DEPARTMENT OF HUMAN SERVICES

Legislative Report

Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study

August 2023

For more information contact:

Minnesota Department of Human Services

Collaboration between Behavioral Health, Housing, and Deaf and Hard of Hearing Services Administration, Aging and Disability Services Administration, and Health Care Administration

540 Cedar Street

St. Paul, MN 55101

651-431-2203

DHS.info@state.mn.us

For accessible formats of this information or assistance with additional equal access to human services, write to Jacob.Owens@State.MN.US, call 651-431-2460, or use your preferred relay service. ADA1 (2-18)

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Executive Summary

This report is the first of two legislative reports that are required by legislation during the 2021 session. Under this legislation, the Minnesota Department of Human Services (DHS) is required to complete the following:

- Conduct an analysis of the current rate-setting methodology for outpatient services in medical assistance and MinnesotaCare, including rates for behavioral health, substance use disorder treatment and residential substance use disorder treatment that apply under the Fee for Service (FFS) program.
- Issue a request for proposals for frameworks and modeling of behavioral health services rates. Rates must be predicated on a uniform methodology that is transparent, culturally responsive, supports staffing needed to treat a patient's assessed need and promotes quality service delivery, integration of care and patient choice.
- Consult with providers across the spectrum of services, from across each region of the state and culturally responsive providers in the development of the request for proposals and for the duration of the contract.
- Submit a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the initial results.
- Submit a final report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance that includes legislative language necessary to modify existing or implement new rate methodologies, including a new substance use disorder treatment rate methodology, and a detailed fiscal analysis.

DHS entered a two-year contract with the Burns & Associates division of Health Management Associates (HMA-Burns) beginning in August 2022 to provide technical assistance to DHS to complete this work. HMA-Burns has previously established rates for State Medicaid Agencies for all the services included in the scope of the study. The current team assisting DHS had previously assisted the DHS in the implementation of its Resource Based Relative Value System, the payment methodology used to pay for many community-based physical health services, in 2010. The team working on this project has been actively engaged in the last year to develop rates for all the behavioral health and substance use disorder treatment services that are included in this rate study.

Organization of this Report

This report begins with a brief introduction of common rate methodologies that have been created for the variety of physical health, mental health, and substance use disorder services by other states and by the Centers for Medicare and Medicaid (CMS) for the Medicare program. HMA-Burns provides an orientation related to CMS's work to migrate its existing rate payment methodologies to more value-based and outcome-based approaches in the next 7 to 10 years.

This report contains an overview pertaining to the data sources used by the HMA-Burns team to conduct the assessment of the rate methodologies used by DHS and the computation of measures that may be used to inform decisions related to how rate methodologies may need to be adjusted to better account for regional or culturally responsive needs. HMA-Burns used the inventory of providers who delivered services in this study to

Medicaid beneficiaries during calendar year (CY) 2021 and the associated payments to providers to build measures for comparative purposes across the state. The HMA-Burns team examined documentation of the current services offered, the rate methodologies used and the date of the last rate update for each service category. HMA-Burns also created measures to help inform its assessment of the rates paid and the rate methodologies used for each service category. These measures are defined in the report.

The key findings for each of the four service categories examined are discussed in detail. This is followed by a summary of ongoing work in CY 2023 that is being conducted with providers to collect data to identify new rates and rate methodologies that will be included in the second report to the legislature.

Key Findings from this Report

There are some general findings that pertain to the system as a whole as well as findings specific to each service category.

General Findings

1. The method(s) in which specific rates have been set by DHS for the services included in this study are not transparent to providers or to external stakeholders. Although rates are published on DHS's website, there is little to no explanation about how each rate was set, and whether adjustments apply based on legislative actions to reduce or increase certain rates. There is some documentation of the methodologies used in what is known as the Medicaid State Plan, but this document is difficult for a layperson to navigate.
2. Where methodologies are established, there is not always a consistent approach applied to individual services within a service category. For example, for physical health services broadly, different rates have been established using a percent of the Medicare rate for subcategories of services. For mental health services, some rates are set as a percent of the Medicare rate, others are set using a DHS-defined approach, and others are set based on provider's actual costs.
3. Legislative actions have caused inconsistencies in rate updates. For example, even if -- in principle -- physical health services were originally set as a percentage of the Medicare rate, the reality is that the final rate paid to providers may not be what is published as the methodology. For example, if a service rate was set by Medicare at $100 and DHS originally set its rate at 77% of Medicare ($77), over the years legislative actions have altered this formula. Continuing the example (for illustration),
    - In Year 1, the legislature increased certain rates by 1%. New rate is $77.77.
    - In Year 2, the legislature decreased the rates by 2%. New rate is $76.21.
    - In Year 3, the legislature increased the rates again by 4%. New rate is $79.26.
    - The rate methodology as published, however, is 77% of the Medicare rate, or $77.00.

    The rate of $79.26 does not match the prescribed methodology nor the rate published, since these other adjustments are accounted for "behind the scenes."
4. Cost-based reimbursement is generally not recognized as a methodology that incentivizes value or efficiency. For many services, particularly in mental health, DHS relies on a methodology to reimburse

providers based on actual costs. This is not considered a payment based on a set of defined public health values since it rewards efficient and inefficient providers equally (the provider gets their full costs back in both cases). Further, this approach offers inconsistent rate changes year-over-year between providers. For example, DHS increased the rates for many of the mental health services on its standard fee schedule by 0% between CY2021 and CY2022 and some others saw a nominal increase of 1% to 2%. But the providers who are paid based on their actual costs for one of the mental health service categories realized rate changes ranging from -20% to +27% between CY2021 and CY2022.

Service-Specific Findings

There are four categories of services that are included in the study:

- Community-based Physical Health Services
- Community-based Mental Health Services
- Community-based Substance Use Disorder Treatment Services
- Early Intensive Developmental and Behavioral Intervention (EIDBI) Services

Collectively, these services represented $1.67 billion in payments for services delivered during CY 2021. The specific services that fall under each of these categories are described in the Findings section of the report.

For community-based physical health services, DHS currently uses Medicare's payment methodology in principle to set rates. Medicare's payment methodology is called the Resource Based Relative Value Scale payment system, or RBRVS. In this payment system, each service billing code, of which there are thousands, is assigned a value relative to a baseline service. This relative value is multiplied by a constant dollar amount to arrive at a payment amount.

DHS's methodology is characterized as following Medicare's RBRVS in principle because DHS does not follow the methodology exactly. This is because there was not sufficient funding to pay 100 percent of the Medicare-established rate for each service at the time it was originally implemented. Although DHS adopts the changes to relative values in its annual update each January, DHS differs from the Medicare formula in that DHS used three dollar amounts (multipliers) to multiply relative values by instead of Medicare's formula.

For CY 2023, Medicare uses one multiplier at $33.8872. DHS's three multipliers are $25.32 (77% of Medicare) for office visits and similar services, $28.44 (84% of Medicare) for mental health services, and $25.30 (77% of Medicare) for all other services paid under RBRVS. Because RBRVS rates are not adjusted for inflation under current state law, the gap between Medicare and Medicaid rates has and will continue to grow over time.

Above and beyond these multipliers, some providers have met criteria established by DHS to be deemed "essential providers." These essential providers are paid between 20 and 25 percent above the rate established using any of the multipliers listed above for certain community clinic, family planning and mental health services.

The assessment for the other three service categories (community mental health services, community substance use disorder treatment services and EIDBI services) is similar. DHS publishes a rate schedule for all covered

services within each service category. The rate schedule includes the service name, service code, service category, unit or duration of service and the rate. The rates were updated as follows:

- For community-based mental health services: some, but not all, in January 2022
- For community-based substance use disorder treatment services: January 2022
- For EIDBI services: July 2015

For mental health and substance use disorder treatment services, two rates are listed on the rate schedule: a standard rate and an enhanced rate. The enhanced rate varies between 120 and 125 percent of the standard rate. Providers must meet specific criteria to receive the enhanced rate. For EIDBI services, there is only one rate for each service.

For one set of services (substance use disorder treatment), DHS applies add-ons to the standard rate that factor in specific client attributes or level of service needed. If a provider is approved by DHS to deliver the add-on service, they can provide the enhanced service to clients within their program based on the client's identified need.

When DHS uses a cost reimbursement methodology, DHS requires providers to submit a cost report in a standardized format on an annual basis. The rates that are set for the service are provider-specific and are based on the costs that they report. There is some description in the Medicaid State Plan about the types of costs considered in rate development (e.g., direct service staff costs, program costs, physical plant costs) and how they are used. A drawback to this methodology, however, is that it always considers costs retrospectively rather than prospectively. There are also few limitations on minimum or maximum values for costs that would be permissible in establishing a rate.

HMA-Burns used the six criteria listed on the left side of the table below in its assessment of each service category examined. As the table shows, the assessment is each service category is due for a rate update and three service categories should also be considered for a change in the rate methodology adopted. Further, the transparency of how each rate is developed can be improved. More details on each of these assessment components appears in the Findings section of this report.

Summary of the Assessment for Each Service Category Examined in this Study

	Community Based Physical Health	Community Based Mental Health	Community Based Substance Use Treatment	Early Intensive Developmental & Behavioral Intervention
Need for Rate Methodology Reform	Low	High	High	High
Need for Rate Update	High	High	High	High
Level of Transparency of Current Rate Methodology and Rates	Medium	Low	Low	Low
Concern Related to Access to Providers	Medium	High	High	High
Opportunity to Add Value-based Component to Rate Methodology	Maybe	Maybe	Yes	Maybe
Opportunity to Add Cultural Competency Component to Rate Methodology	Maybe	Yes	Maybe	Yes

Recommendations to Improve DHS Rate-Setting Processes

Specific recommendations for each service category in this study appear in the Findings section under the subheading for each service category. In summary:

For community-based physical health services:

1. Continue to leverage the methodology developed by CMS for Medicare using the RBRVS, but move towards full adherence to the methodology rather than adopting only selected components of the methodology. Specifically,
    a. Use one standard multiplier (the one set by Medicare each year) instead of three.
    b. Eliminate all previous year-over-year legislative adjustments to rates that have compounded over the years and have made the final rate less transparent. Reset the rates at 100% of the Medicare rate.
2. Assess the utility of maintaining the provider-specific rate premiums paid to "essential providers" for mental health and family planning services, especially if rates are set at 100% of the Medicare rate.
3. Consider rate adjustments to pay providers in medically underserved areas or providers who serve Medicaid clients with needs that require additional resources.
4. Consider developing an infrastructure for reporting in future years to include incentive payments tied to quality and value, keeping in mind that any incentive payments would occur only after the current fee-for-service rates have been updated.

For community-based mental health, substance use disorder treatment, and EIDBI services:

1. Build a framework that shows consistency in the methodology used to set the rates for each of these service categories and publish this methodology in a transparent manner. Where there is a rate established by Medicare for a service (this is specific to some mental health services), reset these service rates to 100% of the Medicare rate, at minimum, as recommended for other acute care services in the RBRVS payment system.
2. Consider and clarify options for enhanced rates based on client attributes and needs, including the cultural context of both the client and provider, and not just provider attributes.
3. Migrate away from wholesale cost-based reimbursement. Instead, utilize cost-informed reimbursement. That is, consider provider costs in setting rates, but establish parameters around defining provider efficiency and value in delivering each service.
4. Similar to what is done in acute care services, consider developing an infrastructure for reporting in future years to include incentive payments tied to quality and value. Any incentive payments, however, would occur only after a more streamlined and transparent methodology for setting the fee-for-service rates has been updated and implemented.

Work Planned in 2023 for the Final Report in 2024

There is considerable work ongoing in CY 2023 to lay the groundwork for developing options for changing the reimbursement methodologies and the rates paid for all the services that are a part of this rate study. The results of the work that is occurring in CY 2023 will be incorporated into the DHS report to the legislature that will be delivered by January 15, 2024. Specific activities include:

- Facilitate provider workgroups: Four different workgroups have been formed. Each workgroup focuses on specific services. Providers that deliver the services (and their provider association liaisons) comprise the workgroup members. HMA-Burns facilitates the meetings. DHS staff attend meetings in a supporting role. The role of workgroup members is to provide feedback on the layout of a provider survey (already completed), review the results of the provider survey (occurred in late March), and provide feedback on future rate models (occurred in May-June 2023).
- Release provider Surveys: Webinars were held January 30-31, 2023 with the providers who are asked to voluntarily submit information on their costs and other measures that will be used to inform future rate development. Three separate surveys were released—one to community mental health providers, one to community substance use disorder treatment providers, and one to EIDBI providers. Surveys were due back to HMA-Burns by March 10, 2023. As of this writing, 82 surveys were received.
- Build market-based rate models: Rates will be built "from the ground up" using information from the provider surveys and other external market sources. Each rate model will include components related to direct service staff salaries and fringe benefits (in 2023 dollars), assumptions related to staff time incurred when not serving clients (e.g., travel time in the community to and from where the client is located), program-related expenses and administrative overhead costs. In total, it is anticipated that 55 rate models will be developed. For each service, the benchmark rate will be established -- that is, the rate that is deemed a competitive market rate to pay providers if sufficient funds are available to do so.
- Assess the fiscal impact of rate changes: HMA-Burns will assist DHS in the submission of the total fiscal impact, including the state share and federal share, if DHS were to implement the new payment methodologies proposed and the benchmark rates recommended for each service in this study. Fiscal impacts will be developed at the overall service category level (e.g., all community-based mental health services), at the individual service level (e.g., residential treatment, psychotherapy, etc.), and at the individual provider level.
- Assess the operational impact of rate methodology and rate changes: HMA-Burns will provide technical assistance to DHS in the development of an implementation work plan if the new rate methodologies are adopted. Items that often need to be considered and built out in a work plan include systems and other programming logic changes to pay claims to providers, development of new billing rules, development of other policies related to the rate change, updates to administrative rules, and gaining approval from CMS for the rate methodology changes, when required.

Background on Rate Setting Methodologies

There are a variety of methodologies that have been developed to use to set the rates paid to providers for services in health care programs. These methodologies vary by the service that is being rendered (e.g., hospital-based services, nursing facility services or community-based services) as well by the payer of the service (e.g., Medicare, Medicaid, other government programs or private insurers).

The Centers for Medicare and Medicaid (CMS) establishes the rate-setting methodologies for the Medicare program. Each methodology is well documented and the rates for most services paid by CMS are updated at least annually. As a result, many State Medicaid Agencies leverage the work that has already been conducted by CMS when it sets rates for its providers. Medicaid agencies will simply adopt the Medicare rate or, more likely, a percentage of the Medicare rate when there are not sufficient funds to pay the full Medicare rate.

State Medicaid Agencies are challenged, however, for services that are covered by Medicaid but not by Medicare since there is no established rate methodology set by Medicare. Examples of these services are many of the community-based services for mental health and substance use disorder. These services, among others, are services that are primarily examined in this report.

Rate Methodologies Used for Medical Services in the Medicare Program

CMS is working to add more sophistication to its own rate methodologies. But there are four key approaches used by CMS to pay for services on what is called a "fee-for-service basis," that is, when each service rendered is paid for individually:

- Per service rate: a rate is established for each individual service (e.g., a visit to a doctor's office, a lab test, an MRI exam)
- Per diem rate: a rate that is established for all services rendered to a patient over the course of a day (e.g., for a single day and overnight in a nursing facility)
- Per case rate: a rate that is established for all services rendered to a patient over the course of a medical event (e.g., over multiple days of an inpatient hospital stay for a surgical procedure)
- Per episode rate: a rate that is established to cover the same or similar services over a defined period (e.g., CMS pays a single rate for a 60-day period for home health services)

Exhibit 1 summarizes the services for what rates have been established under each of these payment methodologies. For each service, CMS has published both its payment rate methodology and the rates themselves in a transparent format in the Federal Register. When annual updates are made for each service category, CMS releases a Proposed Rule and a subsequent Final Rule of any methodological changes made to how the service is paid. The latest rates are also published. In the session between when the Proposed Rule and Final Rule are published, CMS accepts feedback from external stakeholders on the changes that are being proposed.

Exhibit 1

Types of Rate Schedules Developed by CMS for the Medicare Program

Per Service Rate	Acuity Adjustment	Value-based Component?	Quality Reporting?
Ambulance	No	No	No
Ambulatory Surgical Center	No	in progress	No
Clinical Laboratory	No	No	No
Durable Medical Equipment, Prosthetics & Orthotics	No	Yes	No
Clinics	No	No	No
Hospital Outpatient Services	No	No	No
Physicians and Nurse Practitioners	No	Yes	Yes

Per Diem Rate	Acuity Adjustment	Value-based Component?	Quality Reporting?
Home Infusion Therapy	Yes	No	No
Hospice Care	No	No	Yes
Hospital Inpatient Psychiatric Care	Yes	No	No
Skilled Nursing Facility	Yes	No	Yes

Per Case Rate	Acuity Adjustment	Value-based Component?	Quality Reporting?
Hospital Inpatient Acute Care	Yes	Yes	Yes
Hospital Inpatient Rehabilitation Care	Yes	No	Yes
Hospital Long Term Care	Yes	No	Yes

Per Episode Rate	Acuity Adjustment	Value-based Component?	Quality Reporting?
End Stage Renal Disease Dialysis	Yes	No	Yes
Home Health (nursing/therapies)	Yes	No	Yes
Opioid Treatment	No	No	No

As seen in the exhibit, within each service there may be other considerations when establishing the rate methodology. An acuity adjustment can be established to address the varying levels of resources required to serve patients within a service category. For example, different rates are set for inpatient hospital services depending upon the diagnostic condition of the patient. Different rates are set for the per diem payment for

skilled nursing facilities that account for the level of nursing required for each resident to health conditions or memory impairment.

A value-based component is often separate from the fee-for-service payment itself but is part of the total reimbursement methodology. Value-based components are usually tied to the quality of the service delivered by the provider. For example, in the inpatient hospital setting, CMS imposes a penalty to hospitals if they realize a patient readmission rate that is higher than the established target for the year. Physicians and nurse practitioners are eligible for incentive payments outside of the fee-for-service rate based on quality rating scores from patients.

For other services, CMS has required providers to submit information for quality reporting and measurement. The specific information submitted is not directly tied to provider payment unless it is part of a value-based component. CMS is moving toward integrating information from quality reporting into value-based payment methodologies for the services where this does not exist today.

Innovations in Fee-for-Service Rate-Setting are Underway

Minnesota has adopted value-based purchasing and other innovative rate setting practices within its managed care delivery system as well as part of its Integrated Health Partnerships program. Opportunities to implement these practices within the fee-for-service delivery system have historically been limited.

Updates to CMS's current fee-for-service payment methodologies are considered a steppingstone to even more innovative rate setting methodologies that focus more on patient outcomes rather than the quantity of services delivered. The Center for Medicare and Medicaid Innovation (CMMI) within CMS updated its strategic objectives in 2021 with goals to the following:

1. Drive accountable care
2. Advance health equity
3. Support innovation
4. Address affordability
5. Partner to achieve system transformation

As part of his work, the CMMI has already endorsed the Health Care Payment Learning & Action Network (HCP-LAN) four categories of reimbursement methodologies. The categories move from the most rudimentary (category 1) to the most complex (category 4). The four categories are described more fully in Exhibit 2. HMA-Burns recognizes that different services may fall under different pathways migrating from category 1 to category 4. Some services may remain under a reimbursement methodology at category 3 permanently. The most recent goals articulated by HCP-LAN are for Medicaid agencies to achieve 50 percent of all payments in categories 3 and 4 by CY 2030.

Exhibit 2

CMS Approach to Developing Value-based Payment Methodologies

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Fee-for-Service No Link to Quality & Value	**Fee-for-Service Linked to Quality & Value**	**Alternative Payment Models Built on Fee-for-Service Architecture**	**Population-Based Payment**

Options for a category could include one or more of the following:

Option A Establish rate for each service with no other incentive payment	Option A Foundational payments for Infrastructure & Operations	Option A Alternative Payment Models (APMs) with Shared Savings (providers share in savings if state saves money)	Option A Condition-specific Population-Based payment (e.g., all mental health services)
Option A Establish rate for each service with no other incentive payment	Option B Pay for reporting on outcomes	Option B APM with shared Savings and downside risk (providers share in savings if state saves money, but must give back money if state does not achieve savings)	Option B Comprehensive population-based payment (e.g., monthly payment to provider for all services)

Rate Methodologies Used for Home- and Community-Based Services in Medicaid Programs

Home- and community-based services (often abbreviated as HCBS) are services delivered to a patient in their home or in a community setting (that is, not a hospital, nursing facility or other institutional level of care). Services to treat physical health needs may be defined as HCBS. CMS has established payment rate methodologies for these services in its Medicare program. Examples of physical health community services were shown in Exhibit 1. State Medicaid Agencies, including Minnesota's Department of Human Services, use many of these rate methodologies to pay for these same services to providers serving Medicaid beneficiaries.

The more specific definition of HCBS, however, relates to services where Medicaid agencies or other social service agencies within state government are either the primary payer or the only payer of the service. HCBS often include providers who employ practitioners beyond those with expertise in physical health ailments (although physical health practitioners are often part of service delivery as well). The most common HCBS categories paid by state agencies include:

- Services to address mental health needs
- Services to address intellectual or developmental disabilities

- Services to address substance use disorder

Because state agencies do not have rate methodologies established by CMS to rely on for HCBS, there has been less development on a nationwide basis of rate methodologies for these services when compared to physical health services. The four most common methodologies used to set rates for HCBS are shown as columns in Exhibit 3. There are pros and cons to using each of the four rate methodologies listed. Assuming a state is going to pay for HCBS under a fee-for-service rate methodology (as opposed to one of the more sophisticated approaches shown in Exhibit 2), the market-based rate methodology is the most nuanced approach. Rates can be constructed so that they use current provider costs to inform the rate without accepting all costs without parameters as is done in a cost settlement process. Rate models can be shared in a transparent format to stakeholders and updated with low administrative burden. There is, however, some upfront work required to build the methodology itself.

Exhibit 3

Pros and Cons of Rate Methodologies Commonly Used for HCBS

	Cost Settlement	Established by Contract	Informed by Other States or Payers	Market-Based Rates
Uses provider costs as a consideration for payment	Yes	Could, but not always	Not usually	Could, and often does
Methodology is transparent to external viewers	No	No	No	Can be
Methodology incorporates value into payment	No	Could, but not always	Not usually	Could, and often does
Administrative burden level is low	No	No	Yes	Yes

Approach to Conduct This Study

DHS contracted with HMA-Burns to provide technical assistance in the development of new or updated payment rate methodologies for the services included in this study. The HMA-Burns team is also assisting in writing the two reports that are being delivered to the Legislature as required in enabling legislation in 2021 that required the following:

Laws of Minnesota 2021, chapter 7, article 17, section 18

MEDICAL ASSISTANCE OUTPATIENT AND BEHAVIORAL HEALTH SERVICE RATES STUDY.

(a) This act includes $486,000 in fiscal year 2022 and $696,000 in fiscal year 2023 for an analysis of the current rate-setting methodology for all outpatient services in medical assistance and MinnesotaCare, including rates for behavioral health, substance use disorder treatment and residential substance use disorder treatment. By January 1, 2022, the commissioner shall issue a request for proposals for frameworks and modeling of behavioral health services rates. Rates must be predicated on a uniform methodology that is transparent, culturally responsive, supports staffing needed to treat a patient's assessed need and promotes quality service delivery, integration of care and patient choice. The commissioner must consult with providers across the spectrum of services, from across each region of the state and culturally responsive providers in the development of the request for proposals and for the duration of the contract. The general fund base included in this act for this purpose is $599,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) By January 15, 2023, the commissioner of human services shall submit a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the initial results. By January 15, 2024, the commissioner of human services shall submit a final report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance that includes legislative language necessary to modify existing or implement new rate methodologies, including a new substance use disorder treatment rate methodology, and a detailed fiscal analysis.

DHS's contract with HMA-Burns began in August 2022 and continues for a two-year period for a total price of $907,040. HMA-Burns has previously established rates for State Medicaid Agencies for all the services included in the scope of the study. The current team assisting DHS had previously assisted the DHS in the implementation of its Resource Based Relative Value System, the payment methodology used to pay for many community-based physical health services, in 2010 and 2011. The team working on this project has been actively engaged in the last year to develop rates for all the other HCBS that are included in this rate study.

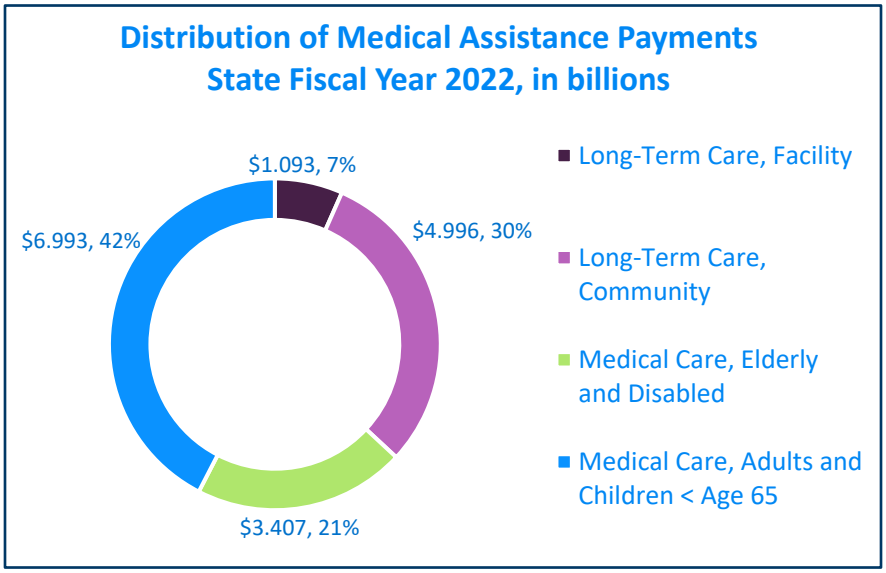
Services Included in the Study

As mentioned earlier in the report, there are a wide variety of services for which rate methodologies are set by Medicaid agencies. The services in this study represent a subset of these services.

Exhibit 4 illustrates four categories of service coverage within Minnesota's Medicaid program. The services included in this study are all part of the blue section of the circle which represents medical care to adults and children in Medicaid, but excludes services specific to the elderly and disabled.

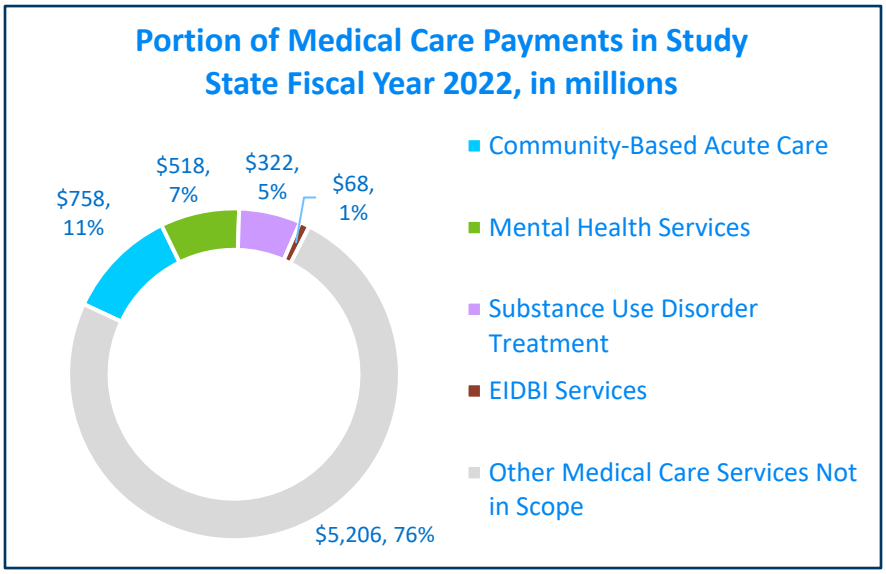
Exhibit 4

Distribution of Medical Assistance Payments, SFY22



Within the $6.99 billion in Medicaid expenditures in State Fiscal Year 2022 to non-elderly adults and children, the services in this study represent $1.67 billion, or 24 percent of the total. The remaining 76 percent cover services in non-community settings (e.g., hospital-based care), pharmacy scripts, or other services not rendered in a face-to-face setting with a client (e.g., medical equipment and supplies).

Exhibit 5



The services that are included in the study have been placed into one of four categories for assessment and ongoing work related to revisions to payment rate methodologies:

- Community-based physical health services
- Community-based mental health services
- Community-based substance use disorder treatment services
- Early intensive developmental and behavioral intervention (EIDBI) services

Data Sources Used to Conduct Assessment

The DHS provided HMA-Burns with multiple sources of information to make the initial assessment of the payment rate methodologies used currently and to support ongoing work as required in the legislation. Data sources used by HMA-Burns include the following:

- MHCP provider manual: HMA-Burns reviewed the Minnesota Health Coverage Programs Provider Manual to better understand each service within the four categories listed above that is covered by DHS, how each service is defined, the unit of service paid, and the current rate.
- Medicaid State Plan: The State Plan is the document that DHS maintains for approvals received from CMS for the methodology under which rates are set for each service category. Because funding for Medicaid is shared between the federal government and each state, CMS maintains authority to approve the rate methodologies adopted by each state to set the rates that it pays to Medicaid providers. HMA-Burns reviewed the State Plan to gain better insight into the methodologies used by DHS today to pay for the services in the study.
- Medicaid fee-for-service claims and managed care encounters with payments: HMA-Burns compiled information on the claims submitted by providers to DHS (under what is called the fee-for-service program) or to DHS's contracted Medicaid managed care organizations, or Managed Care Organizations (MCOs) (under what is called the managed care program). HMA-Burns totaled the units of service delivered and the payments for each service under both delivery systems for services rendered in CY 2021.
- Medicaid enrollment files: HMA-Burns summed the total months of enrollment for each Medicaid beneficiary enrolled in Minnesota's Medicaid program during CY 2021. Enrollment totals were segmented between children (up to and including age 18) and adults (age 19 and over).
- Medicaid provider roster: HMA-Burns identified the unique count of providers that delivered services to Medicaid beneficiaries in CY 2021 for each of the service categories in the study.

The member enrollment, provider enrollment and service payments were incorporated to establish measures that were used to inform HMA-Burns' assessment for each service category. Examples of measures that were tabulated include:

- Payments made per member per month during CY 2021: This measure sums the total payments for a service category and divides the total by the total member months of enrollment during the year. Some

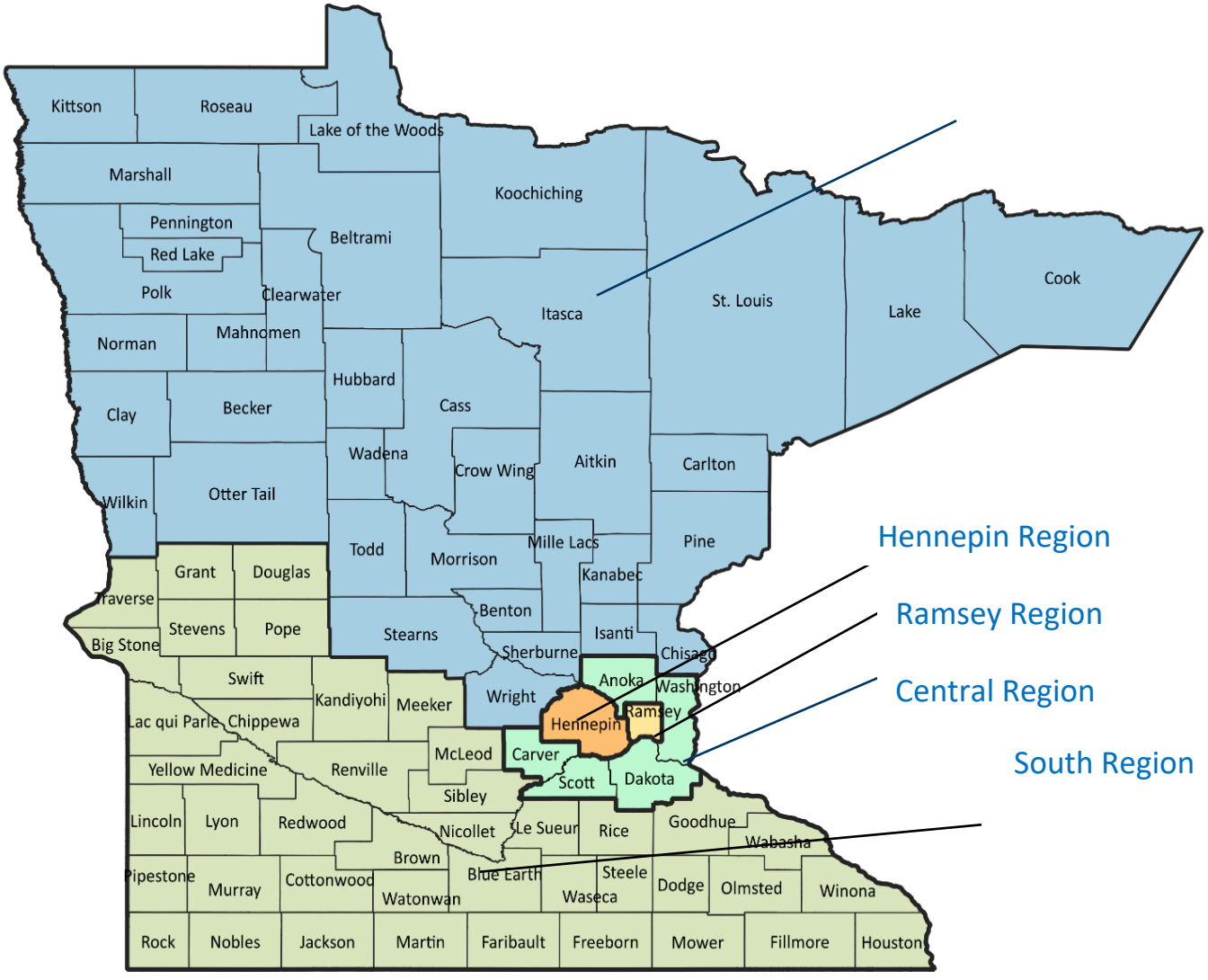
services are provided to the child and adolescent population only or the adult population only. In these instances, the per member per month calculation divides service payments by the total child member months only or the total adult member months only.

- Providers per 100,000 individuals eligible for Medicaid in December 2021: This measure assesses the Medicaid enrollment as of December 2021. The count of providers within a service category that billed for services in CY 2021 was compared to the total enrollment in December 2021. The ratio of number of providers to total Medicaid members is computed, then multiplied by 100,000.

Definitions of Regions Used for Measuring Provider Access

The measures described above were created to assess provider availability and service usage across five regions of the state. The DHS has created five regions for reporting in the Medicaid program. The regions are shown in the map below. The regions include the following (with Medicaid enrollment in December 2021 in parentheses): North Region (359,665), Central Region (248,010), South Region (245,347), Hennepin Region (306,722) and Ramsey Region (170,482). Each of Minnesota's 87 counties are assigned to one region (note that Hennepin and Ramsey counties each serve as their own region).

Because Medicaid enrollment varies by region, the per member per month expenditure measure and the providers per 100,000 Medicaid beneficiaries measure allow for equivalent comparisons across the regions.



Definitions of Assessment Measures Used in the Assessment

The metrics that are reported in the Findings section are defined as follows:

- Need for methodology reform
    - Low (current methodology is fine)
    - Medium (current methodology could be updated)
    - High (wholesale change recommended)
- Need for rate update
    - Low (rates were recently updated)
    - Medium (some rates/providers may have been recently updated, but not all)
    - High (no services/providers have received a rate update in multiple years)
- Level of transparency of current rate methodology and actual rates
    - Low (current methodology and/or rate not publicly available)
    - Medium (methodology and/or rate has some information publicly available, but not easy to follow)
    - High (methodology is publicly available and easy to follow, actual rates are publicly available)
- Concern related to access to providers that may be influenced by current rates: The per member per month payments by region and the providers per 100,000 Medicaid beneficiaries measures were used as part of this assessment.
    - Low (provider access is available throughout the state for Medicaid beneficiaries)
    - Medium (provider access may be available in some, but not all, parts of the state)
    - High (there are provider access concerns throughout the state)
- Opportunity to add value-based component to new or existing methodology.
    - No (current or proposed methodology does not lend itself to adding a value-based component)
    - Maybe (current or proposed methodology could have a value-based component in some aspects of the payment system)
    - Yes (current or proposed methodology has high potential to incorporate a value-based component into the payment system)
- Opportunity to add cultural competency component to new or existing methodology.
    - No (current or proposed methodology does not lend itself to adding a cultural competency component)
    - Maybe (current or proposed methodology could have a cultural competency component in some aspects of the payment system)
    - Yes (current or proposed methodology has high potential to incorporate a cultural competency component into the payment system)

Findings from Assessment

HMA-Burns conducted an assessment of each of the major service categories that were included by DHS in this study as per legislative requirement. Each service category is organized in the findings under its own subheading.

Information is provided about each service category with respect to total expenditures in the DHS Medical Assistance budget, the current number of providers delivering each service, an explanation of the current method used to pay for the services in each category and options to consider for reforming the existing payment methodology.

Community-Based Physical Health Services

Summary Information

Community-based physical health services encompass a wide variety of primary care and specialty care services, including the following:

- Well care visits (e.g., annual check-up) and visits for illness to a primary care doctor
- Vaccine administration
- Visits to specialist doctors
- Services performed by OB/GYNs, including deliveries
- Services performed by specialists (e.g., surgical procedures in a hospital setting, office-based procedures such as removal of skin growths)
- Radiology services (e.g., x-rays, MRIs, CT scans)
- Pathology services (e.g., pap smear, drug screening, specimen testing)
- Eye exams
- Hearing tests
- Physical, occupational, and speech therapy services
- Chiropractic services
- Chemotherapy administration

Collectively, DHS paid $758 million, or 10.8% of the total medical services Medicaid budget, for these services during CY 2021.

Exhibit 6 segments these services into five subcategories. Primary care is defined as office visits for wellness or sickness. Evaluation & Management codes other than primary care are services other than the office visits that are normally delivered by physicians, their assistants or nurse practitioners. Specialties encompasses all the specialist physician services. Radiology includes MRIs, CT scans and the like. Medicine includes all other services not categorized in previous categories.

Exhibit 6

Summary of Utilization, Payments and Providers of Community-based Physical Health Services

Payments for Services in CY2021 (in millions) – Table A

	Primary Care Visits	Evaluation & Management excluding Primary Care	Specialties	Radiology	Medicine
Statewide	**$264.4 (100%)**	**$153.9 (100%)**	**$143.5 (100%)**	**$54.5 (100%)**	**$142.1 (100%)**
North Region	$63.8 (24.1%)	$30.6 (19.9%)	$28.2 (19.7%)	$7.5 (13.8%)	$31.9 (22.4%)
Central Region	$42.5 (16.1%)	$9.9 (6.5%)	$18.8 (13.1%)	$6.6 (12.1%)	$26.6 (18.7%)
South Region	$38.7 (14.6%)	$20.3 (13.2%)	$23.8 (16.6%)	$8.6 (15.8%)	$19.1 (13.5%)
Hennepin County	$85.5 (32.3%)	$70.4 (45.8%)	$52.0 (36.2%)	$20.8 (38.2%)	$45.4 (32.0%)
Ramsey County	$33.9 (12.8%)	$22.6 (14.7%)	$20.7 (14.4%)	$10.9 (20.1%)	$19.1 (13.5%)

Payments for Services in CY2021 Expressed on a Per Medicaid Member Per Month Basis – Table B

	Primary Care Visits	Evaluation & Management excluding Primary Care	Specialties	Radiology	Medicine
Statewide	$17.14	$9.98	$9.31	$3.54	$9.21
North Region	$15.26	$7.32	$6.74	$1.80	$7.62
Central Region	$14.80	$3.46	$6.54	$2.31	$9.26
South Region	$13.62	$7.14	$8.38	$3.03	$6.73
Hennepin County	$24.07	$19.82	$14.65	$5.87	$12.79
Ramsey County	$17.14	$11.43	$10.49	$5.53	$9.68

Number of Medicaid Providers Billing for Services in CY2021 – Table C

	Primary Care Visits	Evaluation & Management excluding Primary Care	Specialties	Radiology	Medicine
Statewide	3,706	1,956	3,194	1,647	5,011
North Region	924	514	809	405	1,207
Central Region	746	344	672	350	933
South Region	681	330	584	268	767
Hennepin County	956	544	809	452	1,451
Ramsey County	399	224	320	172	653

Ratio of Billing Providers to 100,000 Medicaid Beneficiaries Enrolled in December 2021 – Table D

	Primary Care Visits	Evaluation & Management excluding Primary Care	Specialties	Radiology	Medicine
Statewide	279	147	240	124	377
North Region	257	143	225	113	336
Central Region	301	139	271	141	376
South Region	278	135	238	109	313
Hennepin County	312	177	264	147	473
Ramsey County	234	131	188	101	383

Table B of the exhibit shows DHS payments for each sub-category expressed on a per member per month (PMPM) basis. The PMPM payment computes the payment values just for the Medicaid members in this region.

For example, when reviewing the Primary Care Visits column, total payments for services in CY 2021 in this category were $264.4 million. Medicaid enrollment during CY 2021 averaged 1.285 million. If we add the months of enrollment for all these members for the entire year, the total member months were 15,421,607. When dividing the $264.4 million by the 15,421,607 member months, the average payment is $17.14 per member per month.

By computing PMPMs, comparisons can be made across regions of the state. For each of the five categories shown in Exhibit 6, the counties outside the Twin Cities area of the state had lower PMPM values than the metropolitan and the statewide average values. This may be indicative of access to service issues rather than less need for services. The category Evaluation & Management excluding Primary Care is low for the Central Region compared to all others. This may be because many of these services are hospital-based services and payments for these services are captured where the hospital is located, namely Hennepin or Ramsey County. Values for Ramsey County are similar to the statewide values, whereas the values for Hennepin County are much higher than the statewide values.

Table D of the exhibit shows the number of providers that billed for each service category within each region during CY 2021. Similar to the payment data, the actual number of providers are shown in the Table C, but Table D allows for comparisons across regions because the provider counts are expressed as providers-per-100,000 Medicaid beneficiaries.

Whereas there were differences found in the PMPM payments across the regions for each service category, the number of providers is more consistent. The exception is Hennepin County that once again has a higher number of providers delivering services when examined on a per 100,000 beneficiary basis. The provider counts represent the providers that billed DHS or one of its MCOs for any service in the service category during CY 2021. Although the actual number of providers may be consistent across regions, the availability of each provider to accept Medicaid patients could vary.

Assessment for Community-based Physical Health Services

Exhibit 7 summarizes HMA-Burns' assessment of the impacts of DHS' current payment methodology for physical health services. Each domain is discussed in more detail below the exhibit.

Exhibit 7

Summary of Assessment for Community-based Physical Health Services

Need for rate methodology reform	Low
Need for rate update	High
Level of transparency of current rate methodology and rates	Medium
Concern related to access to providers	Medium
Opportunity to add value-based component to new or existing methodology	Maybe
Opportunity to add cultural competency component to methodology	Maybe

Current Methodology, Rates and Level of Transparency

The DHS currently uses Medicare's payment methodology in principle to pay for community-based physical health services. Medicare's payment methodology is called the Resource Based Relative Value Scale payment

system, or RBRVS. In this payment system, each service billing code, of which there are thousands, is assigned a relative value. This relative value is multiplied by a constant dollar amount.

The relative value assigned to each service accounts for the amount of work spent by the practitioner (such as the physician) to deliver the service, the expense incurred by the physician's practice to deliver the services (such as office expenses, supplies, etc.) and malpractice insurance that the practitioner must carry. Each of these values (work, practice expense and malpractice insurance) are also adjusted for regional cost variations around the country. For Minnesota:

- The work values are set at 100 percent of the national average (many states are set at 100% as authorized by Congress as the lowest adjustment value for the work component).
- The practice expense values are adjusted to be set at 101.9 percent of the national average.
- The malpractice insurance values are adjusted to be set at 32.6 percent of the national average.

The relative values are updated annually by the Centers for Medicare and Medicaid (CMS) and take effect each January 1. The American Medical Association maintains a committee that reviews the relative values each year and makes recommendations to CMS on changes to values for specific services.

DHS adopts the changes to relative values in its annual update each January. Where DHS differs from the Medicare formula is in the constant dollar amount that is used to multiply by the relative values.

Medicare uses one multiplier for all services paid in its RBRVS reimbursement system. For CY 2023, this multiplier is $33.8872. When DHS adopted the use of the RBRVS payment system in CY 2011, there was not sufficient budget authority to adopt the single multiplier that Medicare was using at that time. DHS was forced to "back into" rates that use the RBRVS methodology in spirit, but do not pay the full rate established in Medicare's RBRVS. DHS was forced to establish three multipliers against relative values instead of just one. Although some incremental changes have occurred since CY 2011, DHS still maintains three multipliers to stay within its budget:

- For evaluation and management services (office visits and some other services) and services delivered by OB/GYNs, the multiplier is $25.32, or 77.4% of the Medicare rate
- For services delivered by mental health practitioners, the multiplier is $28.44, or 83.9% of the Medicare rate
- For all other services paid under this reimbursement system, the multiplier is $25.30, or 77.4% of the Medicare rate.

Lack of transparency in rates: Above and beyond these multipliers, some providers have met criteria established by DHS to be deemed "essential providers." These essential providers are paid between 20 and 25 percent above the rate established using any of the multipliers listed above. Finally, the Minnesota legislature has enacted a series of rate cuts and rate increases over the years. These adjustments to the rates are subject to multiplication and were not uniformly applied to all services. As a result, the overall effect of these rate adjustments makes it virtually impossible for providers to know what payment they should receive for the services that they have rendered.

DHS also has implemented a supplemental payment that enables DHS to pay up to the average commercial rate for a community-based physical health services for services delivered by the University of Minnesota Medical Center, Regions Hospital and Hennepin County Medical Center.

Description of Network Coverage

Exhibit 8 shows the counties in Minnesota color-coded to represent the number of primary care practitioners per 100,000 members in each county. The map represents only those providers who deliver primary care in a community setting (in other words, practitioners who are based in hospitals are excluded). The counties in dark blue have the greatest proportion of providers for the Medicaid population in the county. The counties in white have the lowest proportion of providers.

Medicaid members can and do cross county lines to receive primary care services. Therefore, this map cannot be used as the only arbiter of access to services. But it can reveal trends:

- Counties in the Northwest region of the state appear to have more limited access to primary care providers than other regions of the state. But each of these counties borders a county that has a higher percentage of primary care providers.
- Other than the Northwest region, there appears to be adequate provider access for primary care services in the state for Medicaid beneficiaries.

Assessment of Options for Adding Innovations to Rate Methodology

CMS has not developed rate differentials in its methodology to pay for community-based physical health services to Medicare beneficiaries. Because the Medicaid population is more diverse than the Medicare population, DHS may want to consider establishing a higher rate of payment for Medicaid providers who are incurring costs to serve clients above and beyond what has been assumed in the work component of the relative values established by CMS in its reimbursement methodology.

Recommendations for the Payment Methodology for Community-based Physical Health Services

HMA-Burns offers the following recommendations to DHS related to the payment methodology for community-based physical health services:

1. Continue to leverage the methodology developed by CMS for Medicare using the Resource Based Relative Value Scale, but move towards full adherence to the methodology rather than adopting only selected components of the methodology. This means:
    a. Adopt a single multiplier to use in the formula with the relative values, not three.
    b. Update Medicare's multiplier value annually as CMS releases updates.
2. Assess the utility of maintaining the percentage premiums paid to "essential providers," especially if Recommendation #1 is implemented (paying 100% of the Medicare rate).
    a. For example, today the DHS is paying 77.4 percent of the Medicare rate for a standard office visit. If an essential provider is paid 23.7 percent above this rate, then this is equivalent to 95.7 percent of the Medicare rate. If 100 percent of the Medicare rate is adopted, then the essential provider premium is redundant.

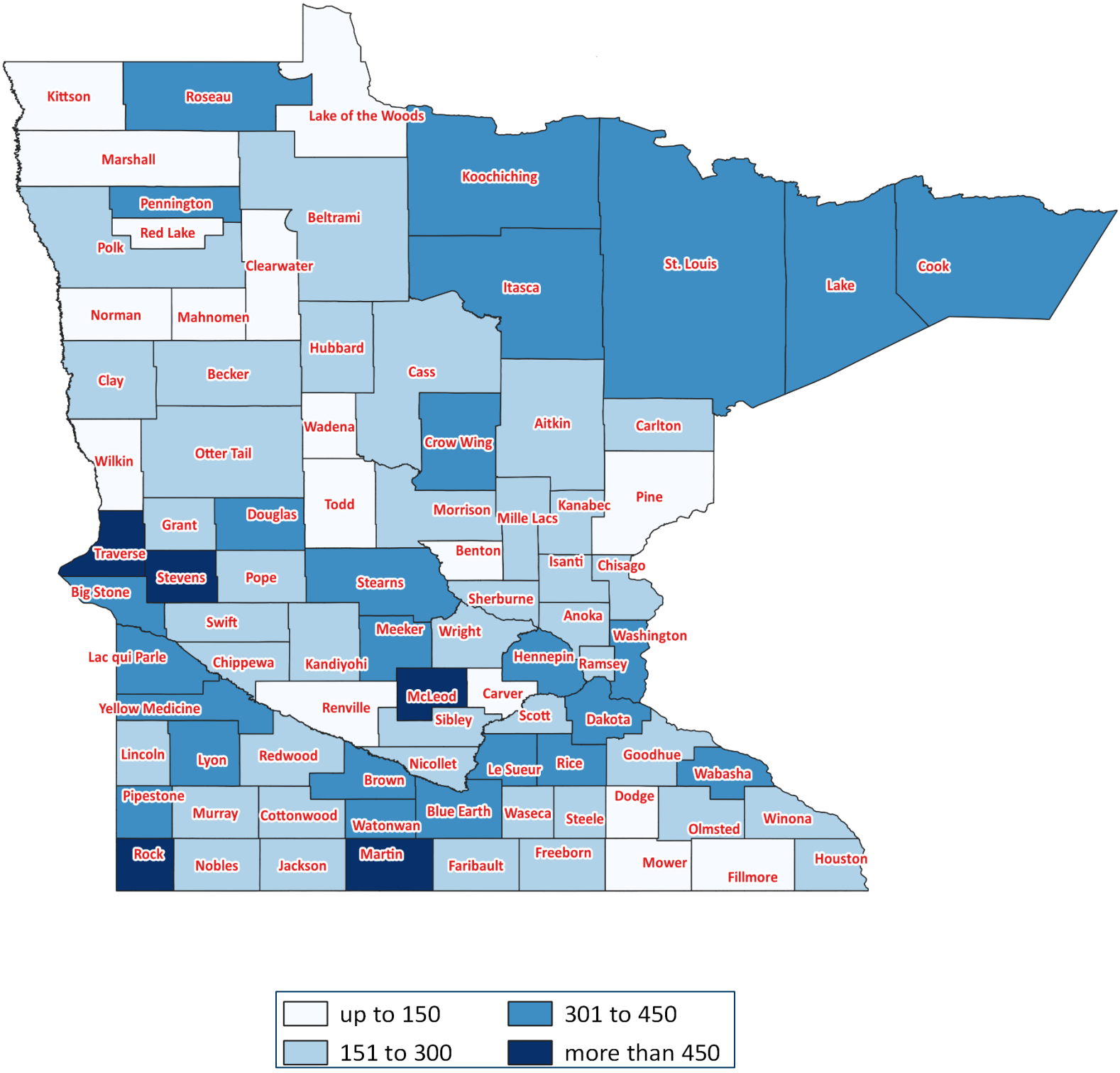
3. Remove all other year-by-year historical pricing changes as mandated by Legislature, especially if Recommendation #1 is implemented.
    a. These year-by-year adjustments are not transparent to the providers or other external parties, especially when they are accumulated over time.
4. Consider rate adjustments to pay providers in medically underserved areas or providers who serve Medicaid clients with needs that require additional resources.
    a. For example, pay a higher rate (e.g., 105% of the Medicare rate) to counties in the Northwest Region that have fewer primary care provider options to incentivize provider participation in the Medicaid program.
    b. For example, pay a higher rate for providers who have built in competencies to serve a larger proportion of Medicaid clients with additional needs, such as clients with limited English proficiency, providers that serve a high proportion of immigrants or providers who serve a high proportion of clients with mental health or substance use disorders.
5. Regardless of the new rates established, continue to maintain the rate differential that is common among payers to account for the personnel delivering the service.
    a. For example, physician assistants and nurse practitioners are paid 90 percent of the rate paid to a physician for the service rendered.
6. After baseline fee-for-service rates have been re-established at or near 100 percent of the Medicare rate (HCP-LAN Category 1, fee-for-service rates with no link to quality and value), consider developing the infrastructure for reporting in future years to include incentive payments tied to quality and value (HCP-LAN Category 2). CMS has established a Merit-based Incentive Payment program (MIPS) that includes 12 Value Pathways (MVPs) that provider groups may report on in CY 2023 to receive incentive payments above and beyond the fee-for-service rate established if certain targets are achieved. Reporting is voluntary in this program. Providers enroll in only one of the following MVPs:
    a. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
    b. Advancing Care for Heart Disease
    c. Advancing Rheumatology Patient Care
    d. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
    e. Improving Care for Lower Extremity Joint Repair
    f. Optimizing Chronic Disease Management
    g. Patient Safety and Support of Positive Experience with Anesthesia
    h. Advancing Cancer Care
    i. Optimal Care for Kidney Health
    j. Optimal Care for Patients with Episodic Neurological Conditions
    k. Supportive Care for Neurodegenerative Conditions
    l. Promoting Wellness

    The categories shown above were designed with the Medicare program in mind. DHS may consider applying the same approach that has been adopted by CMS in its MIPS Value Pathways, but consider alternative pathways that are more applicable to the Medicaid program such as:

    a. Optimal Well Care for Children and Adolescents
    b. Optimizing and Coordinating Mental Health Services
    c. Adopting Best Practices and Coordinating Substance Use Disorder Treatment Services

Exhibit 8

Primary Care Providers per 100,000 Medicaid Beneficiaries – December 2021



Community-Based Mental Health Services

Summary Information

Community-based mental health services include a wide variety of services that vary in the intensity of the service offered and the modality offered. Within the scope of this study, the services that are examined include the following:

- Residential services, meaning that the client resides in a community-based housing setting for a period where services are delivered throughout the week at this location. Residential services for children/adolescents and for adults are reviewed separately. Within the children/adolescent residential services, there are different levels of intensity offered. Notably, psychiatric residential treatment centers, or PRTFs, represent the highest intensity level of residential treatment offered in Minnesota to children and adolescents.
- Intensive treatment in a foster care setting
- Partial hospitalization (not overnight)
- A variety of services delivered in an outpatient setting, meaning outside of a hospital setting and outside of a residential treatment center, to children/adolescents and to adults:
    - Mental health assessment
    - Mental health treatment planning
    - Psychosocial rehabilitation, one-on-one and in group settings
    - Psychotherapy, one-on-one, group setting, family setting
    - Skills training and development
    - Day treatment
    - Assertive community treatment
    - Dialectical behavior therapy
    - Medication education
    - Supports from peers with lived experience
    - Family education
    - Crisis assistance, including dispatch of mobile crisis teams
    - Psychological testing

Collectively, Minnesota DHS paid $517 million, or 7.4% of the total medical services Medicaid budget, for these services during CY 2021.

Exhibit 9 segments these services into four subcategories, two for children and two for adults. Within each age group, the services are categorized under residential treatment and all other services. As a percentage of the total expenditures within mental health services, the services to children comprise 43 percent of the expenditures and adults comprise 57 percent. Within the $222 million spent on children, residential services were 3 percent of expenditures while other community services were 97 percent of the total. For adults, residential services were 17 percent of expenditures while other community services were 83 percent of the total.

Exhibit 9

Summary of Utilization, Payments, and Providers of Community-based Mental Health Services

	Children's Residential Mental Health	Children's Outpatient Mental Health	Adult Residential Mental Health	Adult Outpatient Mental Health

Payments for Services in CY2021 (in millions) -- Table A

	Children's Residential Mental Health	Children's Outpatient Mental Health	Adult Residential Mental Health	Adult Outpatient Mental Health
Statewide	**$6.2 (100%)**	**$216.6 (100%)**	**$50.1 (100%)**	**$244.7 (100%)**
North Region	$1.0 (16.0%)	$64.0 (29.6%)	$11.4 (22.8%)	$58.4 (23.9%)
Central Region	$2.9 (47.1%)	$22.1 (10.2%)	$5.6 (11.3%)	$28.2 (11.5%)
South Region	$0.8 (13.0%)	$39.6 (18.3%)	$8.7 (17.4%)	$31.5 (12.9%)
Hennepin County	$0.3 (5.3%)	$75.6 (34.9%)	$13.3 (26.6%)	$80.5 (32.9%)
Ramsey County	$1.2 (18.6%)	$15.3 (7.1%)	$10.9 (21.9%)	$46.0 (18.8%)

Payments for Services in CY2021 Expressed on a Per Medicaid Member Per Month Basis – Table B

	Children's Residential Mental Health	Children's Outpatient Mental Health	Adult Residential Mental Health	Adult Outpatient Mental Health
	Payments per child member	Payments per child member	Payments per adult member	Payments per adult member
Statewide	$1.00	$34.68	$5.45	$26.66
North Region	$0.58	$37.34	$4.62	$23.65
Central Region	$2.40	$18.10	$3.43	$17.12
South Region	$0.67	$32.37	$5.39	$19.50
Hennepin County	$0.25	$58.18	$5.92	$35.75
Ramsey County	$1.48	$19.44	$9.19	$38.65

Number of Medicaid Providers Billing for Services in CY2021 – Table C

	Children's Residential Mental Health	Children's Outpatient Mental Health	Adult Residential Mental Health	Adult Outpatient Mental Health
Statewide	53	1,680	68	1,870
North Region	17	469	16	484
Central Region	13	291	11	322
South Region	8	259	13	275
Hennepin County	8	459	16	540
Ramsey County	7	200	12	249

Ratio of Billing Providers to 100,000 Medicaid Beneficiaries in CY2021 – Table D

	Children's Residential Mental Health	Children's Outpatient Mental Health	Adult Residential Mental Health	Adult Outpatient Mental Health
	Ratio per 100,000 child members	Ratio per 100,000 child members	Ratio per 100,000 adult members	Ratio per 100,000 adult members
Statewide	10	310	9	237
North Region	11	316	8	229
Central Region	12	274	8	227
South Region	8	244	9	198
Hennepin County	7	407	8	279
Ramsey County	10	295	12	244

When examining the PMPM values in Table B, the PMPMs for children's outpatient services in the Central Region and in Ramsey County are close to half of the overall statewide average, whereas the PMPM for Hennepin County is 68 percent above the statewide average. The finding is not the same for adult community services, however. The Central and South Regions have lower PMPMs for adult community services than the statewide average (up to one-third lower), while Hennepin and Ramsey Counties have PMPMs that are 34 percent and 45 percent, respectively, above the statewide average. The PMPMs for adult residential services are more similar across regions, except that Ramsey County is higher than other regions. The PMPMs for child residential services are too small a component of total expenditures to identify a meaningful finding.

Table D of the exhibit shows the number of providers that billed at least $25,000 for each service category within each region during CY 2021. By absolute count of providers, there are fewer providers in the state who serve children and adolescents for community mental health services (n =1,733) than adults (n =1,938). But when expressed as providers-per-100,000 Medicaid beneficiaries within each age group, the results are higher for children (310) than adults (237).

Though there were differences found in the PMPM payments across the regions for each service category, the number of providers is more consistent. For community services for children, the Central Region and Ramsey County had lower PMPM values than other regions. But the providers-per-100,000 beneficiaries are similar values in these regions compared to the other regions. For adult community services, the Central and South Regions had lower PMPM values than other regions. But for provider availability, only the South Region had lower values than other regions when examined using the providers-per-100,000 beneficiaries measure. The provider counts represent the providers that billed DHS or one of its MCOs for any Medicaid service in the service category during CY 2021. Medicaid members are free to choose providers anywhere in the state, including away from their home location. This may influence some of the results observed.

Assessment for Community-based Mental Health Services

Exhibit 10 summarizes HMA-Burns' assessment of the impacts of DHS' current payment methodology for mental health services. Each domain is discussed in more detail after the exhibit.

Exhibit 10

Summary of Assessment for Community-based Mental Health Services

Need for rate methodology reform	High
Need for rate update	High
Level of transparency of current rate methodology and rates	Low
Concern related to access to providers	High
Opportunity to add value-based component to new or existing methodology	Maybe
Opportunity to add cultural competency component to methodology	Yes

Current Methodology, Rates and Level of Transparency

The DHS publishes a rate schedule for all covered services under the community-based mental health service category. Because there are dozens of unique services, DHS has created a legend that maps each service to one of 21 higher-level categories. These 21 categories include groupings of services specific to children/adolescents and services specific to adults, services related to residential treatment and others related to community-based treatment outside of residential treatment, and others.

The rate schedule includes the service name, service code, service category, unit or duration of service and the rate. Some mental health services are also part of Medicare's RBRVS payment system (discussed in the previous section for physical health services). For these services (e.g., psychotherapy codes), DHS is updating these mental health service rates at the same time as the physical health services. The last rate update to this subset of services occurred in January 2022. Other service rates that are not a part of the RBRVS payment system (that is, services only covered by the state and not by Medicare) were last updated in January 2021. For each service listed on the rate schedule, two rates are shown (with a few exceptions):

- The "standard" rate
- A rate that is 20 to 25 above the standard rate for certain eligible provider types or licensed practitioners

In some instances, a rate that is set at a discount from the standard rate (e.g., 80% of standard) if the service is rendered by personnel who are qualified to deliver the service but have less experience or clinical education than other personnel.

For rates in the services mentioned above, there is no transparency on the approach used to determine each rate, such as the cost variables considered to set the rate itself.

There are still other mental health services that are neither a part of the RBRVS fee schedule nor are they listed as a standard or enhanced rate for all providers. Instead, the rate set for these services is unique to each provider and the rate is established based on the provider's specific costs. The services paid using cost-based reimbursement include assertive community treatment, crisis services to adults, intensive residential treatment services to adults, psychiatric residential treatment facilities for children/adolescents, mental health targeted case management and certified community behavioral health centers (CCBHCs). These rates are updated annually.

The Medicaid State Plan specifies that the methodology to set these provider-specific rates utilizes a cost reporting tool that the State created for each provider to submit the costs it has incurred to render each of these services. There is some description in the State Plan about the types of costs considered in rate development (e.g., direct service staff costs, program costs, physical plant costs) and how they are used. A drawback to this methodology, however, is that it always considers costs retrospectively rather than prospectively. There are also few limitations on minimum or maximum values for costs that would be permissible in establishing a rate. In other words, the provider must attest that costs were actually incurred to be included in a future rate, but there are limited criteria applied to determine if costs appear to be reasonable for an efficient provider who is rendering the service and is appropriate for reimbursement.

Although the provider-specific rates are transparent on the DHS website as to the value of the rates, there is no explanation as to why the variation of rates of payment is so vast across providers.

Description of Network Coverage

Exhibit 11 shows the count of active mental health providers serving Medicaid beneficiaries, children and adults, at the county level using the measure of providers-per-100,000 beneficiaries for comparison. As seen in the primary care map, the counties in Minnesota are color-coded to represent variation across the counties. The counties in dark blue have the greatest proportion of providers for the Medicaid population in the county. The counties in white have the lowest proportion of providers.

Medicaid members can (and do) cross county lines to receive mental health services. Therefore, this map cannot be used as the only arbiter of access to services. But it can reveal trends:

- On a per 100,000 basis, there are many counties on the western side of the state bordering North and South Dakota that have a lower proportion of mental health providers.
- Only two counties have sufficient access on a per 100,000 basis (these are the counties colored dark blue on the map). There are 17 counties that likely have sufficient access (counties in the range of 201 to 300 providers per 100,000). Most counties have insufficient access to mental health services.

Assessment of Options for Adding Innovations to Rate Methodology

There are opportunities for DHS to consider migrating at least some of the community mental health services away from a pure fee-for-service methodology to one that considers a patient's episode of care. The most likely candidate for consideration is for residential treatment. Instead of paying a rate for each day of service, DHS may consider an episode payment that presumes an average length of stay for each client. An episodic payment incentivizes providers to deliver the appropriate treatment needed for each client while also offering more predictability in payment. On the other hand, DHS would need to ensure strong oversight that providers are delivering the appropriate amount of service within each episode without compromising client level of need.

Currently, there are two rates for each service—a standard rate and an enhanced rate that is 20 to 25 percent above the standard rate. The determination of who receives the enhanced rate is usually defined by the status of the provider rather than the status of the patients served. DHS may want to consider options for enhanced rates for some providers under a different definition acknowledging the intensity of resources needed to serve clients, such as underserved client subpopulations or regions within the state.

Recommendations for Updating Payment Methodology for Community-based Mental Health Services

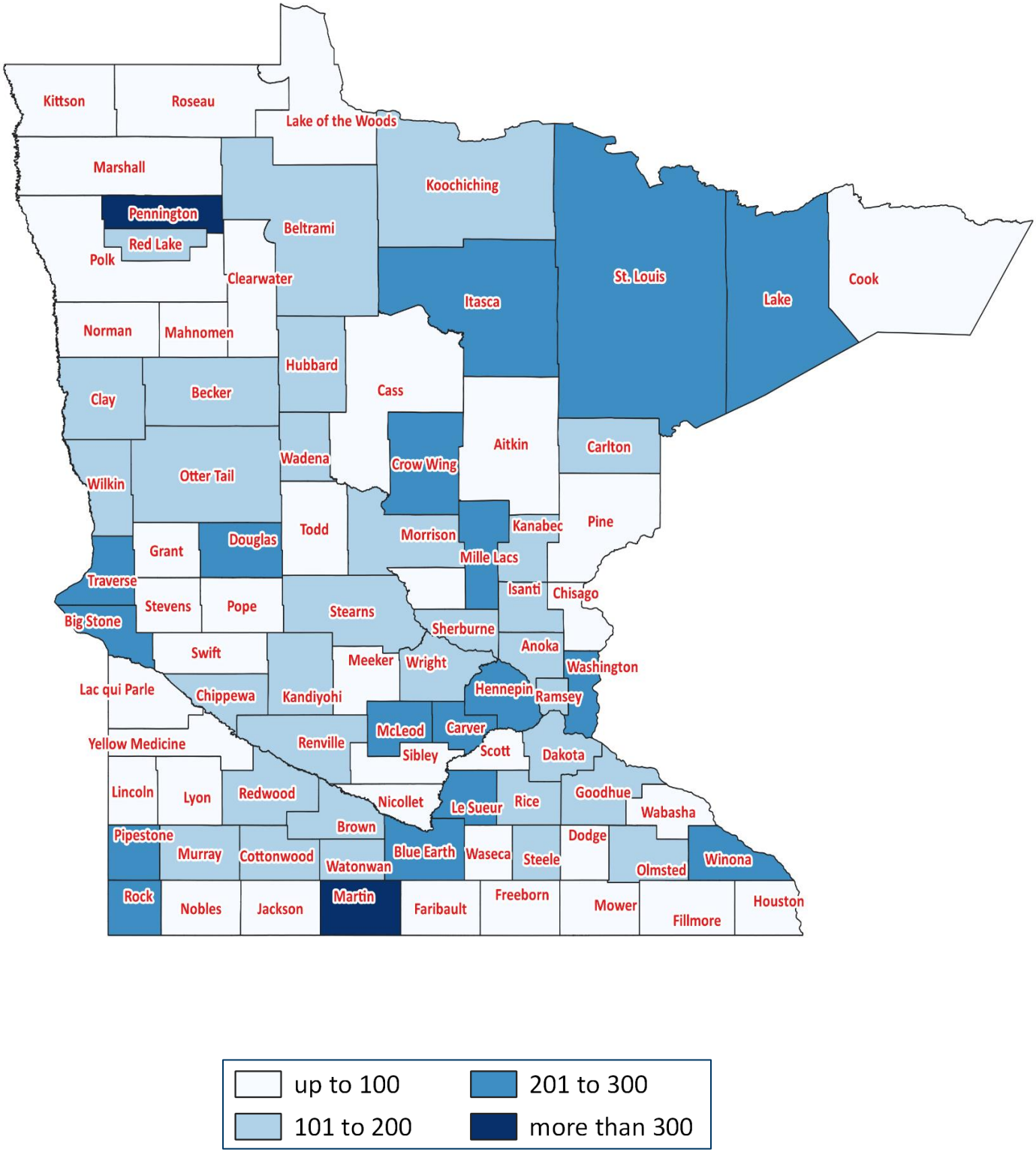
HMA-Burns offers the following recommendations to DHS related to the payment methodology for community-based mental health services:

1. Consider options for enhanced rates based on client needs or attributes, such as level of intensity of service required or cultural competency considerations.

2. Build a framework that shows consistency in the methodology used to set community-based mental health rates and publish this methodology in a transparent manner.
3. Leverage the full value of the rates developed by CMS for Medicare using the RBRVS wherever possible for mental health services.
4. Consider options for enhanced rates based on client needs or attributes, such as level of intensity of service required or cultural competency considerations.

Exhibit 11

Mental Health Providers per 100,000 Medicaid Beneficiaries – December 2021



Community-Based Substance Use Disorder Services

Summary Information

Community-based substance use disorder (SUD) treatment services include a wide variety of services that vary in the intensity of the service offered and the modality offered. Within the scope of this study, the services that are examined include the following:

- Residential services, meaning that the client resides in a community-based housing setting for a period where services are delivered throughout the week at this location. Residential services for adolescents and for adults are reviewed separately.
- Withdrawal management is similar in design to residential treatment where the client resides in a community-based housing setting for a period while experiencing withdrawal. There are two key differences between withdrawal management and other residential services. First, a stay in a withdrawal management facility is usually shorter than other residential services. Second, the personnel in withdrawal management have more of a medical focus whereas the personnel in other residential services are behavioral clinicians to treat the substance use disorder (although some medical personnel are often at residential facilities as well).
- A variety of services delivered in an outpatient setting, meaning outside of a hospital setting and outside of a residential treatment center or withdrawal management facility:
    - SUD comprehensive assessment
    - Individual and group therapy
    - Treatment coordination
    - Substance use disorder services with medications for opioid use disorder
    - Supports from peers with lived experience

Collectively, Minnesota DHS paid $322 million, or 4.6% of the total medical services Medicaid budget, for these services during CY 2021.

Exhibit 12 segments these services into five subcategories: two for adolescents, two for adults, and a fifth for withdrawal management (usually offered only to adults). Within each age group, the services are categorized under residential treatment and all other outpatient services. As a percentage of the total expenditures within SUD services, the services to adolescents comprise 3 percent of the expenditures and adults comprise 97 percent. Within the $10 million spent on adolescents, residential services were 63 percent of expenditures while other community services were 37 percent of the total. For adults, residential services and withdrawal management were 39 percent of expenditures while other community services were 61 percent of the total.

Exhibit 12

Summary of Utilization, Payments, and Providers of Community-based SUD Services

*Residential and Withdrawal Management Services exclude the cost of room and board

Payments for Services in CY2021 (in millions) – Table A

	Adolescent SUD Residential	Adolescent Outpatient SUD Services	Adult SUD Residential	Adult Outpatient SUD Services	Withdrawal Management (Adults)
Statewide	**$6.2 (100%)**	**$3.7 (100%)**	**$113.5 (100%)**	**$188.7 (100%)**	**$9.6 (100%)**
North Region	$3.5 (56.9%)	$2.3 (61.9%)	$46.7 (41.2%)	$60.2 (31.9%)	$1.4 (14.4%)
Central Region	$0.2 (3.2%)	$0.4 (9.5%)	$12.6 (11.1%)	$20.0 (10.6%)	$1.7 (17.5%)
South Region	$1.3 (21.5%)	$0.5 (14.4%)	$20.7 (18.2%)	$13.8 (7.3%)	$0.9 (9.2%)
Hennepin County	$0.7 (11.2%)	$0.4 (10.8%)	$24.5 (21.6%)	$66.2 (35.1%)	$5.4 (56.1%)
Ramsey County	$0.4 (7.2%)	$0.1 (3.4%)	$9.0 (8.0%)	$28.5 (15.1%)	$0.3 (2.8%)

Payments for Services in CY2021 Expressed on a Per Medicaid Member Per Month Basis – Table B

	Adolescent SUD Residential	Adolescent Outpatient SUD Services	Adult SUD Residential	Adult Outpatient SUD Services	Withdrawal Management (Adults)
	Payments per child Member	Payments per child member	Payments per adult member	Payments per adult member	Payments per adult member
Statewide	$0.99	$0.59	$12.37	$20.57	$1.04
North Region	$2.05	$1.34	$18.93	$24.39	$0.56
Central Region	$0.16	$0.29	$7.63	$12.16	$1.02
South Region	$1.08	$0.43	$12.77	$8.53	$0.54
Hennepin County	$0.53	$0.31	$10.89	$29.37	$2.38
Ramsey County	$0.56	$0.16	$7.59	$23.96	$0.23

Number of Medicaid Providers Billing for Services in CY2021 – Table C

	Adolescent SUD Residential	Adolescent Outpatient SUD Services	Adult SUD Residential	Adult Outpatient SUD Services	Withdrawal Management (Adults)
Statewide	66	197	149	448	195
North Region	25	83	59	149	58
Central Region	9	30	19	55	30

	Adolescent SUD Residential	Adolescent Outpatient SUD Services	Adult SUD Residential	Adult Outpatient SUD Services	Withdrawal Management (Adults)
South Region	13	38	25	90	34
Hennepin County	14	28	35	95	49
Ramsey County	5	18	11	59	24

Ratio of Billing Providers to 100,000 Medicaid Beneficiaries in CY2021 – Table D

	Ratio Per 100,000 Child Members	Ratio Per 100,000 Child Members	Ratio Per 100,000 Adult Members	Ratio Per 100,000 Adult Members	Ratio Per 100,000 Adult Members
Statewide	12	36	19	57	25
North Region	17	56	28	71	27
Central Region	8	28	13	39	21
South Region	12	36	18	65	24
Hennepin County	12	25	18	49	25
Ramsey County	7	26	11	58	24

When examining the PMPM values in Table B, the PMPMs for residential services are significantly higher in the North Region for both adolescents and adults than what is found for other regions. However, the PMPMs for other community-based SUD services are also higher in the North Region than in many regions. Collectively, this may indicate a greater need for SUD services in the North Region among Medicaid members than in other regions.

Outside of the North Region, the PMPM values for other regions are more similar to each other for residential treatment, withdrawal management and other community SUD services except that the Central Region is lowest in all categories except Withdrawal Management.

Table D of the exhibit shows the number of providers that billed more than $25,000 for each service category within each region during CY 2021. By absolute count of providers, the North Region has the most providers of any region as well as the highest rate when expressed as providers-per-100,000 Medicaid beneficiaries within each age group. This may explain why the PMPM values are higher in this region than other regions.

The values for providers-per-100,000 Medicaid beneficiaries are higher for adults than for adolescents in each region. The Central Region is lowest in all categories.

Assessment for Community-based Substance Use Disorder Treatment Services

Exhibit 13 summarizes HMA-Burns' assessment of the impacts of DHS' current payment methodology for substance use disorder treatment services. Each domain is discussed in more detail below.

Exhibit 13

Summary of Assessment for Community-based Substance Use Disorder Treatment Services

Need for Rate Methodology Reform	High
Need for Rate Update	High
Level of Transparency of Current Rate Methodology and Rates	Low
Concern Related to Access to Providers	High
Opportunity to Add Value-based Component to New or Existing Methodology	Yes
Opportunity to Add Cultural Competency Component to Methodology	Maybe

Current Methodology, Rates and Level of Transparency

The DHS publishes a rate schedule for all covered services under the community-based substance use disorder treatment category. Rates have been set separately for services delivered to the adolescent and adult populations. The last rate update for SUD services was effective in January 2022.

For many services, two rates are shown:

- The standard rate
- A rate that is 20 to 25 percent above the standard rate for providers that offer additional services above the standard service package.

It should be noted, however, that DHS is preparing all DHS Licensed Residential and Withdrawal Management providers to be ready to deliver the additional services mentioned above by January 1, 2024. At that point, all residential providers will migrate to the enhanced rate since the standard rate will be obsolete.

Unlike other services reviewed in this study, DHS has developed acuity adjustments to the SUD rate schedule to account for the specific needs of certain clients. These adjustments are considered add-ons to the standard or enhanced rates mentioned above. The specific add-ons fall into the following categories:

- Co-occurring complexity, meaning providers that offer services to individuals with both SUD and mental health conditions.
- Disability special populations complexity, meaning providers that offer services to individuals with both SUD and either traumatic brain injury, developmental disabilities, cognitive disabilities or physical disabilities.
- Medical services complexity, meaning providers that offer services to individuals with both SUD and high medical needs. The add-on is intended to cover the costs of medical staff.
- Cultural-specific populations complexity, meaning providers that offer services where a majority of their clients share a specific language, racial, ethnic or social background.

- Clients with children complexity, meaning providers that focus on a client base of parents with their children.

The determination for eligibility for the add-ons is made at the provider level, not the client level. The provider, as a whole, is approved to provide an enhanced service to any client that comes to their program who would benefit from this service. In other words, an add-on amount is paid for each client served by a provider, when that provider has been deemed eligible for the medical services complexity add-on.

The Medicaid State Plan specifies the rates paid for each service and the value of each add-on to the rate. There is language that specifies for many rates that the costs used to inform the rate presume that at least 50 percent of costs are for the direct service staff. Beyond this, however, it is unclear what methodology was used to set each service-specific rate. Similar to mental health services, there is no transparency on the approach used to determine each rate, such as the cost variables considered or other considerations. It should be noted that, unlike some of the community mental health codes, none of the SUD services are included in Medicare's RBRVS methodology.

Description of Network Coverage

Exhibit 14 shows the count of active SUD providers serving Medicaid beneficiaries, children and adults, at the county level using the measure of providers-per-100,000 beneficiaries for comparison. Once again, the counties are color-coded to represent variation across the counties. The counties in dark blue have the greatest proportion of providers for the Medicaid population in the county. The counties in white have the lowest proportion of providers.

Medicaid members can (and do) cross county lines to receive SUD services, particularly residential treatment. Therefore, this map cannot be used as the only indicator of access to services.

As was shown in Exhibit 12, the map shows that many counties in the North Region have a higher proportion of SUD providers per 100,000 beneficiaries than other counties in the state.

Only nine counties are deemed to have sufficient access on a per 100,000 basis (these are the counties colored dark blue on the map). There are 13 counties that likely have sufficient access (counties in the range of 61 to 90 providers per 100,000). The majority of counties are deemed to have insufficient access to SUD services.

Assessment of Options for Adding Innovations to Rate Methodology

DHS has made advances in rate methodology development to account for differences in the populations served for SUD treatment, therefore, this is not an area where innovation is needed as was found for community physical health and mental health services.

Similar to what was mentioned for community mental health, there are opportunities for DHS to consider migrating at least some SUD services away from a pure fee-for-service methodology to one that considers a patient's episode of care. The most likely candidate for consideration is for SUD residential treatment. Instead of paying a rate for each day of service, DHS may consider an episode payment that presumes an average length of stay for each client.

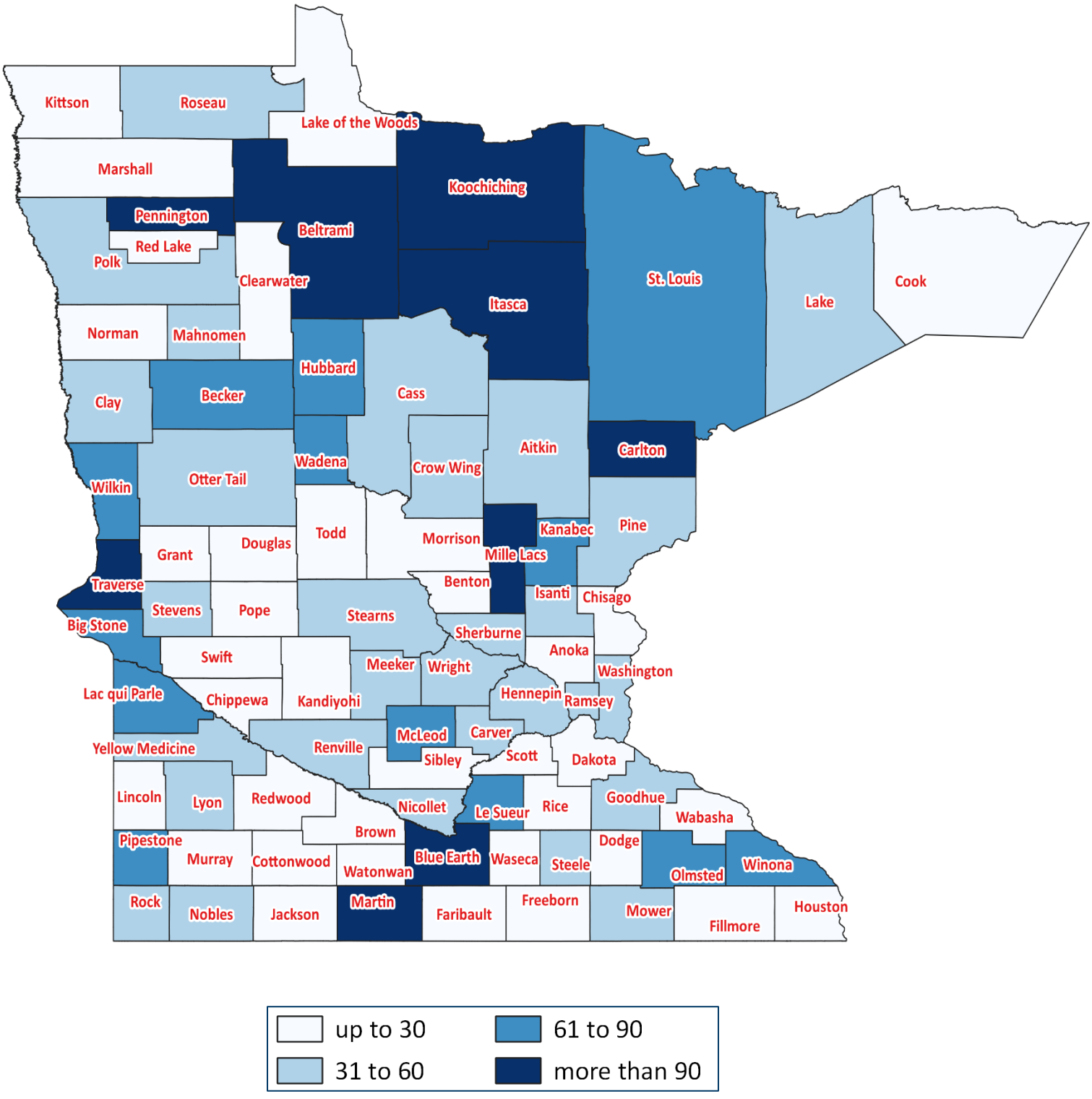
Recommendations for Updating Payment Methodology for Community-based Substance Use Disorder Treatment Services

HMA-Burns offers similar recommendations to DHS related to the payment methodology for community-based SUD services as were recommended for mental health services:

1. Build a framework that shows consistency in the methodology used to set community-based SUD rates and publish this methodology in a transparent manner.
2. Consider options for enhanced rates based on client attributes, not just provider attributes.

Exhibit 14

SUD Providers per 100,000 Medicaid Beneficiaries – December 2021



Early Intensive Developmental and Behavioral Intervention Services

Summary Information

Early intensive developmental and behavioral intervention (EIDBI) services address the person's medically necessary treatment goals related to developing, enhancing, or maintaining developmental skills to improve the person's

- Functional communication (receptive and expressive)
- Social or interpersonal interaction skills
- Interfering or complex behaviors
- Self-regulation
- Cognitive functioning
- Learning and playing skills
- Safety skills
- Self-care skills

Clients receive a comprehensive multi-disciplinary evaluation to determine if they have a medical need for EIDBI services. If they do, then the services are delivered by providers deemed qualified by the State and the services must follows the individualized treatment plan created for each client. EIDBI services are delivered to children and adolescents.

Minnesota DHS paid $68 million, or 1.0% of the total medical services Medicaid budget, for these services during CY 2021.

Exhibit 15 shows information about EIDBI service delivery at the regional level. As expressed on a PMPM basis, four of the five regions have similar results, but Hennepin County's PMPM value of $17.99 is 66 percent above the statewide average PMPM of $10.86.

There were 132 unique providers who billed for EIDBI services in CY 2021. Note that these are agencies—an individual agency often employs multiple staff that deliver EIDBI services and individual agencies vary in the size of their staffing.

The ratio of billing providers per 100,000 child beneficiaries statewide is 24 per 100,000. The North and South Regions have lower ratios than other regions, whereas Hennepin County's ratio is almost twice the statewide average.

Exhibit 15

Summary of Utilization, Payments, and Providers of Early Intensive Developmental & Behavioral Intervention (EIDBI) Services

Payments for Services in CY2021 (in millions)

	EIDBI
Statewide	**$67.8 (100%)**
North Region	$16.0 (23.6%)
Central Region	$12.4 (18.2%)
South Region	$9.0 (13.3%)
Hennepin County	$23.4 (34.5%)
Ramsey County	$7.0 (10.4%)

Payments for Services in CY2021 Expressed on a Per Medicaid Member Per Month Basis, Ages 0-18 Only

No Data	EIDBI
Statewide	$10.86
North Region	$9.34
Central Region	$10.13
South Region	$7.37
Hennepin County	$17.99
Ramsey County	$8.95

Number of Medicaid Providers Billing for Services in CY2021

	EIDBI
Statewide	132
North Region	25
Central Region	24
South Region	15
Hennepin County	53
Ramsey County	15

Ratio of Billing Providers to 100,000 Medicaid Beneficiaries in CY2021, Ages 0-18 Only

	EIDBI
Statewide	24
North Region	17
Central Region	23
South Region	14
Hennepin County	47
Ramsey County	22

Assessment for Early Intensive Developmental and Behavior Intervention Services

Exhibit 16 summarizes HMA-Burns' assessment of the impacts of DHS' current payment methodology for EIDBI services. Each domain is discussed in more detail below.

Exhibit 16

Summary of Assessment for Early Intensive Developmental & Behavior Intervention Services

Need for rate methodology reform	High
Need for rate update	High
Level of transparency of current rate methodology and rates	Low
Concern related to access to providers	High
Opportunity to add value-based component to new or existing methodology	Maybe
Opportunity to add cultural competency component to methodology	Yes

Current Methodology, Rates and Level of Transparency

The methodology for EIDBI services is similar to what was observed for community mental health services. DHS publishes a rate schedule for all covered services under the EIDBI service category. The rate schedule includes the service name, service code, unit or duration of service, an indicator of the personnel that can deliver the service and the rate. Rates for EIDBI services were last updated in July 2015. In some instances, a rate that is set at a discount from the standard rate (e.g., 80% of standard) if the service is rendered by personnel who are qualified to deliver the service but have less experience or clinical education than other personnel.

The Medicaid State Plan specifies that each of the rates is paid the lesser of the charge from the provider or a flat amount specified in the State Plan for each service specifically. As found for community mental health services, it is unclear what methodology was used to set each service-specific rate in this "lesser of" logic. There is no transparency on the approach used to determine each rate, such as the cost variables considered or other considerations. It should be noted also that none of the EIDBI codes are included in Medicare's RBRVS methodology.

Description of Network Coverage

Exhibit 17 shows the number of active EIDBI providers serving Medicaid beneficiaries at the county level using the measure of providers-per-100,000 beneficiaries for comparison. Once again, the counties are color-coded to represent variation across the counties. The counties in dark blue have the greatest proportion of providers for the Medicaid population in the county. The counties in white have the lowest proportion of providers. Of note, only 26 of the 87 counties have an agency-based EIDBI provider, although these EIDBI providers likely serve Medicaid clients across multiple counties in their service area.

Assessment of Options for Adding Innovations to Rate Methodology

There are opportunities for DHS to consider adding further innovation to the rate methodology for EIDBI services beyond simply updating rates using more current cost information. Because each client has an individualized treatment plan for EIDBI services, the amount and intensity of services required are known at the start. DHS may consider building a payment for a client based on client's episode of care that ties to his/her treatment plan in place of billing for each service separately.

DHS may also consider options for enhanced rates for some providers similar to what was designed for SUD services (e.g., add-ons to the rate for individuals with different levels of disability complexity or for individuals with cultural-competency considerations such as providers where a majority of their clients share a specific language, racial, ethnic, or social background).

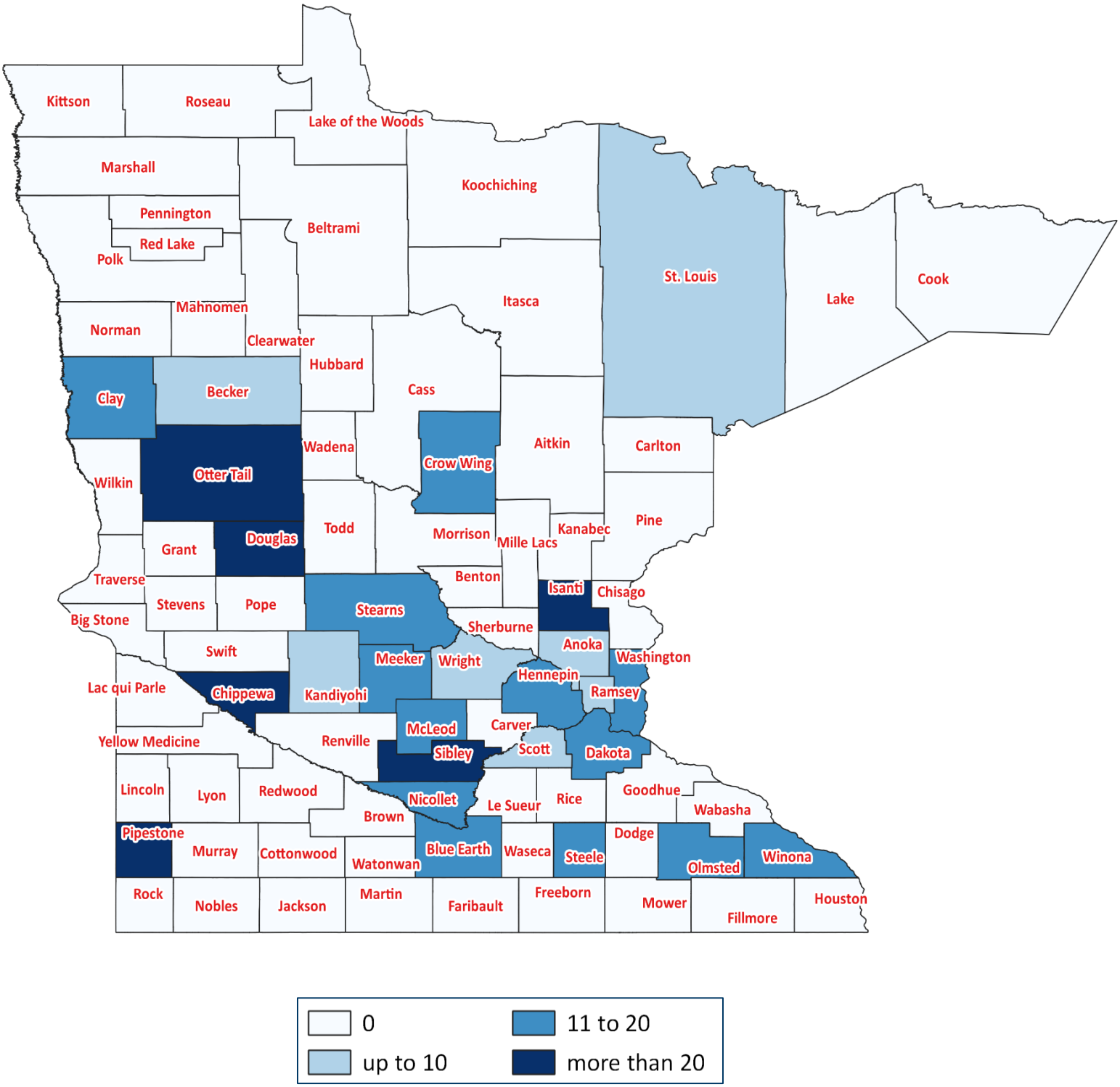
Recommendations for Updating Payment Methodology for EIDBI Services

HMA-Burns offers similar recommendations to DHS related to the payment methodology for EIDBI services as were recommended for mental health and SUD services:

1. Build a framework that shows consistency in the methodology used to set community based EIDBI rates and publish this methodology in a transparent manner.
2. Consider options for enhanced rates based on client need or attributes, such as level of intensity of service required or cultural competency considerations.

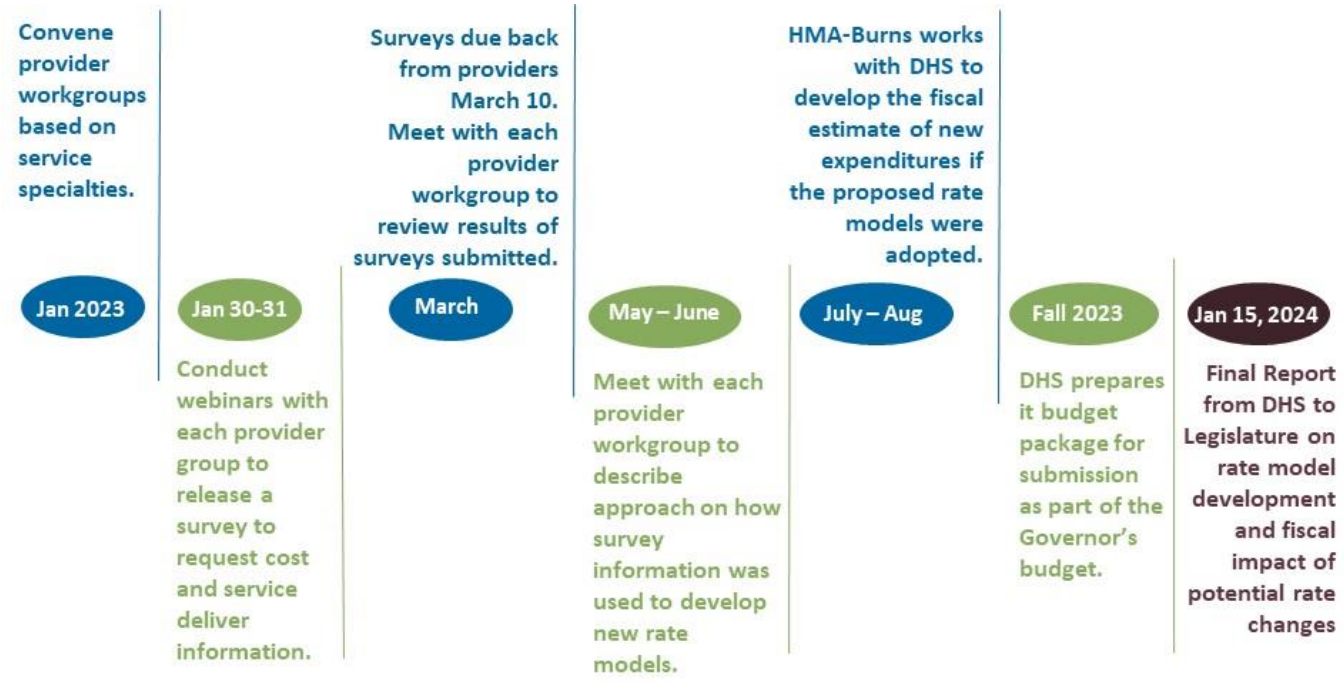
Exhibit 17

EIDBI Providers per 100,000 Medicaid Beneficiaries – December 2021



Ongoing Work in CY 2023

There is considerable work ongoing in CY 2023 to lay the groundwork for developing options for changing the reimbursement methodologies and the rates paid for all the services that are a part of this rate study. The results of the work that is occurring in CY 2023 will be incorporated into the DHS report to the legislature that will be delivered by January 15, 2024. More details on specific activities are described below.



Provider Workgroups

Four different workgroups have been formed and each has a specific focus of the services that will be covered in each workgroup. The four workgroups center around the following services:

1. Community-based mental health services
2. Community-based substance use disorder (SUD) treatment services
3. Early intensive developmental and behavior intervention (EIDBI) services
4. Psychiatric residential treatment facilities (PRTFs) for children and adolescents

HMA-Burns is facilitating each workgroup session. The workgroup members (up to 12 in each workgroup) consist of the providers who deliver the services as well as provider association representatives. DHS staff attend as liaisons to listen to the conversation and take in feedback from each workgroup meeting.

Each workgroup has a similar charter and is meeting at similar intervals between January and June of 2023. The responsibilities for the first three workgroups named above include:

1. Providing feedback related to the design of a survey instrument that will ask questions related to the services of interest to the workgroup. Completed in January 2023. The survey was released to all

providers that deliver these services to DHS clients for voluntary participation to complete (see details in Provider Surveys section below).

2. Review the results from the provider survey after they have been submitted. Meetings were held at the end of March 2023.

3. Provide feedback on assumptions that will be built into development of new rate models, including feedback on costs that need to be accounted for that are specific to regions of the state or specific populations served. Meetings will be held in May and June of 2023.

The PRTF workgroup differs slightly from the others. First, there are only four providers of this service, so all providers are part of the workgroup. Second, the PRTF providers already submit a cost report to DHS, so a separate survey was not required for these providers. HMA-Burns met with the PRTF providers initially as a group and then in one-on-one meetings to learn more about each provider's costs. The PRTF providers will reconvene as a group in early May and early June of 2023 like the other workgroups to review the assumptions that will be built into a rate model for their specific service.

The other services that are a part of the rate study pertain to community-based medical services. HMA-Burns and the DHS team will be meeting separately with the Minnesota Medical Association to discuss methodological considerations for changes in reimbursement for these services.

Provider Surveys

HMA-Burns built survey tools that are specific to each service category. The draft survey tools were vetted by the provider workgroup members. Feedback from the workgroup members was incorporated into the final versions of each survey tool. Webinars were conducted to introduce the surveys that were released to providers:

- A webinar was held on January 30, 2023 for community mental health providers
- A webinar was held on January 30, 2023 for community SUD treatment providers
- A webinar was held on January 31, 2023 for EIDBI providers

All providers of the services mentioned above were invited to participate in the provider survey process, not just the providers that are a part of each workgroup.

Some of the key items that are asked of providers in each survey include the following:

- The provider's assessment of the 2023 market rate for starting salaries for each labor category that they employ. This is being asked to assess workforce pressures overall and at the regional level within Minnesota.
- The costs of employee benefits.
- The level that contracted labor must be used when there are not enough employed staff to fill gaps in staffing needs as well as the associated premium costs paid for contracted labor.

- The cost of training staff—both the time incurred by staff to receive training as well as the cost to administer the training.
- Other programmatic costs to deliver each service beyond labor and fringe benefit costs.
- Administrative costs incurred by agencies who deliver the services in the survey.

HMA-Burns' goal was to encourage agency-based providers who deliver the services within each survey tool to complete the survey. The target group of agencies are the providers who were paid more than $100,000 by DHS (or its MCOs) during CY 2021. Surveys were originally requested back on March 3, 2023. DHS granted an extension to all providers so the surveys were due back on March 10, 2023. In total, 82 surveys were received. The table below summarizes the counts of providers for the intended outreach, the number initially expressing interest (either by attending the webinar, requesting the survey after the webinar or proactive outreach by HMA-Burns), and the total surveys returned.

The response rate for the Mental Health and SUD surveys did not meet the target rate as desired. The EIDBI provider group offered sufficient representation from providers. The information is being considered from all surveys received. But since the response rate is low for the Mental Health and SUD surveys, HMA-Burns will be leaning on feedback from the providers represented in the Mental Health and SUD provider workgroups to validate the assumptions built into the rate models developed for these services.

	Intended Outreach	Initially Expressed Interest	Returned Survey by Mar 14	Responses as % of Intended Outreach	Responses as % of Initial Interest
Mental Health	515	97	29	6%	30%
SUD	192	50	18	9%	36%
EIDBI	54	42	35	65%	83%

Options for Updates to Community-based Physical Health Services

During CY 2023, HMA-Burns is working with DHS to assess alternatives for reimbursement under the RBRVS payment system. In some instances, DHS has developed a rate outside of the RBRVS for a service even if Medicare has an established rate for the service. This has often been due to legislative mandate. In other instances, DHS uses one of the multipliers shown above, but then there are additional adjustments made behind-the-scenes that are a result of legislative mandates implemented historically since DHS implemented the RBRVS system in CY 2011. For administrative simplicity and in an effort to be more transparent with providers, HMA-Burns will work with DHS to model options to "wipe the slate clean" and model Medicare's RBRVS system exactly as CMS models its payment system.

In addition to adopted Medicare's RBRVS "as is," HMA-Burns will work with DHS to assess the cost of making adjustments above and beyond the Medicare rate to account for provider access issues or underserved

Medicaid populations. Each of the options listed below will be included in the January 2024 report to the legislature.

1. The cost to the state to move to 100% of the Medicare multiplier for all services, or stair-step variations of this (e.g., the cost to get to 90% of Medicare, 95% of Medicare, etc.).
2. The cost to the state to make adjustments to the rate for medically underserved areas (e.g., pay 105% of the Medicare rate in counties where the physician supply is more at risk).
3. The cost to the state to make adjustments to the rate for medically underserved populations (e.g., pay a higher percent of the Medicare rate or some other add-on payment for practitioners who serve populations requiring additional resources, such as immigrant population, population experiencing homelessness, clients where English is not their primary language, etc.).
4. The cost of implementing an incentive-based payment that supplements the RBRVS payment for practitioners that meet certain outcomes similar in design to Medicare's MIPS system.

Build a Market-Based Rate Setting Methodology for Mental Health Services, Substance Use Disorder Treatment Services and Early Intensive Developmental and Behavioral Intervention

HMA-Burns' assessment of the rates paid for each of these service categories is that the methodologies used to set the rates are not consistent in the manner in which labor costs, staff time and other operating costs borne by the provider are factored into the final rate that is paid to the provider. Further, with the exception of mental health services paid under RBRVS, the rates within each service category have not been updated in quite some time and do not factor in recent workforce pressures and cost inflation pressures that have been exacerbated since the start of CY 2022.

In the rate models that HMA-Burns will develop for each service, there are four key components:

Direct staff worker wages and benefits include the annual salary assumption for the staff who are providing the direct service to the client. In the provider surveys, each provider was asked what they believe to be the CY 2023 competitive market rate for each salary position. This value may differ from what the provider actually pays for this position today (i.e., the market salary is higher). The rate models will use provider survey information to inform what the appropriate salary assumption is using competitive market data, not historical wage data.

Providers are also asked in the survey what they pay for a variety of employee benefits, such as paid holidays, other paid time off, health insurance premiums, other insurance such as dental or vision coverage, contributions to a retirement benefit or other benefits such as tuition reimbursement. HMA-Burns quantifies the annual dollar costs for these benefits and adds this value to the annual salary assumption.

Direct staff worker productivity factors in time that direct care staff spend during a week performing required duties that do not involve face-to-face time with clients. This non-facing time is a cost to the provider but is not billable to DHS. The cost for this time, therefore, needs to be factored into the rate paid for when providers do bill for client-facing services. An example of the staff worker productivity is as follows:

Assume a staff person who works with clients is paid $30.00 (salary and benefits combined) an hour by an employer. In a standard 40-hour week, this would be a cost of $1,200 to the employer (40 hours x $30.00/hour). But during this week, the staff person is only face-to-face with clients for 30 hours. The remaining 10 hours are spent on activities such as travelling to client homes to deliver the service, meeting with their supervisor, attending training or performing documentation requirements. Since the provider is only billing 30 hours per week, on average, for this staff person, then the rate model needs to assume staffing costs of $40.00 per hour ($1,200 per week in costs divided by 30 billable hours) in the rate model, not $30.00 per hour.

Program-related expenses are those expenses other than the direct staff working with clients that are incurred by the provider to deliver the specific service. This is different from administrative expenses that are the back-office costs that providers incur that are spread across all services. Program-related expenses tend to vary significantly based on the service rendered. For example, mental health therapeutic sessions may be limited in program expenses since the major cost of the service is the therapist her/himself. But program expenses to deliver this service may include the costs of a supervisor or a client appointment scheduler. Contrast this with a residential treatment service that includes facility costs, vehicle costs, housekeeping, repairs and maintenance, medication and supplies to name a few. All these costs are specific to the service being rendered and are not shared with other services that the provider may offer.

Contrast this with administrative expenses that are shared across services. Examples include the salaries and employee benefits of the leadership team, accounting team, and legal team, business insurance and license costs, corporate office rent and ongoing maintenance costs, training and hiring costs, information technology costs, quality assurance costs and taxes.

The expenses for each of the categories mentioned above were asked of providers on the survey that they were asked to complete pertaining to the services that they offer.

HMA-Burns builds its rate models “from the ground up,” meaning that the costs for each component (salary and benefits, staff productivity, program expenses and administrative expenses) are computed and then added together in a step-by-step manner. The costs submitted by providers in the surveys will help to inform the assumptions applied for costs within each component of the model.

HMA-Burns will show the inputs that go into each rate model in Microsoft Excel so that formulas can be built to add the components together. If an assumption changes in one or more components of the rate model, then the final rate is updated automatically using the formulas built in Excel.

By building the rate models in this manner,

- The assumptions made in the model and the calculations used to create the final rate are transparent to all stakeholders.
- Further, the DHS team can easily make adjustments to each rate model in future years simply by changing the assumptions entered in the rate model. For example, the rationale for a rate increase in

future years may be because the market-based salary for the staff position has increased five percent since the initial rate was developed. The new salary can be entered into the model to compute a new rate with this updated salary assumption.

Each rate model that will be developed will use 2023 costs to inform the assumptions in the model. This is defined as the "benchmark" rate for the service. It may be found that current appropriations do not allow DHS to set the rate at this benchmark value. The rate set based on the allowable budget is referred to as the "adopted" rate for the service. In public notices issued, HMA-Burns will assist clients in showing the benchmark rate and the adopted rate side-by-side. In this way, stakeholders can understand what the funding gap is in order to achieve the benchmark rate.

In total, HMA-Burns will work with DHS in the development of 55 rate models. The full listing of the services for which benchmark rates will be set appears in Exhibit 18. For some services, one rate will be built when the service is delivered to clients in a one-on-one setting. Another rate will be built when the service is delivered in a group setting (e.g., psychotherapy). Modifiers to the standard rate will be considered if deemed necessary to account for geographic variation or special populations served.

Exhibit 18

Rate Models Will Be Developed for the Following Services

(some models include two rates, (1) individual client and (2) group setting)

Mental Health Services

Adult Residential Services – Crisis and Non-Crisis Intensive Treatment Foster Care Partial Hospitalization Assertive Community Treatment Day Treatment, Adult and Child Programs Mobile Crisis Team, Adult and Child <u>Adult Rehabilitative Mental Health Services</u> • Psychosocial Rehabilitation • Transition to Community Living • Mental Health Assessment • Mental Health Treatment Plan • Community Intervention • Peer Supports • Medication Education	• Dialectical Behavior Therapy • Diagnostic Assessment • Neuropsychological Testing • Psychological Testing <u>Psychotherapy, Adults and Children</u> • Individual, Group, and Family <u>Children's Mental Health Services</u> • Clinical Care Consultation • Family Psychoeducation • Skills Training and Development • Comprehensive Community Support • Therapeutic Behavioral Services • Mental Health Assessment • Mental Health Treatment Plan

Substance Use Disorder Treatment Services

SUD Residential Services	SUD Assessment
Withdrawal Management (detox)	SUD Treatment Coordination
Individual and Group Therapy	Peer Supports
Substance Use Disorder treatment with Medications for Opioid Use Disorder	

Early Intensive Developmental and Behavioral Intervention

Behavior Identification Assessment	Family Behavior Treatment Guidance
Behavior Treatment by Protocol, Individual	Individual Treatment Plan Development
Behavior Treatment by Protocol, Group	Coordinated Care Conference

Build a Rate Methodology for Psychiatric Residential Treatment Facilities

Because psychiatric residential treatment facilities already submit an annual cost report to DHS, there was no need for a separate provider survey for this provider group. HMA-Burns has reviewed the submission of each provider's most recent cost report and conducted one-on-one meetings with each provider to learn more about the drivers of their costs since the pandemic began.

During CY 2023, HMA-Burns will assist DHS in the development of a prospective rate methodology to consider as an alternative to the cost-incurred reimbursement methodology in place today. Today, the cost-incurred reimbursement approach relies on a retrospective review of costs that may be as much as 18 months past the period when the costs were actually incurred. This means that reimbursement tied to these costs is always trailing the prevailing market trend on items such as salaries of personnel. Further, the cost-incurred reimbursement methodology only captures the costs that the provider actually incurred. In the one-on-one interviews with each provider, it was noted that many costs were not reported for staff salaries and benefits because the provider was unable to attract new hires under the current reimbursement rate. The costs for these vacant positions which are critical to service delivery go unreported on the annual cost report. As a result, the cost-incurred approach never captures the full costs to staff the services needed and the cycle continues.

By developing a reimbursement methodology that is prospective rather than retrospective, DHS can determine the full staffing needs of a provider to serve clients using the most up-to-date market-based salaries. This prospective rate will enable providers to be reimbursed at an appropriate rate in real-time and then use this reimbursement level to attract and retain staff. HMA-Burns will assist DHS in developing strategies to develop this real-time payment model informed by, but not exactly tied to, historical provider costs.

Assessing the Fiscal Impact of Potential Rate Changes

In the report delivered to the legislature in January 2024, HMA-Burns will assist the DHS in the submission of the total fiscal impact, including the state share and federal share, if DHS were to implement the new payment methodologies proposed and the benchmark rates recommended for each service in this study.

HMA-Burns will employ the utilization for services delivered to Medicaid beneficiaries in each service category during CY 2022 as the basis for the fiscal model. This 12-month period is the most recent annual period where there is confidence that all provider claims have been submitted.

Altogether, the fiscal impact will show the total funds and state share funds needed to adopt the proposed benchmark rates. These totals will be compared to the actual amounts paid during CY 2022 to determine the fiscal request for each of the five service categories in the study separately:

- Community-based physical health services
- Community-based mental health services
- Community-based substance use disorder treatment services
- Early intensive developmental and behavioral intervention services
- Psychiatric residential treatment facilities

In the first four categories, the fiscal impact will be further segmented into estimates for each service discretely under the category (this is not necessary for PRTF since there is only one service in this category).

Another view of the fiscal impact will be created to assess the fiscal change on individual Medicaid providers within each service category.

HMA-Burns has worked with many states where the fiscal impact required to implement all the recommended benchmark rates is fiscally untenable. Therefore, additional fiscal estimates will be developed for each service category to estimate the costs to the state if, for example, all rates were updated to pay 85%, 90%, or 95% of the benchmark rate if 100% of the benchmark is not feasible.

Assessing the Operational Impact of Potential Rate Changes

Another element that will be include in the January 2024 report is a proposed timeline for implementation of the rate updates associated with the services in the study. HMA-Burns will provide technical assistance to DHS in the development of an implementation plan. Besides the fiscal resources required, there are often additional operational impacts associated with changing reimbursement methodologies and implementing new rates. Items that often need to be considered and built out in an operations work plan include the following:

- Systems and other programming logic changes made by the fiscal agent (in this case, both the DHS fiscal agent for the fee-for-service program as well as each Medicaid MCO claims payer)
- Development and publication of new billing rules to providers
- Development of other policies associated with service coverage or other aspects of service delivery
- Updates to administrative rules
- Seek and gain approval for rate methodology changes from the Centers for Medicare and Medicaid, where required