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Oregon Health Authority

Oregon Department of Human Services

Office of Child Welfare

Oregon Youth Authority

Children's Treatment Services
Rate Study Report

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Executive Summary

The Oregon Health Authority (OHA), the Oregon Department of Human Services (ODHS) Office of Child Welfare, and the Oregon Youth Authority (OYA) (collectively "the State" or "state agencies") are seeking to address challenges faced by providers participating in the Children's Treatment Services program. Based on discussions with providers and the State, providers are facing workforce sustainability issues stemming from the COVID crisis along with legislative changes that have increased administrative responsibilities. These factors indicate the need for improved system sustainability, and the State determined it was necessary to collect data and conduct a rate study, which the State contracted with Myers and Stauffer to perform. The State and Myers and Stauffer engaged with providers to gain a better understanding of where state reimbursement is not matching the cost of doing business. The goal of the rate study is to combine data from providers with available market data to support the development of an updated rate structure that promotes ongoing sustainability of providers of these services and their participation in Medicaid and other state programs.

The rate study comprised three phases and included the following services:

1. Rate Study Phase 1 – Secure Inpatient Psychiatric Residential (SIP), Psychiatric Residential Treatment Services (PRTS), and Subacute Psychiatric Residential (SA).
2. Rate Study Phase 2 – Substance Use Disorder (SUD) Residential and Psychiatric Day Treatment Services (PDTS).
3. Rate Study Phase 3 – Behavior Rehabilitation Services (BRS) and Intensive In-Home Behavioral Health Treatment (IIBHT) Services.

Through discussions with the State, it was determined the rate study project would contain the following key steps:

1. Develop a survey instrument to collect data from providers on which to establish new or updated rates. For Phase 1, due to the short time frame for rate development, the survey was condensed to facilitate timely provider completion of the survey.
2. Engage the provider community by conducting meetings with the provider entities performing the impacted services to walk through each survey, have an open discussion to hear their concerns regarding the provision of services and current rate levels, and make adjustments to the surveys, as needed, based on provider and State feedback.
3. Collect surveys from providers, review submitted surveys for completeness, and request additional information from providers, if necessary.
4. Construct a rate model for each service type using data reported by providers, supplemented with market data (e.g., Bureau of Labor statistics wage data) if necessary.

5. Prepare draft rates for discussion with the State. SIP, PRTS, SA, SUD, PDTS, and BRS services are reimbursed on a per diem basis. IIBHT services are reimbursed on a per member per month (PMPM) basis.

Phase 1 discussions with the State began on November 9, 2021. Activities related to reviewing background information regarding the programs (which included meetings with individual providers) and the initial design of the data collection surveys took place in November and December 2021. Provider data was submitted, reviewed, and compiled in January 2022, and initial draft modeling was presented to the State in early February 2022, with final modeling provided to the State in late February 2022.

Phase 2 discussions with the State began on June 3, 2022. Activities related to reviewing background information regarding the programs and the initial design of the data collection surveys took place in June 2022. Provider data was submitted, reviewed, and compiled in July and August 2022. Initial draft modeling was presented to the State in September 2022, and updated draft modeling was provided to the State in October 2022.

Phase 3 discussions with the State began on June 27, 2022. Activities related to reviewing background information regarding the programs and the initial design of data collection surveys took place in June and July of 2022. Provider data was submitted, reviewed, and compiled from August to October 2022. Initial draft modeling was presented to the state agencies in November 2022, and final modeling was provided in December 2022, with model adjustments occurring in January and February 2023.

Rate Study Concepts

The objective of the rate studies conducted in all phases was to establish new or updated fee schedule rates across the Children's Treatment Services array. It is important to determine appropriate rates for these services to ensure access to care through long-term workforce sustainability and incentivize delivery of the services under program standards, while remaining cost effective. Rates should generally correlate to the cost of providing services, particularly direct service personnel costs. It is important to note that while rates may be based on cost information, the results of a rate study do not typically result in cost settlement reimbursement to providers.

The fundamental concept of the rate development is a cost modeling methodology. Under this methodology, rates are constructed using cost and utilization data collected from providers, supplemented with market data and other data available to the state. The anticipated outcome is the development of draft rates that facilitate a payment structure that promotes ongoing participation in Medicaid and other state programs by these providers as well as workforce sustainability. The rate setting methodology should also be replicable in future years. In the event state agencies determine a

rate update is warranted in the future, the process deployed for this rate study can be repeated in order to establish updated rates.

Limitations

In conducting this rate study, we relied on information obtained from discussions with OHA, ODHS, OYA and providers, information reported by providers through the information and data collection process, Bureau of Labor Statistics information, and our experience with other similar programs. The rate calculations are supported by numerous data points and assumptions. To the extent there are limitations with the information and data obtained and used in the rate model, the resulting rates will be impacted by those limitations. For example, provider data varied widely across the service types and providers, and for some services, no provider data was reported. Therefore, state agencies should consider the data inputs and assumptions when determining the rates to implement.

In Phase 3, we received no data or incomplete data for the following nine BRS service types: *Shelter Proctor, Community Step-Down Res Non-QRTP, Community Step-Down Res QRTP, ILP Proctor, ILP Res Non-QRTP, ILP Res QRTP, Enhanced Structure ILP QRTP, Short-Term Stabilization Non-QRTP, Short-Term Stabilization QRTP, and IBS Non-QRTP*.

This engagement was performed under the American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. Myers and Stauffer performed this engagement under the direction and oversight of the State, who made and retained responsibility for all management decisions. We were not engaged to and did not conduct an examination or review on the costs, utilization, or other information from providers in Oregon. Accordingly, we do not express such an opinion or conclusion. In addition, Myers and Stauffer prepared this report for the purpose of presenting draft rates for the Children's Intensive Treatment Services (ITS) program to the State. The report should not be used by any other party or for any other purpose.

Stakeholder Engagement and Information Collection

Data Collection Survey Development and Training

The primary data source used in this rate study was information collected from providers through a data collection survey that collected cost, utilization, and other pertinent information. Surveys were developed for each of the services included in this rate study. The structure of the surveys varied and was adapted to collect data applicable to the services performed by providers. Information collected in the surveys included facility information such as beds, client days, and square footage; direct care, administrative, and other staff costs and hours; and non-staffing program costs and facility overhead. As noted previously, the Phase 1 survey was condensed to facilitate a shorter response time by providers. In Phase 3, because IIBHT services are performed in-home, the survey contained fewer schedules than the BRS survey and focused on collecting information on the number of clients, service hours, direct care staffing costs, administrative overhead, and non-staffing costs such as program supplies and travel. In all phases, providers were encouraged to report 12 months of cost data for a period that accurately reflects the cost of providing services under these programs. The time period of data reported on the survey was used to determine the inflationary options that can be applied to staffing and other program costs.

In each phase, stakeholder sessions with providers were conducted in which state agencies and Myers and Stauffer presented an overview of the initiative, listened to provider concerns, suggestions, and feedback, provided instructions for completing the survey document, and discussed timing and next steps. In Phase 1, due to the short time frame and the small number of providers, the State and Myers and Stauffer conducted meetings with individual providers that occurred from December 15, 2021 through December 20, 2021. Providers were asked to submit the surveys as soon as possible in January 2022.

For Phase 2, the State and Myers and Stauffer conducted stakeholder training sessions on June 6, 2022 and June 9, 2022. These training sessions were followed by two Questions and Answers sessions on June 22, 2022 and June 30, 2022. Providers were asked to submit their surveys in July 2022. Extensions were granted for providers who needed more time to complete the surveys.

The State and Myers and Stauffer conducted a stakeholder session with BRS providers on July 27, 2022 and a session with IIBHT providers on August 2, 2022. These training sessions were followed by two Questions and Answers sessions on August 17, 2022 and August 29, 2022 in order to walk through the surveys in further detail and address questions and concerns communicated by the providers. Feedback from these stakeholder sessions was incorporated into the surveys, and final versions were distributed

to providers to complete. Providers received 30 days from the date of the second stakeholder training session to complete and return the surveys. Extensions were granted for providers who needed more time to complete the surveys.

Data Collection Survey Review

We reviewed each of the submitted surveys to determine completeness and accuracy of information. Providers were contacted to request additional documentation and/or to provide an explanation of issues discovered during the review, and to the extent responses were received from providers, the surveys were adjusted as necessary. It should also be noted that while the majority of the submitted surveys could be utilized, there remained certain limitations with the information. Some providers chose not to report on certain schedules and sections in the survey, or reported information that did not appear accurate.

This was the first opportunity in recent years for this group of providers to report this level of information. We typically find that data quality improves with the experience of providers, with the greatest improvement occurring between the first and second survey initiatives. We would anticipate improved, more representative data the next time the State were to survey providers.

Tables 1 through 4 below list the responses received from providers in each phase and indicates whether the submitted survey could be included in modeling. The "Provider Communication" column of each table reflects whether the provider communicated with the State or Myers and Stauffer regarding the rate study initiative, through submission of a survey or through questions regarding the survey completion or rate study process. Not all providers who communicated an interest in the project submitted a survey. The "Survey Data Submitted" column of each table indicates whether the provider submitted a survey. Not all surveys were usable, and the providers with usable surveys are noted in the final column of each table.

For Phase 1, all of surveyed providers submitted a survey for the rate study. For Phase 2, 9 out of 11 surveyed providers submitted a survey for the rate study. For Phase 3, 17 out of 40 surveyed BRS programs submitted a survey for the rate study, and 4 out of 20 surveyed IIBHT programs submitted a usable survey for the rate study.

Table 1 – Phase 1: SIP, PRTS, and SA Provider Responses

Provider Name	Service Type	Provider Communication	Survey Data Submitted	Survey Included in Modeling
Albertina Kerr	SA	X	X	X
Jasper Mountain	PRTS	X	X	X
Looking Glass	PRTS, SA	X	X	X
Trillium	SIP, PRTS, SA	X	X	X

Table 2 – Phase 2: SUD Residential and PDTS Provider Responses

Provider Name	Service Type	Provider Communication	Survey Data Submitted	Survey Included in Modeling
Family Solutions	PDTS	X	X	X
Kairos Northwest	PDTS	X	X	X
Klamath Basin Behavioral Health	PDTS	X	X	
Madrona Recovery	SUD Res.	X	X	X
Olalla Center	PDTS	X	X	X
Old Mill Center	PDTS	X	X	X
Rimrock Trails	SUD Res.	X	X	X
The Child Center	PDTS	X	X	X
Trillium	PDTS	X	X	X

Table 3 – Phase 3: BRS Provider Responses

Provider Name	Provider Communication	Survey Data Submitted	Survey Included in Modeling
Jackson Co. Community Justice–Juvenile Division	X	X	X
Looking Glass	X	X	X
Maple Star	X	X	X
Douglas County Juvenile Department	X	X	X
Marion County Juvenile Department	X	X	X
The Next Door	X	X	X
Parrott Creek	X	X	X
Oregon Community Programs	X	X	X
St. Mary's Home for Boys	X	X	X
Connections 365	X	X	
Family Solutions	X	X	X
Morrison Child & Family Services	X	X	X
Greater Oregon Behavioral Health Inc.	X	X	X
Janus Youth	X	X	X
Homestead Youth & Family Services, Inc.	X	X	X
Washington County Juvenile Department	X	X	
Community Counseling Solutions	X		
Community Justice and Rehabilitation Services	X		
Clackamas County Juvenile Department	X	X	

Table 4 – Phase 3: IIBHT Provider Responses

Provider Name	Provider Communication	Survey Data Submitted	Survey Included in Modeling
The Child Center	X	X	X
Southern Oregon	X	X	X
Malheur County Lifeways	X	X	X
Coos Health and Wellness	X	X	

Information from the providers noted in column 4 of each table were included in rate modeling. Cost data was excluded from modeling if the provider was unable to submit a trial balance or equivalent financial information that could support the reported cost data. In addition, cost data was excluded from modeling if the provider was unable to respond to requests for additional information. This was primarily due to provider staffing shortages or not having the requested information readily available.

Rate Development

Rate Study Components and Rate Calculations

The rate setting methodology utilized in all phases of the rate study incorporates the rate setting concepts described in the Project Background section of this report to build up a payment rate for each service type. The rate calculations are based on multiple data sources. The primary data source is provider-reported staffing and non-staffing program costs and utilization. Other data sources used to supplement provider-reported information include United States Department of Labor, Bureau of Labor Statistics (BLS) wage data and input from the State. For Phase 3 modeling for BRS, the staffing allocation from the State's current BRS rate model was also utilized. For each phase, information from the various source was aggregated into a rate model to calculate the cost per unit of service. Each rate model was designed with the flexibility for state agency staff to modify data inputs and assumptions to adjust the calculated rate(s). Although the rate models varied by phase due to the differences in service rates being modeled, the general steps to develop the rate models are described below. It is recommended that states participate in a provider cost survey process each biennium to ensure ongoing calculations to these methodologies are aligned and current.

Step 1. Collect and review staff costs and hours and calculate hourly cost by staffing position.

We learned during our discussions with the State and feedback from stakeholder sessions that a significant issue facing the provider community is attracting and retaining direct care staff. This includes staff who reflect the demographics of the clients within each program. As a result, current provider cost structures may not represent the cost of providing services in an optimal operating model. One method we used to understand the true cost of service was to collect actual historical staffing cost and staffing cost needed for sustainability. Historical staffing cost data was submitted for a 12-month period chosen by the provider. We encouraged providers to use the most recently ended fiscal year; however, providers could use any 12-month period that most represented the provider's cost of performing the services reflected in the survey.

The sustainability staffing costs were estimates reported by each provider to represent the cost necessary to attract and retain staff in a highly competitive labor environment. In addition to sustainability costs for wages and benefits, providers could also report vacant or budgeted positions that did not have historical costs associated with them. Information for historical vs. sustainability staff positions are separated or denoted in each rate model. If the State chooses to use only historical costs in the models, costs associated with sustainability positions will not be considered in the rate calculations. Whether the models use historical or sustainability costs is dependent on the State's selection in the Options section of each rate model.

In the rate models, wage data can be inflated based on two inflationary indices – the Medicare Economic Index (MEI) or the Consumer Price Index (CPI). The selection of the inflationary index is an option that can be changed in the rate model. Once selected, inflated wages are divided by the total hours reported by providers for each position to develop a wage cost per hour used in Step 2.

Step 2. Compare reported hourly wages by position to BLS benchmark data.

Information from the Bureau of Labor Statistics (BLS) was used as a secondary source of wage data. The rate models allow the State to consider wage blending as a method to increase direct care staffing costs to align with BLS market data (if BLS wages are greater than provider-reported wages). After provider staffing positions were mapped to equivalent positions within the BLS occupational categories, a comparison was made between the average hourly rate for the staff categories computed from cost data and the average hourly rate for the BLS category. An adjustment was made to the cost data by blending the provider-reported wage data and BLS wage data when significant deviations (>25%) exist between the cost data and the BLS wage data, to adjust for certain positions that may have low wages. Within the models, the State can select the level of wage blending in 5% increments, where a 0% selection represents full provider-reported wage data, a 100% selection represents full BLS wage data, and a 50% selection represents the average of both data points. In addition, the rate model contains the flexibility to evaluate by staff position various data points from the BLS wage data in addition to the average, such as the median, 75th percentile, or 90th percentile.

Although all reported positions are mapped to a BLS position, only wages for direct care positions were included in the wage blending calculation. Because BLS data represents base salaries before fringe benefits, we added a calculation to increase fringe benefits proportionately to the increase in hourly cost resulting from wage blending. The inflated salary and benefits were summed to achieve the total inflated compensation cost. In certain models, the State also has the opportunity to increase direct care wages in the rate model in 5% increments. This is an additional option for incorporating market adjustments to provider data and can be used in combination with wage blending. Prior to wage blending, the BLS wage information is inflated per the index selected by the State. Note that in addition to BLS information, Oregon Wage Information (OWI) data is an available option the State can select in the BRS rate model (in alignment with the state's previous BRS rate model).

Step 3. Collect and review non-staffing program costs reported by providers.

The data collection surveys collected historical direct care, administrative, and facility overhead costs incurred during the same 12-month period used to report staffing costs and utilization. We assigned each cost item to a cost category to be used in the rate calculations. Because of differences in the data collection surveys and the rate model structures, cost category assignment differed between the phases. In Phase 1, costs were categorized as Non-Personnel Direct Care Costs, Administrative Overhead Costs, Room and Board Costs, and Regulatory Compliance Costs. The Regulatory Compliance Costs category was a specific cost category included in the survey as a result of feedback during the initial conversations

with providers. In Phase 2, costs were categorized as Non-Staffing Other Program Costs and Room and Board Costs (SUD residential).
In Phase 3, costs were categorized as Direct Care/Admin, Room and Board - Partial, Room and Board - Full, and Other Programs. In the BRS model, we further divided the costs into eight cost categories for rate modeling as follows: Program Supplies, Staff Training and Accreditations, Professional Fees, Client Maintenance/Assistance, Proctor Care, Facility Overhead, Other Admin, and Non-Reimbursed. Room and board cost includes expenditures such as rent, utilities, and food. In the BRS model, costs labeled as partial room and board can be reimbursed by Medicaid through the service rate to the extent that the cost is medical or administrative in nature. The reimbursable amount is determined by using square footage of the facility allocated between direct service, administrative and general, and room and board. The remaining room and board costs are included in the BRS Maintenance rate category. It should be noted that county-based BRS programs that are contracted with OHA are required to directly fund the non-Medicaid portion of the rate.

In all phases, non-staffing program costs were reviewed and validated to supporting documentation supplied by each provider. Providers were asked to provide a working trial balance, profit and loss (P&L) statement, or other source of financial documentation to substantiate reported costs. Where figures differed, we adjusted the reported survey amount to match the financial documentation. After costs were validated to the source documentation, we reviewed reported costs to determine if they were allowable for state reimbursement programs by applying federal reimbursable cost principles. Most reported costs were determined to be allowable costs of operations. Cost items that are non allowable per federal reimbursable cost principles, such as lobbying costs, were removed. We reviewed sustainability cost for allowableness under federal reimbursable cost principles but did not compare to financial documentation as this information is an estimate made by the provider.

Similar to staffing costs, the survey allowed providers to report the amount of non-staffing costs required for sustainability if different from the historical costs on the trial balance. The survey was prepopulated with several direct care, administrative, and room and board cost categories, but the provider was also able to write in cost categories, when necessary. Providers either performed allocations prior to submitting the survey or used the survey's allocation methods based on metrics such as square footage, revenue, and FTEs to determine how much of the total trial balance cost should be allocated to the applicable program. Costs allocated to non-children's ITS programs were not included in rate modeling. Additional details and calculations regarding cost aggregation and allocation steps are outlined in the models.

Step 4. Develop a rate build-up for each service type.

In the rate models, compensation and other program costs were aggregated for each provider. Costs were divided by units of service to determine the rate. The specific approach for each rate model is outlined below.

Phase 1 Rate Model – SIP, PRTS, and SA

We accumulated each provider's costs and units of service from the reviewed surveys. The unit of service for SIP, PRTS, and SA is a day of care. Costs were divided by days to calculate the cost per day for each provider and for each service. The data collection survey allowed providers to report patient days on the basis of actual days or typical days, where actual days represented the number of patient days provided based on actual bed occupancy, and typical days represented the number of patient days that reflects bed occupancy in a non-pandemic environment (i.e., without the impacts of the COVID-19 pandemic on occupancy and utilization). In the model, we also calculated a third option based on bed capacity multiplied by 365 days. These options give the State flexibility in evaluate different rate options using varying units of service denominator values.

In addition to options for calculating patient days, the rate model contained a number of other options for State agency staff to consider in modeling per diem rates for SIP, PRTS, and SA. Options include the type of inflationary index (MEI or CPI), fringe benefits amounts (e.g., reported by providers or calculated from BLS information), occupancy percentage for calculated days of service, and actual vs. sustainability wage information.

Based on the options selected by State agency staff, the model calculates daily rates for SIP, PRTS, and SA. Rate options are presented using weighted average and simple average options of provider cost-per-day values. Table 5 below contains the results of the rate calculations. These amounts may change as the state reviews and edits the assumptions in the rate model workbook. *Refer to the State agency published rates for the final implemented rates.*

***Table 5 – Phase 1 Rates:* SIP, PRTS, and SA**

Service Type	# of Survey Responses	Weighted Average Per Diem	Simple Average Per Diem
Secure Inpatient Psychiatric Residential (SIP)	1	$1,270.00	$1,270.00
Psychiatric Residential Treatment Services (PRTS)	3	$669.00	$631.00
Subacute Psychiatric Residential (SA)	3	$818.00	$927.00

Phase 2 Rate Model – SUD Residential and PDTS

The Phase 2 rate model accumulates each provider's costs and units of service from reviewed surveys to calculate a cost per unit. Similar to Phase 1 services, the unit of service for SUD Residential and PDTS is a day of care. Costs were divided by days to calculate the cost per day for each provider and for each service. The rate model contains three options for determining patient days. The first option is actual patient days reported from the data collection survey. The second option is calculated patient days based on functional bed capacity multiplied by 365 days. Functional bed capacity was obtained from the

state's ITS Capacity Tracker. The third option adjusts the calculated patient days in option 2 by an occupancy percentage that allows for the calculation of lower patient days if patient occupancy is less than 100%. Like Phase 1, these options give the State flexibility to evaluate different rate options by adjusting the units of service denominator values.

The Phase 2 rate model contained other options for State agency staff to consider in modeling per diem rates for SUD Residential and PDTS. Options include the type of inflationary index (MEI or CPI), actual vs. sustainability wage information, fringe benefits options (e.g., provider-reported actual data, provider-reported sustainability data, or calculated from BLS information), the BLS value (mean, median, 75th percentile, or 90th percentile) for wage blending, and the percentage for wage blending with reported wage data.

Based on the options selected by State agency staff, the model calculates daily rates for SUD Residential and PDTS. The rate calculation identifies the non-Medicaid room and board portion of the SUD Residential rate separately. Table 6 below contains the results of the rate calculations. These amounts may change as the state reviews and edits the assumptions in the rate model workbook. *Refer to the State agency published rates for the final implemented rates.*

Table 6 – Phase 2 Rates: SUD Residential and PDTS

Service Type	# of Survey Responses	Total Funds	Service	Room & Board
Substance Use Disorder (SUD) Residential	2	$656.29	$600.49	$55.81
Psychiatric Day Treatment Services (PDTS)	6	$569.09	$569.09	$0

Phase 3 Rate Model – BRS

Initial drafts of the BRS rate model calculated a reimbursement rate using provider-reported costs allocated to each service type. Like Phases 1 & 2, the unit of service for BRS is a day of care. Because of the small number of providers that reported each service, the data varied widely across providers and across services. To mitigate the impact of cost variation and small sample size, the final draft rate model aggregates staffing and other program costs across all providers included in modeling and uses aggregated data, combined with assumptions from the state's current BRS rate model, to calculate draft rates. Key elements of the calculation include:

Calculate the compensation per FTE for each staffing position.

Compensation per FTE is calculated by dividing the total compensation reported by providers for each State staffing position by the total FTEs for each position. Provider staff positions were mapped to staff positions in the State's rate model. In this area of the rate model, the state can select Oregon Wage Information (OWI) as an alternate wage source if desired.

Calculate the total program cost as a percentage of staffing costs for each cost category.
We aggregated the program costs reported by providers for each cost category. The amount for each cost category was divided by the total compensation included in modeling to calculate the percentage of program costs to staffing costs for each cost category.

In the BRS rate model, we developed individual rate calculation tabs to show the combination of staffing and non-staffing program costs by rate category for each of the twenty BRS service types. Each tab contains an allocation of FTEs from the State's current BRS model based on current State regulations and guidance regarding staffing ratios as well as the compensation amount by position title (e.g., Executive Director, Direct Care Staff). The initial FTE allocation includes the 'Admin Overhead' rate category, which is then reallocated across the remaining four categories: Service, Title IV-E, Maintenance, and Other. This is done by multiplying the Admin Overhead amount by the remaining categories' percentage of total cost.

Next, we added the other program cost categories to the rate build-up tabs, allocated across the four rate categories in alignment with the staffing costs allocation. Exceptions to this allocation include proctor care payments, which were allocated 70% to maintenance and 30% to service in alignment with the state's current BRS rate model; client maintenance/assistance, which was allocated 100% to maintenance; and room and board costs, which were allocated 100% to maintenance. In addition to these cost categories, we included three additional costs from the State's current model, if applicable to the BRS program: Staff EBT Costs, After Care, and QRTP Accreditation. The State has the ability to write-in a different amount for these categories in the model. The individual rate calculation tabs also contain placeholder "Other" rows for the user to enter additional cost items if desired.

We calculated a staffing cost per day and a non-staffing cost per day. The number of days was calculated as the number of beds multiplied by an occupancy percentage multiplied by 365 days. The number of beds varies by BRS program and was obtained from the State's current BRS model. The sum of the two cost amounts per day is the calculated per diem rate.

Additional amendments to the BRS rate methodology are recommended in effort to promote long-term workforce sustainability and enhanced quality of service delivery. First, a transition from the current 14-bed model to a 9-bed model for Intensive Residential and Short-Term Stabilization types of BRS care. Those requiring these types of service have more complex needs that are better met in a smaller milieu setting. Lastly, a recommendation to account for costs during a margin of vacancy at 5%. The current BRS model compensates providers for filled beds only, without accounting for vacancy to support costs associated with placement matching or space to hold available capacity for pending intakes.

Table 5 below contains the results of the rate calculations. These amounts may change as the state reviews and edits the assumptions in the rate model workbook. *Refer to the State agency published rates for the final implemented rates.*

Table 7 – Phase 3 Rates: BRS

Service Type	# of Survey Responses	Total Funds	Service	IV-E	Maint.	Other
Shelter Proctor	-	$306.99	$210.44	$21.31	$74.38	$0.86
Shelter Res	1	$365.16	$244.89	$13.56	$106.58	$0.13
Community Step-Down Proctor	1	$312.66	$215.37	$21.88	$74.53	$0.88
Community Step-Down Res Non-QRTP	-	$374.89	$252.02	$14.62	$108.11	$0.14
Community Step-Down Res QRTP	-	$379.33	$255.14	$14.80	$109.25	$0.14
ILP Proctor	-	$312.66	$215.37	$21.88	$74.53	$0.88
ILP Res Non-QRTP	-	$374.89	$252.00	$14.62	$108.13	$0.14
ILP Res QRTP	-	$379.32	$255.12	$14.80	$109.26	$0.14
Proctor Care	3	$328.21	$231.03	$21.25	$75.07	$0.86
Proctor Enhanced Services	3	$353.96	$253.09	$20.42	$79.63	$0.82
Enhanced Structure ILP Non-QRTP	1	$449.03	$292.86	$26.71	$129.32	$0.14
Enhanced Structure ILP QRTP	-	$453.45	$295.89	$26.98	$130.45	$0.13
Basic Res Non-QRTP	2	$435.87	$291.02	$12.81	$131.59	$0.45
Basic Res QRTP	2	$440.32	$294.13	$12.95	$132.78	$0.46
Intensive Res Non-QRTP	1	$666.14	$490.42	$21.64	$153.74	$0.34
Intensive Res QRTP	3	$673.05	$495.74	$21.88	$155.08	$0.35
Short-Term Stabilization Non-QRTP	-	$666.14	$490.42	$21.64	$153.74	$0.34
Short-Term Stabilization QRTP	-	$673.05	$495.74	$21.88	$155.08	$0.35
IBS Non-QRTP	-	$719.15	$518.65	$21.48	$178.34	$0.68
IBS QRTP	2	$726.06	$523.86	$21.70	$179.81	$0.69

Phase 3 Rate Model – IIBHT

IIBHT services are reimbursed on a per member per month (PMPM) basis, as opposed to a per-unit of service basis (e.g., per day). Because IIBHT is reimbursed through a PMPM payment, the annual number of distinct clients and service hours are used instead of days. In the IIBHT rate model, we created a rate build-up tab that contains allowable staffing costs, non-staffing program costs, and the number of annual clients reported by each IIBHT provider. We also aggregated the information across the three providers who reported IIBHT information to develop weighted-average cost information used in the final rate calculation.

For IIBHT, reimbursed on a PMPM basis, the following formula was used to calculate a reimbursement rate:

	Direct Care Staff Costs
+	Program Management and Other Administrative Personnel Costs
+	Non-Staffing Other Program Costs
=	Total Costs
÷	Annual Member Months (Total Number of Clients x 12 months)
=	Total Cost PMPM

Similar to the other rate models, the IIBHT rate model contained options that allow the State to choose inputs used in the final rate calculation. These include options such as the type of inflationary index (MEI or CPI), actual vs. sustainability wage information, fringe benefits options (e.g., provider-reported actual data or provider-reported sustainability data), the BLS value (mean, median, 75th percentile, or 90th percentile) for wage blending, and the percentage for wage blending. The model also contained an adjustment to operational capacity for the member-months calculation. Member months were calculated as total distinct clients annually multiplied by 12 months. The product is then multiplied by a percentage selected by the State to adjust for gaps in occupancy.

Table 8 below contains the results of the rate calculations. These amounts may change as the state reviews and edits the assumptions in the rate model workbook. *Refer to the State agency published rates for the final implemented rates.*

Table 8 – Phase 3 Rates: IIBHT

Service Type	# of Survey Responses	Calculated Rate
Intensive In-Home Behavioral Health Treatment (IIBHT) Services	3	$ 3,404.07

Appendix

BRS Rate Recommendation State Agency Impact

Table 9 – 23-25 Cost Change for Proposed BRS Rate Model: ODHS

Description	GF	OF	FF	TF
Cost Change from CSL if Proposed Rates Are Approved	$ 13,246,521	$ -	$ 7,133,706	$ 20,380,227

Table 10 – 23-25 Cost Change for Proposed BRS Rate Model: OYA

Description	GF	OF	FF	TF
Cost Change from CSL if Proposed Rates Are Approved	$ 22,021,486	$ -	$ 14,608,394	$ 36,629,880

Table 11 – 23-25 Cost Change for Proposed BRS Rate Model: OHA

Description	GF	OF	FF	TF
Cost Change from CSL if Proposed Rates Are Approved	$ -	$ -	$ 1,163,330	$ 1,163,330

*** Even when the increase in Other Funds (OF) would be offset by an increase in Other Revenue coming from the counties, OHA still would need additional limitation for both OF and FF.**

This projection does not consider any change in utilization levels from the previous biennium (21-23).

Likewise, it is important to mention that the amount of total funds (TF) for OHA does not reflect the total increase that counties would experience since OHA leverages only the service portion of the rate. IV-E, Maintenance, and Other are not leveraged through OHA. Service represents only 68% of the full BRS rate.