Virginia Brain Injury Services
Department of Medical Assistance Services (DMAS)

Meeting 4
Employee Benefits, Neurobehavioral Unit & Service Assumptions

May 10, 2023

Agenda

- Employee Related Expenses (ERE) / Provider Fringe Benefits
  - Rates and Finance Workgroup Feedback
- Neurobehavioral Unit Rate Setting Overview
- Targeted Case Management Service Delivery Assumptions
  - Program Design Workgroup & Provider Feedback

Brain Injury Program and Rate Development Scope

Virginia Department of Medical Assistance Services (DMAS) Rate Study

State Plan Targeted Case Management (TCM)

- *For people with severe traumatic brain injury*

1915(c) Home and Community-Based Services

- *For people with brain injury or neurocognitive disorder*
- *Wide range of services including Residential, Behavioral Health, In-Home Services, Day and Employment, Nursing, and Equipment and Modification services*

Neurobehavioral Unit

- *For people who need a level of care as an institutional alternative beyond what is available through waiver*

Rate Methodology and Rate Development

Service Identification, Eligibility Criteria, Definitions, and Specifications

Stakeholder Engagement

Documentation and Reporting

Employee Related Expenses (ERE) or Provider Fringe Benefits

Setting a Competitive Benefits Package

Assumptions for employee-related expenses (ERE) intend to look at what a provider should be able to offer as a competitive benefits package.

- ERE, or fringe benefits, are costs to the provider beyond wages and salaries, such as unemployment taxes, health insurance, and paid time off (PTO). These fall into three distinct categories of benefits:
  - **Legally Required Benefits** including federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation.
  - **Paid Time Off** including holidays, sick days, vacation days, and personal days.
  - **Other Components of ERE** including health, dental, and vision insurance and retirement.

Goal: Understand which benefits providers are offering and contributing to for their staff, and providers can offer.

Direct Care Staff Benefits - Discussion Questions

Benefit Category	Question	Workgroup Notes / Comments
HEALTH, VISION, & DENTAL INSURANCE	Do provider agencies contribute towards health insurance? Yes or No	Yes
	How many staff do organizations that service or will serve brain injury populations employ? Specify.	90-220
	Do staff typically receive single coverage, family coverage, or both? (Single, Family, or Both)	Yes, typically both. A few organizations offer only single with employee paid family coverage, and a others provide comprehensive single and family coverage with single being the popular option.
	Do provider agencies contribute towards dental insurance? (Yes or No)	Yes, a few organizations
	Do provider agencies contribute towards vision insurance? (Yes or No)	Yes, a few organizations
	Do provider agencies contribute towards any other insurance? If yes, specific.	Examples: AD&D, group disability, life insurance

Direct Care Staff Benefits - Discussion Questions

Benefit Category	Question	Workgroup Notes / Comments
OTHER BENEFITS	Do provider agencies contribute towards any other benefits? If yes, specify.	Examples: The Company offers a Health Savings Account, Flexible Spending Accounts, Critical Illness, Accident Insurance, Hospital Insurance, 401(k), Life Insurance, Legal Coverage, Auto & Home Insurance, and Pet Insurance.
RETIREMENT	Do provider agencies contribute to a 401k, 403b or other retirement plan for your staff? (Yes or No)	Yes, a few organizations. -3% IRA match -Contribute to 403b -A discretionary match – firm has historically matched 50% of each pre-tax dollar contributed by employees on the first 3% of pay, for a maximum match equal to 1.5% of their pay
WORKERS' COMPENSATION	What is a provider agency's average workers' compensation cost for staff (per $100 in wages paid)? E.g., $2.97	2.9%-4% of total wages
HOLIDAYS, VACATION, SICK TIME, AND PERSONAL DAYS	How many paid holidays are staff eligible to receive per year?	5-24 days (depending on tenure in some organizations)
	How many paid time off (vacation) days are staff eligible to receive per year?	
	How many sick days are staff eligible to receive per year?	
	How many personal days are staff eligible to receive per year?	

Legally Required Benefits

- **Unemployment Taxes**: Employers in Virginia pay a federal unemployment tax (FUTA)[1] of 6.00% of the first $7,000 in wages and state unemployment tax (SUTA) 2.5% on average up to first $8,000 in 2023[2]. Generally, if you paid wages subject to state unemployment tax, you may receive a credit of up to 5.4% of FUTA taxable wages[1].
- **Federal Insurance Contributions**: Employers pay a combined 7.65% rate for Social Security - 6.2% and Medicare – 1.45% contributions up to $118,500 (Federal Insurance Contributions Act, or FICA)[3].
- **Workers' Compensation**: Employers in Virginia pay an average effective tax of 2.97% toward workers' compensation insurance. (*Source: Class Codes Workers Compensation, Class 8835 – Home/Public Healthcare)*

Legally Required Benefits		
	Proposed BI	**VA DD**
Federal Unemployment Tax (FUTA)	0.60% after credit	0.60% after credit
State Unemployment Tax (SUTA)	2.50%	2.50%
Federal Insurance Contributions (FICA)	7.65%	7.65%
Workers' Compensation	2.97%	2.97%
Legally Required Benefits	**13.72%**	**13.72%**

* Legally required benefits may not apply to whole salary.

1. https://www.irs.gov/taxtopics/tc759
2. The SUTA wage base was on 2023 wages, https://www.vec.virginia.gov/employers/faqs/Employer-UI-Tax-Questions
3. Combined Social Security tax rate of 6.20% and the Medicare tax rate of 1.45% on a maximum of $118,500 in wages (https://www.ssa.gov/oact/cola/cbb.html)
4. https://www.irs.gov/taxtopics/tc751

Benefit Benchmarking Analysis

The table below captures the comparison of benefits reported in the Virginia Medical Expenditure Panel Survey (MEPS), VA DD model, and BLS.

Metric	2021 MEPS Data Total (inclusive of organizations of all sizes)	VA DBHDS Model
Employer Contribution to Health Insurance (Single Coverage)	$5,583	$5,400
Employer Contribution to Health Insurance (Family Coverage)	$14,311	$9,300 (+1) $14,100 (+Family)
Weighted Employer Contribution to Health Insurance	$8,211	$5,651
Health Insurance Inflation* (Mercer)	3.2%	9.5% (2021: 6.3%, 2022: 3.2%)
Inflated Employer Contribution to Health Insurance (2022)	$8,474	-
Percent of full-time employees	83%	75% (average)
Health Insurance Take-Up Rate	56%	42.3% (single), 12.7% (+1), 15.5% (family)
Monthly (2022)	**$706.15**	**$470.90 (2020); $515.64 (2022)**
Adjusted Annual (2022)	$3,909	-

Note: Organizations that provided feedback through the Rates and Finance Workgroup are of varying sizes both under 50 employees and upto 200+ employees, so the '2021 MEPS Data Total' may be most appropriate for insurance costs.

* https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/mercer-national-survey-benefit-trends.html

Retirement, Paid Time Off, and Other Benefits

TCM, Waiver

Retirement Benefits		
	Proposed BI	**Rates & Finance Workgroup Common Feedback**
Retirement Plan Average Contribution	3% (56% Take-up Rate-MEPS)	3%

Average Days: Paid Time Off Benefits		
	Proposed BI	**Rates & Finance Workgroup Feedback**
Total Paid Time Off	25 days per year	5-24 days (depending on tenure in some organizations)

Other Benefits	
	Proposed BI
Other Benefits (BLS & DBHDS Model)	$150 per month (100% take-up)

Employee-Related Expenses (ERE) Calculation Methodology

TCM, Waiver

Calculating ERE requires analysis of the various benefits available to employees in the state based on provider survey and market data.

Inputs include the average cost of benefits described on the previous slides, adjusted using take-up rate and part-time adjustment factor as appropriate:

Example calculation for health, dental, and vision insurance ERE components:

$$\frac{\text{Average Cost of Insurance} \times \text{Insurance Take-Up Rate} \times \text{Part-Time Adjustment Factor}}{\text{Annual Wage}}$$

Example calculation for the retirement ERE component:[1]

$$\frac{\text{Annual Wage} \times \text{Benefit Cost: Percent of Wages} \times \text{Benefit Take-Up Rate} \times \text{Part-Time Adjustment Factor}}{\text{Annual Wage}}$$

1. Legally required benefits are calculated similarly, but the benefit take-up rate is excluded since these benefits must be offered to employees per state and federal statutes

Employee-Related Expenses (ERE)

TCM

ERE is calculated as a percentage of wages as depicted below.

The three components of ERE (Legally Required Benefits, Paid Time Off Benefits, and Other Benefits) are added together to determine total ERE.

ERE Components	Example – Case Manager – Healthcare Social Worker
Hourly Wage (2021 BLS 50PCT Wage + BLS Annual Inflation 8.81%)	$33.91
Annual Wages – FY2022	$70,530
Legally Required Benefits	$8,415 (11.93%)
Paid Time Off Benefits	$5,629 (7.98%)
Other Benefits (Insurance, Retirement)	$4,063 (7.16%)
Total ERE per DSP	**$19,090 (27.07%)**
Hourly Wage with ERE	**$43.09**

Neurobehavioral Unit Rate Setting Overview

Neurobehavioral Rate Development

- Two Rate Types Under Development
  - 1) **Nursing Facility (NF) Add-on Rate**
  - 2) **Neurobehavioral Treatment Facilities**

- The team has been working to identify the service mix and staffing needed for the neurobehavioral rate
  - **Initial assumptions brought to program design workgroup on 5/3**
  - **Today we are sharing the program design workgroup feedback to keep this group up-to-date on our progress**

Note: Slides 14-19 include options for the Neurobehavioral Unit rate development that are under discussion and may be subject to change.

Nursing Facility Neurobehavioral Services Rate Covers the Additional Services Required by the NBU

Core NF Rate Components

- **Direct Operating Rate**
  - Nursing (RN, LPN, CNA)
  - Therapy Services
    - PT/OT/SLP
    - Restorative
    - Recreational
  - Social Services, Drugs, Etc.
- **Indirect Operating Rate**
  - Dietary
  - Housekeeping/Laundry
  - Admin, Ancillaries, Etc.
- **Capital/Plant Rate**
- **Add-on Rates**
  - Value Based Purchasing
  - Nurse Aide Training (NATCEP) Criminal Records Checks (CRC)

Additional Neurobehavioral Services

- Neurological assessment upon admission
- Neurobehavioral/neurocognitive service plan
- Psychopharmacological assessment (admission and periodic)
- Multidisciplinary intensive neurobehavioral/neurocognitive treatment
- Community-based occupational service activities
- Therapy services, including daily active or passive range-of-motion (ROM) activities, monitored by a licensed therapist

Note: Slides 14-19 include options for the Neurobehavioral Unit rate development that are under discussion and may be subject to change.

Neurobehavioral Facility Services: How Much (Amount) and How Often (Frequency)?

NBU

Service Description	Assumptions	Key Feedback Program Design Group
1. Neurological assessment & neurology consultation (admission & periodically)	Assumption: 4 hours for an admission assessment and 2 hours for a re-evaluation	• Assessments could be done by either a Licensed Behavioral Psychologist, Licensed Neuropsychologist, or neurologist; BI experience critical
2. Neurobehavioral/neurocognitive service plan	Assumption: minimum of 1.75 per hour per individual per week	
3. Psychopharmacological assessment (admission and periodically)	Assumption: 1 hour at admission & 0.5 hours per quarter	• Psychopharmacological assessment quarterly - recommend .5 monthly • Recommend MD perform initial assessment; a Nurse Practitioner may be used for follow-up reviews

Note: Slides 14-19 include options for the Neurobehavioral Unit rate development that are under discussion and may be subject to change.

Neurobehavioral Facility Services: How Much (Amount) and How Often (Frequency)?

NBU

Service Description	Assumptions	Key Feedback Program Design Group

4. Interdisciplinary intensive neurobehavioral/neurocognitive treatment	Minimum of six 45-minute sessions of neurobehavioral/neurocognitive treatment per week?	• Essential services: counseling, cognitive services, Board Certified Behavior Analysts (BCBA), and behavioral services
		• Recommend at least two 30 min session daily
		• Recommend 1 to 5 sessions per week of therapy by a behavior analyst and a member may need 40 hours a week of services provided by a Registered Behavior Technician (RBT) or QMHP
		• Staffing mix:
		  • Services would be a mix of individual one-on-one and group
		  • Might have a one-to-five ratio (e.g., BCBA with RBTs, recreational therapists with OT)
		  • Groups work may simulate community integration
		  • Individual treatment planning will be part of the 2-hour service plan being established (see #2 above), so no additional time would be required.
		  • BCBA's might be used as additional therapy as well as to substitute for PT as needed, for example to meet a minimum daily treatment requirement, if appropriate based on the service plan

Note: Slides 14-19 include options for the Neurobehavioral Unit rate development that are under discussion and may be subject to change.

Neurobehavioral Facility Services: How Much (Amount) and How Often (Frequency)?

NBU

Service Description	Assumptions	Key Feedback Program Design Group
5. Therapy services – Baseline (Usual NF level of service at max of 1.7 hours per day)	Do people in a NF/NBU with brain injury need more than 1.7 hours PT/OT/SLP therapy per day? Minimum 3 therapy hours 6 days per week? seems like acute stay, too much (KH) What is the service mix by therapy type (PT/OT/SLP, Restorative, Recreational, etc.)?	• May need more than 1.7 hours a day but less than 3 hours 6 days/wk • Therapy needs would be primarily for OT, then SLP as the next most common, with PT the least common; at least 2 hrs./day of OT/SLP/PT based on individualized plan of care • For those with longer term stays, 1-5 sessions per week
5a. Clinical Director/Supervisor		• Any of these professional qualifications may be acceptable as clinical director, based on their experience with brain injury, which is essential: PT/OT/SLP, Licensed Professional Counselor (LPC), LCSW, Psychologist, BCBA
6. Therapy services - Daily active or passive range-of-motion (ROM) activities		• Best practice would be to have an individual receive about 6 hours a day at 5 to 7 days a week – plus or minus 2 hours based on the individual. • CNA/Life Skills Trainer (LST)are always an important part of the team, so invest in and use them. • LPC/LCSW can be used as adjunct if the patient can benefit from the counseling. Many patients at this level may lack the cognitive ability to engage in a psychotherapeutic relationship.

Note: Slides 14-19 include options for the Neurobehavioral Unit rate development that are under discussion and may be subject to change.

Neurobehavioral Facility Services: How Much (Amount) and How Often (Frequency)?

NBU

Service Description	Assumptions	Key Feedback Program Design Group
7. Community-based activities	How much time does this take? `Routinely? Ad hoc only?	• For those with shorter term stays - Community-based activities could be provided by a recreational therapist or community health worker for 2 to 3 hours minimum per outing. The more complex the community service the more time and effort needed for planning • For those with longer-term stays, a member might leave the NF for a community event at least two times a month; also, events could bring the community into them at the facility more often.

Note: Slides 14-19 include options for the Neurobehavioral Unit rate development that are under discussion and may be subject to change.

Targeted Case Management Service Delivery Assumptions Discussion

Targeted Case Management Fiscal Impact Methodology

TCM

SFY2024 Targeted Case Management Annual Fiscal Impact Estimate

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1. TCM Brain Injury Population Size – Age 18+
(Preliminary: TBD claims; Severe TBI will be subset of target population)

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2. SFY2024 TCM Monthly Rate
(Preliminary: TBD per member per month)

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3. TCM Annual Utilization Assumption
(Sources: - VA claims; - Feedback from providers & DMAS)

Feedback on TCM Service Delivery from State-Funded Providers and Program Design Workgroup

Discussion Questions	Responses (Seven providers as of 5/8)
Frequency of Client Encounters	-3-5 per month -Average 2-3 (meetings, calls, emails) -Dependent on individual need; average 1-3; newer clients or those with urgent need generally more 1-3 per month per individual -Per client: average of 1 – 3 client encounters per month, depending on circumstances. This includes in-person or virtual meetings, phone calls, emails, texts, and/or team meetings. Minimum per client is 1 visit per month for Active clients, and 1 visit every 3 months for Follow Along clients. -Average of 1 – 3 per client encounters per month, depending on circumstances. This includes in-person or virtual meetings, phone calls, emails, texts, and/or team meetings. Minimum per client is 1 visit per month for Active clients, and 1 visit every 3 months for Follow Along clients. -Once a month
Average number of client visits per month	-One consumer depending on service status -One per month -One scheduled meeting is needed/requested -1 visit per month on average. Preferred to be face-to-face, but virtual is allowable if preferred by the individual client. -3-5 visits per month -Each consumer typically receives 1 visit per month. Preferred to be face to face, but virtual is allowable as preferred by the client, or as circumstances necessitate (i.e., weather, sickness, etc.) -Full time case managers maintain a caseload with an average of 25 Active cases and 5 Follow Along cases. This would equate to anywhere between 25-30 client visits per month for Active and Follow Along cases only. Additionally, case managers may have visits with new referrals or family members interested in services, and consultation clients, which may increase the number of client visits per month.

Feedback on TCM Service Delivery from State-Funded Providers and Program Design Workgroup

TCM

Discussion Questions	Responses (Seven providers as of 5/8)
How often is the frequency reassessed	-Usually quarterly but can be assessed anytime -Every 90 days -Quarterly or as needed/requested -Quarterly, unless something happens that requires more, or something concludes, and the frequency of interactions can be decreased -Quarterly reassessment is required with the option to review sooner if deemed necessary by either the case manager or client.
Types of Visits: Proportion of face-to-face vs. virtual visits	-30:70 is face-to-face vs. virtual (greatly shifted post pandemic) -93% of visits are face-to-face -2/3 in person, 1/3 virtual (some virtual if referral comes from a medical facility prior to discharge) -Face-to-face 100% -80:20 face-to-face vs. virtual (case managers try to alternate a virtual visit with in-person visits for clients who live an exceptional distance from the nearest office)
Duration of Visits: Average number of hours per visit	-Depending on the type of visit. Most visits take about an hour however intake or community partner meetings may take two. -1 hour -1 hour; Intake is up to 2 hours -Typical monthly visits are about 1 hour face-to-face with additional travel time associated that varies widely per individual's home location. -Depends on the type of visit: 1-2 hours on average -Typical monthly visits are an average of 1 hour face to face, not including travel time to/from the client's home.

Feedback on TCM Service Delivery from State-Funded Providers and Program Design Workgroup

Discussion Questions	Responses (Seven providers as of 5/8)
What are potential standards to define usual level of daily/weekly/monthly contacts per member for active high-touch cases (e.g., new cases, periods of crisis, level of care, functional limitations)?	Needs vary widely based on individual. Some require once per month visit while others required higher frequency visits Some factors and situations that require increased contact include: - **New clients** • New client intake meetings typically take 1.5-2 hours to complete. Follow up meetings with a new client may occur bi-weekly until the completion of the formal ISP. Initial start of services may require several more contacts with the person as well as collateral contacts while establishing the support needed to meet the individual's needs. It may take 60-90 days for intensity to reduce to the usual maintenance level. - **Progress and time since date of injury** - **Lack of support system or natural supports provider** - **Crisis/urgent, unmet, or insecure basic needs (housing, food, medications etc.)** • Crisis: Initially it is daily contacts. The severity then dictates how far out daily and then weekly contacts last. Clients in high stress/acute need/crisis typically receive additional contact from a case manager until the crisis/issue is resolved. However, this is dependent on the case manager's role related to the client's needs and circumstances. - **Cognitive challenges, functional limitations, medical care needs and support, level of need/care** • Doctor/MH appointments; appointments with other service providers; working with staff/family where housed; putting resources in place; assisting with paperwork for benefits; etc.: 4-5 (average) visits per month; there are also phone calls. - **Challenges with other providers**

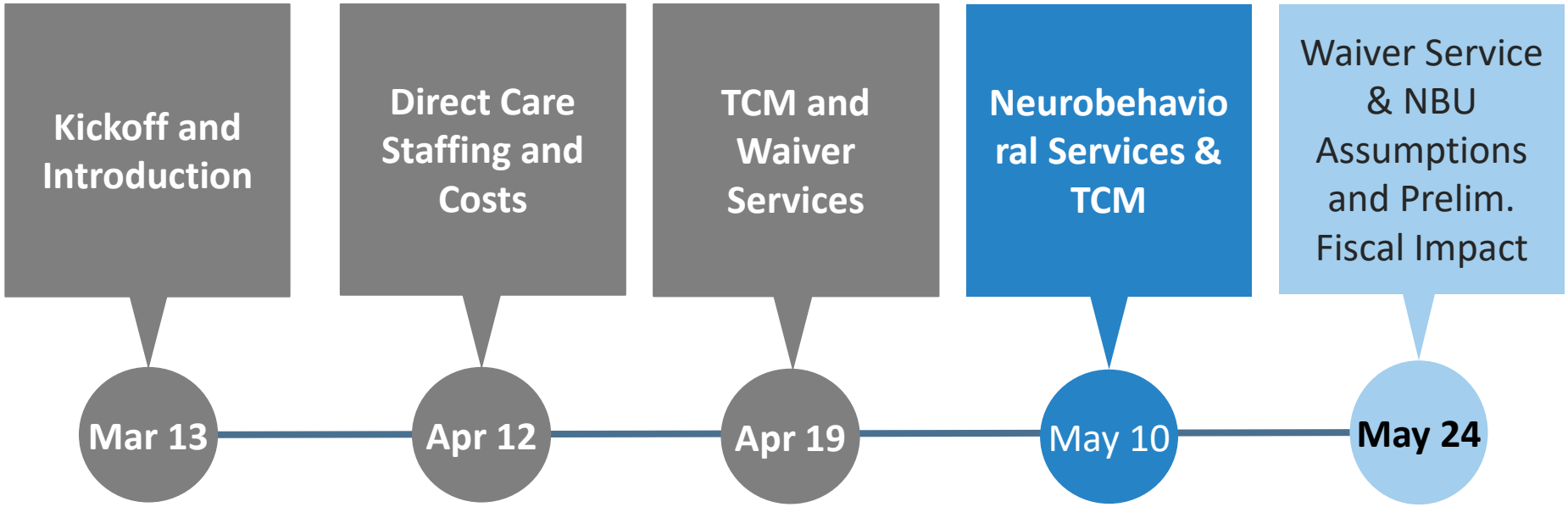
Feedback on TCM Service Delivery from State-Funded Providers

1. What is the “minimum service intensity” as defined by:
   - Frequency of Client Encounters: Average number of client visits per month or per year. How often is the frequency reassessed?
   - Types of Visits: Proportion of face-to-face vs. virtual visits
   - Duration of Visits: Average number of hours per visit
2. What are potential standards to define usual level of daily/weekly/monthly contacts per member for active high-touch cases (e.g., new cases, periods of crisis, level of care, functional limitations)?

Workplan and Timeline

Rates and Finance Workgroup Meeting Plan

The Rates and Finance Workgroup will meet in March and April 2023 to discuss topics related to rate methodology and modeling requirements and results.



Participation in the Workgroup is an opportunity to provide critical feedback that will help inform the development of rate setting methodologies and service rates.

Contacts

Brian Campbell
Department of Medical Assistance Services
brian.campbell@dmas.virginia.gov

David Garbarino
Engagement Director, Guidehouse
dgarbarino@guidehouse.com

Elizabeth Barabas
Stakeholder Lead, Guidehouse
ebarabas@guidehouse.com

2022 Legislative Requirements for DMAS

DMAS, "with relevant stakeholders, shall convene a workgroup to develop a plan for a neurobehavioral science unit and a waiver program for individuals with brain injury and neuro-cognitive disorders. … The workgroup shall make recommendations in the plan related to relevant service definitions, administrative structure, eligibility criteria, **reimbursement rates, evaluation, and estimated annual costs to reimburse** for neurobehavioral institutional care and administration of the waiver program. The department shall include a **rate methodology** that supports institutional costs and waiver services."

Virginia 2022 Appropriation Act, Item 308 CC.1; 2023 Budget Amendment, Item 308 #1s (proposed)

DMAS shall establish and implement effective July 2, 2023, a new State Medicaid Plan service, targeted case management (TCM) for "individuals with severe Traumatic Brain Injury"

Va. Code § 32.1-325(A)(31)(2022)

Independent Rate Build-up Approach

Direct Care Cost

Cost for Direct Care Services
- Wages
- Benefits
- Productivity

Adjusted by staffing ratios or hours, as applicable

Supervisory Direct Care Cost
- Wages
- Benefits
- Productivity

Adjusted by supervisor ratios or hours, as applicable

Varies Based on Service Category

Indirect Cost

Administrative Costs *include 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.*

Program Support Costs *include personnel and non-personnel costs associated with direct care service delivery for each service including:*
- *Staff and Client Transportation*
- *Supplies*
- *Building & Equipment*
- *Depreciation*

Other Rate Adjustments

Geographic Rate Adjustment

Support Coordination / Nursing *(Wages + Benefits + Staffing)*

Occupancy Rate *(Average Days Paid : Billable; Number of vacancy days)*

Service Rate per Unit