

## Introduction and Methodology

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In preparation for transitioning Williams class members into community services, DHS/DMH needed to assess whether the current rates for team-based services, ACT and CST, are adequate to support expansion of capacity for these services. The existing rates for these services were established in the fall of 2006 using the rate methodology in the Illinois Medicaid State Plan as a part of the state plan amendment and Rule 132 revision process. The rates for these services have been unchanged since July 1, 2007. The total capacity for team-based services has decreased since the rule change that became effective at the beginning of FY08. Due to the changes occurring in the community mental health system over the past four years, it has been impossible to determine the cause of the reductions in team-based capacity. During that period, service authorizations have been implemented, provider contracts have been reduced due to state budget reductions, non-Medicaid benefits have been narrowed and currently exclude ACT or CST, and rates have remained unchanged.

A process for examining the current rates for ACT and CST was designed by Parker Dennison to include four provider site visits to review the current operations and costs associated with team based services. DHS/DMH selected providers to obtain a cross section of urban, suburban and downstate providers who currently offer either ACT or CST in areas near IMDs and potential Williams class members. The site visit process and methodology used to examine rates is summarized below:

- ACT providers visited—Human Service Center (Peoria), C4 (Chicago), and Thresholds (Chicago)
- CST providers visited—Association House (Chicago), C4 (Chicago), and Thresholds (Chicago)
- Providers supplied extensive financial information for review prior to and during two day onsite visits, including audited financial statements for June 30, 2010, interim financials statements for December 30, 2010, detailed staffing, expense and billing data for ACT and/or CST.
- The visits were staffed by a combination of consultants and DMH central office and regional staff.
- Staffing, cost and billing data were reviewed for reasonableness and consistency both within a provider's data and across the providers included in the site visit process. Amounts used in the model were reconciled to providers' financial statements and any differences were reviewed with each provider.
- A tool was developed based on the model used for ACT and CST rate setting in 2006 to use provider data to calculate the costs for these services and the margin resulting from the current rates. The tool and results for each provider were submitted to DMH under separate cover.

- Amounts used in the model were reconciled to providers' financial statements and any differences were reviewed with each provider. Providers were also afforded the opportunity to review their rate model prior to finalization of data in this report.
- The visits also included a review of the most recent ACT or CST fidelity reviews conducted by the Illinois Collaborative for Access and Choice to determine that the cost data reflected a service that was in compliance with Rule 132.
- The site visits also included clinical record reviews of a sample of ACT and/or CST clients to support an examination of the current authorization process, which is covered in a separate report. These clinical record reviews yielded a non-statistical overview of the profile of ACT and CST clients which is summarized in this report to facilitate DHS/DMH planning and to support the recommendations for changes to ACT and CST rates and requirements.
- In addition to submitting all requested data, providers were very generous with the staff resources invested in the onsite visits. The staff who were available to consultants and DMH staff throughout the visits allowed a greater exchange of information and more comprehensive analysis and recommendations.

## Analysis

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Summaries of key financial measures for ACT and CST for providers (de-identified) offering these services are available in Attachments 1 and 2, respectively. Two providers offered both ACT and CST, one provider offered only ACT and one provider offered only CST. The results of the rate review are summarized below:

- ACT operated at a positive margin of 12 – 36% of revenues for all three providers, with team sizes ranging from 39 clients to 133 clients. The smallest ACT team will break even with approximately 38 clients per team.
- It was much more challenging to operate CST at a positive margin, with actual margins ranging from breakeven to a negative 4% with teams that ranged in size from 38 – 64 clients.
- The structure of CST contributes to operational and financial challenges for this service since it is not an all-inclusive service. CST staff typically provide a larger range of services than in the ACT model, and the assessment, treatment planning, medication monitoring and counseling services are at lower rates than CST. In addition, providers financial systems were found to allocate revenues for non-CST services provided by CST staff to other cost centers, causing CST to appear to perform at larger losses than when staff expenses and all revenues from those staff are aligned in the CST cost center. The misalignment of CST revenues and expenses may contribute to providers choosing not to add or expand CST services.
- Productivity levels, as measured by billable hours divided by paid hours, varied widely across providers. Productivity for CST staff ranged from 39 – 57%, and 40 – 69% for ACT staff.

- Team leaders' productivity was about half of full time team members due to their supervision responsibilities.
- The provider with high ACT productivity rates indicated that the rates were achieved by exempt staff who consistently worked more than 40 hours per week. Therefore, the ACT productivity rates for this provider should not be considered feasible in future rate setting models.
- Percentages of services delivered outside office settings were high, averaging 82% for ACT and 62% for CST.
- Personnel costs for staff delivering direct services to clients comprise the majority of the service costs and were 65 – 69% for ACT and 59 – 65% for CST.
  - RSAs were used very little on team services, with two of the providers using no RSAs at all. This credential was originally included in the service definition as a doorway for enhanced recovery support specialist involvement in teams, but it appears these teams had recovery support specialists who met the definition of a higher credential. The low representation of RSAs increases the unit costs for these services.
- The rate model used for the visits calculates other direct costs and indirect costs as a percentage of direct service personnel costs because direct service staffing can be identified and measured more consistently across providers.
  - Other direct costs as a percentage of direct service personnel averaged 20% for ACT and 33% for CST.
  - Indirect costs as a percentage of direct service personnel averaged 24% for ACT and 22% for CST.
  - One provider had direct and indirect cost rates that were substantially higher than other providers for CST. A portion of the higher CST costs were attributable to cost allocation methods because other direct and indirect costs were allocated per team and not by personnel costs. However, a change to the allocation method would increase ACT costs and reduce the margin for that service.

### ***Additional Barriers to Expansion of Team Based Services***

Each provider visit included discussions about barriers to expansion of team-based services, and the following themes emerged.

- Reductions in ACT capacity appear to be a result of two primary issues—the higher costs to operate ACT and the requirement that any staffing vacancies be filled within 30 days to continue to bill ACT.
  - Many providers converted to CST in 2007 at the time of the rule change due to the change in service requirements to achieve the evidence-based practice. Additionally, the current positive financial margins for ACT are not widely known in the provider community.

- Filling the RN position on the team is the biggest staffing challenge according to providers' experience. Providers generally agreed that nurses may be available, but their salary costs would be higher than the ranges currently offered by many DMH providers. However, these higher costs for nursing staff are well supported by existing ACT rates.
- Providers uniformly indicated difficulties with the absence of a non-Medicaid benefit for team-based services, and that could impact their ability to serve Williams class members at the time of discharge if Medicaid eligibility is not in place. Also, if class members move in and out of Medicaid eligibility after discharge, access to team services could be problematic.
- The clinical record review showed situations where consumers who would meet criteria for ACT chose to receive CST in order to be able to participate in PSR. Because ACT is an all-inclusive service, if a consumer is enrolled in ACT, PSR cannot be billed except during a limited transition period.
- Providers indicated willingness to expand to geographic areas where team-based services are not available, if there are sufficient eligible and interested clients to support a team. Serving a single client or a small number of clients in an area would be challenging without financial support in addition to the current fee for service rates.
- One provider indicated that FY12 contract reductions could prevent expansion of services even if the reductions were not directly attributable to ACT or CST. The possible level of DMH and DASA contract reductions would require infrastructure and staffing adjustments that could impact the overall viability of this provider.
- One provider budgets for 3% rejected claims, primarily due to Medicaid eligibility issues or post payment review issues. Because other providers did not include reserves in their financials or indicate problems with rejected claims after resubmissions, reserves were not included in the model.
- All providers indicated concerns about expanding services during budget reductions and payment delays.

## Clinical Profile

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As part of a more extensive effort to review the efficacy of the medical necessity authorization process currently in place, Parker Dennison and Division of Mental Health Licensed Practitioners of the Healing Arts (LPHAs) reviewed the clinical records of 25 individuals enrolled in CST and 27 individuals enrolled in ACT. Using a tool developed by Parker Dennison and DHS/DMH clinical staff, the following medical record components were reviewed for the time period July 1, 2010 – December 31, 2010:

- Mental Health Assessments and updates as applicable
- Treatment plans and updates
- LOCUS scores
- Six months of progress notes (both medical staff and program staff notes)

- Integrated summaries (if available).

Sample size for the reviews was significant in all but one provider for CST and was as follows:

CST			
Provider #	# Enrolled in Team as of 12/31/10	# Records Reviewed	% Enrollees Reviewed
1	38	10	26.3%
2	72	5	6.9%
3	1182	10	0.8%
ACT			
1	41	10	24.4%
2	133	10	7.5%
3	59	7	11.9%

Key characteristics from these reviews include:

- Average time enrolled in CST at the time of review was 2.2 years with a median of 2.1 and a range of 1 – 4 years.
- Average time enrolled in ACT at the time of review was 3.2 years with a median of 2.2 and a range of 1 – 10.4 years.
- Frequency of contacts was evaluated as consistent with documented necessity in 92% of the CST records reviewed and 81% of the ACT records reviewed.
  - Patterns of 4-7 contacts per week were noted in most cases where medical necessity was in evidence.
- Assertive outreach and engagement attempts were overwhelmingly present in both ACT and CST records. These contacts were far less likely to occur on weekends.
- On nearly all dimensions, the acuity of the individuals enrolled in CST was as high or greater than those enrolled in ACT. Key elements:
  - Two or more hospitalizations in prior 12 months: CST – 36%, ACT – 37%
  - Two or more crisis services in 30 days: CST – 32%, ACT – 14.8%
  - Chronic homelessness (HUD definition): CST – 20%, ACT – 7.4%
  - Repeat arrests/incarceration: CST – 16%, ACT – 14.8%
  - Approximately 84% of both ACT and CST records reviewed evidenced co-occurring needs, with the highest prevalence in medical needs, followed distantly by co-occurring substance use needs.
  - Individuals in CST were notable for a very high medical acuity and complexity. For example, at one provider the records reviewed for CST documented an average of 11 non-psychotropic medications per individual.
    - Providers expressed concern in some cases that the bulk of their contacts were focused on medical problems and related service coordination and wanted reassurance this did not create a Medicaid

compliance issue. While a statistical review of frequency of medical contacts was not conducted, reviewers anecdotally confirmed a high frequency in notes reviewed.

- Average contact hours per week for ACT were 2.4 hours.
- Average contact hours per week for CST were 1.7 hours.

## Recommendations

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- Based on the sample reviewed it appears that CST is being used to address the needs of individuals with a much higher acuity and complexity than originally contemplated in the service definition. Team composition, especially the lack of medical resources on the team, is not structured to meet the high frequency of co-occurring needs, or to routinely get the level of supervision and medical consultation indicated.
  - Though not standardized or enforceable from a Rule 132 basis, providers have worked around this limitation in most cases but the ala carte billing (in contrast to the bundled rate of ACT) means that most of these consultation and supervision activities are not built into the rate. This likely significantly contributes to the questionable financial viability of offering CST.
  - DHS/DMH should consider expanding the review of CST clinical and definition issues beyond the limited number sampled in this field review. This could be incorporated into the annual service definition fidelity reviews that are part of the role of the ASO. Aggregate results from these fidelity reviews should then be used to inform any necessary service definition changes as described in the options below.
  - If DHS/DMH's fidelity reviews for CST appear largely consistent with the findings in this report, the CST definition should be reviewed and revised for better alignment of requirements and rate with the acuity and needs of the individuals being served. There are several potential approaches to this including:
    - Option 1 – Expand availability of ACT services so there is an available ACT team in each service area in which there is an adequate concentration of covered individuals. With appropriate medical necessity training and review, individuals with higher needs could be referred to ACT while those with more moderate/moderate high need could be referred to CST. This would allow DHS/DMH to continue to work within the existing service definitions while better aligning the service to the acuity it was intended to serve.
    - Option 2 – Modify the CST service definition and team requirements to better reflect the acuity of the individuals being served. This could be done with a change to Rule 132 and would not require a Medicaid State Plan modification unless there is a change in definition or rate methodology that would be in conflict with the existing Plan

language. This would likely result in increased requirements for CST and consequent increased costs resulting in an increase in the rate for CST.

- Option 3 – Modify the definition of CST to make it an all-inclusive service similar to ACT. This change would reflect the nature of the service in practice and allow providers to bill the higher CST rate for the ancillary services provided by CST staff, such as assessment, treatment planning, medication monitoring and counseling. This would require considerable policy discussion to determine how this “new” CST was different from ACT and would likely require a State Plan amendment and Rule change.
  - Option 4 – Modify the team services array to have a single team based service with two (or more) levels of intensity and associated rates. This is more complex and requires considerable policy discussion as it would likely require changes to the ACT definition in the State Plan and associated changes in Rule 132.
- DMH should disseminate the information from this report to providers to ensure understanding of the current financial margin available for ACT and the need to align all revenues for services provided by CST staff with the costs to accurately assess the viability of CST.
  - DMH should consider lengthening the maximum allowed time for team member vacancies from 30 days to 45 days. This combined with provider education regarding successful interim solutions to this issue used by other providers may increase interest in re-establishing ACT teams where needed.
  - The financial viability of CST should be addressed, and three options are available.
    - A portion of the poor margins on CST appears to be attributable to lower productivity rates compared to ACT. Providers should be encouraged to develop strategies to increase CST productivity rates to 50% which appears feasible given the level of offsite CST services.
    - DMH should consider an increase to the CST rate to insure its viability and attractiveness to providers with the planned transition of Williams class members. This will be more important if DMH is unsuccessful in expanding availability of ACT in areas where none currently exists.
  - DMH should proceed with its efforts to develop consumer-operated drop-in-centers to address the needs of consumers enrolled in ACT (and other services). Rule 132 will need to be revised to allow the new drop-in service to be billed for consumers enrolled in ACT. While Medicaid funding may be available for some portion of the funding for this service (requiring state plan and Rule changes), DMH may want to consider piloting the service with non-Medicaid funds targeted to Williams class members. Best practices and other information learned from this pilot could be used to develop the final service definition and Rule language which could be used to draft the necessary Medicaid state plan amendment.

- DMH will need to offer start-up funding to develop team-based services in geographic areas not currently served by providers offering ACT and CST services. Consideration should be given to issuing RFPs or RFIs to develop services in new locations to assure cost effectiveness and establish performance standards for new team development.
- DMH should develop mechanisms to assure availability of team-based services for Williams class members at times where Medicaid eligibility has lapsed. A new eligibility group for Williams non-Medicaid individuals may be the optimal way to track these consumers and prevent the benefits and the associated costs from expanding beyond the targeted Williams class members.
- Unit service costs could be reduced and geographic accessibility could be improved if providers can develop larger teams that operate on a multi-site basis. Larger teams allow physician and nursing staff and non-productive team lead time to be spread over more consumers. Teams that cover more than one site will allow with the economies of scale for larger teams and will improve geographic accessibility. Providers will need to develop practices that allow team meetings and supervision to occur via phone and require physicians and nurses to offer office-based services at different locations throughout the week. DMH should work with providers to develop pilot projects to develop models for multi-site teams.
  - DMH should consider issuing guidance to the field validating that telephonic and video conferencing for team meetings is acceptable and meets fidelity requirements.
- A preliminary analysis comparing the costs projected in the rate model used to set rates in 2007 and current provider costs indicated significant variances in costs by category. For example, compared to current actual results, the rate model for 2007 rates had service costs lower, indirect costs higher, productivity higher and offsite services lower. Since some of the variances offset, the net difference in rates was not as large as expected. The cost differences are likely a combination of the impact of transitioning to fee for service and the time elapsed since the rates were set. However, DMH should consider additional analysis and revisions to the model used to set rates before any new rates are established.

## Attachments

## Attachment 1 ACT Summary

Key Measures	Provider A	Provider B	Provider C	Average
<b>Number of teams</b>	1	1	1	
<b>Number of clients</b>	59	133	41	78
<b>Team FTEs (includes MD/excludes asst)</b>	8.2	15.5	7.3	10
<b>Clients per team FTE</b>	7.2	8.6	5.7	7.1
<b>Average contact hrs/wk</b>	2.5	2.3	2.5	2.4
<b>Offsite service % (hrs)</b>	82%	77%	88%	82%
<b>Weighted avg hourly rate</b>	119	119	121	119
<b>Cost per hour</b>	77	83	106	89
<b>Breakeven clients</b>	38	82	36	52
<b>Direct service personnel % total costs</b>	65.4%	69.1%	68.9%	67.8%
<b>Fringe/tax rate</b>	25.0%	37.0%	24.5%	28.8%
<b>Other direct cost rate (% of direct service personnel)</b>	28.6%	15.2%	17.4%	20.4%
<b>Indirect cost rate (% of direct service personnel)</b>	18.9%	25.7%	27.7%	24.1%
<b>Other direct cost rate (% of total costs)</b>	18.7%	10.5%	12.0%	13.7%
<b>Indirect cost rate (% of total costs)</b>	15.9%	20.4%	19.1%	18.5%
<b>Margin % of revenues</b>	35.9%	30.7%	12.0%	26.2%
<b>Productivity rates (% paid time)</b>				
<i>Team lead</i>	35.5%	25.3%	25.3%	28.7%
<i>Physician</i>	41.7%	27.8%	8.3%	25.9%
<i>RN</i>	51.5%	39.1%	39.2%	43.3%
<i>All other staff</i>	69.4%	48.9%	40.1%	52.8%
<b>Team composition (FTEs)</b>				
<i>Team lead</i>	1.00	1.00	1.00	1.00
<i>Physician</i>	0.19	0.50	0.25	0.31
<i>RN</i>	1.00	1.00	1.00	1.00
<i>LPHAs</i>	1.00	N/A	N/A	1.00
<i>QMHPs</i>	1.00	1.00	3.00	1.67
<i>MHPs</i>	4.00	11.00	2.00	5.67
<i>RSAs (excludes prog asst)</i>	N/A	1.00	N/A	1.00
<b>Average salaries</b>				
<i>Team lead</i>				44,626
<i>Physician (mix of contracted/employed)</i>				211,348
<i>RN</i>				50,167
<i>LPHAs</i>				41,354
<i>QMHPs</i>				37,469
<i>MHPs</i>				33,194
<i>RSAs</i>				20,800

## Attachment 2 CST Summary

Key Measures	Provider D	Provider E	Provider F	Average
<b>Number of teams (sampled teams only)</b>	1	2	4	
<b>Number of clients</b>	38	72	205	
<b>Average clients per team</b>	38	36	51	42
<b>Team FTEs</b>	4.0	8.5	18.0	10
<b>Clients per team FTE</b>	9.5	8.5	11.4	10
<b>Average contact hrs/wk (CST + svc provided by CST staff)</b>	2.0	1.7	1.6	1.7
<b>Offsite service % (hrs)</b>	58%	62%	77%	66%
<b>Weighted avg hourly rate (CST + all other svcs)</b>	77	77	81	78
<b>Cost per hour</b>	77	78	84	79
<b>Breakeven clients (per team)</b>	38	37	44	40
<b>Direct service personnel % total costs</b>	64.7%	65.4%	58.8%	63%
<b>Fringe/tax rate</b>	24.0%	25.0%	24.5%	25%
<b>Other direct cost rate (% of direct service personnel)</b>	34.1%	28.6%	37.7%	33%
<b>Indirect cost rate (% of direct service personnel)</b>	14.6%	18.9%	32.5%	22%
<b>Other direct cost rate (% of total costs)</b>	22.6%	18.7%	22.2%	21%
<b>Indirect cost rate (% of total costs)</b>	12.7%	15.9%	19.1%	16%
<b>Margin % of revenues</b>	0.1%	-4.7%	-3.1%	-3%
<b>Productivity rates (% paid time)</b>				
<i>Team lead</i>	15.7%	28.8%	33.0%	26%
<i>All other staff</i>	56.6%	49.1%	39.3%	48%
<b>Team composition (FTEs for average team)</b>				
<i>Team lead</i>	1	1	1.00	1
<i>LPHAs</i>	N/A	1	N/A	1
<i>QMHPs</i>	1	N/A	1.00	1
<i>MHPs</i>	2	2	4.00	3
<i>RSAs (excludes prog asst)</i>	0	0	0	0
<b>Average salaries</b>				
<i>Team lead</i>				45,217
<i>LPHAs</i>				43,899
<i>QMHPs</i>				34,188
<i>MHPs</i>				31,558
<i>RSAs</i>	N/A	N/A	N/A	N/A