reporting is new to both DPHHS and DPHHS's providers, Guidehouse acknowledges implementing multiple types of cost reports and requiring all providers to engage all at once at the beginning would involve significant administrative, programmatic, and logistical challenges. Although we consider the entirety of the Cost Reporting Plan important to implement, some of the details reflect fewer implementation challenges and greater potential value in learning relative to others.

During the first year of implementation, DPHHS may consider conducting a pilot cost reporting program that would include a subset of all proposed cost reports in the plan. Programs that span services across all populations and include high volume services identified in Section C.3.2 could be prioritized for initial implementation.

[14] Montana Public Records Act. Available online: https://leg.mt.gov/bills/mca/title_0020/chapter_0060/part_0100/sections_index.html

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C.4.2. Engage with providers during implementation of the cost reporting plan.

DPHHS should consider engaging with provider stakeholders to design and implement cost reporting template and instructions. If DPHHS considers implementing the Cost Reporting Plan, additional work will be required to design customized templates to completion and develop supporting material to ensure providers are equipped to complete the cost reports. The Cost Reporting Provider Focus Group provided valuable feedback on the types of revenue and costs that would be relevant to provider organizations, as captured in Appendix B. Similar focus group working sessions with provider representatives during the implementation phase may assist with developing holistic cost reporting material and ease the implementation process for both DPHHS and the providers. DPHHS may also leverage existing stakeholder forums as an avenue to discuss cost reporting implementation updates.

C.4.3. Consider developing a comprehensive web-based portal for cost reporting.

The Department may consider developing a one-stop-shop web portal for providers to submit cost reporting data. A few states have implemented similar solutions for their cost reporting programs, and there are benefits of the web-based method:

- Reduced administrative burden for both DPHHS and the providers: Providers would be able to populate, save, and submit all information through the web portal instead of an Excel spreadsheet. This may reduce the level of effort required by the Department to quality check and standardize the information received from providers.
- Increased accuracy and efficiency in data reporting: The web-based tool reduces human processing errors and rework and increases standardization. This method would also enable fast data reporting processes.

The Department may develop a cost reporting web-based application by using Software as a Service (SaaS) tools. A SaaS platform or application is a way to provide services on the internet through a cloud infrastructure. Once the cost reporting data is finalized, the Department may customize cost reporting forms for providers to access on a SaaS-based platform. This would allow users (e.g., providers, state staff) to access the cost reporting application without having any software installed on their computer. Additionally, the Department may put in place appropriate security protocols and implement multi-factor authentication for restricted access.

Guidehouse also recognizes that DPHHS should consider the initial financial outlay to develop and deploy such a solution. Alternatively, DPHHS could design cost reporting templates on MS Excel which is a common practice in many states.

C.4.5. Establish protocols to protect provider cost reporting data.

Cost reporting data submitted to the Department maybe subject to public disclosure under the right to know provision of the Montana constitution and implementing statutes. However, to protect a provider's identity if the information is ever disclosed, the Department should consider

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implementing protocols to de-identify provider identification details before transmitting the information. Moreover, based on the Department's feedback, Guidehouse notes the Montana Supreme Court has recognized that an entity's property right in confidential or proprietary information should be shielded from public disclosure. Therefore, if the information is ever transmitted to the Department, there is legal authority to shield it from public disclosure where an entity has asserted a property right.

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D. Professional Services Rate Review

D.1. Overview of Reimbursement for Professional Services

The Montana Department of Public Health and Human Services (DPHHS) engaged Guidehouse to perform an analysis of its Medicaid payment rates for professional services. The analysis consisted of an evaluation of the reasonableness and adequacy of current rates when compared to Medicare as well as other state Medicaid programs.

Under Montana Medicaid, the current payment methodology for professional services is either by a fee schedule of pre-determined payment rates or, less commonly, by a reimbursement approach based on a percentage of provider charges. Most services are paid via Montana's Resource Based Relative Value Scale (RBRVS), and payments are limited to the lesser of the actual charge or the applicable fee schedule amount.

D.1.1. RBRVS and the Medicare Physician Fee Schedule

The RBRVS was created by the Centers for Medicare & Medicaid Services (CMS) to form the basis of a fee schedule for physician reimbursement. It is established on the principle that payments for physician services should vary in proportion to the resources required to provide those services. An RBRVS-based fee schedule consists of reimbursement values arrived at by multiplying the relative value units (RVUs) associated with each procedure by a "conversion factor" that translates the relative value of the payment into a specific dollar amount. The conversion factor itself is determined as the quotient of the total budget available for reimbursement, divided by the sum total of RVUs utilized.

Individual RVUs for each procedure are determined by the resources required to perform the service and are assigned to each service code. Since the adoption of the RBRVS by CMS for the Medicare program in 1989, RBRVS-based fee schedules have proliferated in both public and private payer systems. The RBRVS has proven useful to a wide range of payers, because it does not depend on prices applicable only in specific markets, budgets of particular insurers, or samples of costs or charges from a small selection of providers, but instead considers the relative resource requirements among services objectively. Thus, it is easily adapted to different health care systems, and for similar reasons, its pricing mechanisms are less subject to rate inequities stemming from the influence and advocacy of particular industry groups.

The key component of an RBRVS system is the development of a single RVU for each service. This RVU is then applied to a conversion factor, which translates this abstract unit of relative value into a specific dollar rate for a given procedure. Figure 22 depicts the basic structure of a

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RBRVS-based rate.

Figure 22: RBRVS Rate Structure

The RVU used for each procedure in the CMS RBRVS system is the sum of three component RVUs, each of which represents a distinct cost component of delivering services. These components are:

- **Work RVU**, which reflects the time and expertise of the medical professional delivering the service;
- **Practice Expense (PE) RVU**, which reflects the relative costs of maintaining a medical office; and
- **Malpractice (MP) RVU**, a relatively minor cost component that reflects the expense of malpractice insurance.

Each of these three components may be individually modified to reflect unique conditions as they impact the different categories of expense. Because the Medicare Physician Fee Schedule (MPFS) is used to derive the Medicare rates to be implemented in different health care markets across the United States, additional factors called the Geographic Practice Cost Indices (GPCIs) are also applied to adjust RVUs on a state-by-state or regional basis, allowing a single annual conversion factor to be used for most services.

The advantage of this system is by updating a single conversion factor, an entire fee schedule of rates can be updated while maintaining their specific values in relation to one another. In the same way, different payers, programs or geographical regions can use the same RVU-based system as Medicare but apply different conversion factors to reflect their own acuity or programmatic needs as well as budgetary constraints. This “relativity” built into the RVU structure makes it simple to update and highly adaptable from one setting to another; the same RVUs can be used across the country and across years by applying specific local or periodic adjustments.

While annual RVU changes are often incremental, over time these shifts can be substantial. This result is important for Montana Medicaid, as the MPFS has seen a steady, gradual redistribution of overall services from highly specialized and technologically intensive services like surgery and major imaging services, toward basic physician services, such as office visits and other types of evaluation and management (E/M) procedures. In other cases, these re-valuations can be implemented more systematically, as occurred in the Medicare fee schedule in Calendar Year (CY) 2021. In that year, CMS increased the relative value of E/M procedures by an average of 13 percent per code, enacting reimbursement reforms that then-CMS Administrator Seema Verma characterized as “the most significant updates to E/M codes in 30

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years."[15] Whatever the scale, these shifts can affect overall payment levels differently for distinct provider groups and patient populations and must be accounted for in rate setting.

The conversion factor used by Medicare in the physician fee schedule is updated each year in part to compensate for these shifts. The update is based on the previous year's conversion factor and adjusted for the Medicare Economic Index (MEI), the Update Adjustment Factor (UAF), Legislative Change, and Budget Neutrality.[16] The MEI is the inflation rate for medical services, which is generally higher than inflation in consumer prices overall. Part of the regulatory adjustments are centered around access to care. CMS must demonstrate rates are sufficient to ensure access by Medicare beneficiaries and takes this into account when determining annual rate updates. It then follows that Medicare rates can be used as an appropriate index of the cost coverage needed to ensure access. Consequently, the Medicare rate structure and the RBRVS methodology that underlies it have become the standard according to which commercial insurers and most state Medicaid agencies develop and assess the adequacy of their own rates.

Medicare uses only one conversion factor for the physician fee schedule—with the exception of Anesthesia services, whose payment methodology requires a unique conversion factor for anesthesia's minute-based units of service—and this factor is calculated based on a statutory formula by the CMS Office of the Actuary (OACT) as described above. This fee schedule is designed primarily for physician practitioners, but in some cases Medicare also authorizes payment through the physician fee schedule for non-physician practitioners, including psychologists and social workers for mental health, testing, and assessment services, "allied" medical professionals such as occupational and physical therapists (OT/PT) and speech pathologists for rehabilitative therapy services, as well as other medical professionals under the training and supervision of a physician, known variously as "mid-level practitioners," "physician extenders," or "advanced practice providers." Medicare reimbursement for these other practitioners is not necessarily equivalent to the comparable physician rate. Rather than maintaining separate conversion factors for different types of practitioners, Medicare rules establish payments for different classes of non-physician practitioners as a discounted percentage of the full physician rate. For example, mid-level practitioners are reimbursed at 85 percent of the Medicare physician rate, and licensed clinical social workers (LCSWs) receive 75 percent.

[15] https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment

[16] Historically the UAF encompassed the Sustainable Growth Rate (SGR) formula designed to take into account growth or decline in the Gross Domestic Product, changes in the number of beneficiaries, and certain regulatory adjustments that may affect the demand for and costs of providing Medicare services. The SGR was permanently repealed under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and replaced with a stipulated factor in the act for each year through 2026. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7965749/ for further information on the mechanics of Medicare conversion factor calculation.

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D.1.2. Application of RBRVS to Professional Services Reimbursement in Montana

Montana has adopted the RBRVS methodology used by Medicare and adapted it to align with the programmatic and policy requirements specific to its Medicaid program, as have the vast majority of other states across the country. Although Montana's reimbursement policies largely conform to the Medicare model, there are several points of difference between the Medicare and Montana Medicaid methodologies that stem from the broader service array of professional services covered by Medicaid relative to Medicare, as well as the diversity of professional practitioners that serve the Medicaid population in comparison to Medicare. For example, the Medicare program is not a key payer for behavioral health services, but because Medicaid is central to funding the public behavioral health system, it has developed payment policies to reimburse a wide variety of non-physician practitioners for whom RBRVS-based payments were not originally designed.

These programmatic differences result in several technical modifications of the RBRVS approach to support the specific needs of the Medicaid system. For example, Montana uses separate conversion factors for different practitioner types, so that rates for physicians, allied professional services, and non-psychiatrist mental health providers are calculated based on three distinct conversion factors. Additionally, specific adjusters are also applied by procedure, serving as rate multipliers to calculate enhanced rates for select services such as family planning, mental health evaluations, and autism services. Certain provider types receive enhanced or discounted rates as well. Psychiatrists, for instance, receive 112 percent of standard physician rates for all services while mid-level practitioners receive 90 percent of physician rates for adult services and 100 percent for pediatric, in comparison to 85 percent under Medicare for all services.

The DPHHS payment methodology for anesthesia services also mirrors Medicare's approach, and rates are calculated in a similar manner. Instead of relative weights, though, anesthesia procedures are assigned minimum base time units and units of service calculated in minutes, with a single conversion factor appropriate to these units of service. Payment for services is calculated by taking the sum of the base and incremental time units multiplied by the conversion factor. As noted above, the conversion factor for anesthesia is updated by DPHHS annually to compensate for changes in overall base units and legislative reimbursement targets.

All Montana conversion factors are updated annually by DPHHS, both to align these factors with updated Medicare RVU values and to implement biennial legislative expenditure allotments within the total budget. However, uniquely for physician services, DPHHS is required by statute to increase the physician factor at a minimum by the Consumer Price Index for Medical Care, despite any changes in RVU valuations, the Medicare conversion factor, or the MEI.

In light of these differences, Guidehouse's analysis of reimbursement adequacy and the reasonableness of current payment levels focused on three distinct dimensions of Medicaid reimbursement policy:

1) Payment adequacy in Medicaid, as measured against Medicare reimbursement,
2) Rate equity among different Medicaid practitioners, and
3) Technical concerns related to inflationary adjustments to physician service rates.

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The following analysis details Guidehouse's findings for each of these areas of focus.

D.2. Methodology

To conduct our analysis, Guidehouse compared State Fiscal Year (SFY) 2022 Montana RBRVS and anesthesia rates to CY 2022 Medicare rates and the latest available rates and reimbursement methodologies for other states including Colorado, Idaho, North Dakota, Utah, Washington, and Wyoming. This analysis was completed at a service level for procedure codes listed in the Montana RBRVS and anesthesia fee schedule.

Guidehouse also estimated total reimbursement amounts for SFY 2022 professional and anesthesia services. To accomplish this task, Guidehouse first requested claims data from the Montana Medicaid Management Information System (MMIS) with service dates from July 2020 through June 2021 (SFY 2021) to build an analytical data set. Guidehouse repriced the SFY 2021 claims using Montana SFY 2021 professional and anesthesia rates including policy adjusters and modifiers. That calculated payment amount was compared to the claim allowed amount to ensure accuracy. Any claims in which the pricing did not match were excluded from the data set. This resulted in an exclusion of less than 1 percent of claims.[17] Using the same method, the analytical data set was priced using SFY 2022 rates to provide a baseline for comparison against other methods.

Claims were then priced under Medicare CY 2022 professional and anesthesia rates from the Medicare Physician Fee Schedule (PFS) Payment Amount File – National and the Medicare Anesthesia Base Units File. Rates were matched to claim lines via the procedure and modifier codes, when applicable. The CY 2022 PFS national file uses Geographic Practice Cost Indices (GPCIs) by locality, weights from the RVU file, and a conversion factor of 34.6062 to calculate the Facility and Non-Facility payment rates specific to Montana.

When calculating the Medicare payment, an 85 percent reimbursement factor was applied to Mid-Level Practitioner claims, and 75 percent to Social Worker claims as specified by the Medicare Pricing Manual.[18] Since Medicare does not reimburse the entire spectrum of practitioners who deliver services under Medicaid (Licensed Professional Counselors and other types of therapists, for example), the remaining provider types do not have specified factors in the pricing manual. For the purposes of identifying cognate payments under Medicare, licensed professional counselor and marriage and family therapist qualifications were estimated to be at a level comparable with a social worker due to their similar scopes of practice, warranting a reduced payment to 75 percent of Medicare. No reductions were applied to other provider types, as either physicians were performing the work (Psychiatrist), or non-physician practitioners were already assumed to be the primary practitioners in the professional rate itself (OT/PT, mental health counseling, laboratory services).

[17] Claims in which the pricing did not match were not reviewed with DPHHS due to the low impact to the analysis

[18] Medicare Claims Processing Manual. Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf - Chapter 12, Transmittals 120 and 150

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D.3. Analysis

Analysis indicated the following summary trends of Montana Medicaid rates and payments in comparison both to Medicare reimbursement as well as Medicaid rates published by other states:

- Montana pays significantly more than Medicare and all but one other state Medicaid program for Physician and Mid-Level providers, but pays below Medicare for all others;
- After budget reductions in 2017, Physician reimbursement was at 101 percent of Medicare. For 2022, that number has grown to 121 percent;
- Anesthesia services pay 140 percent of Medicare with Physicians at 142 percent and Mid-Levels at 131 percent;
- Minimum increases for the physician conversion factor are causing payment increases beyond CPI.

D.3.1. Recent Budget Trends

In 2016, the Kaiser Family Foundation (KFF) measured each state's fee-for-service physician rates relative to Medicare[19], publishing a survey of rates covering all states that continues to be widely cited and remains consistent with more recent analyses of Medicaid reimbursement trends.[20] When considering all services, KFF found Alaska had by far the highest Medicaid rates, averaging 126 percent of Medicare for all physician services, with Montana having the second highest at 109 percent of Medicare. All other states had rates below Medicare with the national average at 72 percent for all services and 66 percent for primary care. As recently as 2019, the national average is still 72 percent, according to an Urban Institute study conducted in 2021.[21] Table 77 shows the 15 states with the highest Medicaid to Medicare Index in 2016.

Table 77: 2016 State Physician Fees Relative to Medicare – Top 15 by All Services

Medicaid to Medicare Index 2016				
Location	**All Services**	**Primary Care**	**Obstetrics**	**Other Services**
Alaska	1.26	1.27	1.25	1.24
Montana	1.09	1.06	1.17	1.05
North Dakota	0.98	1	0.99	0.92

[19] Kaiser Family Foundation, Medicaid State Indicator. Available online: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index
[20] See, for example, the Urban Institute Study conducted in 2021 that found reimbursement levels similar not only to the 2016 survey, but to findings in 2008 and 2012: Zuckerman et al., "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019," in Health Affairs, vol. 40, no. 2 (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611).
[21] Health Affairs, Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Available online: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611

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Medicaid to Medicare Index 2016				
Location	**All Services**	**Primary Care**	**Obstetrics**	**Other Services**
Wyoming	0.98	0.93	1.05	1.04
Delaware	0.96	0.99	0.84	0.97
Idaho	0.95	1	0.89	0.88
Nevada	0.95	0.95	0.97	0.92
Nebraska	0.92	0.71	1.05	1.33
Virginia	0.92	0.84	1.03	0.97
Mississippi	0.89	0.9	0.89	0.88
New Mexico	0.89	0.78	0.98	1.05
Maryland	0.88	0.92	0.86	0.81
Oklahoma	0.86	0.87	0.85	0.84
Utah	0.86	0.86	0.9	0.8
South Dakota	0.84	0.71	0.89	1.11
US Average	**0.72**	**0.66**	**0.81**	**0.82**

Alaska presents a unique case as it faces extraordinary issues with both access to care and cost of living, and consequently pays a substantial premium relative to other public payers to attract physicians to the state. While access to care and physician supply issues faced by Montana stem from similar demographic and economic issues common to many frontier states, the scale of these issues is significantly more acute in Alaska, and its Medicaid policies should be regarded more as an outlier than a standard for other Medicaid programs, even in other frontier states.

Montana Medicaid updates their SFY rates using current Medicare RVUs, so Montana SFY 2022 rates utilize Medicare CY 2021 RVUs. This results in 6 months of overlap where both payers are using the same RVUs with different conversion factors. We can use this overlap to compare historical differences in rates by differences in conversion factors without having to re-price claims to account for differences in RVUs. During the 2017 Montana legislative session, a series of budget reductions were introduced that dropped the conversion factor difference from 106 percent in SFY 2017 to 102 percent in SFY 2018. Due to built-in increases tied to the Medical Care Consumer Price Index (CPI), the Montana conversion factor has steadily increased while the Medicare factor has remained relatively flat, actually ending lower in 2022 than in 2016 as shown in Table 78. Increases or reductions to the Medicare conversion factor below the Medicare Economic Index (MEI) are to offset overall increases in the RVU rates noted previously.

Table 78: Conversion Factors by Year

Conversion Factors by Year*					
MT SFY / Medicare CY	**MT Physician CF**	**Change**	**Medicare CF**	**Change**	**Percent of Medicare**
2016 / 2015**	36.93		35.84		103%
2017 / 2016	37.89	2.6%	35.80	-0.1%	106%
2018 / 2017	36.53	-3.6%	35.89	0.2%	102%
2019 / 2018	37.81	3.5%	36.00	0.3%	105%

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Conversion Factors by Year*					
MT SFY / Medicare CY	MT Physician CF	Change	Medicare CF	Change	Percent of Medicare
2020 / 2019	38.46	1.7%	36.04	0.1%	107%
2021 / 2020	39.51	2.7%	36.09	0.1%	109%
2022 / 2021	41.88	6.0%	34.89	-3.3%	120%

**When comparing conversion factors, the physician factor for the Montana SFY is compared to the previous calendar year for Medicare to eliminate differences in RVUs.*
***For 2015, Medicare updated the conversion factor in January and July, so the average of the two rates for 2015 was used for CY 2015.*

The 2016 KFF study is valuable not only for providing historical context into physician rate levels prior to the 2018 rate reductions, but also for establishing a convenient baseline for trending changes in the rates, as well as offering insight into identifying appropriate peer states for comparative analysis.

D.3.2. Medicare and Medicaid Peer State Benchmarking: Physicians and Mid-Levels

For evaluating Montana's current rates relative to other state Medicaid programs, Guidehouse selected the top 10 procedures by DPHHS allowed amount for SFY 2021 and compared the Montana SFY 2022 rates both to the CY 2022 rates for Medicare, as well as the most current rates available for Idaho, Utah, and Wyoming.

Table 79 displays the comparison of physician non-facility Montana Medicaid and Medicare rates for the top 10 procedures by allowed amount.

Table 79: Top 10 Procedures by Montana Allowed Amount

2022 Physician Fee Comparison - Medicare				
Code	Description	MT	Medicare[22]	Percent of Medicare
99214	Office o/p est mod 30-39 min	$157.34	$129.68	121%
99213	Office o/p est low 20-29 min	$110.90	$91.97	121%
59400	Obstetrical care	$2,933.57	$2,452.57	120%
99285	Emergency dept visit	$148.42	$122.98	121%
99284	Emergency dept visit	$216.52	$178.58	121%
99204	Office o/p new mod 45-59 min	$203.75	$169.38	120%
99233	Subsequent hospital care	$136.40	$113.72	121%
99291	Critical care first hour	$219.66	$182.90	121%
99232	Subsequent hospital care	$86.19	$71.21	121%
99283	Emergency dept visit	$123.84	$102.32	120%

[22] Center for Medicaid and Medicaid Services, Physician Fee Schedule. Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched

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Table 80 displays the comparison of Montana and peer state Medicaid rates for the same procedures.

Table 80: Top 10 Procedures by Montana Allowed Amount

2022 Physician Fee Comparison – Peer State							
Code	**Description**	**MT**	**ID[23]**	**UT[24]**	**WY[25]**	**Average (ID, UT, WY)**	**Pct of Avg.**
99214	Office o/p est mod 30-39 min	$157.34	$100.03	$93.75	$91.28	$95.02	166%
99213	Office o/p est low 20-29 min	$110.90	$70.13	$65.96	$64.33	$66.81	166%
59400	Obstetrical care	$2,933.57	$1,756.96	$2,026.00	$2,069.78	$1,950.91	150%
99285	Emergency dept visit	$148.42	$102.25	$92.97	$114.29	$103.17	144%
99284	Emergency dept visit	$216.52	$150.68	$135.54	$169.28	$151.83	143%
99204	Office o/p new mod 45-59 min	$203.75	$128.72	$125.46	$146.99	$133.72	152%
99233	Subsequent hospital care	$136.40	$85.48	$83.69	$95.60	$88.26	155%
99291	Critical care first hour	$219.66	$139.81	$131.11	$130.10	$133.67	164%
99232	Subsequent hospital care	$86.19	$63.35	$53.69	$67.21	$61.42	140%
99283	Emergency dept visit	$123.84	$90.79	$77.17	$96.32	$88.09	141%

In addition to comparing rates, Guidehouse also performed an analysis of estimated payments for all claims having procedures with both a Montana Medicaid and Medicare rate. This allows a comparison of what Medicare and other states would currently pay with the same claim data.

In the 2016 KFF study, Montana's percentage of Medicare was 109 percent, 14 percent higher than Idaho, 23 percent higher than Utah, and 11 percent higher than Wyoming. In looking at estimated payments under current 2022 rates, Montana is now 21 percent higher than Medicare, 45 percent higher than Idaho, 57 percent higher than Utah, and 31 percent higher than Wyoming. This shows the extreme growth caused by requiring a minimum increase for physician payments based on CPI.

Expanding to other provider types using the physician conversion factor, a comparison of Montana Medicaid SFY 2022 physician and mid-level procedure payments to calculated CY 2022 Medicare payments shows DPHHS is paying 121 percent of Medicare for physicians, 132 percent for mid-levels for all services, and 123 percent for physicians and mid-levels combined. There was no difference in payment level for pediatric services except for mid-level practitioners that have an increased adjuster for pediatric.

Table 81 shows the difference in payments for physicians, psychiatrists, and mid-level practitioners. This table does not include payments by Medicaid for services not covered by Medicare.

[23] https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=21520&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1

[24] https://medicaid.utah.gov/coverage-and-reimbursement/

[25] https://wyomingmedicaid.com/portal/fee-schedules

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Table 81: Estimated Payments for Physicians, Psychiatrists, and Mid-Level Practitioners

Estimated Payments by Provider Type				
Provider Type	**Medicaid 2022**	**Medicare 2022**	**Difference**	**Percent of Medicare**
Physician (Ped and Adult)	$119,352,817	$98,864,986	$20,487,831	121%
Psychiatrist	$5,412,390	$3,996,330	$1,416,060	135%
Mid-Level Adult	$26,644,280	$20,858,945	$5,785,335	128%
Mid-Level Pediatric	$11,746,980	$8,279,153	$3,467,827	142%
Total	**$163,156,467**	**$131,999,414**	**$31,157,053**	**124%**

Since Montana uses Medicare RVUs, the difference in payments can be ascribed to the high Montana physician conversion factor compared to Medicare's conversion factor, 41.88 to 34.61, resulting in payments that are 121 percent higher than Medicare. Provider types that use this factor have payment levels much higher than Medicare and higher than provider types that use separate conversion factors. In addition, the provider rate of reimbursement factors Montana employs for psychiatrists and mid-level practitioners, which both use the 41.88 rate, push those providers even higher. Psychiatrists get 112 percent of the Montana physician rate, but no increase from Medicare. Mid-levels get 100 percent of the Montana physician rate for pediatric services and 90 percent for adult. Medicare gives mid-levels 85 percent of the physician rate for all services. These factor differences create a larger gap between Medicaid and Medicare with psychiatrists at 135 percent of Medicare and mid-levels at 132 percent.

When looking at the data by service category, payment levels range from 120 percent to 128 percent of Medicare. This range depends on the ratio of procedures performed by psychiatrists or mid-levels, who have a significantly higher level of payment.

Table 82 shows the difference in estimated payments by service category. Similar to Table 81, this table does not include payments by Medicaid for services not covered by Medicare.

Table 82: Estimated Physician and Mid-Level Payments

Estimated Payments by Provider Type				
Service Category	**Medicaid 2022**	**Medicare 2022**	**Difference**	**Percent of Medicare**
Surgery (10000 – 69999)	$27,060,226	$22,266,083	$4,794,144	122%
Maternity and Delivery (59000 – 59899)	$10,507,620	$8,686,780	$1,820,840	121%
Radiology (70000-79999)	$13,217,546	$10,842,143	$2,375,403	122%
Lab (80000 – 89999)	$1,468,072	$1,220,339	$247,732	120%
Medicine and Physical Services (90000 – 98999)	$8,078,193	$6,578,361	$1,499,832	123%
E&M/Other (99000 – 99999)	$37,722,200	$30,822,489	$6,899,711	122%
Office Visits (99201 – 99215)	$57,605,521	$45,944,118	$11,661,403	125%
Mental Health (961XX, 90785-90899)	$1,587,142	$1,237,359	$349,782	128%

Guidehouse performed similar comparative analysis for anesthesia services. For an additional comparison of the current anesthesia rates, neighboring or similar states were selected that use

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Medicare base units and a separate conversion factor. Using these states, the comparison of rates could be simplified to comparing the conversion factors. The conversion factors compared were the SFY 2022 Montana Medicaid, the CY 2022 Medicare, and most current factor for other states, typically SFY 2022 or CY 2022. For the percent of Medicare calculation, state conversion factors were compared to the locality adjusted Medicare conversion factors for each state. Table 83 displays the comparison for anesthesia rates.

Table 83: 2022 Anesthesia Conversion Factors

Anaesthesia 2022 Conversion Factors		
Payer	**2022 Conversion Factor**	**Percent of Medicare***
Montana	30.57	142%
Medicare (MT)	21.53	100%
Colorado	27.25	127%
Utah**	23.73	113%
Washington	21.20	100%

**Percent of Medicare is based on the Medicare locality-adjusted conversion factor for each state.*
***Utah uses Medicare base units, but 12 minute time units, rather than 15.*

As with physician services, Montana Medicaid rates for anesthesia services are well above rates for Medicare and other states. This gap has also been widening since 2017. After budget reductions in 2017 and 2018, Montana was paying 125 percent of Medicare. Under the 2022 rates, that gap has widened to 142 percent of Medicare. This again is due to a combination of increased overall Medicare base units in the fee schedule and the changes in the Montana conversion factor compared to Medicare's, ending at 30.57 to 21.53.for 2022.

As with physicians, the base units in the anesthesia fee schedule are taken from the Medicare anesthesia fee schedule, but the conversion factor is not tied to the Medicare anesthesia conversion factor. Increases in the base units have led to Medicare decreasing the conversion factor by 3 percent between 2016 and 2022. In contrast, Montana's anesthesia conversion factor has increased by 5 percent.

D.3.3. Medicare Benchmarking: Mental Health and Allied Practitioner Rates

Guidehouse also performed an analysis of estimated payments for all provider types paid under the RBRVS fee schedule. While provider types using the physician conversion factor have estimated payments substantially above the Medicare rate, provider types using the allied or mental health conversion factors have estimated payments far below Medicare.

Table 84 displays the Montana Medicaid conversion factor for SFY 2022, applicable Montana Medicaid provider rate of reimbursement factor (PRR), applied Medicare PRR, and estimated percent of Medicare payments for each provider type in the analytical claim data.

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Table 84: Medicaid to Medicare Analysis by Provider Type

Montana Medicaid to Medicare Analysis by Provider Type				
Provider Type	**Medicaid CF SFY 2022**	**Medicaid PRR SFY 2022**	**Medicare PRR**	**Percent of Medicare**
Physician	41.88	1	1.00	121%
Mid-Level Pract. – Adult	41.88	0.9	0.85	128%
Mid-Level Pract. – Pediatric	41.88	1	0.85	142%
Psychiatrist	41.88	1.12	1.00	135%
Podiatrist	41.88	1	1.00	120%
Independent Diag. Testing Facility	41.88	1	1.00	123%
EPSDT	41.88	1	1.00	121%
Laboratory	41.88	1	1.00	120%
Public Health Clinic	41.88	1	1.00	113%
Physical Therapist	24.75	1	1.00	72%
Optometrist	24.75	1.1479	1.00	82%
Occupational Therapist	24.75	1	1.00	73%
Speech Pathologist	24.75	1	1.00	71%
Audiologist	24.75	1	1.00	71%
Optician	24.75	1.1479	1.00	N/A*
Licensed Professional Counselor	21.44	1	0.75	83%
Social Worker	21.44	1	0.75	83%
Psychologist	21.44	1	1.00	68%
Marriage And Family Therapist	21.44	1	0.75	83%

**The Optician provider type did not have claims with procedures on the Medicare fee schedule, precluding Medicare comparison.*

This shows a substantial difference in estimated payments correlating to the associated conversion factor. Although the conversion factor for physicians has been tied to the Medical Care CPI, the factors for allied providers and mental health have not. The physician conversion factor has pulled farther ahead of allied and mental health as a percent of Medicare. In SFY 2017, allied and mental health were at 71 percent and 73 percent respectively. By SFY 2022, allied had increased to only 72 percent and mental health had decreased to 69 percent.

D.3.4. Inflationary Adjustment Mechanisms

Understanding the dynamics driving the precipitous growth in physician expenditures requires a closer examination of conversion factor updates used by Montana to adjust physician reimbursement to keep up with inflation. As noted earlier, requiring minimum increases in the physician conversion factor obligates Montana to increase payments at least as high as medical growth reflected in the Medical Care CPI, but Guidehouse's analysis suggests that annual increases in physician rates are growing well beyond the Medicare Economic Index (MEI) and even Medical Care CPI. Montana physician rates went from 105 percent of Medicare in 2019 to 120 percent of Medicare in 2022, a 14 percent increase. Over this same period, MEI and

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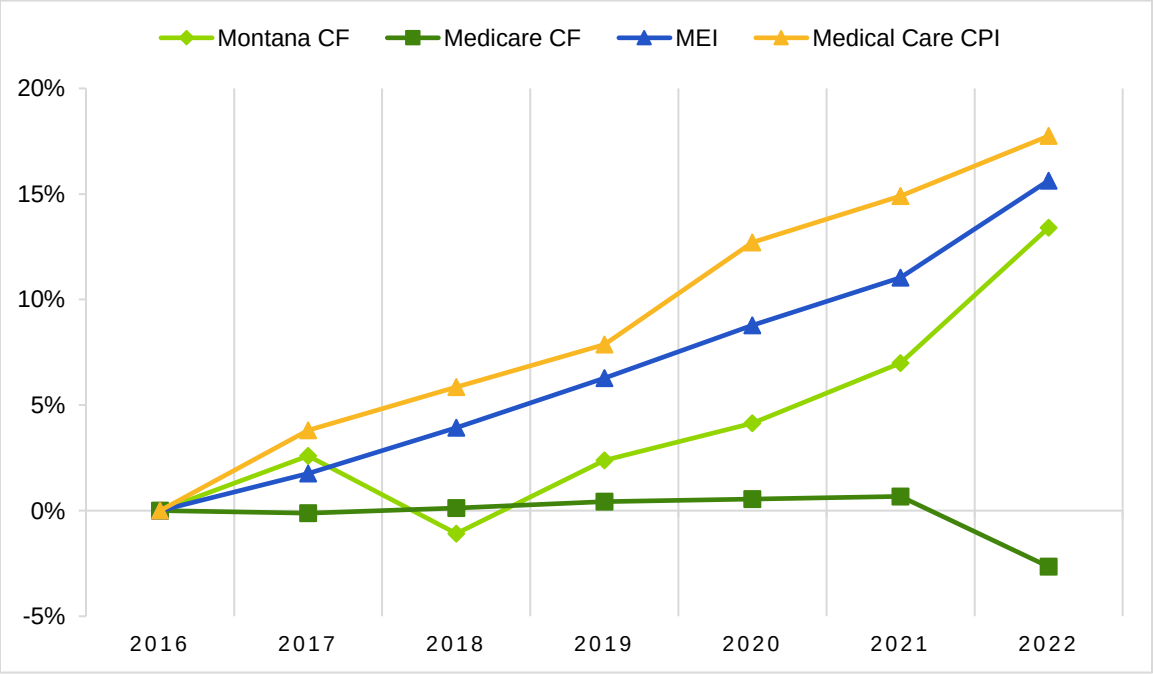
Medical Care CPI increased 10 percent. Even under the assumption that Medicare rates have remained flat since 2018—which they have not—Medicaid physician rates have grown 40 percent faster than the rate of inflation (as measured by Medical Care CPI). However, considering Medicare physician rates have also increased since 2019, the rise in Medicaid reimbursement in the last four years relative to Medicare signals potentially even sharper increases in reimbursement over inflationary trends.

Figure 23 shows the cumulative percentage change since 2016 for the Medicaid and Medicare conversion factors in addition to MEI and Medical Care CPI and demonstrates how tying the conversion factor to Medical Care CPI has moved Montana Medicaid far above Medicare. It is important to note, despite the fact the Medicare conversion factor shows decreases in 2021-2022, Medicare physician rates themselves are not dropping. On the contrary, the declining Medicare conversion factor signals the injection of significant new value into the Medicare fee schedule in the form of additional RVUs for E/M procedures, first implemented in 2021.

Figure 23: 2016-2021 Cumulative Change in Conversion Factors



This infusion of new RVUs into the system did result in an increase in overall Medicare physician rates, but the decrease in conversion factor translated into shifts within the existing budget, away from specialist surgical and imaging procedures to E/M codes billed across physician practices, especially by primary care physicians. The conversion factor plays an important role in rebalancing payments within the physician fee schedule, as well translating relative value units into reimbursement dollars. However, automatic inflationary updates to the conversion factor short-circuits this function to some extent, in effect duplicating the additional value infused into the fee schedule by RVU changes along with inflationary costs.

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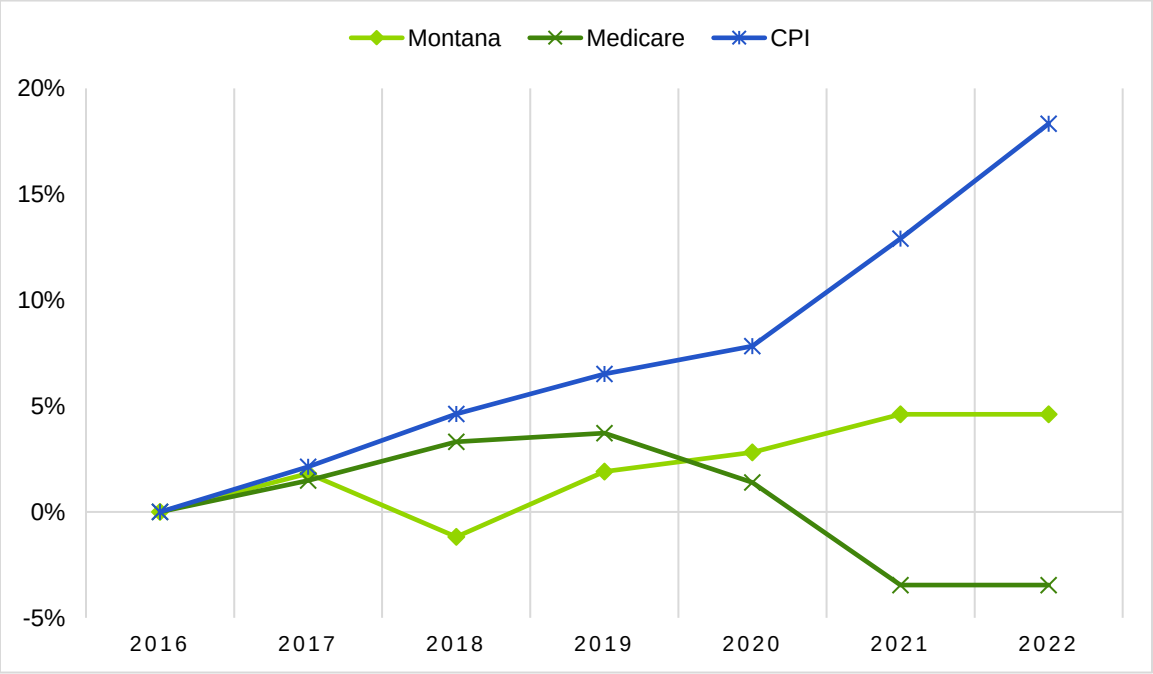
Although DPHHS annually models the impact of implementing the updated Medicare RVUs and may determine the Montana physician conversion factor should be decreased to reach expenditure targets, MCA 53-6-125 requires the Department to increase the conversion factor by at least Medical Care CPI for the previous year. This increases physician payments by both the increase in RVUs and the increase in Medical Care CPI. Depending on the size of the RVU increase, this combination can result in a minimal additional increase as in 2019 and 2020, or a significant addition as in 2021 and 2022. In the event there is a decrease in overall RVUs, DPHHS has authority to increase the conversion factor beyond Medical Care CPI to compensate. There are no similar levers to compensate for increases beyond Medical Care CPI.

Figure 24 shows the cumulative change in the anesthesia conversion factors and Medical Care CPI since 2016, which demonstrates a similar effect for anesthesia reimbursement as for physician reimbursement.

Figure 24: 2016-2021 Cumulative Change in Anesthesia Conversion Factor



This dynamic can be grasped more easily with a concrete illustration. Consider the simplified service array and fee schedule in Table 85 below. In this hypothetical fee schedule, there are four different services, Procedures A-D, with each procedure assigned its own RVU. Procedure A is just a fraction of an RVU, 0.10, while Procedure B has an RVU of 1.00. In this scheme, Procedure A represents only a tenth of the value of Procedure B, while Procedures C and D are worth ten and one hundred times, respectively. In Year 1 of this scenario, the conversion factor is established at 40.00, which means each RVU within the system is worth $40.00. As a result, Procedure A is worth $4.00, Procedure B is worth $40.00, Procedure C is worth $400.00, and Procedure D is worth $4,000. While the actual RBRVS is significantly more complex, spanning

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thousands of codes, these simplified procedures represent the range of values and rates found in the Medicare fee schedule. See Table 85.

Table 85: Hypothetical Fee Schedule Illustration - Year 1 (Baseline)

Hypothetical Fee Schedule: Year 1					
Procedure	**Year 1 RVUs per code**	**Year 1 Units of Service**	**Year 1 RVUs Utilized**	**Year 1 Service Rate *CF = 40.00***	**Year 1 Payment**
A	0.10	10,000	1,000	$4.00	$40,000
B	1.00	2,000	2,000	$40.00	$80,000
C	10.00	400	4,000	$400.00	$160,000
D	100.00	80	8,000	$4,000.00	$320,000
Total			**15,000**		**$600,000**

In addition to the fee schedule variables of RVUs and conversion factors, Table 85 also identifies the total number of units of service utilized for each procedure, as well as the expenditures for each service and the total budget of $600,000 required to reimburse all of the services rendered. With all of these elements presented, the illustration can be used to highlight the relationships among them, showing how the conversion factor is connected to specific RVU valuations, service utilization, individual payment rates, as well as overall budget and expenditures.

While the primary role of the conversion factor is to “translate” each procedure’s RVU into a monetary rate, it is also the mechanism used to distribute the total budget available proportionately to each procedure reimbursed within the system. Just as RVUs express relationships of effort and cost among the spectrum of procedure codes, the conversion factor expresses the relationship between the total number of RVUs reimbursed through the system and the total budget available for expenditure. The conversion factor of $40.00 in Table 85 is itself the quotient of the $600,000 budget available, divided by the 15,000 total RVUs delivered through the system.

To show how Montana’s inflationary adjustments for physician services impact expenditure growth, consider two alternatives for updating this simplified fee schedule to account for a 5 percent growth in costs, as measured by an inflationary index such as CPI. The first alternative, the method prescribed by statutory increases in Montana, would simply apply a 5 percent trend to the conversion factor. In this illustration, this approach would lead to an updated Year 2 conversion factor of $42.00, a 5 percent increase over the conversion factor of $40.00 for Year 1.

The more accurate alternative to inflation adjustment, as performed by DPHHS prior to statutory increases, would be to trend the *budget*, not the conversion factor, by an additional 5 percent. Of course, if there are neither significant shifts in utilization between Year 1 and Year 2, nor any changes in RVU valuation in the fee schedule, the two alternatives yield equivalent results. However, results diverge if either of these variables change in Year 2. Standalone inflationary adjustments to the conversion factor could generate budgetary increases that are greater or less than the 5 percent target if the update does not consider its relationship to the changing RVU ratios or the total budget. The ultimate problem with this approach is that **applying**

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inflationary adjustments directly to the conversion factor mistakes it for an absolute value rather than a relational element within the fee schedule.

Consider an additional elaboration of our hypothetical fee schedule in Year 2 (See Table 86). Instead of applying a 5 percent inflationary adjustment to the conversion factor, the update instead assumes a 5 percent growth in total spending, generating a Year 2 budgetary ceiling of $630,000. Furthermore, the RVUs in the fee schedule have not remained static between Years 1 and 2 but have been altered more or less significantly through the re-valuation process (just as they often do in actual RBRVS updates). Procedures A and B saw increases--from 0.1 to 0.12 RVUs for Procedure A and from 1.00 to 1.05 for Procedure B—while Procedure D saw a slight decrease from 100 RVUs to 99.5. Procedure C was unchanged.

The budgetary inflation approach accounts for increases in costs as well as changes in procedures' relative value by considering additional budget available, projected utilization (which remains unchanged in this example), as well as total number of RVUs delivered, which have increased by an additional 260 RVUs, or 1.7 percent, due to the re-valuation of the procedure codes. To accomplish its 5 percent growth target, the budgetary update calculates a Year 2 conversion factor of 41.28, which is $630,000 divided by 15,260 total RVUs. This process projects a 5 percent growth in expenditures overall, but it also derives individual rates that are each 5 percent higher than they would have been if calculated at a budget-neutral conversion factor.

Table 86: Hypothetical Fee Schedule Illustration - Year 2 (Budget Inflation Scenario)

Hypothetical Fee Schedule: Year 2					
Procedure	**Year 2 RVUs per code**	**Year 2 Units of Service**	**Year 2 RVUs Utilized**	**Year 2 Service Rate *CF = 41.28***	**Year 2 Payment**
A	0.12	10,000	1,200	$4.95	$49,541
B	1.05	2,000	2,100	$43.35	$86,697
C	10.00	400	4,000	$412.84	$165,138
D	99.50	80	7,960	$4,107.80	$328,624
Total			**15,260**		**$630,000**

Applying an inflationary adjustment directly to the conversion factor, assuming the same Year 2 utilization and RVU variables as above, ultimately *overstates* the annual growth in costs, leading to increases in rates and overall expenditures of 6.8 percent, inflating costs 1.8 percent higher than the 5 percent growth targeted, based on the inflation index. Table 87 illustrates this effect, showing how the approach inflates individual rates above the rates calculated in the alternative budgetary method, resulting in approximately $11,000 of additional spending.

Table 87: Hypothetical Fee Schedule Illustration - Year 2 (Conversion Factor Inflation Scenario)

Hypothetical Fee Schedule: Year 2					
Procedure	**Year 2 RVUs per code**	**Year 2 Units of Service**	**Year 2 RVUs Utilized**	**Year 2 Service Rate *CF = 42.00***	**Year 2 Payment**
A	0.12	10,000	1,200	$5.04	$50,400

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Hypothetical Fee Schedule: Year 2					
Procedure	**Year 2 RVUs per code**	**Year 2 Units of Service**	**Year 2 RVUs Utilized**	**Year 2 Service Rate *CF = 42.00***	**Year 2 Payment**
B	1.05	2,000	2,100	$44.10	$88,200
C	10.00	400	4,000	$420.00	$168,000
D	99.50	80	7,960	$4,179.00	$334,320
Total			**15,260**		**$640,920**

While a 1.7 percent additional increase may not seem excessive at the scale of this simplified example, for budgets in the hundreds of millions, the consequence is additional annual expenditures of millions of dollars, which becomes compounded by each new year of inflationary adjustment. The issue is further exacerbated when CMS implements major changes in the relative value scale, as it did in 2021. Unlike Medicare, Montana Medicaid is unable to appropriately adjust for the major changes in RVUs when recalculating the conversion factor due to the statutorily required conversion factor inflation method. This contributes to substantial downstream bumps in physician reimbursement.

D.3.5. Discussion

In 2016 at 109 percent, Montana was one of only two states paying more than Medicare for physician services, the other state being Alaska, with reimbursement at 126 percent of Medicare. In 2018, budget reductions dropped that to 101 percent. Data shows the gap between Medicaid and Medicare is widening considerably. After the budget cuts for SFY 2018, the Montana conversion factor was $0.64 higher than Medicare. As of 2022, it is $6.99 higher. Because of these increases, Montana payments for physician, mid-level practitioner, and anesthesia are much higher than what Medicare considers adequate for quality and access. Payments for physicians are now 121 percent of Medicare, 128 percent for mid-level practitioners, and 140 percent for anesthesia.

While Guidehouse recognizes the unique challenges to physician care access Montana faces as a frontier state may require paying a premium rate, it is important to note the Medicare program in Montana also faces similar challenges and addresses these concerns with reimbursement adjustments unique to Montana, and which are already reflected in its benchmark rates. For example, due to Montana's status as a frontier state, the Practice Expense (PE) GPCI has a 1.0 floor, meaning the GPCI adjustment cannot be below 1. The PE GPCI for Utah is 0.919 and for Idaho it is 0.877. Montana's calculated GPCI would be below 1.0 as well, so this floor artificially increases Medicare payment levels beyond the relative practice expenses. We can discern here that Medicare in Montana pays approximately a 10 percent premium for the PE portion of physician fees. Wyoming, North Dakota, and South Dakota are also frontier states and get an increase due the 1.0 floor.

Medicare rates by design are sufficient to promote quality and access, particularly with the increased GPCI for Montana's frontier state status. Correspondingly, Medicare is accepted by nearly every physician and is used nationwide as a benchmark for commercial and Medicaid payments. Although critics of Medicare physician reimbursement frequently note that Medicare

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rates have not increased in proportion to rising physician practice costs, it is not evident that low levels of increase in rates have had a deleterious effect on physician participation in the Medicare program. For example, in a recent 2020 study of physician participation, researchers noted less than 1 percent of non-pediatric physicians had opted out of Medicare, despite the physician payment "freeze" implemented in Medicare as a part of MACRA statutory reforms.[26] Significantly, Medicare's flat growth in its fee-for-service rates is by design, as the program encourages physician providers to participate in value-based programs in which annual growth in reimbursement is increasingly tied to performance standards.

Guidehouse could find no indication there are access or quality issues with providers under Medicare payment rates that would necessitate such high Medicaid payment levels. Paying more than 20 percent above these rates needlessly commits funds that could be utilized in other areas currently experiencing access issues.

Allied professional services and mental health have not experienced these increases and continue to have rates significantly lower than Medicare and are potentially susceptible to access issues due to payment rates. Psychologists are the lowest at 68 percent, and there are several provider types from 71 percent to 73 percent. These percentages have remained consistent or are decreasing year over year.

Montana's percentage premium above Medicare has increased beyond Medical Care CPI year over year due to statutory minimum increases to the conversion factor that have exacerbated overall RVU value increases rather than compensated for them. This dynamic is causing an accelerated inflationary trend for physician and mid-level reimbursement, particularly when compared to other provider rates. We regard Montana's current methodology for inflation adjustment to be technically flawed and encourage the State to revisit its process for rate adjustment, even if it chooses to continue to pay significantly higher than Medicare.

D.4. Recommendations

D.4.1. Summary Recommendations

Guidehouse recommends targeting reimbursement rates for physicians and mid-level practitioners at the 2019 levels of 105 percent of Medicare. For reasons stated in the discussion above, we view a 5 percent premium above Medicare as adequate to account for any additional access issues unique to the Medicaid population. This decrease in payment for the large volume of these services will realize savings that can be used as increases for other services and will maintain Montana's reimbursement levels for physicians and mid-levels as a percentage of Medicare equal to 2019 levels and higher than all but one other state.

[26] See Nancy Ochieng et al., "How Many Physicians Have Opted Out of the Medicare Program," October 22, 2020 (https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/). Notably, for specialties where opt-out rates are higher than 2%, psychiatry in particular, Montana Medicaid has already implemented reimbursement adjustors that increase payment for psychiatrists and others to encourage greater participation in the Medicaid program.

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Guidehouse also recommends targeting reimbursement rates for mental health practitioners excluding psychiatrists at 90 percent of Medicare. This change would be a 22 percent increase for Psychologists and a 7 percent increase for all others. A study published in July of 2021 found that "…raising the Medicaid primary care fee level close to at least 90 percent of the Medicare level reduces the likelihood that publicly-insured [Children with Special Health Care Needs (CSHCN)] lack a usual source of care in a doctor's office by about 15 percent."[27] Since the most common conditions among CSHCN include mental or behavioral conditions, this study provides justification for using 90 percent of Medicare as an acceptable level of payment for mental health to promote access for all Medicaid patients.

To achieve the above targets, Guidehouse recommends the following steps:

- Update the conversion factors to achieve payment levels at 105 percent of Medicare for physician and anesthesia; 90 percent for mental health
- Reduce the mid-level provider rate of physician reimbursement to 85 percent for adult services, equal to Medicare, and 95 percent for pediatric services to retain the existing premium
- Update RVUs annually (as-is process)
- Implement all future payment level updates through total reimbursement levels rather than having separate requirements for conversion factors
- Re-base conversion factors and provider rate of reimbursement every 3 years

Tying all updates to reimbursement levels allows compensation for increases in overall Medicare RVU or time unit levels. This will help to avoid reimbursement increases beyond intended levels that can be difficult to undo both politically and monetarily.

In addition, rebasing conversion factors and provider rate of reimbursement every 3 years will allow the State to compensate for changes in payment levels for specific services and may require additional policy adjusters to achieve the desired reimbursement for specialty providers. For example, RVUs for a number of high-volume psychological counseling and testing services have been subject to substantial upward and downward movements and may require adjustments to keep payment levels sufficient for psychiatrists or psychologists. Plus, while overall funding for a subset of providers may show acceptable levels, depending on the implementation scenario, these revenues may not be distributed evenly across the provider community. In the case of maternity services and primary care, Medicare publishes a reimbursement rate and methodology for these codes, but these rates do not always align with the programmatic and financial needs of Medicaid programs, where these codes are more essential and frequently utilized.

D.4.2. Fiscal Impact Models

Guidehouse worked with DPHHS to develop payment model scenarios to assess potential

[27] Springer Link, Medicaid physician fees and access to care among children with special health care needs. Available online: https://link.springer.com/article/10.1007/s11150-021-09575-6

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changes to payment rates and evaluate estimated reimbursement impacts to provider types due to those changes. More detailed modeling will need to be done once the reimbursement budget for each provider type has been finalized.

The first model detailed below reduces the physician conversion factor from 41.88 to 36.45 and lowers the anesthesia conversion factor from 30.57 to 22.99. It also reduces the mid-level rate of reimbursement to 85 percent for adult and 95 percent for pediatric services. This achieves the desired reimbursement levels of 105 percent of Medicare for most physician services.

The second model increases the mental health conversion factor from 21.44 to 23.33 and introduces a provider adjuster for psychologists. This brings all mental health providers to at least 90 percent of Medicare.

To model the impact, Guidehouse estimated SFY 2022 payments with the updated conversion factors and provider rates of reimbursement for all provider types that receive the physician conversion factor. The same RVUs and modifier adjustments were used for both the SFY 2022 and updated Medicaid pricing, so to project paid amounts, the total payments were adjusted by the percentage change in conversion factors and rate of reimbursement.

The first model lowered the physician conversion factor to 36.45, the anesthesia conversion factor to 22.99, and the mid-level provider rates of reimbursement (PRR) to 0.85 and 0.95. Due to the changes, total physician payments including anesthesia decreased by $27,309,647, or 14.6 percent, $6,264,833 of which is state share. This model has all providers at a minimum 105 percent of Medicare with psychiatrist and mid-level pediatric at 118 percent and 117 percent respectively. Table 88 shows the rate changes and impacts by provider type for this model.

Table 88: Model Rates and Impact – Physician and Anesthesia

Model Rates of Reimbursement, Conversion Factors, and Impact – Physician and Anesthesia								
Provider Type	**SFY 2022 PRR**	**SFY 2022 Convers. Factor**	**SFY 2022 Percent of Medicare**	**Updated PRR**	**Updated Convers. Factor**	**Updated Pct of Medicare**	**Estimated Payment Impact**	**Est. Pct. Impact**
Physician	1	41.88	121%	1	36.45	105%	-$16,314,708	-13%
Psychiatrist	1.12	41.88	135%	1.12	36.45	118%	-$701,750	-13%
Mid-Level Pract. – Adult	0.9	41.88	128%	0.85	36.45	105%	-$4,916,081	-18%
Mid-Level Pract. – Children	1	41.88	142%	0.95	36.45	117%	-$2,294,840	-17%
EPSDT, Lab, PHC, Pod.	1	41.88	121%	1	36.45	105%	-$629,418	-13%
Anesthesia (All Providers)	1	30.57	140%	1	22.99	105%	-$2,452,850	-25%
Total	**-**	**-**	**124%**	**-**	**-**	**106%**	**-$27,309,647**	**-15%**

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The second model created increased the mental health conversion factor to 23.33 and gave psychologists a reimbursement rate of 1.23. Due to the changes, total mental health payments increased by $3,994,164, or 9.8 percent, $916,261 in state share. In this model, all mental health providers have been raised to at least 90 percent of Medicare. Table 89 shows the rate changes and impacts by provider type for this model.

Table 89: Model Rates and Impact – Mental Health

Model Rates of Reimbursement, Conversion Factors, and Impact – Mental Health								
Provider Type	**SFY 2022 PRR**	**SFY 2022 Conversion Factor**	**SFY 2022 Percent of Medicare**	**Updated PRR**	**Updated CF**	**Updated Pct of Medicare**	**Estimated Payment Impact**	**Est. Pct. Impact**
Psychologist	1	21.44	68%	1.23	23.33	91%	$540,801	34%
Licensed Prof. Counselor	1	21.44	83%	1	23.33	90%	$2,135,393	9%
Social Worker	1	21.44	83%	1	23.33	90%	$1,317,197	9%
Marriage & Family Therapy	1	21.44	83%	1	23.33	90%	$773	9%
Total	**-**	**-**	**82%**	**-**	**-**	**90%**	**$3,964,164**	**10%**

The two models above represent estimated impacts based on changes to rates available at the time of the analysis and the data set. Implementing these suggestions should be done in conjunction with DPHHS to incorporate current and future rates, RVUs, and inflation factors.

E. Rate Review of Medicaid Medical Transportation and Home Infusion Therapy Services

E.1. Overview of Reimbursement for Services

The Montana Department of Public Health and Human Services (DPHHS) engaged Guidehouse to perform an analysis of its Medicaid payment rates for transportation and home infusion therapy (HIT) services. The analysis consisted of an evaluation of the reasonableness and adequacy of current rates when compared to Medicare as well as other state Medicaid programs.

Under Montana Medicaid, the current payment methodology for transportation and HIT services is a fee schedule of pre-determined payment rates or a reimbursement approach based on mileage or a percentage of provider charges. Payments are limited to the lesser of the actual charge or the applicable fee schedule amount.

Ambulance services are paid via the Ambulance Fee Schedule (AFS) using a base rate plus

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separate payments for mileage, life support and supplies. For services not covered by a fee schedule amount, claims are paid at 75 percent of billed charges. In addition to the fee schedule and billed charges payments, for services that have a corresponding Medicare rate, state and county owned providers that have a signed agreement with DPHHS will receive supplemental payments. These supplemental payments are calculated as the shortfall between the Medicaid payment and the Medicare payment on a procedural level.

Non-emergency medical transportation (NEMT) services are paid either via the NEMT fee schedule or reimbursed at 100 percent of billed charges. Taxi and wheelchair van services have a base rate for trips under 16 miles and a mileage rate for trips 16 miles or more. Personal vehicle trips are reimbursed per mile and all other trips such as commercial air and public transportation are reimbursed for the ticket price.

Home infusion therapy is also paid via fee schedule. These services are paid “per diem” under the S code sequence within the Healthcare Common Procedure Coding System (HCPCS) to pay home infusion providers for services, supplies and equipment for each day a member is provided access to a prescribed therapy. There are 31 per diem codes in the HIT fee schedule organized by therapy type and amount. Daily rates are established based on the usual and customary charges reported by home infusion therapy providers in the State of Montana. The daily rate for each therapy is derived by averaging the individual provider charges. The Department worked with providers to reach agreement on reimbursement for members’ infusion therapies. When billing, the HIT provider is not required to include a line on the HIT claim identifying the drug administered. Nursing services provided by licensed nurses are also reimbursed via the fee schedule, but on an hourly basis. All pharmaceuticals associated with the delivery of an infusion therapy are billed through the pharmacy program and were not a part of this review.

Medicare payment for ambulance services is similarly based on the lesser of the actual charge or the applicable Medicare fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage, life support, and applicable adjustment factors. Medicare considers payment for life support mileage and supplies to be bundled into the base, life support, and mileage payments. The amount payable for the air base rate and air mileage rate in a rural area is 1.5 times the urban air base and mileage rate. In addition, the first 17 miles for ground transports provided in a rural area is 1.5 times the rural ground mileage rate.

Since 2004, Medicare has augmented fee schedule payments with temporary add-on payments that have been extended through 2022.[28] These payments currently include a 3 percent increase in the base and mileage rate for ground ambulance services in rural areas, a 2 percent increase in the base and mileage rate for ground ambulance services in urban areas, and a 22.6 percent increase in the base rate for ground ambulance in “Super Rural” areas. These “Super Rural” areas are zip codes that fall in the lowest 25th percentile of all rural populations

[28] Centers for Medicare and Medicaid Services, Ambulance Fee Schedule Public Use Files. Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf

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arrayed by population density.

Medicare only covers NEMT for specific situations such as transport of an individual with end-stage renal disease (ESRD) for renal dialysis services. As will be discussed in greater detail in the Analysis section, Montana's NEMT system relies heavily on personal vehicle mileage reimbursement. For reimbursement based on mileage, Guidehouse referenced the IRS business mileage rate for comparison. While the IRS also publishes a medical reimbursement rate, this rate does not include the fixed costs of operating an automobile and was deemed not sufficiently comprehensive for benchmarking.[29]

A new HIT services benefit has been established under Medicare on January 1, 2021.[30] While Montana Medicaid's fee schedule has more than 30 S codes under HCPCS based on therapy type, Medicare utilizes G codes with 3 infusion categories and differentiation between first and subsequent visits resulting in only 6 codes for services in the fee schedule. The 3 categories are based on the type of drug administered and are contingent upon a home infusion drug J code being billed. A single payment is made for each infusion per day in the designated category. In the event multiple drugs assigned to different categories are administered on the same day, a single payment would be made that is equal to the highest payment category.

[29] IRS Standard Mileage Rates for 2022. Available online: https://www.irs.gov/newsroom/irs-issues-standard-mileage-rates-for-2022
[30] Centers for Medicare and Medicaid Services, Billing for Home Infusion Therapy Services on or After (January 1, 2021). Available online: https://www.cms.gov/files/document/mm11880.pdf

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E.2. Methodology

To conduct our analysis, Guidehouse compared State Fiscal Year (SFY) 2022 Montana transportation and HIT rates to Calendar Year (CY) 2022 Medicare rates and the latest available rates and reimbursement methodologies for other states including Colorado, Idaho, Minnesota, North Dakota, Oregon, Utah, Virginia, and Vermont. This was done on a service level for procedure codes listed in the Montana fee schedules.

Guidehouse also estimated reimbursement amounts for SFY 2022 transportation and HIT services. To do this, Guidehouse requested claims data from the MMIS and Mountain-Pacific Quality Health with service dates from October 2020 through September 2021 (SFY 2021) to build an analytical data set. Guidehouse summarized claims by procedure code priced with SFY 2022 rates by multiplying the rates by the units. The same method was used for CY 2022 Medicare rates for Montana and the most currently available comparison state rates. For rate and payment comparisons, provider add-ons were not included.

Guidehouse did not review provider cost information for this request. Cost data for transportation and HIT providers is not required by Medicare, so cost information would need to be obtained through a provider survey or another mechanism, which was not in scope for this analysis.

In some cases, transportation providers that are part of larger institutions such as hospitals or nursing facilities will have their costs included as part of a facility's cost report, which is readily available for use. However, the costs for those providers are usually not representative of independent providers and would not be a sufficient basis to establish rate adequacy. Additionally, the U.S. Government Accountability Office (GAO) found in a survey published in 2012 that ambulance provider cost varied widely with the cost per transport ranging from $224 to $2,204.[31]

The GAO study also found the median Medicare margin on ambulance services was -1 percent without add-on payments, meaning Medicare was paying around 99 percent of costs for the providers in the study. Another study conducted for MaineCare in 2017 found Medicare rates were also comparable to cost, although the cost numbers in that study varied widely as well.[32] From these findings, we can reasonably conclude Medicare payment rates are at or near the average provider cost.

[31] U.S. Government Accountability Office, Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased. Available online: https://www.gao.gov/products/gao-13-6
[32] State Of Maine Department Of Health And Human Services, Office Of MaineCare Services, MaineCare Ambulance Rate Study. Available online: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/reports/2017/Maine-Ambulance-Rate-Study.pdf

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E.3. Analysis

Analysis indicated the following summary trends of Montana Medicaid rates and payments in comparison both to Medicare reimbursement as well as Medicaid rates published by other states:

- Montana pays significantly less than Medicare for ambulance services, even when taking supplemental payments into account and is below most states included in the analysis.
- For the small number of ambulance providers that receive a supplemental payment, total payments are much higher than Medicare when including life support and routine supplies.
- The NEMT personal mileage rate is below IRS and peer states.
- Montana HIT rates are above all other states that utilize S codes

E.3.1. Medicare and Medicaid Peer State Benchmarking: Ambulance

For evaluating Montana's current rates relative to other state Medicaid programs, Guidehouse selected the top 10 procedures by DPHHS allowed amount for SFY 2021 and compared the Montana SFY 2022 rates both to the CY 2022 rates for Medicare, as well as the most current rates available for Colorado, Idaho, North Dakota, Oregon, and Utah.

Table 90 below displays the comparison of ambulance rates for the top 10 procedures by allowed amount. Included are Montana, Medicare, Colorado, Idaho, and North Dakota. The amount at the bottom of the table is the total re-pricing for all ambulance services. Services without corresponding rates from Medicare or other states were included and considered bundled into another service. Of particular note are the air transport rates. Montana pays rotary wing air transport at just 46 percent of Medicare and fixed wing at 53 percent. When looking at neighboring states, Montana's peers average 95 percent and 87 percent of Medicare respectively.

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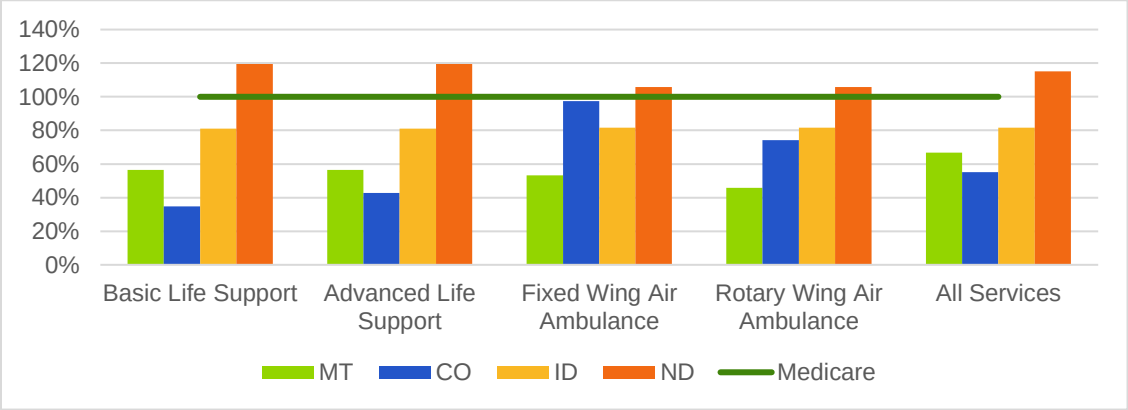
Table 90: Top 10 Procedures by Montana Allowed Amount

2022 Ambulance Fee Comparison						
Procedure	**Description**	**MT**	**Medicare[33]**	**CO[34]**	**ID[35]**	**ND[36]**
A0429	BLS-Emergency	$225.23	$398.68	$138.69	$323.40	$476.80
A0427	ALS1-Emergency	$267.46	$473.43	$202.76	$384.03	$566.20
A0430	Fixed Wing Air Transport	$1,762.90	$3,315.07	$3,230.58	$2,704.92	$3,504.64
A0435	Fixed Wing Air Mileage	$5.61	$9.41	$7.73	$7.79	$10.77
A0431	Rotary Wing Air Transport	$1,762.90	$3,854.27	$2,860.19	$3,144.88	$4,074.66
A0382	Basic Support Routine Suppls	*				
A0398	ALS Routine Disposable Suppls	*				
A0436	Rotary Wing Air Mileage	$14.51	$25.10	$10.40	$20.78	$28.77
A0380	Basic Life Support Mileage	$3.97				
A0425	Ground Mileage	$3.97	$8.02	$2.12	$6.63	$9.56
2022 Pricing – All Services**		**$10,156,489**	**$15,232,067**	**$8,394,975**	**$12,425,937**	**$17,544,288**

** 75 Percent of Charges*
*** Represents total ambulance pricing for all procedures. In some cases, there was no corresponding rate for Medicare or other states.*

Figure 25 highlights the differences in rates from Table 90 for basic and advanced life support, air transport, and overall.

Figure 25: Ambulance Rates as a Percent of Medicare



[33] Centers for Medicare & Medicaid Services, Ambulance Fee Schedule & ZIP Code Files. Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/ambulancefeeschedule
[34] https://hcpf.colorado.gov/sites/hcpf/files/21A_CO_Fee percent20Schedule percent20EMT_07.2021_V1.0.pdf
[35] https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=21520&dbid=0&repo=PUBLIC-DOCUMENTS
[36] https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/fee-schedules/2021-ambulance-fee-schedule.pdf

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In addition to comparing rates, Guidehouse also performed an analysis of estimated payments for all claims. In comparing estimated payments for other states, as with Medicare, services without a corresponding rate are considered bundled by those payers and included in the analysis. This assumption allows a comparison of what Medicare and other states would pay based on the same claim data. Montana is paying 67 percent of Medicare for ambulance services, 12 percent higher than Colorado, 15 percent lower than Idaho and Utah, 48 percent lower than North Dakota, and 5 percent lower than Oregon.

Table 91 shows the difference in payments for life support and ground mileage (A0425-A0429, A0433-A0434), fixed wing transport and mileage (A0430, A0435), rotary wing transport and mileage (A0431, A0436), and life support mileage and supplies (all others). This table includes payments by Medicaid for services not covered by Medicare that are considered bundled.

Table 91: Ambulance Estimated 2022 Payments

Estimated Payments by Provider Type				
Provider Type	**Medicaid 2022**	**Medicare 2022**	**Difference**	**Percent of Medicare**
Life Support, Specialty, and Ground	$4,952,198	$8,848,556	-$3,896,358	56%
Fixed Wing Transport and Mileage	$2,506,934	$4,494,340	-$1,987,405	56%
Rotary Wing Transport and Mileage	$941,845	$1,889,171	-$947,326	50%
Life Support Mileage and Supplies	$1,757,218	$0	$1,757,218	N/A
Total All Services	**$10,158,195**	**$15,232,067**	**-$5,073,872**	**67%**

Although Montana Medicaid averages just 55 percent of Medicare on a rate-by-rate basis, Montana Medicaid SFY 2022 ambulance estimated payments are 67 percent of calculated CY 2022 Medicare payments when including bundled services in the comparison. For the comparison states, results varied widely. Almost all states have estimated payments above Montana, ranging from 8 percent to 73 percent higher, with Colorado being the exception at 17 percent lower.

Table 92 shows the comparison percentages. Montana pays 67 percent of Medicare compared to an average of 84 percent for comparison states.

Table 92: Estimated Ambulance Payment Percent for Comparison States

Ambulance Payment Percentages		
State	**Percent of Montana Payments**	**Percent of Regional Medicare Payments**
MT	100%	67%
CO	83%	54%
ID	122%	87%
ND	173%	115%
OR	108%	72%
UT	124%	86%

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Ambulance Payment Percentages		
State	Percent of Montana Payments	Percent of Regional Medicare Payments
Average*	122%	84%

**Excluding Montana*

State and county owned providers that have a signed agreement with DPHHS receive supplemental payments for services that have a corresponding Medicare rate. Guidehouse modeled these payments by calculating the difference between Montana and Medicare estimated payments for 2022. Although these payments are capped at the Medicare rate, because these payments are independent of other services, they push the total reimbursement level for these providers to over 100 percent of Medicare and the total reimbursement for all providers to 71 percent of Medicare.

E.3.2. Federal and Medicaid Benchmarking: Non-Emergency Medical Transport

It has been mandatory for states to offer the non-emergency medical transportation benefit (NEMT) as of December 2020, when Congress added the requirement to the Social Security Act (the Act) through the Consolidated Appropriations Act of 2021[37]. Specifically, "the Medicaid state plan must include 'a specification that the single State agency . . . will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the method that such agency will use to ensure such transportation.'"

Additionally, the Act generally requires the state plan to provide methods and procedures as may be necessary to assure that "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Montana, like other frontier states, has distinctly different NEMT service needs for its Medicaid population. Nationally, most NEMT (approximately 80 percent) is delivered via wheelchair van or taxi, with personal vehicles comprising a small percentage. However, in Montana, personal vehicles account for 85 percent of all trips. In addition, the average one-way trip for NEMT personal mileage is 68.6 miles. These two factors demonstrate the challenge to Medicaid in enlisting providers and to providers in developing viable business models. In non-urban areas, even the general population does not have significant access to transportation outside of personal vehicles.

These constraints focus concerns around reimbursement adequacy on the mileage reimbursement rate. Although a readymade response to access issues is to consider increasing

[37] Centers for Medicare and Medicaid Services, Medicaid Coverage of Certain Medicaid Transportation under Consolidated Appropriations Act, 2021. Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/cib071221.pdf

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rates to incentivize service provision, reimbursement is not always the root cause or major impediment to underlying access challenges. Typically, if a Medicaid member has access to a personal vehicle to meet his or her needs, mileage reimbursement levels will not be a significant factor in obtaining medical services. However, while reimbursement rates may not be the driving factor of access, they are often the main method available to frontier states to promote access. In addition, mileage rates should not be so low as to deter access by failing to cover the cost of operating a vehicle, particularly given rising inflation and heightened fuel costs.

For this analysis, Guidehouse compared Montana Medicaid, IRS, and other state rates for 2022, analyzed claim details from Montana SFY 2021, and estimated 2022 payments for those claims. Rates for neighboring states vary significantly not only in amounts, but also in payment method. However, all states establish rates for a personal vehicle mileage reimbursement.

The Montana Medicaid mileage reimbursement rate for NEMT services provided by a private vehicle are well below the IRS rate and most neighboring states. Montana Medicaid reimburses mileage at $0.33, while the federal reimbursement is $0.585, or 77 percent higher, and the average state mileage rate is $0.40, or 21 percent higher.

In addition, the fee schedule rates for taxis and wheelchair vans are lower than other states as well, although differences in payment methods for taxis makes that comparison challenging. The average wheelchair van rate is $19.52, or 43 percent higher. Table 93 displays 2022 rates and methods for NEMT transportation types.

Table 93: NEMT Rates for Medicare and Peer States

Montana NEMT Analysis by Type					
Description	**MT**	**IRS**	**CO**	**ND**	**WY**
Private Vehicle	$0.33/mi	$0.59/mi	$0.44/mi	$0.56/mi	$0.26/mi
Taxi	$13.59 base $1.06/mi		Commercial Rate	$24.45	$5.01 base $0.83/mi
Wheelchair Van	$13.59 base $1.06/mi		$32.51 base $1.08/mi	$16.31 base $2.32/mi	$9.75

As shown above, excluding the IRS rate, North Dakota has the highest private vehicle mileage reimbursement at $0.56/mi., Wyoming the lowest at $0.26, with an average of $0.42 for all payers in the study. Colorado has the highest taxi and van rates, paying the commercial rate for taxi and a base rate of $32.51 for wheelchair vans. Wyoming has the lowest base at $5.01 for taxi and $9.75 for wheelchair vans. Montana is lower than all but one state across NEMT services.

E.3.3. Medicaid Benchmarking: Home Infusion Therapy

Home infusion therapy (HIT) is a relatively new service for Medicaid, and as with most new services, reimbursement approaches vary widely. Guidehouse analyzed 37 state Medicaid agencies and the approaches include HIT services not being covered, paying a percent of charges, individual consideration, fee-based reimbursement, and per diems.

Montana uses a per diem approach where supplies and drugs do not receive separate payment.

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Consequently, providers rarely bill procedure codes outside of the per diem services on HIT claims. This precludes comparison to states that have a fee-based reimbursement and to Medicare which is contingent on the drug codes to determine payment category.

Guidehouse found 6 states that reimburse home infusion using per diem S codes: Minnesota, North Dakota, Oregon, Vermont, Virginia, and West Virginia. Unfortunately, North Dakota does not have a rate for most S codes, and both Minnesota and Virginia do not have sufficient rate differentiation between codes to make a strong comparison. Montana was significantly higher than all states with per diem rates.

Table 94 displays the comparison of HIT rates for the top 10 procedures by allowed amount. Included are Montana, Oregon, Vermont, and West Virginia. S9379 is for HIT services that are not otherwise classified (NOC) and is either individually considered (IC) or has minimal or no payment by other states. Excluding NOC, Montana is higher by an average of 78 percent, 70 percent, and 99 percent respectively.

Table 94: Top 10 Procedures by Montana Allowed Amount

2022 Home Infusion Therapy (HIT) Per Diem Comparison					
Procedure	**Description**	**MT**	**OR**	**VT**	**WV**
S9366	HIT TPN 2 Liter Diem	$286.88	$140.47	$196.72	$135.00
S9500	HIT Antibiotic Q24H Diem	$133.11	$87.19	$75.00	$51.00
S9365	HIT TPN 1 Liter Diem	$268.82	$112.59	$152.24	$113.00
S9502	HIT Antibiotic Q8H Diem	$148.87	$107.01	$85.00	$64.00
S9367	HIT TPN 3 Liter Diem	$318.60	$144.76	$239.48	$150.00
S9501	HIT Antibiotic Q12H Diem	$148.87	$87.19	$80.00	$58.00
S9379	HIT NOC Per Diem	$114.16	$9.44	$0.00	IC*
S9374	HIT Hydra 1 Liter Diem	$64.08	$42.89	$30.00	$42.00
S9348	HIT Sympathomim Diem	$144.26	$83.64	$98.67	$45.00
S9503	HIT Antibiotic Q6H Diem	$161.39	$107.01	$90.00	$69.00

** Individual Consideration*

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E.4. Recommendations

E.4.1. Recommendations

MT DPHHS payments for transportation services lag behind Medicare and most surrounding states. Air ambulance services, for example, feature particularly low rates, despite the fact the availability of air transport can have life-or-death consequences for communities located considerable distances from a trauma facility. As noted earlier, Medicare rates are a good approximation of provider cost in general, but costs vary significantly with type, size, and location of providers. Because of this variability, and in the absence of additional evidence that reimbursement falls significantly below provider or that major access issues plague these services, Guidehouse recommends aligning Montana rates with the other states in this study, rather than with Medicare. For ambulance rates, the average state calculated reimbursement under state rates in this study is 84 percent, which we view as adequate to promote access.

NEMT presents unique challenges in determining rates adequate to promote access, quality, and efficiency, particularly in Montana. The bulk of NEMT rides are via private vehicle and reimbursed at a mileage rate. Without additional data measuring service delivery issues, it is difficult to determine whether reimbursement rates contribute to restricted access. After comparison of other states and the federal reimbursement rate, Guidehouse recommends increasing the NEMT mileage rate as well as taxi and wheelchair van rates for trips less than 16 miles to the State averages.

With Medicare implementing permanent HIT benefits on January 1, 2021, we anticipate there will be significant changes to the Medicare HIT rates as well as accurate mappings of S codes to G codes based on full analytical data sets. In addition, more states will be covering HIT services and adopting the per diem or Medicare method. These will provide better benchmarks for comparison of rates. Montana's approach to setting rates is sound and fits with best practices from other services. Until a Medicare based benchmark can be utilized, Guidehouse recommends maintaining the current payment method and payment rates.

To achieve the above targets, Guidehouse recommends the following steps:

- Increasing overall ambulance payment levels (not including supplemental payments) to 84 percent of Medicare
    - Increase rates for services covered by Medicare to 80 percent of Medicare
    - Adopt premium payments for ambulance services in rural localities to achieve a total payment level increase of 5 percent
- Discontinue separate payments for life support and supplies
- Increase NEMT taxi and van rates for trips less than 16 miles to the State average
- Increase the NEMT mileage reimbursement rate to average of the Montana, peer states, and IRS rates

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E.4.2. Fiscal Impact Models

Guidehouse worked with DPHHS to develop payment model scenarios to assess potential changes to the payment rates and evaluate estimated reimbursement impacts due to those changes. More detailed modeling will need to be done once the reimbursement budget for each provider type has been finalized.

The first model detailed below increases the ambulance payment rates to 80 percent of Medicare. It also adds a premium payment for services in rural areas and bundles services that do not have a Medicare rate. This achieves the desired reimbursement levels of 84 percent of Medicare for ambulance services.

The second model increases the NEMT personal vehicle mileage rate to $0.42 and the taxi and wheelchair van rate for trips less than 16 miles to $19.52.

To model the impact, Guidehouse estimated SFY 2022 payments with the updated fee schedule rate. No charge cap was applied, so to project paid amounts, the total payments were adjusted by the percentage change in fees.

To calculate fiscal impact in terms of additional state share spending, we applied 64.12 percent Federal Medicaid Assistance Percentage (FMAP) for non-expansion members and a 90 percent FMAP for expansion. In consultation with the Department, the analysis assumes projected utilization by expansion members will continue to constitute about 50 percent of total claims.

The updates to the payment method in the first model resulted in the following changes:

- $2,027,458 in total additional fee payments
  - $3,784,676 in additional fees
  - -$1,757,218 in savings due to bundling of supplies, life support mileage, and other ancillary payments
- $609,283 in additional payments for rural service premiums
- -$376,928 in reductions to supplemental payments based on increased base and mileage rates
- $2,259,812 in total reimbursement level increase, of which $518,401 would be drawn from the general fund

Table 95 shows the ambulance rate changes and impacts overall and for the Top 10 procedures for this model.

Table 95: Model Rates and Impact – Ambulance

Ambulance Modeled Payment Change by Procedure							
Procedure	**Description**	**SFY 2022 Rate**	**Updated Rate**	**Fee Impact**	**Additional Rural Payments**	**Estimated Total Impact**	**Estimated Percent Impact**
A0429	BLS-Emergency	$225.23	$318.94	$1,055,407	$179,597	$3,771,545	49%
A0427	ALS1-Emergency	$267.46	$378.74	$670,152	$114,040	$2,394,836	49%
A0430	Fixed Wing Air Transport	$1,762.90	$2,652.06	$718,438	$107,143	$2,250,004	58%

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Ambulance Modeled Payment Change by Procedure							
Procedure	**Description**	**SFY 2022 Rate**	**Updated Rate**	**Fee Impact**	**Additional Rural Payments**	**Estimated Total Impact**	**Estimated Percent Impact**
A0435	Fixed Wing Air Mileage	$5.61	$7.53	$370,099	$72,631	$1,525,241	41%
A0431	Rotary Wing Air Transport	$1,762.90	$3,083.42	$426,527	$49,797	$1,045,741	84%
A0382	Basic Support Routine Suppls	*	$0.00	-$505,041	$0	$0	-100%
A0398	ALS Routine Disposable Suppls	*	$0.00	-$428,541	$0	$0	-100%
A0436	Rotary Wing Air Mileage	$14.51	$20.08	$142,965	$25,770	$541,163	45%
A0380	Basic Life Support Mileage	$3.97	$0.00	-$368,757	$0	$0	-100%
A0425	Ground Mileage	$3.97	$6.42	$203,431	$26,681	$560,293	70%
	Totals – All Services			**$2,027,458**	**$609,283**	**$2,636,741**	**26%**

The second model increased NEMT rates as described above. Due to the changes, total NEMT payments increased by $936,051, or 22 percent. The state share of that increase is $214,730. Table 96 shows the rate changes and impacts by service for this model.

Table 96: Model Rates and Impact – NEMT

NEMT Modeled Payment Change				
Provider Type	**SFY 2022 Rate**	**Updated Rate**	**Fee Impact**	**Estimated Percent Impact**
Personal Vehicle Mileage	$0.33	$0.42	$842,831	27%
Taxi	$13.59	$19.52	$88,019	44%
Wheelchair Van	$13.59	$19.52	$5,201	44%
Total			**$936,051**	**22%**

The general fund payment increases of $518,401 for ambulance and $214,730 for NEMT services noted above will allow Montana to meet the reimbursement needed for quality and access to care. In addition, changing the ambulance payment method by bundling supplies and life support mileage into payments for transport services will align Montana more closely with peer states and the Medicare standard, simplifying future rate comparisons.

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