# Legislative Report

# Minnesota Health Care Programs Fee-for-Service Outpatient Services Rate Study

## Second Report

Jan. 22, 2024

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $44,804.

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# Table of Contents


**I. Executive Summary** .......... 4

**II. Legislation** .......... 5

**III. Introduction** .......... 6

**Review of Rate Methodologies** .......... 6

**Medicare Payment Methodology: Community-based physical health services and some community-based mental health services** .......... 6

**Market-based Rates: Community-based mental health (not covered by RBRVS), SUD and EIDBI services** .......... 7

**Provider Survey** .......... 10

**Community Engagement** .......... 11

**Community Feedback** .......... 12

**Feedback from Individual Provider Interviews** .......... 12

**Operational Considerations** .......... 13

**IV. Results** .......... 14

**Professional Services in RBRVS** .......... 14

**Mental Health Services** .......... 14

**One-to-One and Group Services** .......... 15

**Mental Health Provider Travel Time** .......... 15

**Adult and Children's Day Treatment Services** .......... 16

**Mobile Crisis Team Services** .......... 16

**Behavioral Health Home** .......... 16

**One-to-One Services** .......... 17

**Intensive Outpatient (IOP) and Partial Hospitalization (PHP)** .......... 17

**Residential Treatment and Withdrawal Management** .......... 18

**Early Intensive Developmental and Behavioral Intervention (EIDBI) Services** .......... 18

**V. Report Recommendations** .......... 18

**VIII. Appendices** .......... 20

# I. Executive Summary

This report is the second of two legislative reports that are required by legislation passed in 2021. 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 Burns & Associates, a division of Health Management Associates (HMA-Burns) beginning in Aug. 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 team assisting DHS had previously assisted DHS in the implementation of its Resource-Based Relative Value System (RBRVS), the payment methodology used to pay for many community-based physical and mental health services, in 2010. The DHS team working on this project has been actively engaged with HMA-Burns to review and provide recommendations for changes to the current reimbursement methodologies used to pay for services. This report represents the culmination of these efforts. Recommendations contained within this report include:

- A continuation of the RBRVS payment methodology for professional services provided to eligible participants, updating the factors to 100 percent of Medicare
- Recommendation of the adoption of market-based rates for general Mental Health, Substance Use Disorder and Early Intensive Developmental and Behavioral Intervention services
- Recommendation of the elimination of the historical percentage-based rate adjustments enacted by the legislature across multiple service categories

These recommendations will require significant legislative appropriations and law changes to implement.

# II. Legislation

DHS contracted with Burns & Associates, a division of Health Management Associates (HMA-Burns) to provide technical assistance in the development of new or updated payment rate methodologies for the services included in this study. This report is 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 Jan. 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 Jan. 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 Jan. 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 contracted with Burns & Associates, a division of Health Management Associates (HMA-Burns) to provide technical assistance in the development of new or updated payment rate methodologies for the services included in this study. 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 HMA-Burns team had previously assisted DHS in the implementation of its Resource-Based Relative Value System (RBRVS), the payment methodology used to pay for many community-based physical health services, in 2010 and 2011. The HMA-Burns team working on this project has been actively engaged in the last three years to develop rates for all the other community-based services that are included in this rate study.

# III. Introduction

Since the submission of the first legislative report, the HMA-Burns team, in concert with DHS, has continued to complete activities related to developing options for updating the reimbursement methodologies and rates paid for services eligible under the rate study. The primary tasks and topics that generally occurred during this rate study included:

- Review of rate methodologies
  - Review of methodologies for medical services, and
  - Development of market-based rate models
- Development, distribution and analysis of a provider survey
- Community engagement

## Review of Rate Methodologies

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 services
- Early intensive developmental and behavioral intervention (EIDBI) services

### Medicare Payment Methodology: Community-based physical health services and some community-based mental health services

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. The RBRVS method is also used for a large number of community mental health services such as those provided by psychiatrists, addiction medicine specialists and many mental health professionals. 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, called a conversion factor, to determine the payment rate. Both the relative values and the conversion factor are updated by Medicare annually.

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

Medicare uses one multiplier, or conversion factor, 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 updates the relative value units (RVU) each year which ensures that the payment reflects changes in practice patterns. However, due to a lack of legislative budget authority to increase payment rates overall, DHS is forced to "back into" state-specific multipliers each year to ensure that total spending remains budget neutral. In this way, DHS is setting rates that use the RBRVS methodology in spirit, but do not pay the full rate established in Medicare's RBRVS. DHS ultimately established three multipliers against relative values instead of just one. This allows DHS to prioritize funding for the set of services that are most important to the enrolled population within the budget neutrality constraints. 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 professionals, 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

It is recommended that the RBRVS reimbursement methodology be employed for these services and moving the base multiplier to 100 percent of the Medicare levels, thus effectively adopting a single base multiplier for all services.

## Market-based Rates: Community-based mental health (not covered by RBRVS), SUD and EIDBI services

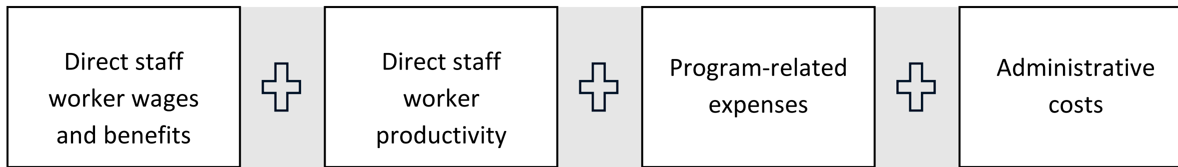
An 'independent rate-setting' approach was utilized when developing payment rates for community-based services. Rather than depending on any single source of information, the rate study draws on data and insights from a variety of sources. This approach recognizes two important features of these types of programs.

First, whereas many medical procedures follow the same guidelines in every state, community-based services may have varying standards of care across jurisdictions. Thus, although state programs generally cover similar arrays of services, the requirements of these services can vary significantly across different states. For example, every state provides coverage for medication education services, but each state establishes its own standards in terms of staffing ratios for group services, staff requirements for direct care, required ancillary supports and other factors. Setting rates for these services, therefore, requires consideration of state-specific requirements.

Second, in every state, most payments for community-based services come from a single source: the state Medicaid program. In contrast, providers of other medical services may receive payments from a variety of sources in addition to state Medicaid programs, including Medicare, commercial insurance and self-pay. Due to the near complete reliance on the state, providers' costs will largely be a function of the rates paid by the state. Thus, if payment rates are too low, costs will be artificially depressed. When payment rates fall short of the true cost of services, this leads to deficits that providers are unable to sustain. Conversely, if rates are too high, services may not be delivered in an efficient manner. The use of external data sources to supplement provider cost data aims to ensure that payment rates reflect actual market costs.

The methodology approach employed by the HMA-Burns team to construct independent rate models is generally inclusive of the factors in Figure 1:

**Figure 1: Factors**




Actual factors that appear in models may vary depending on the service. For example, services that require more than one direct staff worker (e.g., residential) may include factors for costs not appearing in services where one worker is providing service to one individual.

Assumptions within the rate models have been outlined to display the actual values assumed for the various factors. As noted previously, the values were determined through the consideration of several data sources. For example, wage data was collected from the U.S. Bureau of Labor Statistics to determine a baseline amount. In addition to this, providers were asked to report average salary information for various staff used to provide services as well as current market rates to hire new staff. Based upon the current market conditions to hire and retain new staff, more emphasis was placed upon provider feedback and information to aid in determining appropriate staff wage levels.

The various assumptions that have been included in the rate models are intended to reflect 2023 costs, not historical costs. If historical costs were to be used, it is likely that the rates determined would closely align with current rates, since providers must rely on the current rate methodology to determine the costs that can be afforded to provide services. Conversely, if the state's mission is to build a sustainable safety net, payment rates must be reflective of the true cost of services which is driven by a sometimes-volatile market (i.e., supply and demand).

Some of the key factors within the rate models, those that tend to have a larger impact on the eventual rate, are:

- Direct staff wages and benefits – those values selected to represent the wages and benefits (usually expressed as a percentage of the wage)
- Administrative percentage – the factor utilized to adjust the costs to account for non-direct costs associated with the support and administration of the services provided by an organization
- No-show rate or vacancy factor – these values reflect the occurrences when the individual that is intended to use the service does not present oneself for the service

Development of general factors used in the models included:

- Staff Salaries – Median values reported by providers for CY 2023 salaries were chosen for use throughout the rate models. Individual salary levels selected, by direct staff qualifications, is displayed in the table below:

**Table 1: Wages**

| Direct Staff Worker | Hourly Wage | Annual Wage | Direct Staff Worker | Hourly Wage | Annual Wage |
|---|---|---|---|---|---|
| Physician | 108.00 | 224,640 | Level II MH Behavioral Aide | 22.00 | 45,760 |
| Psychiatrist | 103.00 | 214,240 | Certified Peer | 22.00 | 45,760 |
| Nurse Practitioner | 60.00 | 124,800 | Driver | 20.00 | 41,600 |
| Licensed Psychologist | 48.00 | 99,840 | Level I MH Behavioral Aide | 19.00 | 39,520 |
| Occupational Therapist | 48.00 | 99,840 | | | |
| LICSW | 43.00 | 89,440 | ***Behavioral Health Home Only*** | | |
| RN | 42.00 | 87,360 | Team Leader | 52.00 | 108,160 |
| Certified MH Rehab Professional | 41.00 | 85,280 | Integration Specialist | 42.00 | 87,360 |
| LPCC | 40.00 | 83,200 | Systems Navigator | 27.00 | 56,160 |
| Licensed Professional Counselor | 36.00 | 74,880 | Qualified Health Home Specialist | 22.00 | 45,760 |
| Recreation Specialist | 34.00 | 70,720 | | | |
| LADC | 34.00 | 70,720 | ***Early Intensive Developmental and Behavioral Intervention (EIDBI) Only*** | | |
| MH Clinical Trainee | 31.00 | 64,480 | CMDE Provider | 42.00 | 87,360 |
| LPN | 29.00 | 60,320 | Level II provider | 24.00 | 49,920 |
| MH Practitioner | 27.00 | 56,160 | Level I provider | 34.00 | 70,720 |
| MH Rehabilitation Worker | 22.00 | 45,760 | | | |

- Staff Benefits – A standard benefits package was developed and priced by wage level for incorporation into the models. The package includes all required payroll-related costs as well as option benefits, including health coverage and retirement benefits. The actual assumptions are shown in the table below. The resulting benefits percentages, by wage level, are displayed in the appendices at the end of this document.

**Table 2: Benefits**

| Benefit | Amount | Limitation |
|---|---|---|
| FICA | 6.20% | $160,200 of wages |
| Medicare | 1.45% | |
| Workers' Compensation | 2.00% | |
| Retirement | 3.00% | |
| FUTA | 0.80% | $7,200 of wages |
| SUTA | 2.00% | $40,000 of wages |
| PTO (leave, holidays, sick) | 28 days | Based upon salary |
| Health Insurance | $810.00 | Monthly premium |

- Staff Productivity (client-facing time) – Represents the amount of time that individual staff may provide direct services, accounting for duties and responsibilities that are not billable activities (e.g., staff meetings). These assumptions can vary from service to service depending upon the service-specific requirements and level of staff performing the service.
- Support Staff – Where appropriate, models include costs for supervisory staff and schedulers. Not all models have included these costs, so it is suggested that the reader consult the actual rate models in the appendices to determine when these factors have been applied.

- Administrative Costs – Based on provider feedback and review of their administrative costs, a factor amounting to twenty-five percent (25%) of costs detailed within each model has been included to represent the costs associated with organizational administration.

## Provider Survey

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 on the following dates to introduce the surveys that were released to providers:

- Jan. 30, 2023, for community mental health providers
- Jan. 30, 2023, for community SUD treatment providers and
- Jan. 31, 2023, for EIDBI providers

The survey process was not limited to the workgroup attendees. All providers of the service categories identified above were invited to participate in the survey process. Key items 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 they employ; this was asked to assess workforce pressures overall and at the regional level within Minnesota
- The costs of employee fringe 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 encouraged agency-based providers who deliver the services within each survey tool to complete the survey. The target group of agencies was the providers who were paid more than $100,000 by DHS (or its MCOs) during CY 2021. Survey responses were originally requested on March 3, 2023. DHS granted an extension to all providers, so the survey responses were due on March 10, 2023. In total, 82 survey responses 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 EIDBI provider group offered sufficient representation from providers. The response rate for the Mental Health and SUD surveys did not meet the desired target rate. Information was considered from all surveys received. Since the response rate was low for the Mental Health and SUD surveys, HMA-Burns requested feedback from the providers' representatives in the respective workgroups. This request was made in order to validate the assumptions in the developed rate models for these services.

**Table 3: Outreach**

| | Intended Outreach | Initially Expressed Interest | Surveys Returned | 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% |

## Community Engagement

Six different provider workgroups were formed, with each having a specific service line focus. The six workgroups centered around the following services:

1. Community-based mental health services
2. Community-based substance use disorder services (includes residential services)
3. Early intensive developmental and behavior intervention services
4. Behavioral health home services
5. Physical health services

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

Each workgroup had a similar charter and met at similar intervals between January and August of 2023. The responsibilities for the first three workgroups named above included:

1. Provide feedback related to the design of a survey instrument that will ask questions related to the services of interest to the workgroup; this was completed in January 2023, and 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 above)
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 were held in May and August of 2023.

Once the initial rate models for each of the service groupings was developed, feedback from the provider workgroups was sought related to:

- Various assumptions used in the models – for example, wages, benefits and staff productivity
- Actual factors included – for example, inclusion of support staff for supervision and scheduling activities
- Operational factors modeled – for example, the number of individuals served in a group setting and attendance factors for services

Over thirty (30) workgroup meetings occurred in 2023 for the provider-specific workgroups noted. During these discussions, reactions to the rate models were assessed, collected and reviewed by the HMA-Burns team with DHS to consider potential changes. Once decisions were determined, the workgroups were reconvened to review the changes and discuss further observations.

In addition to the workgroups, the HMA-Burns team hosted meetings with provider agencies that requested individual time to share feedback. In some cases, during these meetings, providers shared more detailed information, not generally shared with the workgroups or DHS, to provide support for their suggestions for changes to the rate models.

## Community Feedback

After publication of the preliminary report with initial findings, the HMA-Burns team hosted over thirty (30) provider workgroup meetings. During these meetings, feedback was solicited to understand and verify various assumptions and methodologies employed within the rate models. The meetings were held between June and September of 2023. Some of the general assumptions and feedback obtained from the provider is displayed below:

**Table 4: Topics**

| Topic | Assumption in Model | Feedback Provided |
|---|---|---|
| Staff Salaries | Use median value reported by providers for CY 2023 salaries | General concurrence when feedback was provided. One comment was that supervisor positions are closer to $100,000 annual salary.<br>Consider geographic wage variation (one comment). |
| Fringe Benefits | Use standard benefit package for all services in the study. This is a percentage based on annual salary. | No specific comments. |
| Client Facing Time | Applied median value reported by providers for each staff position. Number of client-facing hours (out of 40) per week. | Concurrence when feedback was provided. |
| Staff Training Time | Applied median values reported by providers for training in 1st year then subsequent years for each position. Applied 50/50 blend across the values for two years (effectively assumes 50% staff turnover). | Concurrence when feedback was provided.<br>One commenter thought the training hours were a bit low. |
| Assignment of Staff to Service | Applied assumptions for staff position for each service as shown in the presentation. | Concurrence when feedback was provided. |
| Assignment of Supervisor | Applied assumptions for supervisor position for each service as shown in the presentation. | Concurrence when feedback was provided. |
| Assignment of Scheduler | Assign scheduler costs into overall administrative overhead percentage. | Some commenters think this cost should be pulled out of admin and shown separately. |
| Admin Costs | Applied a standard percentage across all service categories. | No specific concern on applying a percentage, but feedback on actual percentage to apply. |
| "No-Show" Rate | Applied a standard percentage across most services. | No specific concern on applying a percentage, but feedback on actual percentage to apply. |

## Feedback from Individual Provider Interviews

In addition to the provider workgroup meetings, the HMA-Burns team hosted individual meetings with several providers. During these meetings, detailed information was offered to support suggestions and comments from the provider workgroup sessions. One of the factors that providers reacted to by providing more detailed

documentation to support was the client ‘no-show’ rate, the amount (expressed as a percentage) of appointments missed by clients due to factors beyond the control of the provider community.

There are numerous social determinants of health that impact the ability of recipients of these services to attend scheduled time with a provider. Due to the higher propensity of these factors, and with detail provided to the HMA-Burns team, there were many indications that the factor should be adjusted for most services. Upon review of this information with the DHS teams, there was a consensus to adopt the recommended changes proffered by the HMA-Burns team.

## Operational Considerations

While many of the suggestions and feedback were provided through the provider workgroups and individual provider meetings, all information received was weighed by the HMA-Burns team and recommendations were discussed with the DHS team(s) and subject matter experts. All final changes incorporated into the rate models were vetted and approved by the DHS team(s).

In addition to discussions on various aspects of the rate models, the HMA-Burns team facilitated discussions with the DHS team that involved operational tasks related to the implementation of the rate study pending approval and adoption of recommendations. Some of the specific items discussed include, but are not limited to:

- **Service Definitions**: The assumptions in each rate model articulate expectations of the costs to deliver each service. There may be opportunities to strengthen existing service definitions (e.g., staffing credentials) in support of the various assumptions.
- **Policy Changes**: An inventory of written policies that are in place today should be reviewed to ensure that the policies are in alignment with rate model assumptions. Current policies may also be strengthened given the assumtions that are in each model. New policies will likely need to be developed for new services in the SUD domain and changes with ASAM 4th edition.
- **Systems Changes**: Of greatest significance is identifying pricing logic and determining whether it needs to be eliminated or retained when migrating to the new rate methodology.
- **Additional Education**: Separate educational training for the Medicaid managed care organizations (MCOs) on the elements of the rate methodologies; the proposed fee-for-service rate changes should be developed and distributed.
- **Timeline to Implement**: Any necessary proposals for sequencing the rate increases, if required, should be reviewed and verified.
- **Resources to Implement**: Designation of state staff who will maintain responsibility for each service domain (RBRVS, MH rates, SUD rates, EIDBI rates).

## Repeal of Percentage-Based Legislative Rate Adjustments

Over the past fifteen to twenty years, the Minnesota Legislature has enacted several rate reductions and rate increases that were applied differently across various service categories. This has resulted in some services having payment rates that are higher than other services when measured against a standard such as Medicare. In addition, some rate increases were applied at the provider type level. These rate adjustments resulted in certain providers receiving a higher payment rate than other providers for providing the same service. These rate adjustments were likely a reaction to community priorities in the face of budgetary limitations that add complexity and opacity to the rate setting process. Under DHS’ current rate setting methodologies, most

providers cannot determine what their payment should be or whether they have received the correct payment for the services they have rendered.

If the rate setting methodologies recommended in this report are adopted, payment rates could be completely transparent to both the providers and the patients. But this will not be the case unless the historical legislatively required rate adjustments are eliminated.

# IV. Results

This section highlights the overall recommendations and results of the rate study. Note that this section includes additional detailed information on recommendations mentioned earlier in the report.

## Professional Services in RBRVS

As previously noted, DHS currently uses Medicare's payment methodology in principle to pay for community-based physical health services and some community-based mental health services. In the RBRVS payment system, each service billing code, of which there are thousands, is assigned a relative value. This relative value (RVU) is multiplied by a constant dollar amount or conversion factor for the number of units provided.

Reimbursed Amount = Total RVU * Conversion Factor * Units

While Medicare currently uses one multiplier ($33.8872) for all services paid using the RBRVS reimbursement system, DHS 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 professionals, 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.

It is recommended that the RBRVS reimbursement methodology continue to be employed and that the conversion factor be set equal to 100 percent of the Medicare level, thus effectively adopting a single base multiplier for all services.

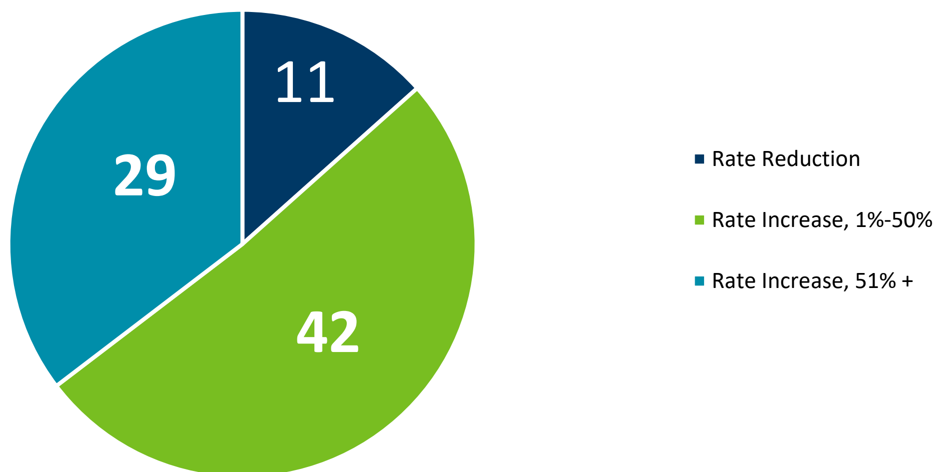
## Mental Health Services

Standardized rate models were constructed for more than 130 service code combinations. However, due to the adoption of the RBRVS rate methodology for selected services within this category, only 89 of the services have recommended rate models. Details for services, by category, are provided below.

## One-to-One and Group Services

This set of services, encompassing eighty-two (82) service codes, are constructed from six (6) primary factors:

- Direct Staff Costs and Billable Time: Details for the staff wage and benefits, as well as the depiction of the amount of time available to bill for services
- Supervisory Position: As appropriate, the assumptions for the supervisory wages, benefits and hours of clinical supervision are provided
- Program Support Position: As appropriate, the assumptions for support staff (e.g., scheduler) wages, benefits and hours are provided
- Other Program Expenses: An additional 5% of costs are included for other programmatic costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs
- No-Show Rate: A service-specific factor, as appropriate, that is added to denote the number of appointments missed for various factors beyond the control of the provider organization




The recommended rates are available in the appendices attached to this report.

## Mental Health Provider Travel Time

This set encompasses one (1) service code and is constructed from two (2) primary factors:

- Direct Staff Costs: Details for the team of staff wages and benefits
- Administrative: A factor of 25% of all costs is included for organizational administrative costs

The recommended rates are available in the appendices attached to this report.

## Adult and Children's Day Treatment Services

This set of services, encompassing three (3) service codes, are constructed from six (6) primary factors:

- Direct Staff Costs and Service Hours: Details for the team of staff wages, benefits and direct service hours
- Indirect Program Staff: The assumptions for the supervisory wages, benefits and hours of clinical supervision are provided
- Facility Costs: The assumptions for size (e.g., square feet), acquisition and operating costs for the location where the services are performed
- Program Expenses: An additional fixed dollar amount is included for other programmatic costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs
- Utilization Factor: A factor, expressed as a percentage, added to denote the percentage of client hours filled for the program. This factor is based upon the number of client and hours per day, per client and the eventual number of hours of services provided.

**Table 5: Rates**

| HCPCS | Description | Current Rate | Proposed Rate | Percent Change |
|---|---|---|---|---|
| H2012-UA-HK | CTSS Behavioral Health Day Treatment | $65.24 | $73.74 | 13% |
| H2012-UA-HK-U6 | CTSS Behavioral Health Day Treatment, Interactive | $76.74 | $120.87 | 58% |
| H2012 | Adult Behavioral Health Day Treatment | $21.43 | $44.46 | 107% |

The recommended rates are available in the appendices attached to this report.

## Mobile Crisis Team Services

This set encompasses one (1) service code and is constructed from four (4) primary factors:

- Direct Staff Costs: Details for the team of staff wages and benefits
- Client-Focused Time: The assumptions for the available client services time and non-billable activities
- Program Expenses: Additional amounts included for other programmatic costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs

The recommended rates are available in the appendices attached to this report.

## Behavioral Health Home

This set encompasses one (1) service code and is constructed from three (3) primary factors:

- Direct Staff Costs: Details for the team of staff wages and benefits including hours per month assumed for each staffing level
- Program Expenses: The assumptions for the costs associated with on-going training activities for direct staff as well as other program-related staff costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs

The recommendation for this service is to adopt a single monthly rate for all eligible participants. The recommended rates are available in the appendices attached to this report.

## Substance Use Disorder Treatment (SUD) Services

Standardized rate models were constructed for fifteen (15) service codes. The current service array generally aligns with the ASAM criteria for care. It should be noted that the ASAM 4th edition was recently released, and it is recommended to review the new criteria to ensure that these recommendations align with the updated service standards, if adopted by DHS for use. Generally, the rate models fall into one of the three following categories and designs:

### One-to-One Services

This set of services, encompassing five (5) service codes, are constructed from seven (7) primary factors:

- Direct Staff Costs and Billable Time: Details for the staff wage and benefits as well as the depiction of the amount of time available to bill for services
- Supervisory Position: As appropriate, the assumptions for the supervisory wages, benefits and hours of clinical supervision are provided
- Program Support Position: As appropriate, the assumptions for support staff (e.g., scheduler) wages, benefits and hours are provided
- Mileage Reimbursement: Allowable mileage reimbursement, if applicable, using the standard IRS mileage rate
- Other Program Expenses: An additional 5% of costs are included for other programmatic costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs
- No-Show Rate: A service-specific factor, as appropriate, added to denote the number of appointments missed for various factors beyond the control of the provider organization

The recommended rates are available in the appendices attached to this report.

### Intensive Outpatient (IOP) and Partial Hospitalization (PHP)

This set encompasses one (1) service code and is constructed from five (5) primary factors:

- Direct Staff Costs: Details for the team of staff wages and benefits including hours per day assumed for each staffing level
- Program Support Position: As appropriate, the assumptions for support staff (e.g., scheduler) wages, benefits and hours are provided
- Program Expenses: An additional fixed dollar amount is included for other programmatic costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs
- No-Show Rate: A service-specific factor, as appropriate, added to denote the number of appointments missed for various factors beyond the control of the provider organization

These services are new services planned for incorporation into the available services array. DHS will require time to develop and implement policies and procedures related to the service design and billing processes prior to use of the services. The recommended rates are available in the appendices attached to this report.

### Residential Treatment and Withdrawal Management

This set encompasses six (6) service codes and is constructed from five (5) primary factors:

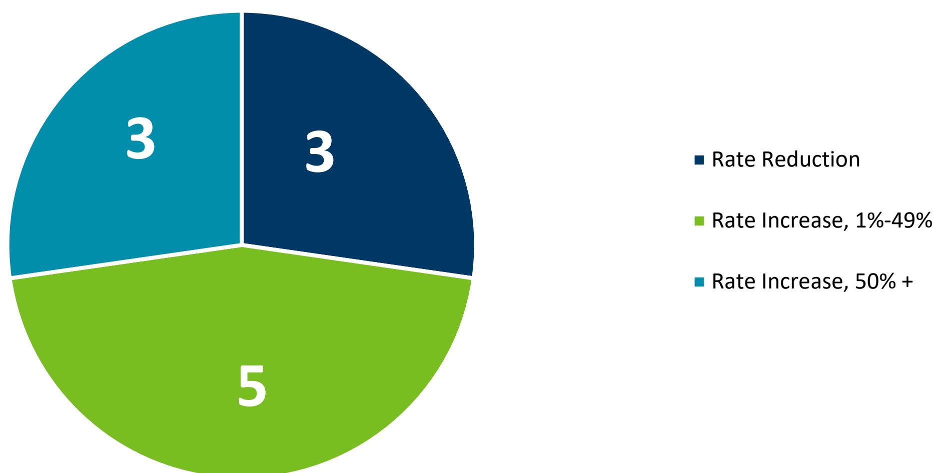
- Direct Staff Costs: Details for the team of staff wages and benefits including hours per day assumed for each staffing level
- Transportation Costs: The assumptions for support staff (e.g., driver) wages, benefits and hours are included to account for client transportation needs
- Program Expenses: Additional costs are included for training, quality and other programmatic costs
- Administrative: A factor of 25% of all costs is included for organizational administrative costs
- Occupancy Assumption: A factor, expressed as a percentage, added to denote the percentage of client bed-days filled for the program. That is, based upon the number of available client days, the eventual number of days of services provided

The recommended rates are available in the appendices attached to this report.

## Early Intensive Developmental and Behavioral Intervention (EIDBI) Services

This set of services, encompassing eleven (11) service codes, are constructed from four (4) primary factors:

- Direct Staff Costs and Billable Time: Details for the staff wage and benefits as well as the depiction of the amount of time available to bill for services
- Supervisory Position: As appropriate, the assumptions for the supervisory wages, benefits and hours of clinical supervision are provided
- Administrative: A factor of 25% of all costs is included for organizational administrative costs
- No-Show Rate: A service-specific factor, as appropriate, added to denote the number of appointments missed for various factors beyond the control of the provider organization




The recommended rates are available in the appendices attached to this report.

# V. Report Recommendations

1. Adopt the methodology developed to build rates for community-based mental health, SUD and EIDBI services that are informed by providers' current costs and market conditions related to workforce.

2. Eliminate all legislatively mandated rate modifications that were implemented for budgetary reasons. Retain rate modifications related to the level of service being delivered or the practitioner delivering the services. For example, as is common across most payers, DHS applies a payment reduction to physician services when the services are delivered by a non-physician practitioner (nurse practitioner, physician assistant). This reduction is related to the service delivery and would be retained.

3. Adopt the benchmark rates proposed for each of the services in this rate study:

    a. For most mental health services, all SUD, and all EIDBI services, the benchmark rate for each service was developed using the methodology employing market-based costs

    b. For some mental health services and all acute care professional services paid under CMS's Resource Based Relative Value Scale (RBRVS), the benchmark rate is equivalent to 100% of the rate paid to providers in the Medicare program

    c. For all services in this study, in concert with adopting the benchmark rate values, rescind all previously established legislative rate and policy adjusters associated with these services as this rebasing of the rates makes these historical adjusters unnecessary

4. Ensure transparency and collaboration with providers on the timing of *rate updates* and *rate rebase activities* for each of the service domains in this rate study.

    a. For *rate updates*, apply a factor on an annual basis that accounts for inflationary cost increases. For the services in the rate study under the categories of mental health, SUD and EIDBI, the recommendation is to apply an inflationary increase each year using CMS' Medicare Economic Index (MEI); for services paid under CMS's RBRVS, an inflationary cost increase is not necessary if the Department is able to pay for these services at 100% of the prevailing Medicare rate, because CMS already accounts for inflationary cost increases in its annual update to its RBRVS payment system.

    b. For *rate rebase activities*, develop a strategy to ensure that a full review of the costs of each service in this study occurs no less than once every four years; the purpose of the rebase is to engage with providers and other community partners about current costs to render each service; the rate rebase effectively compares actual costs incurred by providers against the assumed costs built into the annual inflationary factor and reconciles these differences to re-establish the base costs for another four-year cycle.

5. Update service definitions in policy and billing guidance for each service in the study, where applicable, to better align with the assumptions used to build the benchmark rates under the new rate methodology. Examples may include more transparent language related to the level of expertise of staff that may deliver each service and the staffing assumptions expected in services that require a team-based approach.

# VIII. Appendices

## Appendix A

- Substance Use Disorder Rate Models

### SUD Rate Models

| Service Description | Unit of Service | Current Rate | Modeled Rate | $$ Difference | % Difference |
|---|---|---|---|---|---|
| Comprehensive SUD Assessment | Per Session | $162.24 | **$234.06** | **$71.82** | 44.3% |
| Treatment Coordination | 15 min | $15.02 | **$37.13** | **$22.11** | 147.2% |
| Individual Therapy | 60 min | $86.53 | **$140.27** | **$53.74** | 62.1% |
| Group Therapy | 60 min | $42.02 | **$42.97** | **$0.95** | 2.3% |
| Peer Recovery Support | 15 min | $15.02 | **$28.43** | **$13.41** | 89.3% |
| High Intensity Residential | Per Diem | $224.06 | **$355.02** | **$130.96** | 58.4% |
| Low Intensity Residential | Per Diem | $79.84 | **$216.90** | **$137.06** | 171.7% |
| WM Clinically Managed | Per Diem | $400.00 | **$375.91** | **-$24.09** | -6.0% |
| WM Medically Managed | Per Diem | $515.00 | **$576.18** | **$61.18** | 11.9% |

## Appendix B

- Mental Health Rate Models (starts on the next page)

## MH Rate Models

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| ARMHS | Community Intervention | Per Session | $51.11 | $91.39 | 78.8% | $51.11 | $91.39 | 78.8% |
| ARMHS | Community Intervention | Per Session | $38.33 | $78.86 | 105.7% | $38.33 | $78.86 | 105.7% |
| ARMHS | Transition to Community Living Intervention | Per Session | $51.11 | $129.14 | 152.7% | $51.11 | $129.14 | 152.7% |
| ARMHS | Transition to Community Living Intervention | Per Session | $38.33 | $111.44 | 190.7% | $38.33 | $111.44 | 190.7% |
| ARMHS | Functional Assessment | Per Session | $86.56 | $101.55 | 17.3% | $86.56 | $101.55 | 17.3% |
| ARMHS | Functional Assessment Update/ Review | Per Session | $86.56 | $101.55 | 17.3% | $86.56 | $101.55 | 17.3% |
| ARMHS | Individual Treatment Plan | Per Session | $86.56 | $101.55 | 17.3% | $86.56 | $101.55 | 17.3% |
| ARMHS | Individual Treatment Plan Update/ Review | Per Session | $86.56 | $101.55 | 17.3% | $86.56 | $101.55 | 17.3% |
| ARMHS | Medication Education - Individual | 15 min | $17.82 | $37.68 | 111.5% | $17.82 | $37.68 | 111.5% |
| ARMHS | Medication Education - Group | 15 min | $11.59 | $15.01 | 29.5% | $11.59 | $15.01 | 29.5% |
| ARMHS | Psychosocial Rehabilitation - Individual (basic social & living skills) | 15 min | $18.02 | $28.56 | 58.5% | $18.02 | $28.56 | 58.5% |
| ARMHS | Psychosocial Rehabilitation - Individual (basic social & living skills) | 15 min | $13.51 | $24.64 | 82.4% | $13.51 | $24.64 | 82.4% |
| ARMHS | Psychosocial Rehabilitation - Group (basic social & living skills) | 15 min | $7.92 | $11.41 | 44.0% | $7.92 | $11.41 | 44.0% |
| ARMHS | Transition to Community Living (TCL) | 15 min | $18.02 | $28.56 | 58.5% | $18.02 | $28.56 | 58.5% |
| ARMHS | Transition to Community Living (TCL) by a mental health rehabilitation worker | 15 min | $13.51 | $24.64 | 82.4% | $13.51 | $24.64 | 82.4% |
| Child Outpatient | Clinical Care Consultation - Face to Face, 5 to 10 min | 5 to 10 min | $14.80 | $21.81 | 47.4% | $14.80 | $21.81 | 47.4% |
| Child Outpatient | Clinical Care Consultation - Non-Face to Face, 5 to 10 min | 5 to 10 min | $11.09 | $20.13 | 81.5% | $11.09 | $20.13 | 81.5% |
| Child Outpatient | Clinical Care Consultation - Face to Face, 11 to 20 min | 11 to 20 min | $30.59 | $45.33 | 48.2% | $30.59 | $45.33 | 48.2% |

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| Child Outpatient | Clinical Care Consultation - Non-Face to Face, 11 to 20 min | 11 to 20 min | $22.94 | $41.84 | 82.4% | $22.94 | $41.84 | 82.4% |
| Child Outpatient | Clinical Care Consultation - Face to Face, 21 to 30 min | 21 to 30 min | $50.33 | $68.68 | 36.5% | $50.33 | $68.68 | 36.5% |
| Child Outpatient | Clinical Care Consultation - Non-Face to Face, 21 to 30 min | 21 to 30 min | $37.74 | $63.40 | 68.0% | $37.74 | $63.40 | 68.0% |
| Child Outpatient | Clinical Care Consultation - Face to Face, 31 min plus | 31 min plus | $79.82 | $137.36 | 72.1% | $79.82 | $137.36 | 72.1% |
| Child Outpatient | Clinical Care Consultation - Non-Face to Face, 31 min plus | 31 min plus | $59.86 | $126.80 | 111.8% | $59.86 | $126.80 | 111.8% |
| Child Outpatient | Family Psychoeducation - Individual | 15 min | $29.75 | $39.47 | 32.7% | $29.75 | $39.47 | 32.7% |
| Child Outpatient | Family Psychoeducation - Group, per recipient | 15 min | $5.96 | $15.64 | 162.5% | $5.96 | $15.64 | 162.5% |
| Child Outpatient | Family Psychoeducation - Multiple families with or without recipients | 15 min | $8.26 | $15.64 | 89.4% | $8.26 | $15.64 | 89.4% |
| Child Outpatient | Family Psychoeducation - Single family with recipient | 15 min | $24.97 | $39.47 | 58.1% | $24.97 | $39.47 | 58.1% |
| Child Outpatient | Family Psychoeducation - Single family without recipient | 15 min | $24.12 | $39.47 | 63.6% | $24.12 | $39.47 | 63.6% |
| CTSS | Psychotherapy, with patient and/or family member | 30 min | $65.99 | $74.25 | 12.5% | $84.91 | $74.25 | -12.6% |
| CTSS | Psychotherapy, with patient and/or family member when performed with an E&M service | 30 min | $60.31 | $168.99 | 180.2% | $77.60 | $168.99 | 117.8% |
| CTSS | Psychotherapy, with patient and/or family member | 45 min | $87.19 | $111.37 | 27.7% | $112.20 | $111.37 | -0.7% |

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| CTSS | Psychotherapy, with patient and/or family member when performed with an E&M service | 45 min | $76.14 | $253.48 | 232.9% | $97.97 | $253.48 | 158.7% |
| CTSS | Psychotherapy, with patient and/or family member | 60 min | $128.40 | $148.50 | 15.7% | $165.23 | $148.50 | -10.1% |
| CTSS | Psychotherapy, with patient and/or family member when performed with an E&M service | 60 min | $100.32 | $337.97 | 236.9% | $129.09 | $337.97 | 161.8% |
| CTSS | Psychotherapy for Crisis | 60 min | $122.43 | $155.14 | 26.7% | $157.54 | $155.14 | -1.5% |
| CTSS | Psychotherapy for Crisis, additional 30 min (add on to 90839) | 30 min | $60.01 | $155.14 | 158.5% | $77.22 | $155.14 | 100.9% |
| CTSS | Family Psychotherapy - without patient present | Per Session | $83.01 | $157.36 | 89.6% | $106.82 | $157.36 | 47.3% |
| CTSS | Family Psychotherapy - with patient present | Per Session | $85.99 | $157.89 | 83.6% | $110.65 | $157.89 | 42.7% |
| CTSS | Multiple Family Group Psychotherapy | Per Session | $30.15 | $67.21 | 122.9% | $38.78 | $67.21 | 73.3% |
| CTSS | Group Psychotherapy | Per Session | $22.98 | $49.10 | 113.7% | $29.55 | $49.10 | 66.2% |
| CTSS | Biofeedback Training | 20 to 30 min | $51.35 | $84.78 | 65.1% | $66.06 | $84.78 | 28.3% |
| CTSS | Individual psycho-physiological therapy incorporating biofeedback - with psychotherapy | 45 to 50 min | $89.58 | $127.17 | 42.0% | $115.27 | $127.17 | 10.3% |
| CTSS | Administering and reporting standardized measures | Per Session | $86.56 | $97.67 | 12.8% | $86.56 | $97.67 | 12.8% |
| CTSS | Treatment Plan Development and Review | Per Session | $86.56 | $86.40 | -0.2% | $86.56 | $86.40 | -0.2% |
| CTSS | Skills Training & Development - Individual | 15 min | $13.44 | $28.56 | 112.5% | $13.44 | $28.56 | 112.5% |
| CTSS | Skills Training & Development - Group | 15 min | $9.03 | $11.41 | 26.3% | $9.03 | $11.41 | 26.3% |
| CTSS | Skills Training & Development - Family | 15 min | $17.50 | $28.56 | 63.2% | $17.50 | $28.56 | 63.2% |
| CTSS | Comprehensive Community Support Services (Crisis Assistance) | 15 min | $14.33 | $28.08 | 95.9% | $14.33 | $28.08 | 95.9% |

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| CTSS | Therapeutic Behavioral Services (Level I MHBA) | 15 min | $6.33 | $22.29 | 252.1% | $6.33 | $22.29 | 252.1% |
| CTSS | Therapeutic Behavioral Services (Level II MHBA) | 15 min | $8.28 | $24.64 | 197.6% | $8.28 | $24.64 | 197.6% |
| CTSS | Therapeutic Behavioral Services (Direction of MHBA) | 15 min | $9.24 | $42.39 | 358.8% | $9.24 | $42.39 | 358.8% |
| Crisis - Adult | Mental health crisis assessment, intervention and stabilization - individual | 15 min | $39.04 | $34.28 | -12.2% | $39.04 | $34.28 | -12.2% |
| Crisis - Child | Mental health crisis assessment, intervention and stabilization - individual | 15 min | $39.04 | $34.28 | -12.2% | $39.04 | $34.28 | -12.2% |
| Crisis - Adult | Mental health crisis assessment, intervention and stabilization - individual | 15 min | $27.33 | $28.08 | 2.7% | $27.33 | $28.08 | 2.7% |
| Crisis - Child | Mental health crisis assessment, intervention and stabilization - individual | 15 min | $27.33 | $28.08 | 2.7% | $27.33 | $28.08 | 2.7% |
| Crisis - Adult | Mental health crisis assessment, intervention and stabilization - individual | 15 min | $19.51 | $24.01 | 23.1% | $19.51 | $24.01 | 23.1% |
| Crisis - Adult | Adult Crisis Stabilization - Group, Non-Residential | 15 min | $9.75 | $14.07 | 44.4% | $9.75 | $14.07 | 44.4% |
| Crisis - Adult | Community Intervention | Per Session | $51.11 | $102.11 | 99.8% | $51.11 | $102.11 | 99.8% |
| Crisis - Adult | Community Intervention | Per Session | $27.66 | $87.30 | 215.6% | $27.66 | $87.30 | 215.6% |
| DBT | Individual DBT Therapy for adults | 15 min | $42.00 | $39.03 | -7.1% | $42.00 | $39.03 | -7.1% |
| DBT | Individual DBT Therapy for adolescents | 15 min | $42.00 | $39.03 | -7.1% | $42.00 | $39.03 | -7.1% |
| DBT | DBT Skills Group for adults | 15 min | $19.06 | $8.94 | -53.1% | $19.06 | $8.94 | -53.1% |
| DBT | DBT Skills Group for adolescents | 15 min | $19.06 | $12.74 | -33.1% | $19.06 | $12.74 | -33.1% |
| Diagnostic Assessment | Diagnostic Assessment Interactive Complexity | Per Session | $12.53 | $132.00 | 953.4% | $15.49 | $132.00 | 752.1% |
| Diagnostic Assessment | Diagnostic Assessment Brief | Per Session | $152.29 | $70.17 | -53.9% | $188.38 | $70.17 | -62.7% |

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| Diagnostic Assessment | Diagnostic Assessment Standard | Per Session | $152.29 | $210.51 | 38.2% | $188.38 | $210.51 | 11.8% |
| Diagnostic Assessment | Adult Diagnostic Assessment - Update | Per Session | $122.02 | $140.34 | 15.0% | $150.93 | $140.34 | -7.0% |
| Diagnostic Assessment | Diagnostic Assessment (with Medical Service) - Brief | Per Session | $136.58 | $150.21 | 10.0% | $168.94 | $150.21 | -11.1% |
| Diagnostic Assessment | Diagnostic Assessment (with Medical Service) - Standard | Per Session | $145.66 | $150.21 | 3.1% | $180.18 | $150.21 | -16.6% |
| Diagnostic Assessment | Diagnostic Assessment (with Medical Service) - Update | Per Session | $136.58 | $300.42 | 120.0% | $168.94 | $300.42 | 77.8% |
| Neuro | Neuropsychological Assessment - (neurobehavioral status exam) 1st hour | Hourly | $81.21 | $150.72 | 85.6% | $100.46 | $150.72 | 50.0% |
| Neuro | Neuropsychological Assessment - (neurobehavioral status exam) each additional hour | Hourly | $67.48 | $150.72 | 123.4% | $83.47 | $150.72 | 80.6% |
| Neuro | Brief emotional/behavioral assessment | Per Assessment | $3.87 | $12.51 | 223.2% | $4.78 | $12.51 | 161.7% |
| Neuro | Neuropsychological Assessment - (neurobehavioral status exam) 1st hour | Hourly | $112.57 | $150.72 | 33.9% | $139.24 | $150.72 | 8.2% |
| Neuro | Neuropsychological Assessment - (neurobehavioral status exam) each additional hour | Hourly | $87.48 | $150.72 | 72.3% | $108.21 | $150.72 | 39.3% |
| Neuro | Neuropsychological Testing/Scoring (2+ tests) 1st 30 min | 30 min | $38.22 | $75.36 | 97.2% | $47.27 | $75.36 | 59.4% |
| Neuro | Neuropsychological Testing/Scoring (2+ tests) each additional 30 min | 30 min | $34.63 | $75.36 | 117.6% | $42.84 | $75.36 | 75.9% |

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| Neuro | Neuropsychological Testing/Scoring - any method (2+ tests) 1st 30 min | 30 min | $30.45 | $75.36 | 147.5% | $37.66 | $75.36 | 100.1% |
| Neuro | Neuropsychological Testing/Scoring - any method (2+ tests) each additional 30 min | 30 min | $31.04 | $75.36 | 142.8% | $38.39 | $75.36 | 96.3% |
| Neuro | Neuropsychological Testing - Electronic automated results only | Per Session | $1.49 | $4.97 | 233.8% | $1.83 | $4.97 | 171.8% |
| Neuro | Cognitive Rehabilitative Therapy | Hourly | $39.69 | $169.56 | 327.2% | $49.09 | $169.56 | 245.4% |
| Peer Supports | Adult Self-Help/Peer Services | 15 min | $15.77 | $27.86 | 76.7% | $15.77 | $27.86 | 76.7% |
| Peer Supports | Adult Self-Help/Peer Services | 15 min | $18.02 | $32.28 | 79.2% | $18.02 | $32.28 | 79.2% |
| Peer Supports | Adult Self-Help/Peer Services Group Setting | 15 min | $7.92 | $9.92 | 25.2% | $7.92 | $9.92 | 25.2% |
| Psych Consult | Psychiatric Consultation for primary care – face to face | Per Session | $29.75 | $88.18 | 196.4% | $33.05 | $88.18 | 166.8% |
| Psych Consult | Psychiatric Consultation for primary care – face to face | Per Session | $62.75 | $84.49 | 34.6% | $67.74 | $84.49 | 24.7% |
| Psychotherapy | Psychotherapy, with patient and/or family member | 30 min | $65.99 | $76.18 | 15.4% | $81.62 | $76.18 | -6.7% |
| Psychotherapy | Psychotherapy, with patient and/or family member when performed with an E&M service | 30 min | $60.31 | $76.18 | 26.3% | $74.60 | $76.18 | 2.1% |
| Psychotherapy | Psychotherapy, with patient and/or family member | 45 min | $87.19 | $114.27 | 31.1% | $107.85 | $114.27 | 6.0% |
| Psychotherapy | Psychotherapy, with patient and/or family member when performed with an E&M service | 45 min | $76.14 | $114.27 | 50.1% | $94.18 | $114.27 | 21.3% |

| DHS Service Category | Service Description | Unit of Service | Current Standard Rate | Proposed Standard Rate | Percent Difference: Proposed vs Current Standard Rate | Current Enhanced Rate | Proposed Enhanced Rate | Percent Difference: Proposed vs Current Enhanced Rate |
|---|---|---|---|---|---|---|---|---|
| Psychotherapy | Psychotherapy, with patient and/or family member | Hourly | $128.40 | $152.36 | 18.7% | $158.83 | $152.36 | -4.1% |
| Psychotherapy | Psychotherapy, with patient and/or family member when performed with an E&M service | Hourly | $100.32 | $152.36 | 51.9% | $124.09 | $152.36 | 22.8% |
| Psychotherapy | Psychotherapy for Crisis | Hourly | $122.43 | $121.89 | -0.4% | $151.44 | $121.89 | -19.5% |
| Psychotherapy | Psychotherapy for Crisis (add on to 90839) | 30 min | $60.01 | $60.94 | 1.6% | $74.23 | $60.94 | -17.9% |
| Psychotherapy | Family Psychotherapy without patient present | Per Session | $83.01 | $169.56 | 104.3% | $102.67 | $169.56 | 65.1% |
| Psychotherapy | Family Psychotherapy with patient present | Per Session | $85.99 | $169.56 | 97.2% | $106.37 | $169.56 | 59.4% |
| Psychotherapy | Multiple Family Group Psychotherapy | Per Session | $30.15 | $67.21 | 122.9% | $37.29 | $67.21 | 80.2% |
| Psychotherapy | Group Psychotherapy | Per Session | $22.98 | $49.10 | 113.7% | $28.42 | $49.10 | 72.8% |
| Psychotherapy | Individual psycho-physiological therapy incorporating biofeedback, with psychotherapy | 20 to 30 min | $51.35 | $84.78 | 65.1% | $63.52 | $84.78 | 33.5% |
| Psychotherapy | Individual psycho- physiological therapy incorporating biofeedback, with psychotherapy | 45 to 50 min | $89.58 | $127.17 | 42.0% | $110.81 | $127.17 | 14.8% |
| Testing | Explanation of Findings | Per Session | $73.75 | $127.92 | 73.5% | $91.22 | $127.92 | 40.2% |
| Testing | Psychological Testing - 1st hour | Hourly | $102.72 | $127.92 | 24.5% | $127.06 | $127.92 | 0.7% |
| Testing | Psychological Testing - each additional hour | Hourly | $76.14 | $127.92 | 68.0% | $94.18 | $127.92 | 35.8% |

## Appendix C:

Behavioral Health Home rate models

| DHS Service Category | Service Description | Unit of Service | Current rate | Proposed Rate | Percent difference between current and proposed rates |
|---|---|---|---|---|---|
| Behavioral Health Home | BHH services care engagement, initial plan | Monthly (limit of six engagement payments in a member's lifetime) | $350 | $408.76 | 15.5% |
| Behavioral Health Home | BHH services ongoing standard care maintenance of plan | Monthly | $250 | $408.76 | 48.2% |

## Appendix D:

Early Intensive Developmental and Behavioral Intervention rate model

| DHS Service Category | Service Description | Unit of Service | Current rate | Proposed Rate | Percent difference between current and proposed rates |
|---|---|---|---|---|---|
| EIDBI | Behavior identification assessment and plan of care | 15 min | $50.11 | $47.98 | -4.3% |
| EIDBI | Behavior treatment by protocol administered by technician | 15 min | $20.17 | $24.89 | 23.4% |
| EIDBI | Group behavior treatment by protocol administered by technician, per recipient | 15 min | $6.72 | $19.41 | 189.1% |
| EIDBI | Group behavior treatment by protocol administered by technician, per recipient | 15 min | $6.72 | $8.56 | 27.5% |
| EIDBI | Behavior treatment with protocol modification administered by physician or other qualified professional (CMDE provider) | 15 min | $20.17 | $34.46 | 70.8% |
| EIDBI | Behavior treatment with protocol modification administered by physician or other qualified professional (Level 1 provider) | 15 min | $20.17 | $26.30 | 30.4% |
| EIDBI | Family behavior treatment guidance administered by qualified professional, single family | 15 min | $20.17 | $28.71 | 42.4% |
| EIDBI | Family behavior treatment guidance administered by qualified professional, per family | 15 min | $6.72 | $7.18 | 6.9% |
| EIDBI | Individualized treatment plan development and monitoring | Per session | $94.80 | $99.62 | 0.9% |
| EIDBI | Coordinated care conference, medical team conference | Per session | $112.67 | $99.65 | 111.6% |
| EIDBI | Intervention - Higher Intensity | 15 min | $24.19 | $47.55 | 96.5% |

## Appendix E:

Top ten most utilized RBRVS codes

| CPT Code | Service Description | Units | Medicaid as a Percent of Medicare |
|---|---|---|---|
| 90837 | Psychotherapy, 60 min | 1,224,525 | 85% |
| 99214 | Office visit, estab patient | 1,184,779 | 82% |
| 99213 | Office visit, estab patient | 1,219,814 | 75% |
| 90834 | Psychotherapy, 45 min | 438,926 | 92% |
| 99215 | Office visit, estab patient | 199,463 | 81% |
| 99233 | Inpatient hosp care, 35 min | 255,870 | 71% |
| 99285 | ED Visit | 156,728 | 79% |
| 99284 | ED Visit | 221,935 | 79% |
| 99204 | Office visit, new patient | 167,100 | 76% |
| 97530 | Therapeutic activity | 712,398 | 71% |