Montana Part C & FES Rate Studies

Montana Milestones Part C of the IDEA Early Intervention Program & Family Education & Support (FES) Program

Presented to:

Montana Department of Public Health and Human Services

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A. Executive Summary

In this report, Guidehouse Inc. (“Guidehouse”) presents our analysis and considerations based on reviewing the cost of providing early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA) and the Family Education & Support (FES) program reimbursed by the Montana Department of Public Health and Human Services (“DPHHS”, “Department”).

The Department contracted with Guidehouse to conduct a comprehensive provider rate study of services delivered under these programs to perform an analysis of current provider costs and review child population trends for the two program to evaluate current and future rate adequacy. Additional objectives included comparison of Montana’s reimbursement methodology for early intervention services with other state programs as well as other Montana health programs serving the same population. As a part of these studies, Guidehouse identified reimbursement best practices as well as evaluated the feasibility and potential desirability of transitioning to alternative payment approaches, such as a fee-for-service (FFS) system.

Stakeholder Engagement

At the inauguration of the rate study, Guidehouse worked with the Department to discuss the goals and background context of the rate study with providers, providing detailed information on the cost analysis approaches and avenues for provider engagement. Guidehouse and the Department conducted an extensive stakeholder engagement effort devised to inform, test, correct, and validate the provider cost and service delivery assumptions used in the analysis of provider costs and comparison to the current rates to inform the Department on the nuances in the current payment system and the changes in costs based on provider-reported data.

Guidehouse communicated the operating norms and scope of the engagement at the start of the rate study process and clarified that the Rate Methodology Workgroup would work to accurately capture the costs of service delivery in Montana. The Rate Methodology Workgroup, composed of the five Part C and FES providers and DPHHS staff, provided subject matter expertise on the provider survey and cost analysis process. The workgroup also reviewed and validated the factors and assumptions that impact current rates and provider costs incurred in providing services, including wages and salaries, benefits, administration, program support, and staffing. As part of the decision-making process, Guidehouse further coordinated with Department staff to review stakeholder feedback and cost analysis approaches.

Data and Methods

The rate study process drew on a wide array of data sources to review changes in population and provider trends. Guidehouse relied on provider-reported costs specifically collected via a Provider Survey and objective publicly available data sources. Guidehouse conducted the provider survey to capture provider cost data to furnish a cost foundation for rate studies, collect information on number of members served, billed, and in receipt of individualized service plans

to determine the appropriate metric for cost analysis, receive uniform inputs across all providers to develop standardized assumptions, and gather information for services under the Part C and FES programs.

The cost assumptions in the report frequently rely on the provider survey data in addition to national and regional standards that reflect wider labor markets while taking advantage of economic indicators reported in near-real time and more responsive to rapidly changing wage expectations. Guidehouse has documented the population trends and cost analysis in its full report, which also includes multiple methods for capturing and appropriately accounting for the providers costs for the Part C and FES programs.

Population Trend Analysis

The report also describes Part C and FES member count trends as reported in the provider survey over four years from SFY2019 through SFY 2022. Of note, the total number of unique billed member months has declined since SFY2019 for both Part C and FES programs. Conversely, the target population rates are projected to increase from the current rate at 2.36 percent to 2.86 percent in FFY 2025. While the target rates are projected to increase, given the declining population in Montana for this age group, the estimated target population for the Part C program for instance is projected to remain consistent with current trends. Guidehouse also noted that the FES program target population is estimated to be roughly 70 percent of the Part C program given a vast majority of Part C clients age into the FES program, based on analysis of contracted fee schedule data, claims, and provider survey data.

Cost Analysis

Guidehouse used two methods for determining typical costs per individual per month within the Part C and FES programs. One method (“top-down”) involves a review of the current bundled rate, utilizing aggregate cost data and utilization data (unique monthly members billed) to arrive at a monthly cost per member. An alternative, “bottom-up” method was used to estimate reasonable costs attributable to Service Coordination services for the FES program. As indicated in provider feedback, the FES program primarily consists of service coordination while Part C entails a wider range of additional services. Although current base rates for Part C and FES are identical, a working hypothesis of the rate study is that FES monthly costs are less than Part C monthly costs per capita. Analysis of the FES service coordination costs represent an effort to inform the Department on the major provider costs driving service delivery under the FES program. Guidehouse analyzed the costs to arrive at multiple sets of per capita costs for both the Part C and FES programs based on variation in target population rates and individual cost component assumptions. The SFY 2022 costs are projected to FFY 2025 to align with the anticipated implementation period as highlighted in the table below.

Cost Per Member Per Month Analysis for Part C and FES Programs

Program	SFY2022 Cost per Member per Month	SFY2025 Cost per Member per Month
Part C (Part C Only)	$502.98	$555.83
Part C (Combined)	$494.37	$546.32
FES (“Top-Down”	$481.83	$532.46
FES (“Bottom-Up”)	$430.36	$475.59

Fiscal Impact Analysis

Based on the cost per member per month and population estimates for the Part C and FES programs, Guidehouse conducted a fiscal impact analysis to review the differences between FFY 2025 projected annual expenditures and current CY 2022 annual expenditures. Additionally, Guidehouse assessed the impact assuming various monthly per capita costs obtained from the cost analysis (e.g., Part C costs based on Part C provider data only, Part C costs based on Part C and FES combined costs), as well as varying population target rates including the historical actual target (1.74 percent), the current target (2.36 percent), and the projected target (2.86 percent).

The table below provides a projection of the additional dollars inclusive of state and federal contributions necessary to fund the projected per member per month costs for the Part C and FES programs. For Part C, the analysis suggests the system would require additional annual expenditures ranging from $78,000 up to $2.7 million depending on the expected population target rate and projected cost per member per month. For FES, the additional costs that would be incurred under projected per member per month costs amounts to between $94,000 and $367,000, with the top-down costs requiring a larger increase at 12 percent difference.

Fiscal Impact to Part C and FES Programs

Part C and FES Cost Comparison					
Program	**Time Period**	**Population Target Rate**	**Total Expenditure**	**Difference from CY 2022**	**Percentage Difference from CY2022**
Part C	CY 2022	1.74%	$3,878,196	-	-
	FFY 2025 Part C Only	1.74%	$4,024,751	$146,556	3.8%
		2.36%	$5,458,858	$1,580,662	40.8%
		2.86%	$6,615,396	$2,737,200	70.6%
	FFY 2025 Combined	1.74%	$3,955,890	$77,694	2.0%

Part C and FES Cost Comparison					
		2.36%	$5,365,459	$1,487,264	38.3%
		2.86%	$6,502,209	$2,624,014	67.7%
FES	CY 2022	-	$3,128,534	-	-
	FES "Top Down"	-	$3,495,133	$366,534	11.7%
	FES "Bottom Up"	-	$3,222,465	$93,865	3.0%

Final Considerations

Guidehouse concluded review of these services with some final considerations around potential payment redesign as well as establishing stronger utilization reporting and monitoring processes. Although Guidehouse did not determine that transition to a new methodology is necessarily warranted, a substantial deficiency of the current reimbursement system is that it does not require significant provider reporting on service delivery, limiting the Department's ability to monitor Part C and FES programs for appropriate utilization and adequate access to care.

To address this deficiency, Guidehouse recommended potential frameworks for establishing basic reporting systems, along with allied considerations for harnessing better monitoring to support payment transition to FFS, if desired, as well as improve program alignment with other payer sources, including Medicaid and private insurance.

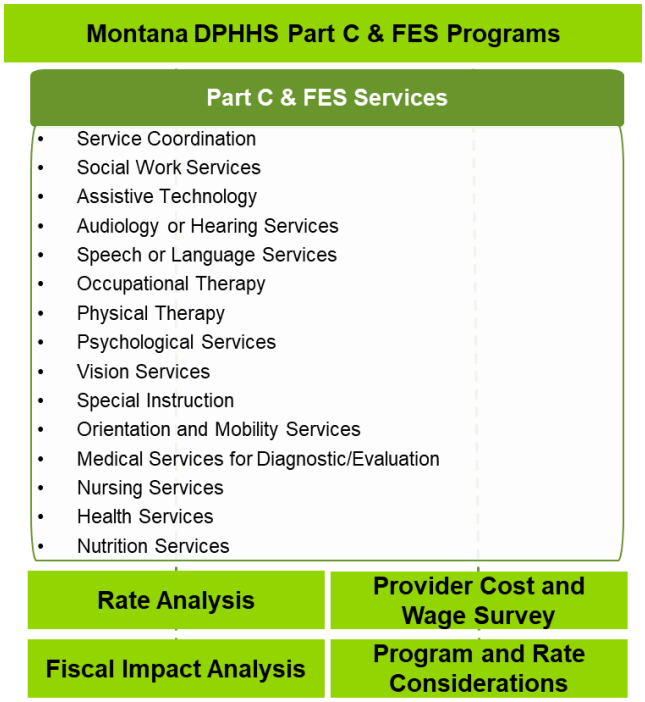
B. Introduction

Montana's Department of Public Health and Human Services ("DPHHS", "Department") contracted with Guidehouse Inc. ("Guidehouse") to conduct a comprehensive rate review of Part C of the IDEA Early Intervention Program & Family Education & Support (FES) Program. In fulfillment of these requirements, the engagement scope included the following study elements as highlighted in Figure 1:

1. Rate Analysis: Analysis of existing Part C and FES program rates and cost of providing services under the two programs
2. Provider Cost and Wage Survey: Data collection initiative from providers for rate analysis efforts
3. Fiscal Impact Analysis: Analysis of the impact of updating current rates based on analysis of provider costs
4. Program and Rate Considerations: Considerations for transparency in service Delivery and reimbursement

The study utilized a multitude of data sources, survey data collection, and avenues for stakeholder feedback to analyze costs and offer considerations to the Department for future planning and budgeting needs, as further described in this report.

Figure 1: Overview of DPHHS Part C and FES Rate Study



C. Provider Engagement

To support a holistic study of the costs for the State's programs, Guidehouse and the Department worked with service providers through multiple forums. The rate study considered worker wage levels and benefits, providers' administrative costs, and program support costs, target population estimates, among other factors. This effort was informed by a comprehensive provider cost and wage survey soliciting broad provider participation, analysis of provider-submitted financial and service delivery data, as well as ongoing, extensive stakeholder input throughout the rate study, as highlighted in Figure 2.

Figure 2: Provider Engagement and Opportunities for Input

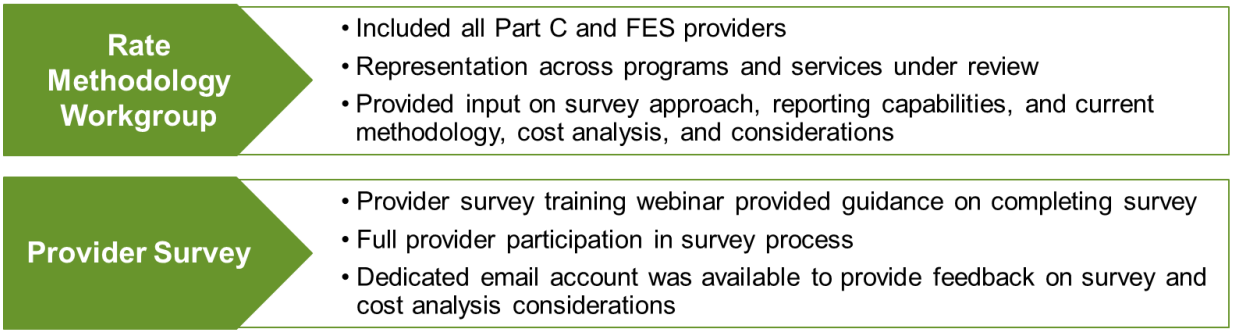


Figure 3 describes the composition of the Rate Methodology Workgroup, its roles, and major discussion topics over the course of the sessions.

Figure 3: Rate Methodology Workgroup Composition and Roles

Rate Methodology Workgroup
5 Members (Part C and FES)
Composition: • Provider representatives who reflect the full range of programs and services included within the rate study scope • Members have a strong understanding of provider finances, reporting capabilities, and service costs
Role: • Provide subject matter expertise on provider survey and rate methodology development • Review and validate cost assumptions, including wages, benefits, administration, program support and staffing • Provide considerations for the Department

Rate Methodology Workgroup
5 Members (Part C and FES)
Discussion Topics: • Provider Survey design, administration, and results • Peer state selection for comparison • Target population analysis • Benchmark wages, adjustments, and inflation factor • Indirect cost assumptions including administrative and program support costs • Final cost analysis results, current program utilization landscape, and fiscal impact of projected costs

D. Data Sources

D.1. Overview of Data Sources

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

Guidehouse conducted a provider cost and wage survey to obtain the actual cost of delivering services from providers, including employee salaries and wages, administrative costs, program support costs, provider fringe benefits, and additional service-specific costs. The cost and wage survey provided valuable and detailed information on staff salaries, provider fringe benefits, administrative costs, program support costs, hourly staff wages, and staffing patterns for all programs included in the rate study. Guidehouse also analyzed trends in the detailed claims data for services that were in scope for this specific rate study from each of the programs to project the differences between the current program expenditure and the projected expenditure resulting from the cost analysis in the rate study.

Although a majority of cost assumptions used for analysis were derived from provider-reported survey data, publicly available sources were required for supplemental cost data and for validation purposes to establish a comprehensive rate for some services. The key features of the provider cost and wage survey as well as the other sources used in the rate development process are described in detail in the section below.

D.2. Provider Cost & Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey (“Survey”) based on the operations of Part C and FES provider agencies and landscape of services provided under the programs. The aim of the survey was to collect provider cost data across associated with these programs that would serve as the basis for further analysis in the rate studies. Additionally, Guidehouse aimed to utilize the survey to:

- Capture provider cost data to provide cost foundation for rate studies;
- Collect information on number of members served, billed, and those with individualized service plans to determine the appropriate metric for cost analysis;
- Receive uniform inputs across all providers to develop standardized rate model components;
- Establish baseline cost assumptions for comparing Part C and FES program costs;

- Determine cost basis for evaluating rate equity for services;
- Gather data to understand billable vs. non-billable time and staffing patterns per service.

D.2.1. Survey Design and Development

Guidehouse designed this survey with input from DPHHS staff and Rate Methodology Workgroup members, as well as drawing on knowledge gained from conducting similar surveys in other states. Guidehouse and the Department worked with the Rate Methodology Workgroups to develop, review, update and release the survey. The survey was designed in Microsoft Excel and included eight (8) sections or worksheets on topics outlined in Table 1 below. During the Rate Methodology Workgroup meetings in April 2023, Guidehouse provided an overview of the survey including the objectives, topics, and questions on each worksheet within the survey document and solicited feedback from stakeholders. With the aim of collecting annual wage, benefit, administrative cost, program support cost, and service delivery data from SFY2019 through SFY2022, Guidehouse collected information on the survey components highlighted in Table 1. Guidehouse requested specific financial datasets from different time periods considering impacts of the COVID-19 Public Health Emergency (PHE) and consequent changes in service costs. SFY 2022 data was best suited to capture relationships between different cost components. On the other hand, data going back to 2019 was useful in understanding evolving membership patterns and evaluating impacts and recovery from the COVID-19 PHE.

Table 1: Provider Cost and Wage Survey Organization and Data Elements

Worksheet # - Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
1 – Organizational Information	Provider identification, contact information, organizational details, and organizational revenues	SFY 2019, SFY 2022
2 – Member Counts	Total unique members served and billed each month across four years	SFY 2019, SFY 2020, SFY 2021, SFY 2022
3 – Total Organizational Costs	Employee salaries, taxes and benefits; non-payroll administrative costs and program support costs; and facility, vehicle and equipment costs	SFY 2022
4 – Programs and Services	Programs operated and services delivered	SFY 2022
5 – Staff Wages	Staff types, hourly wages, supplemental pay, bonuses, rate increases, and training time	SFY 2022

Worksheet # - Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
6 – Staffing Patterns and Service Design	Billable vs. Non-Billable, supervisor and staffing patterns; training requirements, and other service design and delivery specifications	SFY 2022
7 – Benefits	Benefits that organizations offer full-time and part-time employees who deliver services – health, vision and dental insurance; retirement, unemployment benefits and workers' compensation; holiday, sick time, and paid time off	SFY 2022
8 – Additional Information	Clarifying comments in addition to the information covered in other worksheets or sections	Not Applicable

D.2.2. Survey Administration and Support

The survey was released via e-mail on April 7, 2023 to all Part C and FES providers. A detailed instruction manual accompanied the survey to assist providers with responding to the survey questionnaire. To conduct a successful and accurate survey, Guidehouse facilitated a live provider training webinar available to all providers on April 11, 2023, following the release of the survey. In the training session, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions. Representatives from all five regional providers attended. The trainings were recorded and posted to the Montana website devoted to the rate study.

Additionally, Guidehouse offered ongoing support and resources in helping providers to complete the survey, through a dedicated electronic e-mail inbox which providers could access to receive answers to their specific questions. Providers were allowed three weeks to complete the survey and granted an extension option of one week if additional time was needed, with a final survey deadline of April 28, 2023.

D.2.3. Provider Cost and Wage Survey Participation

All five providers eligible to complete the survey participated and returned complete survey submissions. Given the small community of providers and active participation from all providers in the Rate Methodology Workgroup, the 100 percent response was met and exceeded typical response rate standards.

D.2.4. Provider Cost and Wage Survey Review and Validation

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

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

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

The survey data reported by providers was utilized to develop several key rate components including baseline hourly wages, Employee Related Expenses (ERE), and administrative and program support cost factors. Sections G and H further outline how the survey data was utilized for rate setting purposes.

D.3. Claims Data

The Department provided claims data covering the period from November 2020 through February 2023. This request included all claims filed and tracked in the State of Montana's Medicaid Management Information System (MMIS) during that period for Part C and FES reimbursement. The MMIS data for the Part C program included only encounter information allowing Guidehouse to get an understanding of the number of individuals served each month by each provider. However, the data did not provide financial information that could be used as is for fiscal impact. Therefore, Guidehouse computed the total Part C expenditure for each provider based on the number of clients served per month and the associated contracted tiered rate for the provider. However, Guidehouse was able to harness the years of data available to examine utilization trends over time and determine SFY 2022 was the most complete and appropriate year of information. The 2022 data was used to capture a normal and expected utilization year to understand utilization trends and project fiscal impact accurately.

D.4. Other Data Sources

Cost assumptions developed throughout the study rely on a wide variety of data sources. The rate study aimed to understand the necessary cost requirements required to promote access to quality services going forward. As will be detailed in greater depth in the sections that follow, Guidehouse's provider cost and wage survey furnished the majority of our assumptions on the typical number of clients, employee wages, provider fringe benefit offerings, administrative costs, program support costs, and transportation requirements for both programs.

While cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate in the face of future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the resources required to provide services in the near future or are not comparable to or competitive with the industry as a whole, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the population estimates that impact the costs frequently draw from regional standards, at least for comparison purposes, that reflect wider labor markets, to benchmark Montana reported information from the provider cost and wage survey. Table 2 below summarizes some of the additional public data sets used to inform assumptions used for population trending and costs analysis.

Table 2: Other Data Sources

Data Source	Description
Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)	Federal wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage geographic and industry wage comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Consumer Price Index – Medical Services (CPI)[1]	Federal index of inflation across multiple industries for Medicaid populations. Updated monthly and includes data series on professional services, hospital and related services, and health insurance. Used for reference to understand annual inflation for provider costs.

[1] Bureau of Labor Statistics, CPI-U for Medical Care Services. Available online: https://www.bls.gov/cpi/factsheets/medical-care.htm

Data Source	Description
Montana Census and Economic Information Center (CEIC) Data (2021)[2]	The Census and Economic Information Center is located within the Montana Department of Commerce. Provides Montana specific data on population and population demographics
Montana's State Performance Plan/ Annual Performance Report: Part C for FFY 2015, 2019, 2020[3]	Report published annually by Montana which includes information on various indicators and milestones from prior years as well as future targets.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS)[4]	Federal data on health insurance costs, including Montana specific data regarding multiple aspects of health insurance (employer offer, employee take-up, premium and deductible levels, etc.) Used for reference in estimating health care costs for benchmark ERE assumptions.
Other State Fee Schedules and Reimbursement Methodologies	Data from other states on reimbursement levels for services as well as overall service design. Used for peer state comparison and well as development of best-practice recommendations for improving supported service delivery.
Internal Revenue Service[5]	The Internal Revenue Service is the revenue service for the United States federal government, which is responsible for collecting taxes and administering the Internal Revenue Code, the main body of the federal statutory tax law.

[2] Montana Census and Economic Information Center (CEIC) Data (2021) Available online: https://ceic.mt.gov

[3] Montana's State Performance Plan/ Annual Performance Report: Part C for FFY 2015, 2019, 2020 Available online: https://dphhs.mt.gov/ecfsd/childcare/montanamilestones/partcreports

[4] Medical Expenditure Panel Survey (MEPS), Health Insurance Costs. Available online: https://meps.ahrq.gov/data_stats/state_tables.jsp

[5] Internal Revenue Service (IRS), 2023 Mileage Rate. Available online: https://www.irs.gov/newsroom/irs-issues-standard-mileage-rates-for-2023-business-use-increases-3-cents-per-mile

E. Current Rate Methodology

This section includes the Department's current rate methodology for Part C and FES services. The five Part C and FES providers provide services under five distinct regions in the State[6].

The current methodology is built on a population-based payment structure with a bundled rate associated with tiers dependent on the number of clients served. The methodology assumes same rate per member per month for both Part C and FES and for every provider. The monthly contracted amount per provider depends on the population targets in the regions served by the providers, the expected number of clients to be served, and the monthly per capita rate. Although the foundation of the current methodology is similar for Part and FES, there are some differences in the reimbursement mechanisms between the two programs.

- **Part C Reimbursement:**
  - The Part C rate structure for each provider includes six tiers with monthly bundled rates dependent on the number of clients served in the respective service regions
  - Monthly bundled rates are ultimately based on a standard rate per client that is same across all providers but adjusted by tier
- **FES Reimbursement Structure**:
  - The FES rate structure is a single rate provided per client per month that is same across all providers
  - Reimbursement is based on the allocation for number of contracted clients and service months

The number of targeted clients for each provider is based on the population of infants and toddlers in the counties served and the service targets established by DPHHS back in 2015[7]. The targeted population penetration rate per provider is 2.20 percent, based on the Part C State Performance Plan / Annual Performance Report (SPP/APR). Indicator Child Find (Birth to Three) in the SPP/APR highlights that the target is 2.20 percent represents percent of infants and toddlers birth to 3 with Individual Family Service Plans (IFSPs) [8]. The report highlights the 2015 national benchmark for the same indicator is 2.95 percent, at 0.75 percent more than the Montana target. As captured in Table 3 below, the total number of infants and toddlers in

[6] Montana DPHHS Early Childhood and Family Support Division, Regional Programs. Available online: dphhs.mt.gov/assets/ecfsd/PartC/ECSBPartC.pdf

[7] Montana DPHHS Part C Reports. Available online: https://dphhs.mt.gov/ecfsd/childcare/montanamilestones/partcreports.

[8] Montana DPHHS< Part C Annual Performance Reviews (2015). Available online: https://dphhs.mt.gov/assets/ecfsd/PartC/AnnualPerformanceReviews/ECIFFY2015APR.pdf

Montana as included in SFY2015 calculations is 37,213 across all regions, with the total targeted population being nearly 819 clients.

Table 3: Target Population in Current Methodology Per Region

Region	Total Number of Infants and Toddlers (<1; 1-2, 2-3 years of age) in Montana in SFY2015	Total Number of Clients at SY2015 2.20% Target
Region 1	3,590	78.98
Region 2	6,287	138.31
Region 3	8,120	178.64
Region 4	8,864	195.01
Region 5	10,352	227.74
Total	**37,213**	**818.68**

The minimum client counts at the 100-109% tier (Tier 3) is aligned with the estimated target population. The Part C and FES monthly rate per client per tier at the targeted population for each provider is $476.62. The Part C tiered monthly rates per client for Tiers 1, 2, 5, 6 are based on a percentage of the maximum rate per client (Tiers 3, 4) and the rates range from $457.55 to $476.55 depending on the tier, as delineated in Table 4 below.

Table 4: Current Part C Tiered Rate Structure

Tier Number	Tier	Monthly Rate Per Client Per Tier	Outreach/ Utilization Target Adjustment
Tier 1	117% plus	$467.09	98%
Tier 2	110% - 116%	$471.85	99%
Tier 3	100% - 109%	$476.62	100%
Tier 4	95% - 99%	$476.62	100%
Tier 5	80% - 94%	$467.09	98%
Tier 6	70% - 79%	$457.55	96%

Section G.2 provides additional information about the actual and target population rates as part of the current methodology that impact cost analysis and fiscal impact analysis.

F. Population Trend Analysis

F.1. Montana Population Trends

Montana has faced many challenges over the past few years regarding population targets. Some of these challenges, like the COVID-19 PHE, are waning and programs are beginning to rebound. Others, such as a declining fertility rate, will continue to impact Part C and FES programs in the coming years. Montana collects data on new births in the state and published figures in December 2020. In 2010, there were 67.0 births per 1000 women. By 2019, that had dropped to 56.8 births per 1000 women, an average change of -1.02 births per year. The largest declines were among the 15-19 (-1.84) and 20-24 (-3.53) year old populations[9]. Fertility rates in Montana may be a factor in the membership decline that may persist beyond pandemic recovery.

Furthermore, per the United States Census Bureau, Montana's population over the past eight years has increased by nearly 10 percent. However, the population for ages 0-3 has effectively decreased by over 5 percent during the same time period. Table 5 below highlights population trends from 2014 through 2021 including the population for ages 0-3 as applicable to the Part C and FES programs. Therefore, it is imperative to consider these changes and challenges when setting future population target rates both regionally and statewide.

Table 5: Montana Population Trends for Ages 0-3 Based on Cencus[10]

Population by Year	2014	2015	2016	2017	2018	2019	2020	2021
Total Population in Montana (All Ages)	1,021,869	1,030,475	1,040,859	1,052,482	1,060,665	1,087,075	1,106,227	1,122,867
Annual Change in Population (All Ages)	-	0.8%	1.0%	1.1%	0.8%	2.5%	1.8%	1.5%
Total Population in Montana (Ages 0-3; 36 months)	36,936	37,346	37,633	37,791	37,243	36,694	35,984	34,951
Annual Change in Population	-	1.1%	0.8%	0.4%	-1.5%	-1.5%	-1.9%	-2.9%

[9] Montana DPHHS Fertility Rate Data, General, Age-Specific, and Total Fertility Rates in Montana, 2010-2019 (December 2020). Available online: https://dphhs.mt.gov/assets/publichealth/Epidemiology/VSU/VSUFertilityRate.pdf

[10] Note: Population for ages 0-3 estimate based on derivation from census data for ages 0-5 (60 months)

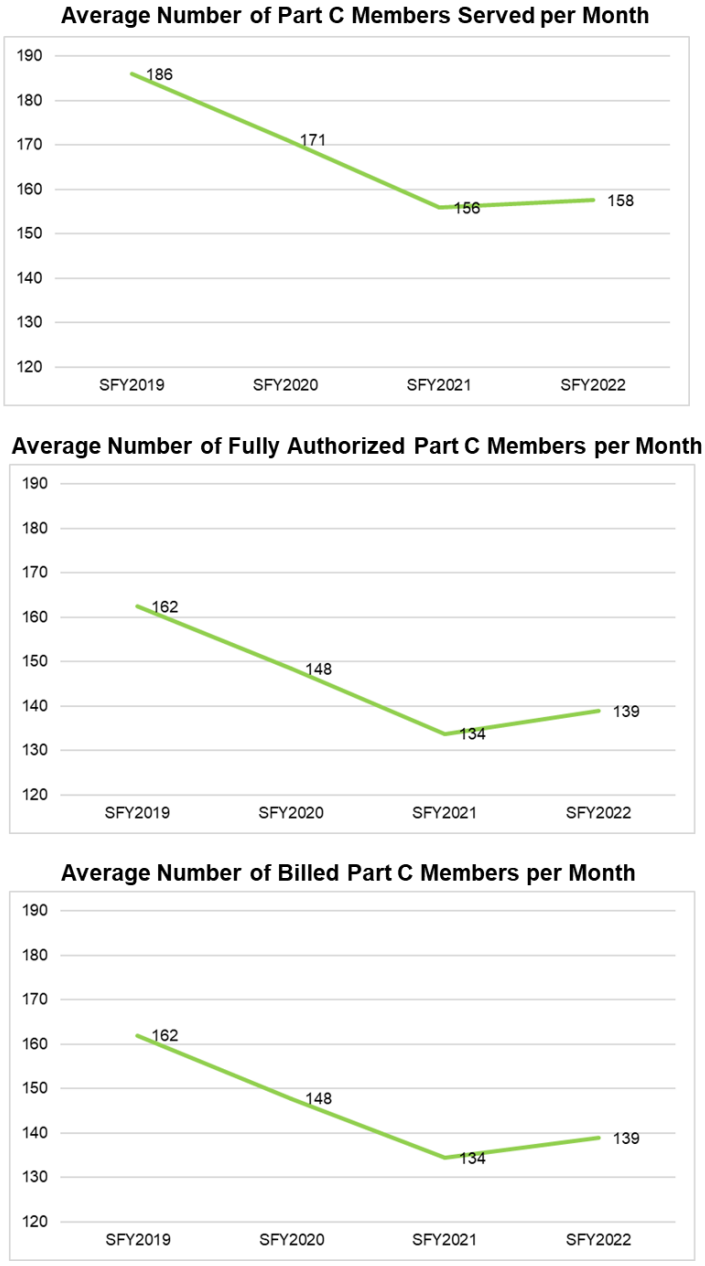
Population by Year	2014	2015	2016	2017	2018	2019	2020	2021
(Ages 0-3; 36 months)								

To further review the Part C and FES population trends in Montana, Guidehouse analyzed member count trends in the provider survey over four years from SFY2019 through SFY 2022. As part of the survey, all provider agencies reported the unique number of Part C and FES clients served, fully authorized, and billed in a month. This information allowed Guidehouse and the Department to analyze multi-year trends in the number of individuals served by provider agencies and contextualize the impacts of the COVID-19 PHE, activities and requirements in the most fiscal year, and effects on the cost of providing services. Given the variation in nomenclature used across providers organizations, the survey included three standardized metrics related to the number of clients, defined as:

- **Served**: includes the total number of distinct individuals receiving services and resources as part of the Part C or FES program including referrals and intake.
- **Fully Authorized**: includes the total number of distinct individuals authorized for services with signed Individualized Family Service Plan (ISFP) under the Part C or FES program.
- **Billed**: includes the total number of distinct individuals billed to the Part C or FES program for the month.

Provider survey data revealed that the average annual Part C member counts, in aggregate, decreased since SFY2019. On average the number of members both billed and fully authorized represented roughly 87 percent of member served, and the overall trends in fully authorized members and billed members is consistent across the years. Therefore, the number of 'Billed' members was identified as the appropriate metric for per capita cost analysis. Figure 4 below includes Part C member count trends across all providers.

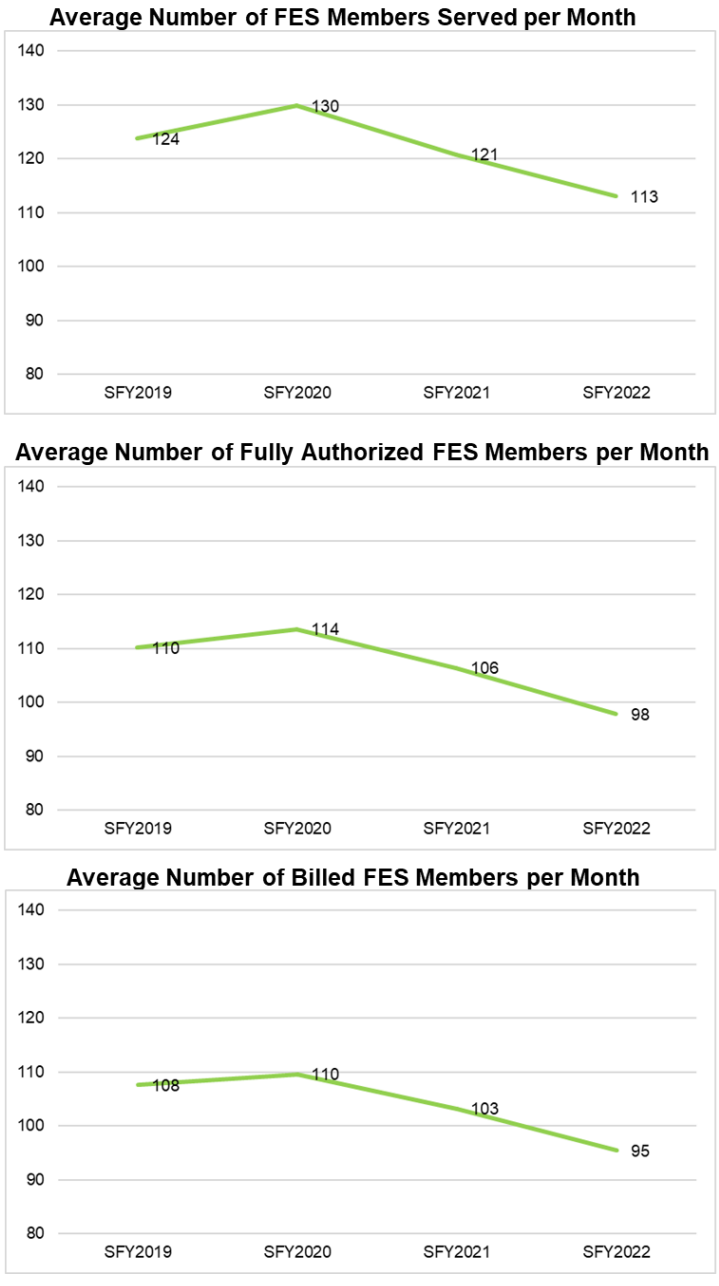
Figure 4: Part C Member Count Trends Across All Providers



Similar to Part C, average annual member counts for FES have decreased since SFY2019 in aggregate. The average number of fully authorized and billed members are 88 percent and 85

percent of the average number of members served. Figure 5 includes FES member count trends across all providers.

Figure 5: FES Member Count Trends Across All Providers



Sections F.1 and F.2 below highlights trends the Part C and FES member months based on survey data as well as projected target population estimates based on Montana's SPP/APR that informed the analysis of costs for the two programs.

F.1.1. Part C and FES Member Count Trends

The total number of unique billed member months has declined since SFY2019 for both Part C and FES programs. The decline in Part C service begins in 2020 as the COVID -19 pandemic took hold. The decline in membership continued in 2021 but membership increased by 3 percent in 2022, indicating that the impacts of the COVID-19 PHE on the program are beginning to wane. This trend is shown below in Table 6 that captures annual changes in Part C member counts. FES member months also declined during the COVID-19 PHE but followed declines in Part C with the first signs of attrition not occurring until SFY 2021 and a 12 percent drop in membership between 2021 and 2022 shown in Table 7. As the FES program is expected to be largely fed by Part C recipients as they age out of the program, this staggered response is expected and the post pandemic recovery of FES may follow the Part C recovery pattern. DPHHS will need to consider this when setting regional population targets for FES.

Table 6: Part C Annual Member Count Trends

Part C	SFY2019	SFY2020	SFY2021	SFY2022
Total Unique Part C Member Months Billed	9,717	8,876	8,077	8,327
Annualized Change Since SFY2019	-	-9%	-9%	-5%
Year Over Year Change	0%	-9%	-9%	3%

Table 7: FES Annual Member Count Trends

FES	SFY2019	SFY2020	SFY2021	SFY2022
Total Unique FES Members Billed	6,466	6,582	6,172	5,718
Annualized Change Since SFY2019	-	2%	-2%	-4%
Year Over Year Change	-	2%	-5%	-12%

F.1.2. FES Population Utilization Trends

Additional analysis was performed to compare the contracted FES clients to the actual clients

served from the claims and provider-reported survey data. In most regions, as expected, the member counts from the claims aligned with the provider survey. Conversations with stakeholders revealed that the FES program can often have a waiting list, and since FES clients are previously served by the Part C program, enrollment in the Part C program may be a useful indicator of FES needs regionally. Analysis of the Part C and FES survey data revealed that there are roughly 70 percent as many FES clients compared to Part C in SFY 2022. Table 8 below includes the FES population utilization trends as captured from the contracted amounts, the claims, and the provider survey. Average monthly FES clients counts from both the claims and the provider survey aligned closely with the 70 percent of Part C client counts obtained from the provider survey data. The relationship between the Part C and FES monthly client counts may be explored further by the Department in establishing population targets for the FES program. For fiscal impact purposes, Guidehouse utilized the actual average monthly client counts based on the CY 2022 FES claims, as outlined further in Section I.

Table 8: FES Population Trends by Data Sources and Regions

Region	Number of FES Clients				
	Current Contracted – Fee Schedule (2020)	Average Monthly Clients – FES Claims (CY 2022)	Average Monthly Clients – FES Claims (SFY 2022)	Average Monthly FES Clients – Provider Survey (SFY 2022)	70% of Average Monthly Part C Clients – Provider Survey (SFY 2022)
Region 1	89	82	85	87	54
Region 2	80	87	80	81	79
Region 3	106	99	100	100	167
Region 4	156	96	101	100	60
Region 5	116	100	107	109	107
Total	**547**	**464**	**473**	**477**	**467**

F.2. Projected Target Population Estimation

Part C target populations are set by the Department with the aim of consistently improving and reaching more of Montana's population in need of early intervention services. Indicator 6 in Montana's SPP/APR that focuses on child find metrics (Birth to Three) highlights actual and targeted population metrics. Table 9 captures historical population targets and actual from the Part C program. While the Department fell short of their goal of 2.2 percent in FFY 2015, the state exceeded goals for the following four years as shown below.

Table 9: Historical Population Targets & Actuals

Period	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020
Population Target	2.20%	2.20%	2.20%	2.25%	2.25%	2.36%
Actual	1.93%	2.34%	2.21%	2.28%	2.36%	1.74%

FFY 2020 shows a significant decrease in the population reached by the program, likely due to disruptions form the COVID-19 PHE as noted in the SPP/APR. Currently, the Department has set goals through 2025 with target populations increasing by 0.25 percent in even years, shown below in Table 10.

Table 10: Current and Projected Population Targets

Period	Baseline Year (2019)	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025
Population Target	2.36%	2.36%	2.36%	2.61%	2.61%	2.86%	2.86%

While the target rates are projected to increase, given the declining population in Montana for this age group, the estimated target population counts are projected to remain consistent with current trends. For example, Table 11 below notes that the population assumptions included in the current rate structure established in 2015 is 819 clients across all providers which aligns closely with the 825 clients based on 2021 Montana census data. For cost analysis purposes, Guidehouse considers most recent population counts in modeling and projecting total expenditure.

Table 11: Example of Impacts of Population Trends in Montana on Estimated Target Population

Time Period	Total Population	Population Target Rate Assumption	Estimated Target Population
2015 - Population Assumptions in Current Rate Structure	37,213	2.20%	819
2021 – Montana Census Data (up to 36 months)	34,951	2.36%	825

In light of the refreshed population trends available since the 2020 census as well as lingering

impacts of the COVID-19 public health emergency on current and near-future service utilization, DPHHS will want to consider significant reevaluation of its population assumptions identifying targets for its next contract period.

G. Cost Analysis

Guidehouse used two methods for determining appropriate costs per individual per month within the Part C and FES programs. One method ("*top-down*") involves a review of the current bundled rate, utilizing aggregate cost data and utilization data (unique monthly members billed) to arrive at a monthly cost per member. An alternative method was used to develop a "*bottom up*" rate for Service Coordination for the FES program. As indicated in provider feedback, the FES program primarily consists of service coordination while Part C entails a wider range of additional services. Although current base rates for Part C and FES are identical, a working hypothesis of the rate study is that FES monthly costs are less than Part C monthly costs per capita. To support reimbursement adequacy for both programs, a priority of the rate study has been to distinguish Part C from FES costs as closely as possible to get a better understanding of the cost of providing services under the individual programs. However, analysis of the total costs for the two programs does not provide sufficient clarity on the distinct cost of delivering services under each program. Analysis of the FES service coordination costs attempts to inform the Department on provider costs for delivering services under the FES program.

G.1. Cost Analysis Overview

As part of building up the costs, an analysis of each of the costs components was performed using the provider survey data and validated against publicly available data. The section is divided into the following areas:

- Direct Care Staff Wages
- Employment Related Expenditures (ERE)
- Administrative Expenses
- Program Support Expenses
- Cost Trending Factor

G.1.1. Direct Care Staff Wages

Direct care wages are often the largest cost that programs support. Survey respondents were asked to provide information on the types of staff that they employ, their wages, and associated FTEs. This data was then aggregated and weighted based on the number of FTEs across programs to account for variation in different sizes of providers. Guidehouse compared the FTE weighted wages to similar job classifications listed in publicly available data from BLS OEWS for Montana for the same time period. This served to justify the validity and representativeness of wages reported through the survey, as weighted average wages fell around the mean BLS-reported wage for many job types. Wages reported by providers were comparable to similar

positions withing the state. Table 12 below includes the FTE-weighted benchmark wages and the comparable BLS average and median wages.

Table 12: Provider Survey and BLS Hourly Wage Comparison

Montana Part C / FES Provider Cost and Wage Survey Data (SFY2022)				BLS Statewide Benchmark Wages (May 2022 Montana Data)		
Job Type	**Direct Care vs. Supervisor**	**FTEs**	**SFY2022 Survey Wage (Weighted)**	**Job Classification**	**Mean**	**50 PCT**
Family Service/Support Specialist	Direct Care	73.5	$19.64	Child, Family, and School Social Workers (21-1021)	$20.85	$19.66
Speech Therapist	Direct Care	4.5	$37.89	Speech-Language Pathologists (29-1127)	$38.06	$38.15
Occupational Therapist	Direct Care	3.3	$39.52	Occupational Therapists (29-1122)	$40.71	$40.22
Physical Therapist	Direct Care	2.1	$39.43	Physical Therapists (29-1123)	$41.12	$39.50
Board Certified Behavior Analyst	Direct Care	1	$31.26	50% Clinical and Counseling Psychologists (19-3033) + 50% Substance Abuse, Behavioral Disorder, and Mental Health Counselors (21-1018)	$31.67	$31.28
Family Service Specialist Supervisor	Supervisor	9.5	$24.35	First-Line Supervisors of Office and Administrative Support Workers (43-1011)	$28.25	$26.39
Clinical Director	Supervisor	1	$25.48	First-Line Supervisors of Office and Administrative Support Workers (43-1011)	$28.25	$26.39

G.1.2. Employee Related Expenses (ERE)

Total compensation includes wages as well as employment-related expenses (ERE) – for example, direct care staff earn not only their wages over the course of the year, but also benefits such as days off, health insurance, and employer retirement contributions. These ERE or fringe benefits include legally required benefits, paid time off, and other benefits such as health insurance. Based on provider survey data, ERE can be estimated by calculating the proportion of aggregate costs spent on benefits, or by modeling the cost requirements of a competitive benefits package.

The ERE was computed as total taxes and benefits reported in the survey compared to total wages and salaries reported by providers. This calculation shows that ERE is currently 27 percent of the total salaries and wages across providers, as shown in Table 13 below. Of note, the 27 percent ERE is calculated using all *five* regions for Part C, but only *four* in FES since one provider contracts FES services with a third-party organization and the associated costs are captured as contractor costs since granular data regarding provider benefits was not readily available for reporting.

Table 13: Provider Fringe Benefits as a Percentage of Salaries and Wages

Metric	Value
Total Salaries and Wages (Part C and FES)	$4.4M
Total Taxes and Benefits (Part C and FES)	$1.2M
Total Taxes and Benefits as a Percentage of Salaries and Wages[11]	27.1%

As part of looking at what a provider should be able to offer as a competitive benefits package, the following components were reviewed based on provider-reported data. This approach accounts for benefits that are not necessary provided by all provider agencies in an attempt to model a comprehensive benefits package. Not all providers who responded to the provider cost and wage survey have historically offered a "full" or competitive benefits package. To determine competitive contributions for benefits which are not legally required, Guidehouse analyzed paid time off components in aggregate and data on other benefits only from providers who contribute to their full-time employees' benefits.

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation. Employers in Montana pay a federal unemployment tax (FUTA) of 6.00 percent of the

[11] Excludes one provider for FES – provider contracts all FES services

first $7,000 in wages and state unemployment tax (SUTA) of a range of 0.13 percent to 6.30 percent of the first $35,300 in 2021 wages.[12] Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.4 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 percent rate of the first $160,200 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act (FICA) contributions. Per the cost and wage survey, employers in Montana pay an average effective tax of 1.82 percent toward workers' compensation insurance.

- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The median aggregate number of paid days off per year, per the cost and wage survey, was 32 days total. As PTO benefits only apply to full-time workers, the daily value of this benefit is multiplied by a **part time adjustment factor**, which represents the proportion of the workforce which works full-time for the provider organizations responding to the cost and wage survey.
- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part time adjustment factor, as well as a **take-up rate** specific to each benefit type which represents the proportion of employees who actually utilize the benefit.

Other Components of ERE

Health Insurance

Health insurance data from the survey was compared to the Medical Expenditure Panel Survey (MEPS) data. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage. The most recent MEPS data (2021) was used and inflated by 12.6 percent for comparison.[13] Monthly average insurance costs from the survey are comparable to MEPS data.

Of note, the average monthly premium reported in the MEPS Montana data was $727 after applying an inflation factor which came in slightly lower than the average of $762 reported in the survey, as observed in Table 14. Reported information in the survey was largely in line with costs identified in the MEPS data, corroborating and confirming the applicability of the MEPS data as an appropriate benchmark for identifying health insurance costs.

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

[13] Business Wire, Employer-Sponsored Health Insurance Cost Rose Sharply in 2021 based on Mercer Data. Available online: https://www.businesswire.com/news/home/20211213005119/en/Employer-Sponsored-Health-Insurance-Cost-Rose-Sharply-in-2021-Outlook-for-2022-Is-Uncertain

Table 14: Health Insurance Cost Comparison

Metric	2022 MT Provider Survey Data	2021 MEPS Data (< 50 employees)	2021 MEPS Data (> 50 employees)	2021 MEPS Data Total
Employer Contribution to Health Insurance (Single Coverage)	$8,272	$5,339	$5,883	$5,596
Employer Contribution to Health Insurance (Family Coverage)	$12,244	$12,337	$14,784	$13,338
Weighted Employer Contribution to Health Insurance	$9,145	$7,108	$8,937	$7,750
Inflation	-	12.6%	12.6%	12.6%
Inflated Employer Contribution to Health Insurance	$9,145	$8,004	$10,063	$8,727
Percent of full-time employees	79.6%	74.3%	85.6%	83.4%
Health Insurance Take-Up Rate	69.5%	60.8%	61.8%	62.7%
Monthly	$762	$667	$839	$727
Adjusted Annual	$5,059	$3,616	$5,320	$4,565

The health insurance take-up rates and monthly premiums are taken from survey data. MEPS take up rates range from 61% - 63%. Dental, Vision, and Other Benefits are all derived from provider survey responses. This package includes both dental and vision packages even though these are not offered by all providers. Table 15 below captures average values among providers that offer these benefits. The example calculations captured in this table are based on a Family Support Specialist wage of $19.64 per hour.

Table 15: Monthly Benefit Costs

Category	Take Up Rate	Monthly Premium	Annual Cost	Percent of Annual Wage
Health	69.5%	$762	$5,059	12.4%
Dental	48.9%	$188	$73	0.2%
Vision	61.1%	$164	$80	0.2%
Other Benefits	73.3%	$385	$225	0.6%

Final ERE Calculations

Calculating each ERE component as a percentage of the annual wage assumption for the Family Support Specialist, or $40,853 per year, yielded a competitive fringe benefit package of 35.85 percent of wages as outlined in Table 16 below.

Table 16: Components of ERE for Direct Service Providers

Component	Value / Calculation	
Annual Wage	$40,853 ($19.64 x 2080 hours)	
FUTA	0.60% of up to $7,000	$42 (0.10%)
SUTA	1.12% of up to $35,300	$395 (.97%)
FICA	7.65% of up to $118,500	$3,125 (7.65%)
Workers' Compensation	2.96%	$744 (1.82%)
Legally Required Benefits	**-**	**$4,306 (10.54%)**
Daily Wage	$19.64 x 8 hours	$157.13
Part-Time Adjustment Factor	79.64%	
Paid Time Off	32 days	

Component	Value / Calculation	
Paid Time Off	**$157.13 x 79.64% x 32 days**	**$4,306 (10.54%)**
Insurance Take-up Rate	49% – 69%	
Retirement	4.48%	$900 (2.2%)
Health Ins.	$762/mo.	$5,059 (12.38%)
Dental Ins.	$187.50/yr.	$73 (0.18%)
Vision Ins.	$164/yr.	$80 (0.20%)
Other Benefits	$385/yr.	$225 (0.55%)
Other Benefits	**-**	**$6,337 (15.51%)**
Total ERE per DSP	**Legally Required Benefits + Paid Time Off + Other Benefits**	**$14,648 (35.85% of Annual Wage Assumption)**

G.1.3. Administrative Expenses

Administrative expenses reflect costs associated with operating a provider organization, such as costs for administrative employees' salaries and wages along with non-payroll administration expenses, such as licenses, property taxes, liability and other insurance. Rate models typically add a component for administrative expenses so as to spread costs across the reimbursements for all services an organization may deliver.

To determine an administrative burden, Guidehouse calculated the ratio of administrative costs to direct care wages and benefits by summing administrative costs reported in the cost and wage survey, then dividing by total direct care wages and benefits inflated according to new wage and fringe assumptions for direct care workers for the time period captured in the survey.[14] Administrative costs include several categories:

- **Payroll Administrative Expenses:** Employees and contracted employees who perform

[14] The calculation to determine average administrative expense ratios excluded providers that did not report administrative or direct care costs. Some individual line items were capped to the average of other providers.

administrative activities or maintenance activities earn salaries and benefits, which count toward payroll expenses in the calculation of total administrative costs.

- **Non-Payroll Administrative Expenses:** Costs including office equipment and overheard comprise non-payroll administrative expenses, net of bad debt and costs related to advertising or marketing.
- **Facility and Utilities for Administrative Use:** Rent, mortgage, and depreciation for administrative space factors into total administrative costs, as do utilities and telecommunication expenses relating to administrative use.

Direct care costs include the salaries, wages, taxes, and benefits for direct care employees. After dividing administrative costs by direct care costs for each provider, Guidehouse calculated an average ratio of 22.12 percent. The Service Coordination cost estimate in Section H.3 incorporates this ratio of 22.12 percent, which adds a dollar amount to a unit rate by multiplying the rate components of productivity-adjusted direct care staff and supervisor compensation by the median administrative percentage.

G.1.4. Program Support Expenses

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

- **Program Support Wages and Direct Care-Related Costs**: Employees and contracted employees who perform program support activities earn salaries and benefits, which count toward direct care-related expenses in the calculation of total program support costs. These may also include costs for staff training and development, activities costs, and expenses for devices and technology, all of which are related to the quality of care but not specifically billable.
- **Supplies**: This includes the costs of program supplies used by client in, for example with Speech, Occupational, and Physical Therapy services.
- **Staff Transportation**: Staff transportation is not reimbursed in the same manner as client transportation, which may be bundled into a specific service or its own standalone service (e.g., Non-Medical Transportation). To incorporate reimbursement for staff transportation into a service rate, Guidehouse developed assumptions of the miles traveled by staff using the reported travel time from the cost and wage survey. Distances traveled per week were averaged across comparable services and reconciled to reported time spent traveling between client sites. This assumption could vary from service to service, so we leaned on the survey reported mileage heavily to understand the total time spent traveling between client sites to determine the average number of miles traveled. The Internal Revenue Service (IRS) standard mileage reimbursement for

2023 is 66 cents, which we then multiplied by the estimated distances traveled for certain services to arrive at a service-specific staff transportation add-on.[15]

Like the calculation for administrative costs, the program support percentage is calculated based on cost data reported in the provider survey. Program support costs reported by providers were calculated in relation to direct care costs reported in the provider survey. The largest components of this add-on are program support wages and direct care-related costs, which comprise 3.05 percent of the direct care costs.

G.1.5. Cost Trending Factor

Guidehouse worked with the Department to consider multiple sources to trend costs from SFY 2022 to FFY 2025 when new rates are estimated to take effect. Ultimately, the Consumer Price Index (CPI) Medical Services was identified to trend costs. The CPI-U for Medical Care Services comprises changes in prices of professional services, hospital services, nursing home services, adult day care, and health insurance, and services provided by other medical professionals. Medical Care Services include services performed by professionals such as psychologists, therapists, social workers, and nurse practitioners that are pertinent to the Part C and FES programs. The 3-year annual average trend in CPI-U for MCS is 3.7 percent. Costs are inflated using this metric since it is representative of a time period prior to the COVID-19 PHE as well as the most recent change in costs. SFY2022 provider-reported costs are inflated to the mid-point of FFY2025 by 10.51 percent over 33 months or 2.75 years, as noted in Table 17 below.

Table 17: CPI-U Medical Care Services

2019-2022 Annual Average Change	FFY2025 (Mid-point, April 2025)
3.70%	10.51%

G.2. Bundled Cost Analysis

Guidehouse considered costs for bundled services under both the Part C and FES programs. Combining costs for the programs was considered. For some aspects, such as ERE, this was warranted since the same staff serves clients in both programs. However, analysis showed that the per member costs were materially different. These represent reasonable and allowable costs on a per client, per month basis. A monthly average client cost is calculated by dividing the average adjusted monthly cost by average monthly members served within the program as

[15] IRS Standard Mileage Rates for 2023. Available online: https://www.irs.gov/newsroom/irs-issues-standard-mileage-rates-for-2023

captured in Figure 6.

Figure 6: Part C and FES Bundled Cost Components

Total Costs

Utilizing data from the survey, total costs were aggregated across providers for each program. Thresholds were placed on a few individual administrative line items where the proportion of that expense exceeded the average of other providers. Some line items do not represent allowable costs, such as bad debt, and were excluded.

Guidehouse also examined allocation of costs between the Part C and FES programs. Conversations with one provider revealed that some reported values were skewed towards Part C, such as transportation costs, due to record keeping practices. Costs for that provider were reallocated amongst programs to standardize proportionality with other providers.

Member Months

Providers were asked to provide a count of unique members billed, fully authorized, and served each month as part of the survey. Ultimately, a cost per member is best reflected by the number of clients billed each month. Annual membership was aggregated across regions to obtain a total number of clients billed each month.

Monthly Cost Per Member

Dividing annual costs by member month, we arrive at an average cost per member per month. This cost is then inflated 33 months using the CPI Medical Services index to arrive at an estimate of monthly costs in FFY2025. Table 18 below captures the estimated cost per member per month calculations.

Table 18: FFY 2025 Estimated Cost per Member per Month

Program	SFY2022 Total Costs	SFY2022 Unique Member Months	SFY2022 Cost per Member per Month	Inflation Factor	SFY2025 Cost per Member per Month
Part C	$4,188,331	8,327	$502.98	3.7%	**$555.83**
FES	$2,755,113	5,718	$481.83	3.7%	**$532.46**

G.3. Service Coordination Cost Analysis

Guidehouse developed a cost profile for service coordination from the bottom up using information reported in the survey supported by publicly available data. The cost profile starts with the wage of the direct care staff that will provide service for the client. From there, supervisor wages and ERE for direct care and supervisory staff are added. Admin and program support add-ons are then considered as a percentage of direct care wages. Finally, staff transportation costs are included. The final costs are shown on a per client per month basis and inflated to represent the costs in FFY 2025, as delineated in Table 19 below.

Wages and Supervision

Family Service/Support Specialist was identified by providers as the staff type that provides Service Coordination services in the FES program. Wages were weighted by FTE and averaged to obtain a representative wage for direct care staff and supervisors. Supervisor wages, span of control (the number of staff each supervisor oversees), and supervision hours per week were also captured through the survey. Assumptions of $19.64 and $24.35 were used as hourly wage assumptions for service coordinators and supervisors respectively. ERE is applied to each of these wages and included in total costs.

Indirect Costs

As discussed above, admin and program support add on factors were generated as a percentage of direct care wages. Program support does not include staff transportation costs as these costs were calculated independently from the program support add on.

Transportation

Transportation costs were calculated separately from a program support add on because total transportation costs varied widely from provider to provider, but responses were more consistent in identifying trips and milage. Providers reported an average of 44 miles per day driven by service coordinators. Based on the IRS standard milage reimbursement, staff transportation costs providers $7,493 annually.

Estimated Costs

Total per client estimated costs calculated by the Service Coordination cost estimate model are $430.36. However, this is in terms of SFY 2022 costs. The same inflation factor of 3.7 percent was applied as above. Note that this factor is listed as 10.51 percent as it is applied for a total of 33 months. The inflated per Client per Month cost is $475.59.

Table 19: Service Coordination Cost Profile

Center	Input	Input Description	Calculation	FES - Service Coordination
Wages and Benefits	a	Hourly Wage	Provider Survey	$19.64
	b	Annual Wage	a * 2080	$40,851.20
	c	ERE (% of Wages)	Provider Survey	27%
	d	Hourly Compensation	a * (1 + c)	$24.94
	e	Annual Compensation	b * (1 + c)	$51,881.02
Supervision	f	Hourly Supervisor Wage	Provider Survey	$24.35
	g	Annual Supervisor Wage	f * 2080	$50,648.00
	h	Supervisor ERE	Provider Survey	27%
	i	Hourly Supervisor Compensation	f * (1 + h)	$30.92
	j	Annual Supervisor Compensation	g * (1 + h)	$64,322.96
	k	Supervision Hours per Week	Provider Survey	20
	l	Supervisor Span of Control	Provider Survey	8.0
	m	Supervision Hours per Staff per Hour	k / l / 40	0.06
	n	Supervision Cost per Staff per Hour	j * m	$4,020.19
	o	Annual Total Compensation	t * 2080	$55,901.21
Admin and Program	p	Administrative Overhead Percent	Provider Survey	22.12%
	q	Administrative Overhead Annual Factor	o * p	$12,365.35
	r	Program Support	Provider Survey	3.05%
	s	Program Support Annual Factor	r * o	$1,704.99
Transport	u	Total Daily Miles	Provider Survey	44.00
	v	Total Weekly Miles	u * 5	220.00
	w	IRS Mileage Rate	IRS 2023 Mileage Rate	$0.66
	x	IRS Mileage Per Week	v * w	$144.10
	y	Annual Mileage Cost	x * 52	$7,493.20
Total Cost	z	Total Annual Cost	o + q + s + y	$77,464.74
	aa	Total Monthly Cost	z / 12	$6,455.40
	ab	Caseload	Provider Survey	15.00
	ac	**Monthly Cost Per Client**	**aa / ab**	**$430.36**

Center	Input	Input Description	Calculation	FES - Service Coordination
	ad	Inflation Factor	CPI Medical Services Index	**10.51%**
	ae	**FFY 2025 Inflated Cost Per Client**	**ac * (1+ad)**	**$475.59**

G.4. Cost Coverage Analysis

Guidehouse analyzed the relationship between provider agencies' revenue and costs and the proportion of the Part C and FES program costs that are covered by the Part C and FES program revenue. The provider survey data revealed that $6.9 million of $7.3 million or 95 percent of total costs across providers are covered by Part C and FES program revenue. The unique cost drivers and revenue sources impacting the five distinct providers warrants further exploration of the cost coverage by individual providers. Moreover, a few providers may operate and receive funds from other state programs that may further impact the revenue sources that cover the Part C and FES program costs. Tables 20 and 21 below highlight the cost and revenue analysis by provider. As captured in the first table, the cost coverage for most providers is close to 95 percent. However, two providers deviate from the trend and are further broken down distinctly by the Part C and FES programs in the second table, as reported in the provider survey.

Table 20: Part C and FES Combined Cost Coverage Analysis

Part C and FES Combined Program Cost and Revenue Analysis – SFY2022 Survey Data			
Provider	**Part C and FES Cost**	**Part C and FES Revenue**	**Part C and FES Revenue / Part C and FES Cost**
Region 1	$1,044,177	$901,403	86%
Region 2	$1,140,767	$1,091,559	96%
Region 3	$1,825,916	$1,771,546	97%
Region 4	$1,427,590	$1,457,382	102%
Region 5	$1,865,228	$1,693,496	91%

Part C and FES Combined Program Cost and Revenue Analysis – SFY2022 Survey Data			
Provider	**Part C and FES Cost**	**Part C and FES Revenue**	**Part C and FES Revenue / Part C and FES Cost**
Total	**$7,303,677**	**$6,915,386**	**95%**

Guidehouse notes that 87 percent of Part C costs are covered by Part C program revenue, and 108 percent of FES costs are covered by FES program revenue. This trend is consistent with feedback received from the Department and providers that revenue shifting may take place between the Part C and FES programs to cover the cost of providing services. Barring one provider agency, the Part C cost coverage is lower than the FES coverage across all providers. Changes in the number of clients served by the provider in more recent years may explain the anomaly. However, the provider survey focused primarily on capturing providers' cost of providing services under the Part C and FES programs. While we can glean high-level insights based on minimal data reported by providers, this information warrants further review and discussions with stakeholders. While there are no cost coverage standards established for these programs and they are payers of last resort, the reasons for coverage beyond 100 percent or significantly under the average deserves further review.

Table 21: Part C and FES Cost Coverage Analysis

Provider	Part C Program Cost and Revenue Analysis – SFY2022 Survey Data			Family Education and Support (FES) Program Cost and Revenue Analysis – SFY2022 Survey Data		
	Part C Survey Costs	Part C Survey Revenue	Part C Revenue / Cost	FES Survey Costs	FES Survey Revenue	FES Revenue / Cost
Region 1	$533,454	$425,594	80%	$510,724	$475,810	93%
Region 2	$735,291	$629,715	86%	$405,476	$461,845	114%
Region 3	$1,272,912	$1,173,864	92%	$553,004	$597,681	108%
Region 4	$735,867	$871,616	118%	$691,722	$585,766	85%
Region 5	$1,475,695	$1,051,101	71%	$389,533	$642,395	165%

Provider	Part C Program Cost and Revenue Analysis – SFY2022 Survey Data			Family Education and Support (FES) Program Cost and Revenue Analysis – SFY2022 Survey Data		
	Part C Survey Costs	Part C Survey Revenue	Part C Revenue / Cost	FES Survey Costs	FES Survey Revenue	FES Revenue / Cost
Total	**$4,753,218**	**$4,151,889**	**87%**	**$2,550,459**	**$2,763,497**	**108%**

H. Fiscal Impact Analysis

H.1. Fiscal Impact Overview

Guidehouse analyzed how project costs would affect projected expenditures in an effort to estimate the fiscal impact of accounting for the changes in provider costs for the State of Montana. This analysis was conducted exclusively for the purposes of the rate study, to assess the implications of changing monthly per capita costs for the Part C and FES programs to the levels identified by study cost benchmarks. Moreover, these assumptions represent Guidehouse's best judgment based on the utilization data available, but do not necessarily reflect State legislative or executive decision-making, nor do they indicate additional commitments to future financing.

In the following sub-sections, Guidehouse describes the data sources for our utilization assumptions, including the service periods reflected in the data as well as any exclusions or other limitations that frame the data set. The analysis also considers factors that influenced utilization assumptions and our approach to addressing these factors, including COVID-19 service impacts, or adjustments to utilization stemming from proposed changes to the targeted population. With these caveats in mind, the report presents the fiscal impact for both Part C and FES programs.

H.2. Baseline Data and Projection Assumptions

The fiscal impact analysis for both Part C and FES relies on the most recent expenditure data and utilization assumptions based on the most recently completed calendar year of payments. Although Guidehouse collected data for CY 2021 and CY 2022, review of the data and discussions with the Department revealed that the public health emergency prompted by COVID-19 led to a systemic disruption of service delivery that altered patterns of utilization, resulting in CY 2021 data unrepresentative of client volume as well as likely utilization in the future. Therefore, we ruled out the CY 2021 service period as a base period for analysis. Guidehouse selected CY 2022 data instead of SFY2022 because the calendar year is inclusive of 6 months of data (July-December 2022) after the end of SFY 2022 (June 2022), and 2022 may be considered a "normal" year for utilization assumptions relative 2021. Moreover, CY 2022 appears to be the most comprehensive data set available from MMIS (Montana Medicaid Management Information System). Lastly, providers expressed during Rate Methodology Workgroup meetings that they invested in child find activities in 2022 which had an impact on the number of clients served and might be representative of the number of clients they would continue to be serve. For these reasons, Guidehouse chose to use the CY 2022 period as the baseline for fiscal impact analysis.

As noted in Section D.3., Guidehouse computed the annual Part C expenditure for each provider based on the number of clients served per month and the associated contracted tiered

rate for the provider. On the other hand, the MMIS data for the FES program included expenditure data for each provider and was used as is to analyze the current expenditure and assess the fiscal impact.

Furthermore, as discussed in Section H, Cost Analysis, the costs are projected to April 2025 to align with the anticipated start of a new 5-year contract period. FFY 2025 expenditure is calculated based on per member per month costs projected to FFY 2025.

Guidehouse utilized the Montana 2021 Census and Economic Information Center (CEIC) data for population assumptions, to further update the 2015 data used in the current rate structure. Guidehouse modeled fiscal impact projections for Part C and FES based on three different utilization assumptions drawn from the historical SPP/APRs, as noted below.

- 1.74%: actual population penetration rate
- 2.36%: present targets
- 2.86%: 2024-2025 projected targets

Finally, the projections presented later in this section should not be taken as a representation of the total estimated state budget for the programs given there are multiple funding avenues that support the program. Guidehouse chose to analyze the costs assuming a wide range of utilization assumptions informed by historical targets opting to err on the side of overstating rather than understating the financial implications to provide decision-makers with all the required information.

H.3. Fiscal Impact across Part C and FES Programs

This section includes the most recent (CY2022) as well as projected (FFY 2025) population and expenditure, as well as comparisons between the current rates and projected costs. Table 22 below includes the current expenditure based on CY 2022 claims for Part C. The total Part C annual expenditure for serving 700 members on average per month is roughly $3.9M across all providers with the individual provider costs ranging between approximately $396k and $1.2M per year.

Table 22: CY 2022 Part C Expenditure by Region

CY 2022 Part C		
Region	**Average Monthly Members Served**	**Expenditures Calculated from Claims**
Region 1	75	$396,658
Region 2	116	$596,696
Region 3	241	$1,173,863

CY 2022 Part C		
Region	**Average Monthly Members Served**	**Expenditures Calculated from Claims**
Region 4	88	$749,474
Region 5	181	$961,504
Overall	**700**	**$3,878,196**

Table 23 below includes the current expenditure based on CY 2022 claims for the FES program. The total FES annual expenditure is around $2.7M for an average of 464 members served every month across all providers. FES expenditure is $1.2 million lesser than Part C expenditure which aligns with cost trends from provider survey.

Table 23: CY 2022 FES Expenditure by Region

CY 2022 FES		
Region	**Average Monthly Members Served**	**Expenditures Calculated from Claims**
Region 1	82	$471,377
Region 2	87	$496,638
Region 3	99	$563,841
Region 4	96	$546,683
Region 5	100	$573,850
Overall	**464**	**$2,652,390**

Table 24 shows the projected expenditure for Part C based on the cost per member per month (labelled “Cost Per Member Per Month (PMPM)”) obtained from the combined costs reported in the provider survey and the monthly average population (labelled “Monthly Average Base Population”) from the most recent census data. Guidehouse applied the three different population target rates of 1.74 percent, 2.36 percent, and 2.86 percent to arrive at the respective total projected costs (labelled “Total Costs”) as highlighted in the table below. The total annual projected costs at $546.32 cost per member per month range from nearly $4 million to $6.5 million dollars across all providers depending on the population target rate.

Table 24: FFY 2025 Part C Projected Expenditure Based by Region (Combined Cost)

FFY 2025 Part C (Combined Program Cost)					
Region	**Monthly Average Base Population (2021 CEIC)**	**Cost Per Member Per Month (PMPM)**	**Total Costs (1.74% Target)**	**Total Costs (2.36% Target)**	**Total Costs (2.86% Target)**
Region 1	3,034	$546.32	$346,093	$469,414	$568,866
Region 2	5,806	$546.32	$662,300	$898,292	$1,088,608
Region 3	7,458	$546.32	$850,746	$1,153,886	$1,398,353
Region 4	8,739	$546.32	$996,872	$1,352,079	$1,638,536
Region 5	9,642	$546.32	$1,099,879	$1,491,789	$1,807,846
Overall	**34,679**	**$546.32**	**$3,955,890**	**$5,365,459**	**$6,502,209**

Similarly, Table 25 captures the projected expenditure by region, but the cost per month assumption is based on the distinct Part C costs reported in the provider survey. Given the higher per member per month cost in this case compared combined costs, the total annual projected costs are 1.7 percent higher ranging from $4 million to $6.6 million across all providers depending on the population target rate.

Table 25: FFY 2025 Part C Projected Expenditure by Region (Part C Only)

FFY 2025 Part C (Part C Specific Cost)					
Region	**Monthly Average Base Population (2021 CEIC)**	**Cost Per Member Per Month (PMPM)**	**Total Costs (1.74% Target)**	**Total Costs (2.36% Target)**	**Total Costs (2.86% Target)**
Region 1	3,034	$555.83	$352,118	$477,585	$578,768
Region 2	5,806	$555.83	$673,829	$913,929	$1,107,558
Region 3	7,458	$555.83	$865,555	$1,173,972	$1,422,694
Region 4	8,739	$555.83	$1,014,225	$1,375,615	$1,667,059
Region 5	9,642	$555.83	$1,119,025	$1,517,757	$1,839,316
Overall	**34,679**	**$555.83**	**$4,024,751**	**$5,458,858**	**$6,615,396**

Table 26 below includes a projection of expenditures for Part C if service utilization were to be

paid at population target rates (labeled “Population Target Rate”) and FFY 2025 projected monthly member costs, which is compared to the baseline current expenditures during CY 2022 to identify the overall fiscal impact, a figure that reflects new expenditures needed to finance projected increase in costs (representing the “Difference from CY 2022” and “Percentage Difference from CY 2022” from between projected and current spending). The table also captures the fiscal impact for Part C Cost Per Member Per Month obtained from both Part C only costs (labeled “FFY 2025 Part C Only”) as well as combined Part C and FES costs (labeled “FFY 2025 Combined”).

Analysis suggests the system would require an additional annual spending that ranges from 78 thousand up to 2.7 million dollars—which includes potential state and federal dollars—depending on the expected population target rate and projected cost per member per month. The projected additional funding varies substantially depending on decisions made around population targets. The comparison at 1.74 percent population target results in 2-3.8 percent difference between current and projected expenditure. The percentage difference increases to roughly 38-41 percent at the present population target of 2.36 percent, and 68-71 percent at the projected population target of 2.86 percent.

Table 26: Fiscal Impact to Part C Program

Part C Cost Comparison CY 2022 to FFY 2025				
Time Period	**Population Target Rate**	**Total Expenditure**	**Difference from CY 2022**	**Percentage Difference from CY2022**
CY 2022	1.74%	$3,878,196	-	-
FFY 2025 Part C Only	1.74%	$4,024,751	$146,556	3.8%
	2.36%	$5,458,858	$1,580,662	40.8%
	2.86%	$6,615,396	$2,737,200	70.6%
FFY 2025 Combined	1.74%	$3,955,890	$77,694	2.0%
	2.36%	$5,365,459	$1,487,264	38.3%
	2.86%	$6,502,209	$2,624,014	67.7%

Table 27 shows the projected expenditure for FES based on the cost per member per month obtained from both the top down (labeled “FES Top Down Cost PMPM”) and bottom up (labeled “FES Bottom Up Cost PMPM) cost build up approaches, and the contracted monthly clients per provider (labeled “Contracted Monthly Base Population”) from the most recent census data. The current expenditure for FES is roughly $3.1 million and the total annual projected costs moderately increase to $3.2 million at $490.93 PMPM and $3.5 million at $532.46 PMPM.

Table 27: FFY 2022 FES Projected Expenditure by Region

FFY 2025 FES Expenditures				
Region	**Contracted Monthly Base Population**	**Current Rate ($476.62 PMPM)**	**FES Top Down Cost PMPM ($532.46)**	**FES Bottom Up Cost PMPM ($490.93)**
Region 1	89	$509,030	$568,667	$524,303
Region 2	80	$457,555	$511,162	$471,283
Region 3	106	$606,261	$677,289	$624,450
Region 4	156	$892,233	$996,765	$919,002
Region 5	116	$663,455	$741,184	$683,361
Overall	**547**	**$3,128,534**	**$3,495,067**	**$3,222,399**

Based on the feedback from both the Department and providers that the Part C program includes a wider range of services compared to FES, there are significant differences in the funding needs projected between the Part C and FES programs. The additional costs that may be incurred to shift from the current to projected per member per month costs for FES is around $94-$367 thousand dollars with the top-down costs requiring a larger increase at 12 percent difference. Table 28 below includes the fiscal impact estimations for the FES program.

Table 28: Fiscal Impact to FES Program

FES Cost Comparison CY 2022 to FFY 2025			
Time Period	**Total**	**Difference from CY 2022**	**Percentage Difference from CY 2022**
CY 2022	$3,128,534	-	-
FES "Top Down"	$3,495,133	$366,534	11.7%
FES "Bottom Up"	$3,222,465	$93,865	3.0%

I. Considerations for Payment Redesign and Service Delivery Reporting and Monitoring

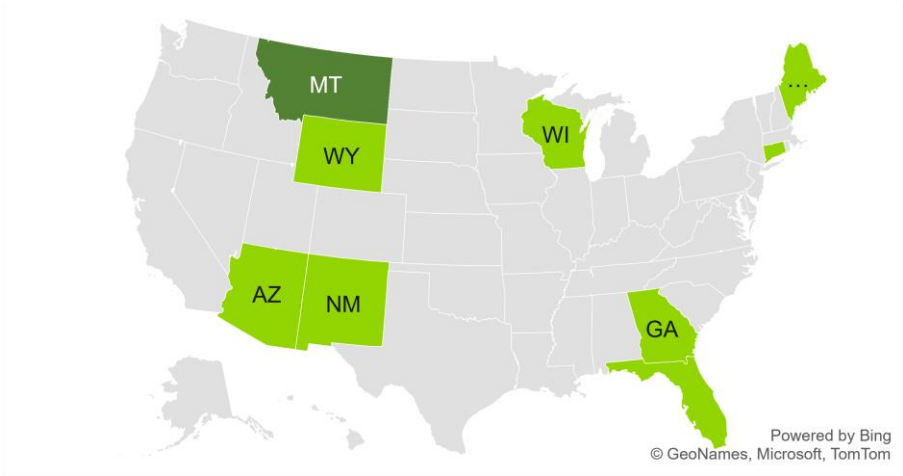
Based on the rate study process and results, Guidehouse identified several financial and policy considerations highlighted in this section for the Department to discern as it navigates the implementation of updated rates for the programs under review. These considerations are rooted in a peer state comparison analysis, whose findings are described in greater detail below, as well as a scan of national best practices. Guidehouse also considered input provided by stakeholders throughout the rate development process in arriving at these recommendations for the Department.

J.1. Peer State Analysis

Guidehouse gathered information on early intervention service payment systems in several peer states to compare and contrast Montana's rate methodology to other approaches across the country. Due to the uniqueness of each state's reimbursement framework, no single program is exactly comparable to Montana's program. However, it is helpful to compare program design to similar systems in other states to understand whether current design best serves the goals of the state and the needs of providers and clients.

Guidehouse appreciates that Montana is unique among other states geographically, demographically, and culturally. Therefore, we identified states with diverse methodologies to examine alternative payment scenarios, providing diverse options for future cost reimbursement. Figure 7 highlights the eight states considered for peer state analysis.

Figure 7: Overview of Peer States



Guidehouse identified states with diverse methodologies for comparison to the current methodology used by DPHHS. These were categorized into three basic types of payment methodology: 1) bundled payment, 2) fee-for-service (FFS), and 3) retrospective reconciliation based on cost report. These approaches are summarized in Table 29 below and described in greater depth in Guidehouse's rate structure considerations in Section J.2. Guidehouse research into other Part C payment systems revealed a variety of payment methods rather than a single, dominant approach. Montana uses a "population-based payment structure" similar to a few other states, but with its own unique features. Peer state comparison revealed substantial diversity in approaches, with some stark differences from state to state.

Table 29: Part C Methodology Comparison

Methodology	Description	State
Bundled Payment (I): Population Based Payment Structure	Current methodology. Bundled rate with tiers dependent on the number of clients served.	Montana, New Mexico, Maine, Wyoming
Bundled Payment (II): Individual Bundled Rate	Bundled rate that pays per client. Similar to current FES reimbursement.	
Fee-for-Service Rates[16,17]	Per service FFS rates	Arizona, Connecticut, Georgia, Florida
Retrospective Reconciliation	End of year cost and revenue reconciliation where Part C pays for costs not covered by other revenue streams	Wisconsin

Among the states that have adopted a FFS approach, Guidehouse also noted considerable diversity in the coding and billing structure adopted by each program, with states such as Georgia adopting a Medicaid billing model employing detailed medical coding conventions, while other states chose a more simplified format for structuring service claims and billing. Guidehouse will discuss some of the implications of these alternative approaches in Section J.4.1.

J.2. Rate Structure Considerations

According to a national report by the Infant Toddler Coordinators Association (ITCA) titled *Part C System A Resource and Technical Assistance Paper for Reimbursement Methods in IDEA*

[16] Arizona Department of Economy Security, Arizona Early Intervention Program. Rates are available online: https://des.az.gov/azeip
[17] Georgia Department of Public Health, Babies Can't Wait Program. Rates are available online: https://dph.georgia.gov/babies-cant-wait

Part C, a financing system as a whole and a reimbursement structure should include the following considerations:

1) Ensure Lead Agency and provider accountability, as well as provide reasonable support in a manner that is responsive to direct service providers to ensure the delivery of quality, comprehensive services to meet the needs of children and families.
2) Rates encourage & support service delivery to meet individualized child and family needs and are delivered within the context of the child's natural environment.
3) The structure should support early intervention philosophy and beliefs.
4) The structure should support best practice.
5) The structure should support the hiring and retention of qualified staff.
6) The structure should consider impact of service specific versus discipline specific reimbursement.
7) The structure should consider clustering similar disciplines at the same rate of reimbursement.
8) The structure should support a transdisciplinary approach.
9) The structure should consider the potential for higher reimbursement for home- and community-based services to account for reduced billable time and the cost of provider or practitioner transportation.
10) Rates should be rounded to the nearest whole dollar amount.
11) Reimbursement should consider the different methods across funding sources.

Upon detailed review of the current reimbursement model used by the Department to fund local early intervention programs in Montana, Guidehouse found that DPHHS' bundled payment system adequately conforms to these principles in general, but suggests that the Department to consider how alternative payment systems might promote greater accountability from providers in serving clients with the appropriate level and range of care, while also encouraging providers to leverage additional funding from multiple payer sources. Due to significant implementation challenges and potential uncertainty in moving from a bundled payment approach to alternatives such as FFS, Guidehouse is not recommending an immediate transition in Montana's current reimbursement approach. However, the potential advantages of a FFS are worth considering for payment redesign down the road.

In the subsections below, Guidehouse details the features of the various payment approaches implemented in state programs across the country, laying out the potential merits and drawbacks of each approach for Montana's early intervention system.

J.2.1. Bundled Payment (Montana's Current Model)

Definition: A bundled rate is a single payment for individuals served and is designed to cover all the services received by the child and family. Depending on the state, this rate may or may not include Service Coordination.

Methodology: Typically, this is paid on a monthly basis for each child and family served regardless of how many services are rendered to the child and family. The rate is often developed based on the average number of units that children and families receive and is based on utilization data across the whole cohort served in a period of time (i.e., each program or provider would receive a common monthly reimbursement amount even though some individuals would receive more services units, while others would receive less). Guidehouse noted a key difference between Montana and several other states within a general bundled payment approach; namely, Montana utilizes a method akin to a "population-based payment structure" rather than a per capita payment that ties reimbursement to specific individuals.

Considerations:

- Because reimbursement rates are largely based on the average cost per child, direct service providers may limit services to more involved children and families, with the perception that they are not being reimbursed for units provided beyond the average.
- Bundled rates are paid even if the individual receives minimal services that month, unless the billing requires a minimum services delivery (e.g., 1-hour of service must be provided in order to bill the bundled rate).
- Medicaid is increasingly moving away from bundled rates, and private insurance may not approve payment for a bundled rate.
- It is helpful for Medicaid and state funding be aligned to avoid perception of inequities in reimbursement.
- Budgeting can be easier for service providers as they can estimate revenue based on caseload per monthly times the monthly rate.
- Bundled payments typically promote a transdisciplinary or primary service provider model, including consultations among practitioners, which is harder to reimburse under an FFS reimbursement system.

J.2.2. Fee-for-Service

Definition: Fee-For-service (FFS) is a method of reimbursement whereby the provider bills for each encounter, event, or service rendered. The fee is established by the state.

Methodology: Service units are typically either 15-minutes or 1-hour; Service units can also be for an encounter or event (e.g., an assessment or evaluation). Note: Medicaid often requires 15-

minute units and may have an algorithm to calculate the number of units to be billed (e.g., is 50 minutes three 15-minute units or four. Modifiers can be added for group versus individual service provision, or by location (i.e., home and community versus office and clinic settings). A modifier can also be applied to account for geographical differences (e.g., frontier areas).

Considerations:

- FFS encourages services to be provided that are on the IFSP, as all services are compensated and provide little financial risk for direct service providers delivering services because they are reimbursed for all services rendered.
- Need for controls on total expenditures (i.e., through the frequency, units, and length authorized on the IFSP to estimate financial commitment). This could include prior authorization for services on the IFSP over a certain amount.
- Unit rates can be used for Medicaid and private insurance. Having common rates can ensure that there are not disincentives for direct service providers serving children and families with differing insurance coverage as the rate of reimbursement is the same.
- A central billing system can be used to process payments. A data system needs to collect certain service log data elements in order to process payments including date of service, time in and time out, location, method (i.e., individual or group), service type, etc.
- Budgeting can be harder for service providers as they have to estimate revenue based on utilization (i.e., the average number of service units provided to children and their families).
- Fee-for-service is the most common funding methodology nationally for state early intervention Part C programs (N=51 states + DC).[18] 27 (53%) = fee for service; 2 (4) = capitation; 11 (22.5%) = grants; 11 (22.5%) = contracts.

J.2.3. Retroactive Reconciliation

Definition: An agency-developed reimbursement system that may include information such as agency characteristics, utilization data, cost and charges, and financial expenditure data. This is typically an 'after the fact' process that can involve submission and review of costs and utilization (i.e., provision of services).

Methodology: Service providers may be required to submit a budget for approval for the fiscal year with monthly payment adjusted based on review of data submitted on expenditures and utilization. It may involve provider agencies submitting annual budget (i.e., salaries and benefits for direct and support staff, operating costs, indirect costs, etc.) and approval by the state, with payments made against the contracted amount that is adjusted based on service utilization and actual expenditures for the month.

[18] Infant Toddler Coordinators Association (ITCA) - State Profiles & Topical Matrices https://www.ideainfanttoddler.org/pdf/Funding-Structure.pdf

Considerations:

- A Funding formula or cost reimbursement can be complex and may require additional administrative time for service providers and the state agency to adjudicate costs and adjust payments.
- Adjustments may need to be made several months after services are reimbursed by third party payors (e.g., Medicaid and private insurance).
- The costs of a unit of service may be obscured and lead to perceived inequities with other funding sources (e.g., Medicaid).
- The complexity of the funding formula may confuse programs, direct service providers, funders, and advocates leading to mistrust and lack of understanding of the true cost of services.
- Involves few financial risks to service providers, although they may perceive that funds 'allocated' to them in a contract are being 'taken away' if utilization or expenditures are low.
- Funding for transdisciplinary consultation between staff can be built into the formula.

J.3. Alignment with Other Payer Sources

As a part of the Part C and FES rate study, Guidehouse was charged with reviewing the financial alignment of these programs with other potential funding sources, including private insurance as well as Medicaid. In the subsections below, Guidehouse details potential opportunities to improve leverage these payer sources through a combination of payment redesign, supporting legislation, and additional infrastructure to improve billing processes.

J.3.1. Private Insurance

An increasing number of state IDEA Part C and related early intervention programs receive reimbursement for early intervention services through private health insurance plans, generating $81.5 million nationally, and 2% of the overall revenue. However, this may be an undercount due to the fact that the state office may not know the amount of revenue collected by service providers at the local level.

Sixteen states (46%) that responded to a national survey[19] (of 35 total surveyed) stated that they have statutory language in place requiring private health insurance plan coverage of Part C early intervention services. Additionally, 22 states (85%) responded (of 26 total surveyed) that there is no annual cap on payment, while four states (15%) indicated there is a cap that ranged

[19] Infant Toddler Coordinators Association - 2018 Finance Survey Report https://www.ideainfanttoddler.org/pdf/Finance-Survey-Report-Pt-2-public-private-insurance-family-fees.pdf

from $3,000 to $6,500.

Considerations:

- Passing health care legislation at the state level that mandates payment for early intervention services increases the amount of revenue that state early intervention programs receive as compared to just billing health plans without legislation, which often results in denial of payments.
- If a state already bills Medicaid as the public health insurer the argument can be made that private health insurers should also fund these 'medically' necessary services. States often bill the private health plans the same rates and use the same codes and modifiers that they use to bill Medicaid.
- In order to pass insurance legislation, it is helpful to analyze utilization of services, (i.e., the number of services provided in a year, as well as the number and percent of children estimated to have private health insurance coverage). Public or state insurance regulators can help access these data. This can result in a calculation of the projected revenue that would be realized through billing private health plans.
- State Part C programs must decide whether to include an annual cap that private health plans would pay for early intervention services. As Medicaid does not have an annual cap, so an argument can be made that a cap should also not be applied to private health insurance payments.
- Some state Part C programs have developed central billing systems that have the advantage of removing the administrative burden on service providers that otherwise would need to hire and train insurance billing staff to process private health insurance claims. A central billing system collects delivered services data (e.g., date of service, time, service, location, and method that is then converted into a billable claim with the appropriate billing code and modifier. The actual claims processing, reconciliation, and follow-up can be done by state staff or a through contracted billing agent.
- State Part C programs must also decide whether they will implement a 'pay and chase' system, where the state 'pays' the service provider for the services rendered and then 'chases' the 3rd party health plan for the reimbursement, which comes to the state as revenue, verses direct payment to service providers.
- Medicaid often requires the billing of private health plans when there is co-insurance (i.e., the child is covered by both Medicaid and private health plan), with Medicaid being the payor of last resort.
- State insurance mandates do not apply to self-insured health plans subject to ERISA (Employee Retirement Income Security Act of 1974). Therefore, it will be necessary to research the percent of the state that is covered by fully insured employer-sponsored group health plans verses self-insured plans in order to project potential revenue for early intervention.

As a part of these considerations, the Department should note potential resistance from policy makers, service providers, and parents in billing private health insurance. Some possible strategies for addressing these barriers include:

- Explaining to policy makers the increase in revenue supporting legislation could generate, and that private health plans should be seen as a significant payer of early interventions services just like Medicaid, which is the largest public health insurance plan.
- Addressing service provider concerns with the administrative time and costs associated with billing private health plan which could be alleviated if the billing is done centrally by the state office.
- Responding to concerns from parents regarding increased costs of co-pays and deductibles, which could be addressed in a private insurance statute for early intervention, that prevents copays and deductibles being charged to families. However, even without a statutory language change, DPHHS could begin to bill private insurance and issue a policy that states that co-pays or deductibles will not be collected from families; e.g., if the early intervention service is $115.00 and the insurance plan pays $100.00, i.e. less a $15.00 co-pay – DPHHS would just not collect the $15.00 from the family.

J.3.2. Medicaid

All state Part C programs report accessing Medicaid funds to some degree. Nationally, federal Medicaid revenues are $848 million, which is 35% of the total revenue reported by states. However, it is thought that this is an undercount as not all states can accurately account for all Medicaid revenue if billing is done at the local level.

Medicaid is managed regionally by the Centers for Medicare and Medicaid Services (CMS), which approves all state Medicaid plans. State plan differences, as well as varying early intervention services and service models, often result in differences in the early intervention services that are reimbursed by Medicaid between states. Also, Medicaid funding for early intervention may be under different forms of Medicaid, including: Early Periodic Screening, Diagnosis & Treatment (EPSDT), managed care, waiver programs, rehabilitative, and general Medicaid state plan, and may also include administrative claiming. Some states need to be able to ‘carve out’ early intervention services from managed care systems.

In addition to therapy services, 27 (73%) states are reimbursed by Medicaid for ‘Special Instruction’ and 30 (81%) are reimbursed for Service Coordination.

Considerations:

- Medicaid can fund all early intervention services, including Special Instruction and Service Coordination.
- Medicaid is often willing to fund early intervention services at the same rate paid to direct service providers with state general funds and IDEA Part C funds. This is especially true

for states where the state match (Federal Medical Assistance Percentage) appropriation from the legislature comes to the state early intervention program. Having the same rates paid by Medicaid and state general funded reduces the potential for provider to favor serving one group of children and families based on their insurance coverage.

- Some state Part C programs have developed central billing systems that collect delivered services data (e.g., date of service, time (minutes), service type, location, method (individual or group) that is then converted into a billable file with the appropriate billing code and modifier. The actual claims processing, reconciliation, and follow-up can be done by state staff or through a contract billing agent.
- Working with Medicaid to enable the state program to access the Medicaid enrollment file conduct eligibility checks for the billing of early intervention services for all Medicaid enrolled children, rather than relying on direct service providers to ask families whether their child is enrolled in Medicaid and obtaining the Medicaid card / number and entering into a database (which can result in data entry errors). Data sharing agreements are not needed for a billing agent to collect enrollment data as part of the HIPAA electronic transaction 270/271 'Health Care Eligibility Benefit Inquiry and Response' process (270/271).

J.3.3. Central Billing System

In the discussion above regarding opportunities to better leverage program financing through billing to private insurance and Medicaid, Guidehouse noted the potential for establishing a central billing system. As a part of the rate study, Guidehouse did not explore Montana's current technical capabilities to determine the feasibility of a central billing system, or the resources needed to implement and support it. Based on the experiences of other states, however, there is a plausible argument to be made that implementation would be a costly and time intensive infrastructure change for DPHHS even if it would increase revenue.

As a first step in considering feasibility more concretely, DPHHS could consider a request for information for potential vendors prior to issuing a procurement that could establish the range of models for central reimbursement system administration and payment (including build costs, monthly administrative fee, contingency i.e. percent of revenue collected, or hybrid) that can change the upfront costs to the Department.

J.4. Reporting and Monitoring and Payment Transition Considerations

J.4.1. Utilization Reporting and Monitoring

Although Guidehouse did not identify challenges in Montana's current reimbursement system for Part C and FES services sufficient to warrant major changes in its payment methodology, a substantial deficiency in the Department's bundled payment framework is that it does not

require detailed reporting on actual service delivered by its contracted providers, which both limits DPHHS' ability to monitor access to services and quality and appropriateness of care delivery, as well as restricts the Department's ability to implement alternative payment methods that may be desirable to the agency and its providers alike.

Although a FFS system requires reporting on utilization for billing purposes, the bundled payment framework does not require this administrative data, although improved reporting does support more accurate determination of rate adequacy. Guidehouse recommends establishing at least a minimal reporting process, both to support the Department's current framework as well as to facilitate payment transition to a FFS system in the near future if desired.

Depending on how closely the Department chooses to align its early intervention program with related programs in Medicaid, such as EPSDT, DPHHS could consider developing a rigorous reporting structure using medical coding consistent with program designs fully aligned with Medicaid. As discussed in the peer state analysis in Section J.1., Georgia's fee schedule for early intervention services offers a representative framework for capturing service utilization in deep detail to support close program alignment between early intervention and Medicaid programs.

If service utilization is captured solely for monitoring purposes rather than to support a FFS payment system, DPHHS should consider a simpler reporting framework to ease burden on providers. At minimum, the Department would merely need to specify the basic service designation and its associated unit of service, as represented in Table 30:

Table 30: Simplified Reporting Framework

Service	Unit of Service
Evaluation	Event
Service Coordination	15 minutes
Audiology	15 minutes
Speech Therapy	15 minutes
Developmental Therapy	15 minutes
Psychology	15 minutes
Nutrition	15 minutes
Social Work	15 minutes

Service	Unit of Service
Interpreter	15 minutes
Physical Therapy	15 minutes
Physical Therapy Assistant	15 minutes
Occupational Therapy	15 minutes
Certified Occupational Therapy Assistant	15 minutes

J.4.1. Transitioning to Fee-for-Service

The chief obstacle to transitioning to a fee-for-service system—and the primary reason why Guidehouse did not recommend an immediate process of transition—is that the lack of current utilization data creates substantial budget uncertainty, not only system expenditure as a whole, but also for individual provider revenues. Although establishing a utilization reporting and monitoring process would address this challenge, there are several challenges specific to FFS implementation that DPHHS will need to consider to determine feasibility and desirability of a payment redesign.

First, while a FFS system incentivizes the provision of all services on the IFSP and may increase the average number of survives up to closer to the national average of 4.5 hours per month – as providers are reimbursed for all services provided – a volume-based methodology such as FFS could lead to the overprovision of services by programs to generate greater revenue. In preparing for future payment transition, DPHHS should confirm that monitoring of both IFSP service authorization and service utilization is reasonable. This monitoring process can include reports that show service levels over a certain amount per month for auditing purposes and prior review for services levels over an extremely high monthly level. This will require that the DPHHS data system is able to both capture and report these data.

Second, movement to a FFS system could be seen by DPHHS and service providers as less predictable for projecting expenditures/revenue for budgeting. FFS allows a direct payment for the services provided, and if used for state early intervention programs and Medicaid, a report in Montana's data system can provide an accurate picture of the reimbursement amounts the program will receive. Programs can conduct revenue forecasts month the month of the revenue projected to receive and after the first year they will have a history for comparison of month-to-month trends (e.g., a dip in service provision and revenue in December due to the holiday).

Third, FFS could be seen by early intervention service providers as administratively cumbersome, as it requires additional documentation and service logging. A FFS system will encourage providers to enter all services accurately into the claiming system in order to be

reimbursed. Providers will need to set up procedures to ensure entry of all direct services provided for paper service logs.

Although each of these perceived challenges represents a legitimate concern, none is an insurmountable barrier in itself. Ultimately, the desirability of transitioning to FFS system will largely depend on findings from an established utilization reporting process and the determination of how best to encourage appropriate service delivery with available funds.