Cost Reporting Summary for the Community Behavioral Health Rehabilitation Services

04/07/2023

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1 Introduction

1.1 Background and Purpose

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Department of Community Health (DCH) engaged with Deloitte Consulting LLP (Deloitte) to undertake a study of Georgia's Medicaid Community Behavioral Health Rehabilitation Services (CBHRS) Fee for Service (FFS) reimbursement rates. The study included an analysis of current CBHRS rates and reimbursement methodology, a rate scan summarizing current rates in select comparator states, and a review of industry standards. These efforts were performed to understand whether Georgia's current CBHRS reimbursement rates (enacted in 2008) are aligned with current market conditions. In addition, the rate study was undertaken to meet the following expectations:

- Georgia Legislative Act No. 865, House Bill 911 – the FY [Fiscal Year] 2023 Appropriations Bill – which provided DBHDD "one-time funds for a behavioral health provider rate study"[1]
- Expectations related to rate study and methodology as defined in the Georgia Department of Community Health American Rescue Plan Act (ARPA) Initial Spending Plan Conditional Approval Memorandum, General Conditions[2]
- Centers for Medicare and Medicaid Services (CMS) expectations that service costs are analyzed periodically for the purposes of rate setting

One key element of the rate study is understanding the costs incurred by CBHRS providers when they deliver these services to their clients. The purpose of the remainder of this report is to describe the approach taken to collect cost data from providers, including a description of the cost reporting tools used to survey the providers, and to summarize the survey responses received.

1.2 Disclosure of Data Reliance

The data described in this report includes self-reported data from behavioral health providers who offer CBHRS in Georgia. Providers were given explicit instructions for how to report their data, and upon submission, the data was reviewed for reasonableness before being used in this analysis. Despite these measures, errors, anomalies, or other inconsistencies may exist in the submissions, as an audit was not performed on the data. To the extent that these errors, anomalies, or

[1] Georgia House Bill 911. (2022, May 12). Governor's Office of Planning and Budget. Retrieved February 27, 2023, from https://opb.georgia.gov/hb-911-fy-2023-appropriations-bill-signed

[2] Georgia Department of Community Health American Rescue Plan Act (ARPA) Initial Spending Plan Conditional Approval Memorandum. (2022, February 14). Georgia Department of Community Health. Retrieved February 27, 2023, from https://dch.georgia.gov/programs/hcbs

inconsistencies exist, they may affect the integrity of the summarizations provided in this report.

Deloitte makes no representations to an entity outside of DBHDD/DCH regarding the contents of this report. Non-DBHDD/DCH entities should not place reliance on this report which would result in the creation of legal duty or liability by Deloitte, its employees, or third parties.

2 Approach

In rate studies, a number of inputs are often considered when setting rates. These considerations can include industry standard assumptions (e.g., local wage data), state or federal goals and priorities, comparisons to rates for the same or similar services in other states, and provider cost data inputs. While this report is focused on summarizing findings related to CBHRS provider costs, it is important to note that cost data is one input of several that are used for rate setting.

In order to understand the costs that providers incur when delivering CBHRS, Deloitte, in collaboration with DBHDD and DCH, developed a cost reporting tool in Microsoft Excel to collect this information from providers. A subset of CHBRS providers (the "stakeholder group") was selected for inclusion in the study and the cost reporting tool was circulated to this group for data collection. In addition, a smaller subset of the stakeholder group (the "core work group") was selected to provide qualitative feedback on preliminary drafts of the tool to flag survey questions that may be difficult for providers to understand or report.

2.1 Stakeholder Group Selection Process

At the start of the rate study, a group of stakeholders was sampled from the total set of Georgia's CBHRS providers. Providers were removed from consideration if they were on pre-payment review (where medical records are reviewed to make sure a claim was medically necessary prior to payment of the claim – a measure often taken to reduce fraud, waste, or abuse), or if they did not have CBHRS utilization in the past 12 months. Study participants from the remaining group of providers were selected based on the following criteria:

- All Tier 1 Providers (Community Service Boards [CSBs]) were selected for participation, given that these providers serve as Georgia's behavioral health safety net
- Tier 2 and tier 2+ providers with the highest State Fiscal Year (SFY) 2020 spend, based on data from the Georgia Collaborative ASO, were selected for participation in the study.[3] Some Tier 2 providers were selected for their regionality despite not being among the highest-spend Tier 2 providers, in an effort to ensure the provider sample was regionally diverse
- Tier 3 specialty providers were selected if the sample of Tier 1 and Tier 2/2+ providers did not result in three or more sampled providers for each of the CBHRS considered in the study. Where this was the case, Tier 3 providers were selected to ensure at least three providers were sampled for each service.

This sampling process resulted in a stakeholder group consisting of 23 Tier 1 providers, 29 Tier 2/2+ providers, and nine Tier 3 providers. This group included a

[3] Payment Type and Provider (PM1) - Statewide. (2020, May 14). The Georgia Collaborative ASO. Retrieved September 8, 2022, from https://s18637.pcdn.co/wp-content/uploads/sites/15/98035.0.02-Payment-Type-and-Provider-PM1-May.pdf

selection of providers reflecting diversity across agency tier, services offered, and geographic location. From this set of stakeholders, 13 providers were selected for participation in the core work group.

2.2 Core Work Group Feedback

A preliminary draft of the cost reporting tool was distributed to the core work group and discussed during a conference call to solicit their input into the data elements being requested. Specifically, providers gave feedback on elements which may be difficult to report (for example, because of incompatibility between their internal accounting or billing systems with the format data was being requested), or data elements which needed additional clarification within the instructions. Upon completion of this session, stakeholder perspectives were considered, and adjustments were made to the cost reporting tool in an effort to provide additional clarification and simplify the reporting process. At this stage the survey tool was finalized and circulated to the broader stakeholder group and posted to the DBHDD website prior to the cost report training webinar.

2.3 Provider Training Webinar

Soon after the finalized cost reporting tool was distributed to providers, a webinar session was held, during which providers were briefed with:

- A summary of the overall rate study purpose, goals, and objectives, emphasizing the importance of provider participation in the cost reporting process
- An overview of key cost reporting elements and their definitions
- A live demonstration of the cost reporting tool, during which each element of the survey was explained
- A live question and answer session which allowed providers to ask questions related to the cost reporting tool and process
- A summary of next steps, which included the deadline for cost report completion as well as the potential for follow-up questions to be asked about their submissions

Following the session, a Frequently Asked Questions document which summarized answers to the questions that occurred most frequently during the webinar session was produced and distributed to providers along with the webinar recording. These files were also posted to the CBHRS Rate Study page of the DBHDD website.

2.4 Provider Follow-Ups and Technical Assistance

Providers were given approximately seven weeks to complete and submit cost reports, and during this time a technical assistance email inbox was monitored for provider questions related to the cost reporting process. This inbox was also used to receive completed cost reports. Upon receipt, each submitted cost report was reviewed for reasonableness, and where submissions appeared unreasonable, incomplete, or warranted clarification, follow-up emails were sent to providers requesting resubmissions or clarifications to their submission. Providers were given

7-10 business days to respond to follow-up questions and/or resubmit updated cost reports.

3 Overview of the Cost Reporting Tools

The overall goal of the cost reports is to provide a better understanding of provider costs and income received related to the CHBRS they offer. This information can provide a valuable benchmark for several assumptions that are used for rate setting. This section describes the key cost reporting elements that were requested from providers within the cost reporting tools. Within the instructions for the cost reports, the data elements being requested were explained to providers and it was emphasized that, unless otherwise specified, the data requested should be specific to Medicaid FFS CBHRS service delivery (and exclude, for example, costs, revenues, and staffing information related to Care Management Organization [CMO] CBHRS service delivery, service delivery to patients from other payers, or service delivery outside the CBHRS program).

In total, three cost reporting tools were sent to providers. For services which are currently reimbursed using rates that are determined based on the number of minutes the practitioner provides the service (e.g., 15 minutes, 30 minutes, 45 minutes), a cost reporting tool (the "Main Cost Reporting Tool") was sent to collect cost information related to these services. For two services – Intensive Customized Care Coordination (IC3) and Crisis Stabilization Unit (CSU) – supplemental cost reporting tools were sent to IC3 and CSU providers to collect additional service-specific cost information. While some cost information for these services was captured in the main cost reports, supplemental data collection was warranted given that IC3 is currently reimbursed using a monthly rate, and CSU is a facility-based service, both of which are distinctions from other services which warrant an examination of additional costs.

3.1 Main Cost Reporting Tool

3.1.1 Cover Page

On the cover page of the cost report, providers were requested to submit general information about the provider organization, including their Beacon Provider ID, any Provider Site ID(s) associated with the organization, reporting period (months during State Fiscal Year [SFY] 2019 and 2022 during which the organization provided CBHRS), and CBHRS services provided. The list of CBHRS included in the rate study is provided in Table 1. Data from SFY2022 was requested within the cost reports in order to obtain the most recent cost data available, while SFY2019 data was requested to provide a pre-pandemic baseline for the costs incurred. The cover page tab also captured the name, title, and contact information for the staff members who completed and certified the cost report.

Table 1 – List of CBHRS Included in the Rate Study

Community Behavioral Health Rehabilitation Services Included in the Rate Study	
Non-Intensive Outpatient Services	**Specialty Services**
Addictive Diseases Support Services	Addictive Diseases Peer Support Program
Behavioral Health Assessment	Addictive Diseases Peer Support Services (Individual)
Behavioral Health Clinical Consultation	Ambulatory Substance Abuse Detoxification
Case Management	Assertive Community Treatment (ACT)
Community Support	Community Support Team
Crisis Intervention	Crisis Stabilization Unit Services
Diagnostic Assessment	Intensive Case Management
Family Outpatient Services - Family Counseling	Intensive Customized Care Coordination
Family Outpatient Services - Family Training	Intensive Family Intervention
Group Outpatient Services - Group Counseling	Mental Health Peer Support Program
Group Outpatient Services - Group Training	Mental Health Peer Support Services (Individual)
Individual Counseling	Opioid Treatment
Medication Administration	Parent Peer Support (Group)
Nursing Assessment and Health Services	Parent Peer Support (Individual)
Psychiatric Treatment	Peer Support, Whole Health & Wellness (Group)
Psychological Testing	Peer Support, Whole Health & Wellness (Individual)
Psychosocial Rehabilitation - Individual	Psychosocial Rehabilitation - Program
Service Plan Development (Individual Recovery Plan)	Substance Abuse Intensive Outpatient Program
	Task-Oriented Rehabilitation Services (TORS)
	Youth Peer Support (Group)
	Youth Peer Support (Individual)

3.1.2 Staff Wages

Average practitioner wages, dollars spent on benefits and workers compensation, and leave time (split into vacation hours, sick time hours, and holiday hours) were requested on the staff wages tab of the cost reports. This information was requested for each of Georgia's staffing roles, as defined in the CBHRS provider manual.[4] The staffing roles for which wage data was requested are shown in Table 2. If a provider does not use staff of a particular staffing role to deliver Medicaid FFS CBHRS, it was requested that they leave cells blank for that role. An open response box was provided to allow providers to add any relevant narrative to their staff wages data entries (for example, to specify that wages for certain staffing roles represent contractor salaries). Wage, benefits, and leave information is potentially useful given they are key components of the costs to provide services

[4] Georgia Department of Behavioral Health and Developmental Disabilities. (2022, June 1). Provider Manual for Community Behavioral Health Providers. Community Provider Manuals. Retrieved August 15, 2022, from https://dbhdd.georgia.gov/be-connected/community-provider-manuals

and can help inform wage and employee related expenses (ERE) assumptions used for a rate build up.

Table 2 – List of Practitioner Levels and Staffing Roles Included in the Cost Reports

Practitioner Level	Staffing Role
Level 1	Psychiatrist
Level 1	Physician
Level 2	Physician's Assistant
Level 2	Nurse Practitioner
Level 2	Clinical Nurse Specialist-Psychiatry/Mental Health
Level 2	Psychologist
Level 2	Pharmacist
Level 3	Licensed Professional Counselor
Level 3	Licensed Clinical Social Worker
Level 3	Licensed Marriage & Family Therapist
Level 3	Licensed Dietician
Level 3	Certified Addictions Counselor II/Georgia Certified Alcohol and Drug Counselor II
Level 3	Registered Nurse
Level 4	Licensed Associate Professional Counselor
Level 4	Licensed Master's Social Worker
Level 4	Licensed Associate Marriage & Family Therapist
Level 4	Trained Paraprofessional with Master's or Bachelor's
Level 4	Certified Peer Specialist with Master's or Bachelor's
Level 4	Certified Psychiatric Rehabilitation Professional with Master's or Bachelor's
Level 4	Certified Addictions Counselor I/Georgia Certified Alcohol and Drug Counselor I with Bachelor's
Level 4	Addictions Counselor Trainee with Master's or Bachelor's
Level 4	Licensed Practical Nurse
Level 5	Trained Paraprofessional with High School diploma or equivalent
Level 5	Qualified Medication Aide
Level 5	Certified Peer Specialist with High School diploma or equivalent
Level 5	Certified Psychiatric Rehabilitation Professional with High School diploma or equivalent
Level 5	Certified Addictions Counselor with High School diploma or equivalent
Level 5	Addictions Counselor Trainee with High School diploma or equivalent

3.1.3 Revenue and Units

Providers were asked to provide FFS revenue and units for each CBHRS they provided during SFY2019 and/or SFY2022. In an effort to reduce data entry errors, the tool was designed such that providers were only able to enter data for CBHRS they indicated on the cover sheet that their organization provides. Medicaid CBHRS FFS expenditures and units were requested as this information provides a basis for providers to allocate non-CBHRS-specific expenditures (e.g., administrative costs) across services. In addition, the information can be used for validation purposes, as

the data submitted by providers can be compared to FFS claims data summaries provided by DCH.

Providers were also asked to provide other Medicaid revenue and units (e.g., from CMOs, or non-CBHRS Medicaid), and non-Medicaid revenues and units. If any of the revenue or units fields did not apply for one or both SFYs for which data was being requested, providers were instructed to leave the corresponding fields blank.

3.1.4 Hours

Billable and non-billable hours were requested for each practitioner staffing role the provider organization uses to deliver Medicaid FFS CBHRS. For staffing roles and years for which hours for a particular staffing role do not apply, providers were instructed to leave the appropriate fields blank. In addition, it was emphasized to providers in the instructions to only report hours related to Medicaid FFS CBHRS, and to only report hours that are allowable under Georgia Medicaid's allowable cost requirements as billable hours. While total billable and non-billable hours were requested, it was also requested that, for each staffing role, billable and non-billable hours were reported by service provided and delivery setting (in clinic, out of clinic, and telehealth). Both billable and non-billable hours were requested to inform provider productivity assumptions for rate development.

3.1.5 Expenditures

The cost reports also requested that providers report SFY2019 and SFY2022 expenses that are reflective of the expense incurred for clients serviced by Medicaid CBHRS FFS services. Costs were requested to be reported separately for in-clinic, out of clinic, and telehealth service delivery, as this information can provide insight into the extent to which these settings bear a disproportionate share of costs. Providers were instructed to report only the expenditures that were allowable under Georgia Medicaid allowable cost requirements. Specific cost components requested include the following:

- **Direct care costs** (e.g., salary & wages, overtime wages, and benefits) for practitioners that provide CBHRS services
- **Program costs** related directly to the provision of services to clients, including costs related to program support staff or clinical supervisors, training costs, transportation, telehealth, office space, and liability/malpractice insurance.
- **Indirect care (administrative) costs**, which include management and administrative overhead costs. These costs include costs related to management and administrative support staff, software, telephone/internet, electronic health records, building, office supplies, marketing, and professional fees.

Providers were also requested to report their total non-FFS Medicaid costs, including costs related to the provision of CBHRS CMO or non-CBHRS costs, in addition to costs that are unallowable or attributed to a non-Medicaid payer.

3.1.6 Staffing Patterns

CBHRS provider staffing patterns were also requested within the cost report template. Specifically, providers were asked to specify, for SFY2019 and SFY2022, the number of employees their organization had at the beginning of the year, at year end, and the number of terminations during each year, for each staffing role used to provide CBHRS. In addition, SFY2019 and SFY2022 full time equivalent (FTE) practitioners were requested for each staffing role, and providers were instructed to assume that one FTE is equivalent to an employee who works on average eight hours per day, and to report partial FTEs using a decimal. It was also requested that reported staffing patterns be Medicaid CBHRS FFS specific (in other words, specific to the staff required to provide CBHRS to Medicaid clients on an FFS basis).

3.1.7 Group Services Staffing Ratios

Individual-to-staff ratios were requested for all CBHRS that are delivered as group services. Providers were instructed to only report ratios for services that their organization provides (as selected on the cover page). In addition to SFY2019 and SFY2022 ratios, individual-to-staff ratios were requested based on the provider's (or clinical) judgment of how a service *should* be staffed to meet individuals' needs. Individual-to-staff ratios were requested for the following services:

- Mental Health Peer Support Program
- Peer Support, Whole Health & Wellness (Group)
- Psychosocial Rehabilitation - Program
- Parent Peer Support (Group)
- Youth Peer Support (Group)
- Group Outpatient Services - Group Counseling
- Group Outpatient Services - Group Training
- Addictive Diseases Peer Support Program
- Substance Abuse Intensive Outpatient Program
- Assertive Community Treatment (ACT)

3.2 IC3 Cost Reporting Tool

A separate cost reporting tool for IC3 was sent to Georgia's IC3 providers because the service is reimbursed with a monthly rate, which is unique compared to most CBHRS services which are reimbursed based on intervals of a specified number of minutes (e.g., 15 minutes, 30 minutes, etc.). IC3 is a high fidelity wrap around service that has several components making a monthly rate appropriate. In addition, there are some staffing roles that are IC3-specific, so cost information was collected for these roles. The supplemental IC3 cost reporting tool was sent to both of the two providers which offer IC3 services.

3.2.1 IC3 Membership

IC3 providers were requested to submit information related to the number of IC3 members (i.e., clients) served per month, for each year between SFY2019-SFY2022, inclusive. It was requested that providers separate FFS Medicaid IC3

members, CMO Medicaid IC3 members, and IC3 members serviced by other payers, when reporting these figures. For rate setting, reported membership information can be used to adjust assumed monthly costs to caseload-adjusted monthly costs.

3.2.2 IC3 Salaries, ERE, and FTEs

Given that IC3 utilizes a unique mix of providers compared to other CHBRS, IC3-specific staff salaries, ERE, and FTEs were requested from providers that offer the service. Specifically, SFY2022 average annual salary, average annual benefits, and average annual worker's compensation were requested, as well as staff FTE counts for state fiscal years ranging from SFY2019-SFY2022. This set of years was requested to provide both a pre-pandemic baseline (2019) and a year-by-year accounting of shifting staffing patterns. This information was requested for the following staffing roles:

- Care Coordinators
- Certified Peer Specialist – Parent (CPS-P)
- Care Coordinators Supervisor
- CPS-P Supervisor
- Care Management Entity (CME) Director

In addition, it was requested that providers specify any other IC3 staffing roles not in the list above, along with the relevant salary, benefit, and FTE information for those professions. This information was requested to provide insights into average wage and ERE assumptions for rate setting.

3.3 CSU Cost Reporting Tool

Compared to other CBHRS, crisis stabilization unit services are unique in that they are facility based and represent an intensive level of care, and as such reimbursement has historically been on a per diem basis. Given these differences from most CBHRS, a supplemental CSU-specific cost report was sent to CSU providers to help provide insights into the service's costs. Information related to CSU utilization, staff salary and wages, and direct and administrative expenditures was collected. It was emphasized that the CSU information being requested was limited to CSUs with fewer than or equal to 16 beds to ensure that only those CSUs able to bill Medicaid were included (this comprised both Adult and Child/Adolescent units).

3.3.1 CSU Utilization

SFY2019 and SFY2022 total CSU beds and average number of occupied beds were requested from each CSU provider in order to inform bed occupancy assumptions used for rate setting. A free response comment box was provided to allow providers to provide additional relevant context to their entries.

3.3.2 CSU Staff Salary and Wages

Providers were asked to provide average SFY2022 annual salary, average SFY2022 benefits, and average SFY2022 workers compensation for each staffing role required to staff a CSU. In addition, SFY2019 and SFY2022 FTEs were requested for

each role, and providers were instructed to only report the FTE based on the amount of time a staff member works at the CSU. In addition, providers were instructed to assume a full-time staff member works 40 hours per week (thus, for example, if a full time [40 hours per week] staff member spends 80% of the time working at the CSU, the FTE entry would be 0.8 for this position). Wage and FTE information was requested for the staffing roles in the list below. Additional space was provided to allow providers to write in additional staffing roles used in their CSU, if necessary.

CSU Staffing roles:

- Clinical Director
- Certified Peer Specialist
- Health Service Technician
- Licensed Clinician
- Licensed Practical Nurse
- CACs/CADCs
- Nurse Manager
- Nurse Practitioner/Physician Assistant
- Pharmacist
- Physician/Psychiatrist
- Registered Nurse
- Administrative Clerk
- Security
- Transporter

3.3.3 CSU Direct and Administrative Expenditures

Medicaid allowable expenses (FFS and managed care combined) that are generally reflective of the expense incurred to operate the CSU were also requested. The instructions emphasized that providers should only report expenses that are allowable under Georgia Medicaid allowable cost requirements. The requested expenditures were split into three categories: direct care costs and indirect care (management and administrative overhead) costs, and costs that are Medicaid unallowable. Providers were reminded not to report wages within these fields given that wage information was collected in a separate worksheet.

The requested direct care cost components include the following:

- Staff training costs
- Telehealth costs
- Building and occupancy costs (rent, utilities, depreciation, taxes, etc.)
- Liability/malpractice insurance
- Medication and medical supply costs
- Other supplies costs
- Transportation related cost (non-salary)
- Other program costs (providers were instructed to specify both the dollar amount of these costs and a qualitative description of cost components

included). Additional program costs may include laundry costs and other direct benefits to clients.

The requested indirect care (management and administrative overhead) costs include the following:

- Software costs (billing, payroll, accounting)
- Telephone/wireless/internet/computer (separate from telehealth costs)
- Electronic health record costs
- Office supply expenses
- Marketing expenses
- Professional fees
- Other indirect care costs (providers were instructed to specify both the dollar amount of these costs and a qualitative description of cost components included). Additional indirect care costs may include other equipment or furnishings, allocation for human resources, IT services, printing, licenses etc.

4 Main Cost Report Results

Twenty-eight providers completed and submitted cost reports, of which 19 (68%) were Tier 1 providers, 7 (25%) were Tier 2 or Tier 2+ providers, and 2 (7%) were Tier 3 providers. Table 3 contains a summary of provider responses and response rates by tier. Overall, the responding providers represented approximately 39% of FFS CHBRS claims dollars in SFY2022, based on an analysis of SFY2022 claims data provided by DCH Decision Support Services. Although not all providers offer every CBHRS, all CBHRS had at least one provider that submitted a cost report.

Table 3 – Summary of Provider Types that Completed and Submitted Cost Reports

Provider Type	Number of Responses	Number in Sample	% Responding
Tier 1	19	23	83%
Tier 2/2+	7	29	24%
Tier 3	2	9	22%
Total	**28**	**61**	**46%**

As described previously, each cost report was reviewed for reasonableness, data anomalies, inconsistencies, or omissions. This approach was conducted section-by-section within each cost report, as the quality of data reported varied across sections. While the data was reviewed for reasonability based on factors such as internal consistency and knowledge of industry standards and norms, an audit was not performed on the data and therefore inconsistencies, omissions, or errors may exist in the data that were not identified within the checks for reasonability.

For example, data submissions related to practitioner salaries and wages were on average well populated and reasonable. In other sections, the data submitted was more sparsely populated or may have included anomalies. For staff hours, many providers were able to report billable hours but many reported difficulties with reporting non-billable hours. Thus, each submitted cost report was used in the results summarized for a given section within this report to the extent that it provided data that was deemed reasonable for that section.

4.1 Practitioner Wages

Within this section, annual SFY2022 staff wages summarized from the cost reports are compared to Bureau of Labor Statistics (BLS) May 2021 Georgia Occupational Employment and Wage Estimates.[5] In addition, cost report salaries were summarized separately for CSB and Non-CSB providers in order to provide insight into potential wage differences by provider type. Generally, CSBs reported lower salaries than non-CSBs for practitioner levels 3-5 (Table 4). The mean salary represents a weighted average of salaries across the staffing roles that fall within a

[5] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment Statistics, on the Internet at https://www.bls.gov/oes/current/oessrcst.htm (visited November 2022).

practitioner level. Mean salaries at each level were weighted by FTEs reported in the cost reports.

Table 4 – Cost Report Mean Salaries by Practitioner Level, SFY2022

	Mean Cost Report[a]		
Practitioner Level	All Providers	CSB	Non-CSB
Level 1	$ 213,466	*	*
Level 2	$ 124,874	$ 126,708	$ 117,905
Level 3	$ 63,586	$ 59,004	$ 73,259
Level 4	$ 41,229	$ 39,393	$ 45,105
Level 5	$ 31,653	$ 29,549	$ 39,648

[a] Cost report salaries are reported for SFY2022 (July 2021-June 2022)

*Level 1 CSB/Non-CSB breakdown was suppressed due to low non-CSB response rate for Level 1 practitioners.

The median salary represents the "middle" salary of all salaries reported for a practitioner level across cost reports, weighted by the distribution of practitioners within the level. Median salaries by practitioner level reported in the cost reports are summarized in Table 5. Like the mean salaries, non-CSB median salaries were generally higher than CSB median salaries. Comparing mean reported salaries to median reported salaries, there is no apparent trend across practitioner level or provider type indicating that mean versus median reported salaries are consistently higher or lower.

Table 5 – Cost Report Median Salaries by Practitioner Level, SFY2022

	Median Cost Report[a]		
Practitioner Level	All Providers	CSB	Non-CSB
Level 1	$ 219,147	*	*
Level 2	$ 116,184	$ 114,364	$ 131,427
Level 3	$ 57,706	$ 57,000	$ 67,486
Level 4	$ 41,805	$ 41,034	$ 43,986
Level 5	$ 32,074	$ 31,500	$ 38,000

[a] Cost report salaries are reported for SFY2022 (July 2021-June 2022)

*Level 1 CSB/Non-CSB breakdown was suppressed due to low non-CSB response rate for Level 1 practitioners.

BLS salaries from May 2021 - the most recent BLS data available – were used as a benchmark for salaries reported from the cost reports. For each practitioner level, relevant BLS occupation codes were used to create a blended average to obtain a salary for each level. These occupation codes were weighted using the distribution

of practitioners within each level identified in the cost reports. While the BLS salaries are Georgia-specific, there was not a way to distinguish salaries for practitioners providing services to Medicaid patients specifically, and thus the reported BLS salaries reflect, for each practitioner type, a statewide average across care setting, industry, and patients served. Georgia's 50th percentile (i.e., median), mean, and 75th percentile BLS salaries corresponding to practitioner levels 1-5 are shown in Table 6.

Table 6 – Bureau of Labor Statistics Salaries by Practitioner Level

	BLS Salaries[a]		
Practitioner Level	50th Percentile BLS	Mean BLS	75th Percentile BLS
Level 1	$105,648	$180,566	NA[b]
Level 2	$95,741	$104,002	$116,558
Level 3	$56,287	$57,313	$66,343
Level 4	$42,900	$46,144	$49,678
Level 5	$29,580	$31,660	$37,110

[a] BLS salaries are reported from May 2021

[b] The 75th percentile salaries for Level 1 practitioners were not available in BLS and were thus not reported here.

4.2 Employee Related Expenses

The cost report template requested that providers report SFY2022 dollar amounts for practitioner benefits and worker's compensation. Reported values in these categories were summed to produce one ERE estimate and analyzed by practitioner level as a percentage of the reported salary for each level. Summarized ERE average and median reported values by practitioner level are reported in Table 7. Non-CSB mean and median reported ERE percentages were close to half the reported ERE percentages reported for CSBs. In addition, across all practitioner levels, the reported Median ERE percentage was higher than the reported mean ERE percentage. Some non-CSB providers did not report any benefits for some staffing roles thus leading to a lower benefits percentage, and this may reflect providers using contractors in place of hired staff.

Table 7 – Cost Report ERE as a Percentage of Salary, by Practitioner Level and Provider Type, SFY2022

	Mean Cost Report ERE %			Median Cost Report ERE %		
Practitioner Level	All	CSB	Non-CSB	All	CSB	Non-CSB
Level 1	30%	*	*	32%	*	*
Level 2	32%	35%	19%	37%	39%	21%
Level 3	36%	39%	19%	39%	41%	21%
Level 4	34%	38%	19%	41%	42%	11%
Level 5	37%	39%	26%	40%	41%	21%
All	35%	38%	20%	39%	41%	20%

*Level 1 CSB/Non-CSB breakdown was suppressed due to low non-CSB response rate for Level 1 practitioners.

The 2008 CBHRS rate development assumptions used a benefits percentage of 42% applied to each level (Table 8). Compared to the ERE percentages from cost reports, the prior 42% assumption best aligns with the median reported ERE percentage for CSBs. The overall mean and median reported ERE percentages calculated from the cost reports were lower, however, and the reported ERE values from the cost reports do also suggest ERE percentages vary by practitioner level.

Table 8 – ERE Assumptions Used to Develop the Current Rates

	Current Rate Assumption
Level 1	42%
Level 2	42%
Level 3	42%
Level 4	42%
Level 5	42%

4.3 PTO

Providers were asked to report average hours of practitioner vacation time, holiday time, and sick time for each staffing role used to provide CBHRS. These types of leave time were then summed to create one PTO value for each practitioner level. On some cost reports, providers appeared to have reported leave time in days instead of hours. Thus, where leave time entered was less than 48 hours, the entry was manually adjusted to hours (i.e., multiplied by 8, assuming an 8-hour workday). Mean and median leave time was summarized by CSB/Non-CSB provider category and practitioner level, and this summary is shown in Table 9. Overall, CSBs reported higher amounts of paid time off compared to non-CSBs.

Table 9 – Cost Report Mean and Median PTO Time Reported

	Mean Cost Report PTO (Days)			Median Cost Report PTO (Days)		
Practitioner Level	**All Providers**	**CSB**	**Non-CSB**	**All Providers**	**CSB**	**Non-CSB**
Level 1	26	25	37	29	27	37
Level 2	22	21	28	25	24	27
Level 3	26	26	22	28	28	22
Level 4	24	25	21	28	28	21
Level 5	24	24	22	26	25	22
All Practitioners	25	25	23	28	28	22

[a] Only 2 non-CSB level 1 practitioners were reported on

4.4 Productivity

Billable and non-billable hours were requested by staffing role, at the facility level (i.e., in-clinic, out of clinic, telehealth), and at the individual service level. As noted previously, several providers reported difficulties providing billable and non-billable hours at this level of detail. More than half of providers did not fill out non-billable hours in this section or reported no or unrealistically low billable or non-billable hours. Consequently, the resulting sample of responses was not large enough to allow for productivity to be reported at the facility and individual service levels.

Productivity for each staffing role is calculated as billable hours divided by total hours. Once this calculation was performed, there were additional concerns with the range of reported values across providers, given 50% of responses being within 25% of the median response (after removing any providers that didn't include non-billable hours). Thus, the summaries provided in this analysis represent the median productivity by practitioner level given that reporting the median value to some extent reduces the ability for outliers to have a disproportionate effect on the calculation.

Overall, the median reported productivity rates by practitioner level were higher for SFY2019, during which reported productivity ranged from 65%-70% (Table 10). SFY2022 median reported productivity rates ranged from 56% for Level 4 practitioners to 70% for Level 5 practitioners. The lower SFY2022 productivity compared with SFY2019 may reflect the COVID-19 pandemic's impacts on service use and delivery.

Table 10 – Cost Report Median Productivity Percentages – SFY2019 and SFY2022

Median Productivity Percentage		
Practitioner Level	**SFY2019**	**SFY2022**
Level 1	65%	61%
Level 2	67%	65%
Level 3	65%	62%
Level 4	65%	56%
Level 5	70%	70%

The median reported productivity was also compared the productivity that was assumed for the current rates set in 2008 (Table 11). The productivity levels used in the prior methodology varied based on service and facility type, and thus a weighted average productivity (across services and facility types) was used for comparison to cost report results. It was not clear whether providers reported productivity inclusive or exclusive of PTO, and thus current (2008 rate methodology) productivity calculations inclusive and exclusive of PTO are provided for comparison to productivity resulting from the cost reports. The cost report median productivity is more aligned with the current rate assumptions exclusive of PTO but is still higher for all practitioner levels except for Level 1.

Table 11 – Comparison of Cost Report Productivity to Productivity Assumptions Used to Set the Current Rates

Practitioner Level	Current Rates before PTO Weighted Average	Current Rates after PTO Weighted Average	2019 Reported Median[a]	2022 Reported Median[a]
Level 1	69%	59%	65%	61%
Level 2	62%	53%	67%	65%
Level 3	56%	48%	65%	62%
Level 4	54%	47%	65%	56%
Level 5	53%	46%	70%	70%

[a] Providers that reported no non-billable time were excluded from the median calculation

4.5 Program and Administrative Costs

As described in section 3.1.5, *direct care costs* include the salaries and benefits of practitioners delivering services to clients, *program costs* directly support the provision of services to clients, and may include costs for program support staff, supervisors, training, etc. (but exclude practitioner salaries and benefits). *Administrative costs* include management and other overhead costs, including software, building, office supplies, marketing, etc.

Program and administrative costs were collected separately in the provider cost reports but analyzed together. Many of the line items separated into the program

and administrative cost categories described in section 3.1.5 of this report potentially overlap, particularly given that the cost reports may be interpreted differently from provider to provider. Because of the possibility of overlap across categories, a total administrative and program cost percentage was developed relative to total Medicaid CBHRS costs (i.e., program and administrative costs were summed and divided by total costs to provide CBHRS).

The program and administrative costs reported by providers ranged from 39-46% across SFY2019 and SFY2022 (Table 12). In general, program and administrative cost median and mean percentages were 5-6% higher in SFY2019 than in SFY2022. Mean reported program and administrative costs were slightly lower than median values for both years. One possible explanation for this may be that the wage costs experienced a greater increase over the SFY2019-SFY2022 time period than admin and program costs, resulting in a lower proportion of program and admin costs to total costs.

Table 12 – Cost Report Mean and Median Program and Administrative Costs, SFY2019 and SFY2022

Program and Administrative Costs			
	SFY19	**SFY22**	**Total**
Mean	44%	39%	41%
Median	46%	40%	44%

Table 13 contains a summary of the combined program and administrative costs as a percentage of total costs, based on the assumptions used to set the current rates that went into effect in 2008. In the 2008 rate assumptions, program and administrative assumptions were applied separately, so to compare the assumptions to the cost report findings, the prior program and administrative assumptions were recalculated together to be shown as a percentage of total costs.

The program and administrative costs reported by providers in the cost reports were similar to the assumptions used to set the current rates. For the current rate assumptions, program and administrative costs are around 21% for Level 1 practitioners and 41% for practitioner Levels 2-5.

Table 13 – Program and Administrative Cost Assumptions Used for Current Rates

Current Rate Assumptions – Administrative and Program Costs	
Level 1	21%
Level 2	41%
Level 3	41%
Level 4	41%
Level 5	41%

Cost report program and administrative costs were also analyzed by care delivery setting (in clinic, out of clinic, and telehealth) in order to identify whether there are any settings for which administrative and program costs are disproportionate relative to the other settings. Several providers, however, reported difficulties allocating expenditures by setting due to internal systems not tracking expenditures at this level of detail. Some providers stated they were not able to allocate expenditures by specific setting and indicated they had entered all expenses as "in clinic." This may result in overstated in clinic expenditures and understated out of clinic and telehealth expenditures. Other providers did report setting specific expenditures, but variations in provider allocation methodologies posed challenges for data interpretation. *Thus, the summarized administrative and program expenditures by setting should be interpreted with caution.*

Program and administrative costs by setting were combined and summarized as a percentage of total expenditures for the setting, as shown in Table 14 and Table 15 for SFY2019 and SFY2022, respectively. In both SFY2019 and SFY2022, reported mean and median program and administrative costs as a percentage of total costs were lower for out of clinic and telehealth service delivery compared to in clinic service delivery.

Table 14 – Cost Report Mean and Median Program and Administrative Costs by Setting, SFY2019

Program and Admin as a % of Total Cost (SFY2019)				
	In Clinic	**Out of Clinic**	**Telehealth**	**Total**
Mean	45%	39%	37%	44%
Median	51%	38%	40%	46%

Note: Across all cost reports, providers reported 64%, 30%, and 6% of total SFY2019 expenses into in clinic, out of clinic, and telehealth service delivery, respectively.

Table 15 – Cost Report Mean and Median Program and Administrative Costs by Setting, SFY2022

Program and Admin as a % of Total Cost (SFY2022)				
	In Clinic	**Out of Clinic**	**Telehealth**	**Total**
Mean	46%	30%	35%	39%
Median	42%	18%	36%	40%

Note: Across all cost reports, providers reported 66%, 21%, and 13% of total SFY2022 expenses into in clinic, out of clinic, and telehealth service delivery, respectively.

4.6 Group Staffing Ratios

Table 16 contains the mean and median SFY2019, SFY2022, and "ideal" staffing ratios reported in the cost reports for the group services listed in section 3.1.7 of this report. The staffing ratios are reported as individual-to-staff ratios, and thus the numbers reported in the table represent the number of individuals served per

one practitioner. The current rates, with assumptions developed in 2008, assume a staffing ratio of 5:1 for all services, whereas the mean and median reported SFY2019, SFY2022, and ideal staffing ratios exceeded this value for all services. As a point of reference, the CBHRS provider manual specifies "Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance" for group counseling and training.[6]

Table 16 – Cost Report Mean, Median, and "Ideal" Staffing Ratios for Group Services, SFY2019 and SFY2022

	Mean Staffing Ratio for Group Services			Median Staffing Ratio for Group Services		
Service	**SFY 2019**	**SFY 2022**	**Ideal**	**SFY 2019**	**SFY 2022**	**Ideal**
Mental Health Peer Support Program	11	12	14	11	10	15
Peer Support, Whole Health & Wellness (Group)	*	*	13	*	*	12
Psychosocial Rehabilitation - Program	11	10	12	12	12	12
Parent Peer Support (Group)[a]	NA	NA	13	NA	NA	13
Youth Peer Support (Group)	*	*	15	*	*	15
Group Outpatient Services - Group Counseling	9	8	11	9	8	10
Group Outpatient Services - Group Training	9	8	12	9	8	10
Addictive Diseases Peer Support Program[a]	NA	NA	11	NA	NA	11
Substance Abuse Intensive Outpatient Program	10	9	11	11	10	12
Assertive Community Treatment (ACT)	7	6	9	6	6	10

[a] No providers responded with SFY2019 and SFY2022 estimates for Parent Peer Support and Addictive Diseases Peer Support

* Reported values were suppressed due to low sample size (less than or equal to two provider responses)

[6] Georgia Department of Behavioral Health and Developmental Disabilities. (2022, June 1). Provider Manual for Community Behavioral Health Providers. Community Provider Manuals. Retrieved August 15, 2022, from https://dbhdd.georgia.gov/be-connected/community-provider-manuals

5 Supplemental IC3 and CSU Cost Report Results

5.1 IC3 Cost Report Results

Supplemental IC3 cost reports were received from each of the two providers that offer the service. This section compares information reported in the cost reports to industry and clinical benchmarks to provide context to the reported values. Reported IC3 costs related to provider salaries and staffing ratios are discussed below.

5.1.1 IC3 Staff Wages

Table 17 contains a summary of reported salaries for IC3-specific staffing roles. In addition to the staffing roles explicitly requested in the IC3 cost report, wages for two additional staffing roles – QA coordinator and clinical director – were reported by providers. As a benchmark for reported wages, 50th percentile, mean, and 75th percentile wages from BLS May 2021 Georgia Occupational Employment and Wage Estimates are also provided.[7] Generally, the wages that providers reported for IC3 staff were lower than the wages for the corresponding practitioner level reported by BLS. Most notably, the reported supervisor salaries were approximately 32% lower than the mean report from the BLS.

Table 17 – Cost Report vs. Bureau of Labor Statistics Salaries for IC3 Staffing Roles

	BLS Salaries[a]		Cost Reports	
Staffing Role	**50th Percentile BLS**	**Mean BLS**	**75th Percentile BLS**	**SFY2022 Average Salary**
Care Coordinator	$43,333	$46,610	$50,180	$39,180
CPS-P	$29,580	$31,660	$37,110	$31,200
Care Coordinator Supervisor	$60,975	$61,830	$70,060	$46,992
CPS-P Supervisor	$60,975	$61,830	$70,060	$46,992
CME Director	N/A	N/A	N/A	$63,600
QA Coordinator/ Clinical Director	N/A	N/A	N/A	$66,151

Note: BLS Salaries are provided for the Georgia Level 1-5 practitioner level to which each staffing role corresponds. Staffing roles were cross walked to practitioner levels as follows: Care Coordinator – Level 4, CPS-P – Level 5, Care Coordinator and CPS-P supervisor – Level 3.

[a] BLS salaries are reported from May 2021

[7] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment Statistics, on the Internet at https://www.bls.gov/oes/current/oessrcst.htm (visited November 2022).

5.1.2 IC3 Staffing Ratios

IC3 staffing ratios were calculated by taking the reported numbers of annual IC3 members in a given year divided by the number of FTEs in that year for each IC3 staffing role (Table 18). IC3 staffing requirements stated in the DBHDD Provider Manual for Community Behavioral Health Providers are also provided as a benchmark for the staffing ratios calculated based on cost report data.[8]

The reported number of members per staff member was higher than provider manual specifications for Care Coordinators and CPS-Ps, approximately equal to provider manual specifications for care coordinator supervisors, and below provider manual specifications for CPS-P supervisors. There were more supervisor FTEs than expected based on requirements in the provider manual for this number of members, which may be indicative that IC3 providers supplement some of the higher caseloads of care coordinators and CPC-Ps with additional supervision.

Table 18 – IC3 Cost Report – Reported Members per Practitioner vs. Provider Manual Specifications

	Members Per Practitioner	
Staffing Role	**Provider Manual Specifications**	**Average Cost report (SFY2019-SFY2022)**
Care Coordinator	10	17
CPS-P	30	53
Care Coordinator Supervisor	60	59
CPS-P Supervisor	180	144

5.2 CSU Cost Report Results

Supplemental CSU cost reports were received from seven of the ten providers from which they were requested. Reported CSU staff wages, ERE, admin and program costs, and occupancy are summarized below.

5.2.1 CSU Staff Wages and Employee Related Expenses

Across cost report submissions, CSU staff composition varied considerably – some CSUs deployed more contracted staff, while others primarily used salaried workers. Given the diversity in staffing arrangements across providers, salary and ERE costs (including benefits and worker's compensation) were summed across all reported practitioner types for each cost report submission to create a total staff wage and ERE value.

The mean and median of annual and daily salary and ERE costs across the seven submitted cost reports are shown in Table 19 and Table 20. Given that salaries

[8] Georgia Department of Behavioral Health and Developmental Disabilities. (2022, June 1). Provider Manual for Community Behavioral Health Providers. Community Provider Manuals. Retrieved August 15, 2022, from https://dbhdd.georgia.gov/be-connected/community-provider-manuals

were only collected for SFY2022, the SFY2019 totals represent reported 2019 FTEs multiplied by reported 2022 salaries. Thus, the increase of about 14% in the median salary and ERE costs from SFY2019-SFY2022 is likely driven by a general increase in the number of FTEs, a shift to more costly practitioner types, or both.

Table 19 – Mean and Median Reported CSU Annual Salary and ERE Costs

	Reported Annual Salary and ERE Costs	
Summary Statistic	**SFY2019[a]**	**SFY2022**
Mean	$2,631,919	$3,260,026
Median	$2,722,551	$3,111,648

[a] SFY2019 wages were not collected in the supplemental CSU cost report. Thus, reported SFY2019 Salary and ERE costs are estimated by multiplying reported SFY2019 FTEs with reported SFY2022 salaries.

Table 20 – Mean and Median Reported CSU Daily Salary and ERE Costs

	Reported Daily Salary and ERE Costs	
Summary Statistic	**SFY2019[a]**	**SFY2022**
Mean	$7,211	$8,932
Median	$7,459	$8,525

[a] SFY2019 wages were not collected in the supplemental CSU cost report. Thus, reported SFY2019 Salary and ERE costs are estimated by multiplying reported SFY2019 FTEs with reported SFY2022 salaries.

5.2.2 CSU Admin and Program Costs

Reported CSU admin and program costs include costs related to CSU operation and overhead (and exclude staff costs). While CSU administrative and program costs were requested separately in the cost report template, variations in cost reporting across providers necessitated that program and administrative costs are summarized in aggregate.

Summarizations of annual and daily admin and program costs per day are reported in Table 21 and Table 22 below. There were outliers that increased the average compared to the median, including one CSU that built a new building in SFY2022, resulting in higher than usual administrative costs. The staff cost per day for the median report was around $1,159 in SFY2019 and $1,791 in SFY2022.

Table 21 – Mean and Median Reported CSU Annual Admin and Program Costs

	Reported Annual Admin and Program Costs	
Summary Statistic	**SFY2019**	**SFY2022**
Mean	$454,395	$771,806
Median	$423,024	$653,701

Table 22 – Mean and Median Reported CSU Daily Admin and Program Costs

	Reported Daily Admin and Program Costs	
Summary Statistic	**SFY2019**	**SFY2022**
Mean	$1,245	$2,115
Median	$1,159	$1,791

Admin and program costs were also calculated as a percentage of total costs (total costs is calculated as the sum of administrative and program costs + salary and benefits costs), and the results of these calculations across cost reports are summarized in Table 23. Several salaries in section 5.2.1 include the admin and program costs associated with salaries and benefits which explains why the reported amounts are lower for CSU compared to the program costs and admin in main cost reports. The median reported admin and program costs percentage for SFY2022 was 17%, which is an increase of 4 percentage points from SFY2019.

Table 23 – Mean and Median Reported CSU Admin and Program Costs as a Percentage of Total Costs

	Reported Admin and Program Percent of total Cost	
Summary Statistic	**SFY2019**	**SFY2022**
Mean	15%	19%
Median	13%	17%

5.2.3 CSU Occupied Beds

Providers reported the average number of occupied beds their CSUs in SFY2019 and SFY2022, and the average and median occupied beds across cost reports are summarized in Table 24. Several of the providers noted that bed occupancy was affected by the COVID-19 pandemic, and that reported SFY2022 numbers reflected this impact. The reported SFY2019 median and mean occupancy rates are similar to one another at 12.1 beds and 11.7 beds, respectively. In SFY2019, the median and mean occupancy for CSUs were similar at around 12 beds occupied.

Table 24 – Mean and Median Reported CSU Bed Occupancy, SFY2019 and SFY2022

	Reported Number of Occupied Beds	
Summary Statistic	**SFY2019**	**SFY2022**
Mean	11.7	9.2
Median	12.1	10.2

6 Appendix

Appendix A - Summary list of all tables and figures contained in this document.

Appendix B - Supporting work products were provided electronically and delivered to DBHDD and DCH. These include the following:

- Statewide Cost Reporting Tool
- Frequently Asked Questions (FAQ)

- Statewide Cost Report Webinar Recording