

**REVIEW OF RATES FOR BEHAVIORAL HEALTH AND  
TARGETED CASE MANAGEMENT SERVICES  
(MAINECARE SECTIONS 13, 17, 28, AND 65)**

**PUBLIC COMMENTS AND RESPONSES**

– PREPARED FOR –

**MAINE DEPARTMENT OF HEALTH  
AND HUMAN SERVICES**

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## **PROJECT BACKGROUND**

In an ongoing initiative to ensure the adequacy and appropriateness of provider reimbursement rates for MaineCare services, the Maine Department of Health and Human Services has conducted rate studies for a number of programs in recent years, including home and community based services for persons with intellectual and developmental disabilities (Section 21 of the MaineCare Benefits Manual), personal care and related services (Sections 12, 19, and 96), crisis services (Section 65), and behavioral health homes (Section 92). Consistent with these efforts and pursuant to a Fiscal Year 2016-17 budget provision that directed DHHS to undertake a rate study for services provided under Sections 28 and 65, the Department – assisted by the national consulting firm Burns & Associates, Inc. (B&A) – has completed its review of rates for targeted case management and behavioral health services.<sup>1</sup>

The rate review encompassed several tasks, including:

- A detailed review of service requirements, billing rules, and DHHS’ policy objectives.
- Multiple meetings with service providers, including ‘provider advisory groups’ established for each of the four Sections incorporated in the study and visits to four providers’ offices for in-depth discussions of their programs.
- Development and administration of a provider survey that was emailed to all providers to collect information regarding service designs and costs.
- Identification and research of other available data to inform the development of the rate models, including cross-industry wage and benefit standards and rates paid for comparable services in other states.
- Analyses of claims data.

Based on this work, detailed rate models were developed. The models included the specific assumptions regarding the costs that providers face in the delivery of each service, such as direct support workers’ wages, benefits, and billable time; staffing ratios; travel; and agency overhead.

DHHS released the proposed rate models and related documentation on March 16, 2016. Stakeholders and providers were notified by email and a webinar explaining the proposals was recorded and posted online.

Interested parties were asked to submit their comments in writing to a dedicated email account. The comment period was originally scheduled to last three weeks, but in response to requests from providers, the deadline was extended to May 16, 2016, allowing nearly nine weeks for stakeholders to submit comments. Further, any comments submitted after the deadline were also considered.

During the comment period, the Legislature passed legislation requiring DHHS to submit the completed rate study to the Health and Human Services Committee by January 2 and enjoined the Department from commencing rule-making for at least 60 days after a presentation of the study results to the Committee.<sup>2</sup>

In total, comments were received from more than 150 organizations and individuals. Most comments were thoughtfully written and constructive, and DHHS appreciates all those who took time to provide feedback. In addition to consideration of these comments, the Department convened meetings with

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<sup>1</sup> Although the budget provision (P.L. 2015, ch. 267, § AA) only mentioned Sections 28 and 65, the Department included Sections 13 and 17 in order to conduct a comprehensive review of rates for behavioral health services.

<sup>2</sup> P.L. 2016, ch. 88.

provider representatives to further discuss three services and a follow-up survey was developed and administered to collect additional information related to Psychological and Neuropsychological Testing.

In response to the public comment and additional research and analysis, DHHS has made a number of changes to the March proposals:

- All rate models incorporate more recent Bureau of Labor Statistics wage data and Internal Revenue Service mileage rates that became available after publication of the proposed rates.
- Paid days off (holidays, vacation, and sick leave) for direct service staff were removed from the benefit rate calculations and added as a productivity adjustment (which had the effect of modestly increasing most rates).
- The productivity assumption for employer and one-on-one supervision time was increased to 1.5 hours per week for most services (and to one hour per week for master's-level and licensed staff).
- Annual training was increased to 52 hours in the Case Management, Community Integration, and Children's Home and Community Based Treatment rate models and to 65 hours for Specialized Section 28 services.
- The service provider tax was added to rate models for Section 28 services.
- The assumption that children annually attend 1,275 hours of their Section 28 or Children's Behavioral Health Day Treatment program was reduced to 1,000 hours for the purpose of amortizing program space costs.
- New rates were established for Section 28 and Children's Behavioral Health Day Treatment services provided by behavioral health professionals with a bachelor's degree (DHHS also intends to standardize BHP qualifications across these two services at 60 college credit hours).
- The assumed workweek for behavioral health professionals providing Section 28 or Children's Behavioral Health Day Treatment services was reduced from 40 hours to 36 hours (38 hours for staff providing Section 28 services in children's homes and communities).
- Changes to rates for Children's Behavioral Health Day Treatment preschool programs are being suspended pending discussion of cost and funding issues with the Department of Education and service providers.
- Recordkeeping time for master's-level staff providing Children's Behavioral Health Day Treatment services was increased from three to five hours per week.
- The assumed wage for psychiatrists in the Medication Management and Assertive Community Treatment rate models was increased from \$185,000 annually to \$232,000.
- Separate Medication Management rate models were developed for services delivered to children, reflecting more time for coordination and collateral contacts.
- The proposal to eliminate billing for collateral contacts associated with Children's Home and Community Based Treatment services was withdrawn and the corresponding productivity adjustment for collateral contacts was removed from removed.
- The proposed lower rates for Multi-Systemic Therapy, Problem Sexualized Behavior, and Functional Family Therapy were withdrawn.
- Productivity assumptions were lowered and assessment instrument costs were added to the rate models for Psychological and Neuropsychological Testing.

The remainder of this document provides DHHS' response to each specific comment. The document is organized by MaineCare Section and service:

- Services across multiple Sections, beginning with comment 1
- Section 13 Targeted Case Management, beginning with comment 16
- Section 17, beginning with comment 36
  - Community Integration, beginning with comment 38
  - Daily Living Support Services, beginning with comment 53
  - Skills Development, beginning with comment 58
  - Day Support, beginning with comment 62
  - Assertive Community Treatment, beginning with comment 64
  - Community Rehabilitation Services, beginning with comment 66
- Section 28 Children's Habilitative Services, beginning with comment 68
- Section 65
  - Children's Behavioral Health Day Treatment, beginning with comment 85
  - Outpatient Services, beginning with comment 101
  - Medication Management, beginning with comment 110
  - Children's Home and Community Based Treatment, beginning with comment 121
  - Psychological and Neuropsychological Testing, beginning with comment 128
- Project Administration and Approach, beginning with comment 135

## **ALL SERVICES**

### **Direct Care Staff Wages, Benefits, and Productivity**

1. *One commenter asked whether the wage data used in the rate models is based on State, regional, or national data. Another commenter expressed concern that the use of national wage data that is higher than reported by providers will be used by MaineCare to justify not increasing payments when the minimum wage is increased.*

The wage assumptions in the rate models are generally tied to Bureau of Labor Statistics wage data for occupations that reflect the requirements of each service. The BLS data is state-specific data, so the assumptions reflect wages for employees in Maine.<sup>3</sup>

As the commenter notes, the wages assumed in the rate model generally exceed the averages reported by provider survey participants. Assumptions regarding wages – like those for other cost drivers – are intended to reflect the cost of providing services. As with other rate model assumptions, the wage assumptions are not prescriptive – providers may choose to pay staff more or less than assumed.

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<sup>3</sup> The proposed rate models released for public comment on March 16, 2016 incorporated the most recent BLS data available at the time, the May 2014 dataset. Subsequent to the posting of the proposed rate models, the BLS released the May 2015 dataset. The rate models were updated to reflect this newer data.

The impact of scheduled minimum wage increases will be considered as necessary, but all wage assumptions are greater than the \$9.00 minimum wage taking effect in January 2017 and the lowest assumed wage – \$12.00 for certified intentional peer support specialists – is equal to the \$12.00 minimum wage that will become effective in 2020.

**2. Several commenters stated that the benefit rate assumed in the rate model is less than their costs. Several comments objected to assumptions regarding specific benefits, suggesting that the rate models include:**

- *More than \$400 per month for health insurance because provider survey respondents reported an average monthly cost of \$583 and State-paid health insurance is \$780 per month, the assumption is based on ‘old’ or inappropriate data, and the assumption does not provide for dependent coverage,*
- *30 or more days of paid time off rather than the 25 days assumed,*
- *Funding for a retirement contribution, particularly given the generous retirement program for State employees,*
- *More than the \$25 per month for other benefits given that provider survey respondents reported an average monthly cost of \$48, and*
- *A higher workers’ compensation rate.*

The rate models for all services included in this rate review incorporate the following benefits:

<b>Figure 1: Comparison of Rate Model Assumptions for Employee Benefits to Provider Survey</b>		
<b>Benefit</b>	<b>Rate Model Assumption</b>	<b>Provider Survey Average<sup>1</sup></b>
Social Security/ Medicare Taxes	7.65% of Wages	-
Federal Unemployment Insurance	0.60% of First \$7,000 in Wages	-
State Unemployment Insurance	2.20% of First \$12,000 in Wages	1.97%
Workers’ Compensation	3.20% of Wages	1.93%
Paid Time Off (Holiday, Vacation, Sick)	25 Days per Year	25.5 Days
Health Insurance	\$400 per Month	\$410 per Month
Other Benefits	\$25 per Month	\$36 per Month

<sup>1</sup>Reflects effective average across all full-time workers. Several figures cited by commenters include only *participating* employees and do not account for staff not receiving the benefit.

Excluding paid time off, which has been converted to a productivity adjustment as explained in the response to comment 5, these assumptions were translated to a benefit rate as a percentage of wages. In total, the benefit rates included in the rate model are slightly greater than the benefit rates calculated based on costs reported by provider survey participants for full-time staff. Reported benefits for part-time staff – which were reported to account for about 18 percent of the overall workforce across all services – are much less than assumed in the rate model.

As with all rate model assumptions, the assumed benefits package is intended to reflect a provider’s reasonable costs. For any given provider, it may certainly be true that costs for one or more benefits

are higher than assumed in the rate model, but other benefits (or other cost factors, such as wages) may be less than assumed.

**3. *One commenter expressed concern that the rate models do not include pay or benefit increases.***

As discussed in the responses to comments 1 and 2, the rate models include wage assumptions based on wage levels for comparable positions across the State from the most recent Bureau of Labor Statistics data and a comprehensive benefits package. These assumptions are generally greater or equal to what providers report currently paying. These assumptions are detailed and could be adjusted over time as necessary.

**4. *One commenter disagreed with benefit rates that vary by wage because some benefit costs are fixed.***

The rate models assume the same benefit package for all staff regardless of their wage. The fact that certain benefit costs are fixed is the very reason that the rates vary by wage. For example, it is assumed that the cost of health insurance is \$400 per month for all employees; this amount does not change. For someone earning \$15 per hour, this health insurance benefit is equivalent to 15.4 percent of their salary, but for someone earning \$25 per hour this same benefit *amount* is equal to a 9.2 percent benefit *rate*. In brief, benefit rates will decrease as wages increase because the components of the benefit package that are fixed will be allocated over a larger wage base.

In order to increase the accuracy of the benefit rate calculations, the rate models have been adjusted so that the benefit rate is calculated to the wage to the penny. Previously, the calculation was based on the wage rounded down to the nearest dollar.

**5. *One commenter suggested that paid time off should be reflected as a productivity adjustment rather than incorporated in the benefit rate.***

As noted in the response to comment 2, the rate model assumes that staff receive 25 days of paid time off (holidays, vacation, and sick leave). The draft proposed rate models converted this to a cost (that is, 25 days of pay), which was included in the calculation of benefit rates. As the commenter noted, paid time off may be better thought of as a reduction to the number of billable hours that a staff person can deliver over the course of a year. The Department agrees with this position and the rate models have been adjusted to exclude paid time off from the benefit rate and include 25 days per year (3.85 hours per week) as a productivity adjustment.

As illustrated in Appendix C of the final proposed rate models packet, the rate model for each service now begins with assumptions related to a 'typical' workweek for a direct support staff person. A typical workweek will include work activities that occur most weeks, such as one-on-one supervision and employer time, recordkeeping, and travel. The billable hours that remain in the typical workweek represent the target for staff for the weeks when they are 'in the office'. These are also the figures that should be compared to the provider survey averages.

However, staff are not always 'in the office'. Thus, the typical workweek is then adjusted to account for other productivity factors that occur over the course of a year but not typically on a weekly basis, specifically paid time off and training. The annual hours assumed for these two productivity factors are proportionally allocated to all of the work activities assumed in the typical workweek. The result is an 'average' workweek that accounts for paid time off and training hours. Multiplying the billable hours in the average workweek by 52 produces the total number of annual billable hours assumed for a full-time direct support staff person providing that service.

Overall, this methodological change had the effect of modestly increasing most rates.

**6. *Several commenters objected to specific productivity assumptions. A common concern across services was the amount of time included for employer and one-on-one supervision time.***

Discussion of productivity assumptions are included in the responses to comments related to specific services. In response to multiple comments, however, the productivity assumption for employer and one-on-one supervision time was increased for most services.

The proposed rate models for most services included one hour per week for one-on-one supervision and other employment-related activities. As noted by several commenters, several services require that staff receive 48 hours of supervision annually, which was covered by the one hour assumption, but did not leave time for other employment-related responsibilities. As a result, the assumption in most rate models was increased to 1.5 hours per week, with the assumption for master's-level and licensed staff increased to one hour per week.

**7. *Several commenters expressed concern that the rate models do not account for turnover. One commenter stated that the rates should include 'ramp-up' time at the start of employment and titration of caseloads to zero at the end of employment.***

Participants in the provider survey reported that turnover ranged from less than 20 percent to as high as 50 percent depending on the service. The rate models account for turnover in two areas. First, training requirements are greater in the first year of employment than in subsequent years so the number of annual training hours included as productivity adjustment represents a weighted average of first year and subsequent year training. Second, human resource staff and other hiring and training expenses are considered to be part of the administration and program support assumptions discussed in the response to comment. There is no specific productivity assumption related to start-up and phase-out of staff; rather the productivity assumptions are intended to be reasonable targets across all staff with some providing more billable services and others (such as new employees) providing less.

### **Operating and Overhead Costs**

**8. *One provider asked how the rate review process accounted for differences in provider structures (agency versus affiliate, provider size, urban versus rural). Another commenter stated that the proposed rate will not support small agencies (such as one with five staff).***

With limited exceptions (such as Section 65 Outpatient Therapy rates for independent providers), current rates do not vary based on the types of provider characteristics cited by the commenter. The Department intends to maintain this one-rate approach. Consequently, the rate review did not make any specific allowances for these differences.

Rather, the resulting rate models are intended to reflect the reasonable cost of providing services, consistent with MaineCare requirements. For any individual provider, it is expected that some costs will be greater than assumed in the rate model and others will be less. For instance, providers in rural areas will have greater travel requirements, but may have lower wage and office space costs. Similarly, a smaller provider may operate more efficiently with fewer services and/or locations while larger providers may benefit from certain economies of scale.

**9. *Several commenters noted that the rate models do not account for profit or program growth and would eliminate excess dollars.***

The rate models resulting from this rate review do not include a factor for agency profits (or surpluses for nonprofit organizations) and are not intended to generate 'excess' dollars. Since the rate model

assumptions are not mandates, agencies may earn a profit by reducing costs below those assumed in the rate model (for example, by lowering overhead costs).

***10. Several commenters stated that the rate models do not account for various overhead costs. In particular, commenters noted insurance, billing software, and office supplies; contractual reporting requirements, licensing reviews, etc.; and supervision.***

The functions cited by the commenters are included in the administrative and program support factors included in the rate models. Since it is not practical to separately delineate every individual expense within a rate model, the models include two ‘blanket’ factors to account for these costs. In particular, the models include \$25 per day for program support and 15 percent of the total rate for administrative expenses. In total, these factors produce an average of a 28 percent overhead rate across all services.

***11. Several commenters objected to the overhead assumptions in the rate models. Some commenters suggested that overhead should be 35 percent of the total rate rather than the 28 percent average assumed in the rate models. Some commenters asked why the overhead assumptions are the same across all services and stated that the fixed program support cost does not adequately fund more intensive services.***

As noted in the response to comment 10, the rate models include two components related to overhead. Administration is set at 15 percent of the total rate. Since this cost is a percentage of all costs, more costly services (due to higher staff wages, fewer billable hours, or any other reason) receive more administrative funding. Program support is set at \$25 per day across all services. The fixed amount has the effect of providing relatively more funding for group services and those provided by lower-paid staff. Overall overhead funding averages 28 percent across all services. In addition, rate models for some services also include funding for office space for direct care staff as discussed in the response to comment 13 and/or an additional administrative support position as discussed in the response to comment 14. When these additions are included, the overhead funding in the rate models across all services exceeds 33 percent.

The Department considered establishing service-specific overhead rates. However, there was limited data from which to ascertain the differences and the provider survey data that was available showed that most (but not all) services had generally comparable overhead rates, mostly ranging from 35 to 40 percent. The 28 percent average included in the rate models – or 33 percent when including specified support staff and clinical space – is less than the averages reported in the provider survey as the Department is concerned that generous payment rates have resulted in unnecessarily high overhead, noting for example, that the reported overhead rate for services other than those included in the rate review was only 25 percent. Consequently, the overhead assumptions were derived in large measure from previous rate reviews for Section 65 crisis services and Section 92 behavioral health homes.

***12. One commenter stated that the overhead rate is calculated as a percentage of wages rather than as a percentage of total costs.***

This comment is not accurate; administrative funding is calculated as a percent of the total rate before the addition of the service provider tax, if applicable. For the service cited by the commenter – Community Integration – the total cost per hour before the service provider tax is assumed to be \$60.79. The assumed administrative rate is 15 percent so, as is clear in the rate model, the administrative funding in the rate model is \$9.12 per hour (15 percent of the \$60.79 total).

**13. Several commenters asked how the office space assumptions were developed.**

The rate models resulting from this rate review incorporate administrative space and common areas (such as lobbies, hallways, conference rooms, and bathrooms) in the administrative and program support assumptions discussed in the response to comment 11. For services such as Targeted Case Management, Outpatient Therapy, Medication Management, and others where it is presumed that staff have their own dedicated workspace, the rate models include *additional* funding for their workspace. This additional funding is not intended to account for the cost of administrative space and common areas that is included in the overhead funding for all services.

Rate models for staff expected to have their own dedicated workspace generally include 100 square feet, which allows for a 10 foot by 10 foot office, which is in-line with various building standards. For offices in which members are likely to be served (e.g., Outpatient Therapy), the space is doubled (or more, for groups). The rate models assume an annual cost of \$15 per square foot based on research of the cost of advertised office space (for example, 29 medical offices were listed at loopnet.com in March 2016, with an average cost of about \$13 per square foot).

**14. Several commenter stated that one support person for every two direct care providers does not account for human resources, billing, IT, etc.**

Certain services – such as Section 65 Outpatient Therapy and Medication Management – include one support position for every two service providers in order to provide direct support such as scheduling and office management needed for short-duration, office-based services. This position is *in addition* to the administrative and program support funding in all of the rate models to account for the functions cited by the commenter.

**15. One commenter objected to the ‘Costs Other Than Direct Care Staff (Informational Only)’ calculation included on the rate model forms because it includes direct care staff travel as part of the calculation while the survey analysis packet does not include travel in the same manner.**

As the commenter notes, the rate models include a summary of the amount of funding per billable hour for costs other than direct care staff and the corresponding percent of the total rate. These calculations are not part of the actual rate model, but were provided to offer commenters summary data regarding the proportion of costs that are not part of direct care staff wages and benefits.

The calculation in the proposed rate model packet included mileage as part of the non-direct care funding amount, but as the commenter notes, these costs are not part of the overhead rates calculated from provider survey results. In order to allow for easier comparisons between the rate model assumptions and the provider survey analysis, mileage has been excluded from the summation of costs other than direct care staff as the commenter suggested.

## **TARGETED CASE MANAGEMENT (SECTION 13)**

### **General**

**16. One commenter asked whether costs for Targeted Case Management services provided directly by DHHS were considered.**

The Department’s costs for Targeted Case Management were not part of the rate review.

- 17. Several commenters stated that a reduction to the Targeted Case Management rate will result in the elimination of providers' ability to provide ancillary supports such as gas cards, to pay expenses such as medication and co-payments, and to serve persons who do not receive MaineCare.**

Although the supports noted by the commenters may be laudable, Targeted Case Management is not intended to provide these services so it is not appropriate to include related expenses in the rate.

- 18. One commenter stated that the proposed rate will result in agency closures, which will result in the loss of representative payees, noting that some providers do not charge for this function and asking whether the cost is included in the rate model. The commenter asked whether State staff will be able to assume the resulting workload.**

The Targeted Case Management rate is not intended to cover the cost of representative payee services so no related expenses are incorporated in the TCM rate model. As necessary, DHHS will work with any individual to identify a new representative payee.

- 19. One commenter noted that the Targeted Case Management rate has not been adjusted since 2009 although costs have increased and responsibilities have been added.**

The rate review process was intended to produce a rate that appropriately compensates service providers for Targeted Case Management and behavioral health services consistent with MaineCare policies rather than simply adopting an inflationary factor. For many services, this review resulted in rates that are higher than the existing rates – often by amounts that exceed inflation – while for other services the review determined a rate reduction was appropriate.

In the case of TCM, the rate review found that the existing rate is too high. This is partly evidenced by the fact that providers participating in the provider survey and the public comment process reported using TCM revenues to pay for supports that are not an expectation of the service such as those discussed in comments 17, 18, and 29.

Given the reduction to the TCM payment rate, the Department compared its rates to those paid in other New England states. The results are included in Figure 2. As the table shows, the current MaineCare rate is among the highest in the region while the new rate is more in line with these other states. Although there are limitations when comparing rates across states due to differences in service requirements and billable activities, the Department believes that this comparison provides additional evidence of the appropriateness of the new rate.

<b>Figure 2: Comparison of Targeted Case Management Rates in New England States</b>				
State	Service	Rate	Compared to Maine Current	Compared to Maine Revised
Maine	Current	\$21.52		
	Revised	\$15.92	(26.0%)	
Connecticut	Behavioral Health Clinician (T1016)	\$10.50	(51.2%)	(34.0%)
	Mental Health Clinic (T1016)	\$15.00	(30.3%)	(5.8%)
	Mental Health Clinic (T1017)	\$18.81	(12.6%)	18.2%
	Mental Health Waiver (G9012)	\$16.19	(24.8%)	1.7%
	TCM, Non-Contracted (T1017)	\$12.00	(44.2%)	(24.6%)
Massachusetts	Children's BH, Bachelor (T1017)	\$19.07	(11.4%)	19.8%
	Children's BH, Master (T1017)	\$24.53	14.0%	54.1%
	MFP Demonstration	\$16.28	(24.3%)	2.3%
New Hampshire	Choice for Independence Program (T1016)	\$8.52	(60.4%)	(46.5%)
	(T1017 HC)	\$11.25	(47.7%)	(29.3%)
Rhode Island	Long Term Care, 2009 (T1016 / T1017)	\$15.00	(30.3%)	(5.8%)
	Early Intervention (T1016)	\$17.48	(18.8%)	9.8%
	Blind and Visually Impaired (X0620)	\$14.00	(34.9%)	(12.1%)
Vermont	Mental Health Clinic (T1017)	\$24.78	15.1%	55.7%
	Dev. Disabilities (T1017); TBI (T1016)	\$12.50	(41.9%)	(21.5%)
	Choices for Care - Home Health Agencies and Area Agencies on Aging	\$17.35	(19.4%)	9.0%
CT - <a href="https://www.ctdssmap.com/CTPortal/Provider/ProviderFeeScheduleDownload/tabid/54/Default.aspx">https://www.ctdssmap.com/CTPortal/Provider/ProviderFeeScheduleDownload/tabid/54/Default.aspx</a> ; accessed May 1, 2016 MA - <a href="http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html">http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html</a> ; accessed August 1, 2016 NH - <a href="https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms">https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms</a> ; accessed May 1, 2016 RI - <a href="http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf">http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf</a> <a href="http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reimbursement%20Manual%20January%202014%20Update.pdf">http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reimbursement%20Manual%20January%202014%20Update.pdf</a> <a href="http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Value_Purchasing_for_Home_and_Com_Nov_2009.pdf">http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Value_Purchasing_for_Home_and_Com_Nov_2009.pdf</a> VT - <a href="http://dvha.vermont.gov/for-providers/2016-fee-schedule-1/">http://dvha.vermont.gov/for-providers/2016-fee-schedule-1/</a> ; accessed May 1, 2016 <a href="http://www.ddas.vermont.gov/ddas-publications/publications-ddas/dail-asd-ddsd-services-medicaid-claims-codes-and-reimbursement-rates">http://www.ddas.vermont.gov/ddas-publications/publications-ddas/dail-asd-ddsd-services-medicaid-claims-codes-and-reimbursement-rates</a> <a href="http://mentalhealth.vermont.gov/publications">http://mentalhealth.vermont.gov/publications</a>				

- 20. *One commenter stated that the new rates will force providers to institute billing quotas, changing the focus from quality to quantity and eliminating the focus of being family/client driven and empowering individuals to be more independent.***

The rate model is intended to reflect the reasonable cost of providing Targeted Case Management services consistent with MaineCare regulations. The reduction to the rate may require providers to adjust their business models, potentially by eliminating supports that are not intended to be covered by TCM such as those discussed in the response to comment 17, 18, and 29, and by increasing productivity as discussed in the response to comment 28. The Department believes that the final proposed rate is aligned with MaineCare requirements and is adequate to support quality services.

- 21. *One commenter suggested that Targeted Case Management should employ a monthly rate in order to better address ‘outliers’.***

The Department considered establishing a monthly rate for Targeted Case Management for the purposes of administrative simplicity. Ultimately, however, DHHS opted to maintain a 15-minute unit rate due to concerns that monthly rates are *less* responsive to individuals with more significant needs.

With a monthly rate, a provider is paid the same amount regardless of the amount of support that they deliver to an individual. In concept, the monthly rate would be established to represent a reasonable average amount of support with some individuals requiring more support and others requiring less. However, since the monthly rate is the same regardless of whether an individual receives one hour of support or ten hours, there is little incentive to serve individuals with more significant needs. With a 15-minute rate, however, the provider is reimbursed for every hour of support they actually provide, thereby earning more for those with greater needs.

As an alternative, DHHS also considered tiered monthly rates by which there would be a range of rates based on the amount of support that an individual requires. However, this approach would require a means to assess acuity for each of the eligible populations and would still result in rates that are not directly aligned with the supports provided, although the variances would be lessened.

## **Eligibility Groups**

- 22. *Several commenters stated that there are differences in costs across eligibility groups. One commenter noted that case management for adults requires more substantial use of EIS and more work related to finance and guardianships. Another commenter noted that homeless young adults require a ‘higher level’ of case management.***

There is currently a single Targeted Case Management rate regardless of population served and the Department intends to maintain this approach. Although the nature of TCM will vary from individual-to-individual and group-to-group, DHHS does not have sufficient data to create differentiated rates and believes that final proposed rate model offers a reasonable system-wide rate.

The comment in regards to a ‘higher level’ of TCM is unclear. In qualitative terms, MaineCare service requirements do not establish any differences in staff qualifications based on eligibility group. In quantitative terms, the use of a 15-minute unit ensures that providers bill for what they deliver so they earn more when they provide a greater amount of support.

**23. *One commenter stated that agencies providing Targeted Case Management for adults with intellectual and developmental disabilities were not invited to participate in the provider survey.***

The provider survey was emailed to all providers that provided Targeted Case Management services in fiscal year 2015 – including those serving adults with intellectual and developmental disabilities – using email addresses on file with DHHS. Responses were received from 11 of these providers.

**Case Manager Wages, Benefits, and Productivity**

**24. *Several commenters objected to the wage assumption in the rate model. One commenter stated that wages must be adequate to employ competent, quality staff and noted that there are no pay increases built into the rate model. Another commenter stated the job classification used as a benchmark in the rate model for case managers is an ‘entry-level direct care position’. For one provider, three of seven case managers have a master’s degree, and wage level for these staff is not accounted for in the rate model. Another commenter notes that they need master’s level staff to serve the homeless population***

The Department agrees that a reasonable wage is an important element in ensuring the quality of case managers and the services they deliver. The wage assumption built into the rate model is intended to reflect the requirements of the position. In particular, the rate model assumption is derived from Bureau of Labor Statistics data for healthcare social workers (standard occupational classification 21-1022).

The TCM rate model uses the 25th percentile wage reported by the BLS for this occupation rather than the 50th percentile (median) that is used in most rate models because the BLS job classification typically requires a master’s degree and, although some providers employ case managers with master’s degrees, this is not a MaineCare requirement or expectation.. DHHS believes the resulting wage assumption built into the rate model – \$20.46 per hour (about \$42,600 per year), which is 20 percent greater than the current \$17.03 weighted average wage reported by providers participating in the provider survey – is reasonable.

The commenter correctly notes that the rate model does not include pay increases in future years, but the assumption is documented so that the Department (and stakeholders) can evaluate its appropriateness on an ongoing basis.

**25. *One commenter asked whether overtime is included in the rate model.***

The rate model does not include a specific assumption related to overtime. That said, as noted in the response to comment 24, the wage assumed in the rate model - \$20.46 per hour – is 20 percent greater than the \$17.03 average reported by providers, which *does* include overtime.

**26. *One commenter stated that the provider survey asked for productivity goals rather than actual productivity.***

The commenter’s statement is not accurate. The survey asked for information about a typical workweek and made no statements regarding agency goals. Quoting from the instructions that accompanied the survey:

This [productivity] section requests information regarding the ‘typical’ week for each case manager for each eligibility group.

*Note:* If a ‘typical’ week is the same regardless of the eligibility group served by your agency’s case managers or if your case managers have ‘mixed’ caseloads of multiple eligibility groups, record the same information in each applicable column.

*Note:* It is understood that the number of hours that a case manager works and how they spend their time may vary from week-to-week. To complete this section of the form, informed judgement will be necessary to consider these variations and determine what constitutes an average week.

- 27. Several commenters stated that the productivity adjustments in the rate model are inadequate and that billable hours are significantly higher than reported in the provider survey. Alternative suggestions ranged from 13 to 23 billable hours per week. One commenter noted that with the statutorily caseload limit of 35, a case manager would need to bill one hour per week for 76 percent of their caseload. Another commenter stated that the rates would require providers to operate at the maximum allowable caseload of 35, but that this is not feasible for case managers serving adults with developmental disabilities, given service requirements such as person-centered planning.**

After making the adjustments related to training and paid time off detailed in the response to comment 5, the rate model assumes that case managers provide 23.29 hours of billable services per week, which translates to 1,211 hours per year.

To provide an equivalent comparison to provider survey results, the rate model assumptions need to be adjusted to add back paid time off and training (since the provider survey did not ask respondents to report paid time off and training as productivity adjustments). As illustrated in Appendix C of the rate model packet, the model assumes that case managers provide 26.50 billable hours of service per week (equivalent to 5.30 hours per workday) *before accounting for training and paid time off.*

Considering the eligibility categories for which there were more than three respondents, providers reported case managers serving adults with intellectual and developmental disabilities deliver 22.48 billable hours per week, case managers serving children with I/DD deliver 23.30 hours, and those serving children with behavioral health disorders deliver 24.22 hours. However, survey respondents also reported spending time on activities that are not part of service requirements, including transporting members and providing ‘after-care’ support. If time spent on these tasks was redirected to billable services, the figures for the aforementioned three eligibility categories would increase to 23.87 hours, 23.79 hours, and 25.21 hours, respectively. Other than these tasks, the categories that account for the largest differences between the provider survey and rate model assumptions are ‘employer time’ such as staff meetings and supervisor counseling and time ‘lost’ due to missed appointments.

Even after accounting for time spent on activities that are not part of the expectations of Targeted Case Management, the rate models assume a greater number of billable hours than reported in the provider survey. The Department believes that the rate model assumptions are reasonable, though it is acknowledged that the resulting rate may require increased efficiency.

The rate model does not include any assumption related to caseload size. As discussed, the rate model assumes that case managers will provide 26.50 billable hours in a typical workweek. If a case manager is serving individuals with more significant needs, it is likely that they will have smaller caseloads while case managers serving persons with relatively fewer needs may have a caseload closer to the 35-case limit in order to generate sufficient billable hours.

**28. Several commenters objected to specific productivity related assumptions, suggesting the model should include:**

- *Between 7.5 and 17 hours per week for recordkeeping including APS Healthcare and Enterprise Information System (EIS) requirements rather than the assumed five hours (before accounting for training and paid time off),*
- *Between 2 and 3.5 hours for weekly employer and one-one supervision time to account for one hour of required supervision as well as staff meetings, peer audits, clinical case reviews, and crisis debriefs rather than the assumed one hour (increased to 1.5 hours as discussed in the response to comment 6),*
- *Between two and two-and-a-half hours per week for missed appointments rather than the assumed one hour, with one provider stating that they experience 10 missed appointments per week when service individuals experiencing homelessness, and*
- *Between 6.5 and 10 hours per week for travel between members rather than the assumed five hours.*

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a case manager may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. As discussed in the response to comment 27, the overall productivity expectation is higher than reported in the provider survey, but DHHS believes the assumption is reasonable.

**29. Several commenters mentioned activities that should be incorporated as a productivity adjustment in the rate models, including:**

- *Support to individuals receiving inpatient care,*
- *After-care support,*
- *Arranging travel,*
- *Coordination efforts with new clients before billing begins,*
- *Sitting in a waiting room or waiting for a meeting to start, and*
- *Employee breaks.*

For the most part, the commenters correctly note that there are not productivity assumptions in the Targeted Case Management rate model related to the activities listed. However, the model does include one hour per week (before adjusting for training and paid time off) for ‘coordination and collateral contacts’, which is intended to account for various non-billable tasks on behalf of an individual such as the type of onboarding described by the commenter as well as time lost due to rounding. In general, the remaining activities are not a requirement or expectation of the service.

The rate model does not account for support providing to someone in an inpatient setting or for ‘after-care’ in which a provider continues to support someone to whom they are no longer providing Targeted Case Management. These supports are excluded from the rate model because they are not an expectation of the service.

The rate model also does not include a provision for employee breaks. According to the Maine Department of Labor, employees have a right to a 30 minute break after six hours of work, but there is no requirement that this break must be paid. Paid breaks are therefore not incorporated in the rate model.

**30. One commenter stated that the rate model does not account for periods when caseloads are not full and low billing months.**

The productivity adjustments are intended to reflect a typical workweek, recognizing that a case manager's actual time will vary from day-to-day and week-to-week for a variety of reasons, including those noted by the commenter. Overall, the Department believes that the assumption that case managers can provide 26.50 hours of billable service per week (5.30 hours per weekday) is reasonable.

**31. One commenter stated that MaineCare requires more than 170 hours of annual training for case managers, but the rate model includes only 39 hours. Other commenters reported that case managers received between 40 and 60 hours annually.**

There is no requirement that case managers receive 170 hours of annual training, and the average reported by participants in the provider survey was 46 hours. In response to this comment and to increase consistency across rate models, training assumed in the Targeted Case Management rate model was increased from 39 hours per year to 52 hours. This is intended to be an average across all case managers, recognizing that there are more training requirements in the first year of employment and less in subsequent years. The Department believes that this assumption is adequate to accommodate required training.

### **Travel, Operating, and Overhead Costs**

**32. Several commenters stated that the rate model assumption that case managers travel 175 miles per week is inadequate, with alternative proposals ranging from 183 to 500 miles. Specific concerns were expressed for the rural parts of the State. One commenter suggested that travel should be a separately billable service.**

As the commenters note, the rate model assumes that case managers travel 175 miles per week. This assumption was derived from the provider survey. Considering the eligibility categories for which there were more than three surveys submitted, respondents to which reported an average of 169 miles per week (adults with intellectual and developmental disabilities), 190 miles (children with I/DD), and 166 miles (children with behavioral health disorders).

This rate model assumption – like all others – is intended to be a reasonable average across all providers. For any given provider, some costs are likely to be less than assumed in the rate model and others are likely to be greater. For a provider operating in a rural area, it is almost certainly true that their case managers will drive more. However, these higher costs may be offset by lower costs in other areas such as office space or wages.

**33. One commenter noted that the rate model does not include the cost of tolls, parking, and ferry rides.**

The commenter is correct that there is not a specific assumption related to these costs. Rather, these expenses are intended to be included in the agency administration and program support funding included in the rate models and discussed in the response to comment 11.

**34. Several commenters objected to the assumptions related to office space, with some noting their costs are 'almost twice as high' and others asking how common space is incorporated.**

See the response to comment 13.

- 35. One commenter calculated that their costs are \$19.11 per billable 15-minute unit compared to the current rate of \$21.52, and noted that a reduced rate would eliminate their profit. Another commenter stated that the rate model does not account for ‘program growth’.**

As noted in the response to comment 9, the rate models resulting from this rate review do not include a factor for agency profits or surpluses. Since the rate model assumptions are not mandates, Targeted Case Management agencies may earn a profit by reducing costs below those assumed in the rate model (for example, by lowering overhead costs).

## SECTION 17 GENERALLY

- 36. One commenter stated that, due to changes in Section 17 regulations, historic cost data will not represent future needs.**

Recent changes to Section 17 rules have focused on establishing clear clinical criteria for services. Expectations associated with service delivery have not changed and the Department believes that the new rates are sufficient to cover the cost of services consistent with MaineCare requirements.

- 37. One commenter stated that eligibility for Section 17 services should not be restricted and that Section 65 Outpatient services and behavioral health homes will not meet the needs of those who lose Section 17 eligibility.**

Eligibility-related issues are outside of the scope of the rate review.

## COMMUNITY INTEGRATION (SECTION 17)

### General

- 38. One provider asked how the current rate developed.**

The process for developing the current rate was similar to this more recent rate study, in that it included assumptions related to the wages and benefits for the MHRT/C providing services, the number of billable hours of service that they provide, and agency overhead costs.

Comparing the two sets of figures, the final proposed rate model resulting from this recent rate study is about six percent greater for MHRT/C wages and benefits while the previous calculation provided significantly more funding for other operating, support, and administrative costs (42 percent of total costs compared to 32 percent). Overhead funding is discussed in the response to comment 13.

Most significantly, the previous calculation assumed many fewer billable hours, assuming that staff have only 44 workweeks and provide 21 hours of billable service per week, for a total of 924 billable hours per year. In contrast, the final proposed rate model assumes that MHRT/C’s provide 1,211 billable hours of service per year, which is discussed in greater detail in the response to comment 43.

- 39. One commenter stated that this is the only case management service available for individuals who are not eligible for MaineCare so, if the service is lost, members will not be able to access behavioral health homes as MaineCare members may.**

The intent of the rate change is to align payments with service requirements, not to eliminate access to Community Integration services. That said, the Department will work with individuals whose providers opt to discontinue services in order to identify other options.

## Staff Wages, Benefits, and Productivity

- 40. One commenter reported paying MHRT/C's providing Community Integration \$0.83 per hour more than assumed in the rate model. Another commenter suggested that the position use the same wage assumption as Targeted Case Management.**

After incorporating newer Bureau of Labor Statistics data that became available after the proposed rates were published (as discussed in the response to comment 1), the wage assumption for MHRT/C's increased from \$18.44 to \$19.18 (very close to the \$19.27 implied by the commenter).

The wage assumption is substantially greater than the \$15.48 per-hour average for Community Integration staff reported by provider survey respondents, but is intended to reflect the duties and requirements of the job. The wage assumptions in the Targeted Case Management and Community Integration rate models differ due to differences in staff requirements.

- 41. One commenter explained that, due to a shortage of MHRT/C's, provisional certifications were established. The commenter noted that these provisional staff require additional supervision, which is not incorporated in the rate model.**

The Community Integration rate model includes 1.5 hours per week for supervision and other employer time (increased from one hour in the proposed rate model as discussed in the response to comment 6), which as the commenter notes, may not be sufficient for provisional staff. However, it is likely that provisional staff earn less than the wage for 'full' MHRT/C's assumed in the rate model and that reduced costs for wages would offset the cost of additional supervision.

- 42. Several commenters stated that the productivity adjustments in the rate model are inadequate and that billable hours are significantly higher than reported in the provider survey. Alternative suggestions ranged from 21 to 24 billable hours per week.**

After making the adjustments related to training and paid time off detailed in the response to comment 5, the rate model assumes that MHRT/C's provide 23.29 hours of billable services per week, which translates to 1,211 hours per year.

To provide a fair comparison to provider survey results, the rate model assumptions need to be adjusted to add back paid time off and training (since the provider survey did not ask respondents to report paid time off and training as productivity adjustments). As illustrated in Appendix C of the rate model packet, the model assumes that MHRT/C's provide 26.50 billable hours of service per week (5.30 hours per workday) *before accounting for training and paid time off*, which does exceed the amounts reported by provider survey respondents.

Survey participants reported that MHRT/C's providing Community Integration services deliver 24.95 billable hours per week. However, providers also reported that staff spend an average of 1.80 hours per week transporting members, which is not an expectation of the service (unless it is associated with a covered service as defined in the MaineCare Benefits Manual; for example, if the member had trauma associated with driving and the transportation was associated with addressing this issue, such time would be billable). If these hours were redirected to billable activities, the reported total would increase to 26.75 hours per week, effectively equal to the rate model assumption. The Department believes the overall productivity expectation is reasonable although it is acknowledged that a provider with staff providing less than 5.30 billable hours per workday may need to increase efficiency.

**43. Several commenters objected to specific productivity related assumptions, suggesting the model should include:**

- *Nine hours per week for recordkeeping – including APS continued stay reviews, ISP development, and progress notes – rather than the assumed five hours (before accounting for training and paid time off),*
- *Three-and-a-half hours for weekly employer and one-one supervision time to account for one hour of required supervision as well as staff meetings, peer audits, clinical case reviews, and crisis debriefs rather than the assumed one hour (increased to 1.5 hours as discussed in the response to comment 6),*
- *Two hours per week for missed appointments rather than the assumed one hour, particularly given that providers are working with persons with chronic mental health issues, and*
- *More than the five hours assumed for travel between members.*

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, an MHRT/C may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. As discussed in the response to comment 42, the overall productivity expectation is very close to the average reported by provider survey participants and the Department believes the overall productivity expectation is reasonable.

**44. One commenter stated that the rate model does not account for caseload build-up or members transitioning out of service.**

The productivity adjustments are intended to reflect a typical workweek, recognizing that an MHRT/C's actual time will vary from day-to-day and week-to-week for a variety of reasons, including those noted by the commenter. Overall, the Department believes that the assumption that staff can provide 26.50 hours of billable service per week or (5.30 hours per workday) is reasonable.

There is no specific productivity adjustment in the rate model to account for turnover. The overall rates are intended to be a reasonable average across all staff. New staff may have lower productivity, but it is also likely that they receive a lower wage.

**45. Several commenters stated that the rate model assumption for non-billable coordination and collateral contacts is inadequate. Another commenter stated that the rate model does not include time for participation in four-to-five assessments per year or time for a clinician to review assessment results.**

Coordination and collateral contacts are generally billable Community Integration activities. The Community Integration rate model includes one hour per week (before adjusting for paid time off and training as discussed in the response to comment 5) for non-billable coordination and collateral contacts such as time lost due to rounding in order to mirror the assumption in the Targeted Case Management rate model.

The rate model does not include a productivity adjustment for participation in assessments because staff are permitted to bill for this time.

Costs associated with agency clinicians are incorporated in the administration and program support factors discussed in the response to comment 11.

- 46. One commenter stated that the rate model assumption for training is insufficient and that 50 hours per year should be included. Another commenter suggests that staff require 129 hours in the first year, which incorporates time to ‘gain knowledge’ of their caseload, including ‘spending time with the individual’.**

The annual training hour assumption in the Community Integration rate model has been increased from 39 hours to 52 hours in order to ensure consistency across services with MHRT/C positions. This assumption recognizes that there are more training requirements in the first year of employment and less in subsequent years. This assumption is close to the 57-hour average reported by participants in the provider survey and the Department believes it is adequate to accommodate required training.

### **Travel, Operating, and Overhead Costs**

- 47. Several commenters stated that the rate model assumption that staff travel 175 miles per week is inadequate, particularly in rural parts of the State. One commenter suggested that the rate model assume 280 miles per week.**

As the commenters note, the rate model assumes that MHRT’s providing Community Integration services travel 175 miles per week, the same as assumed in the Targeted Case Management rate model. The assumption is less than the 221-mile average reported by provider survey participants, although half of the respondents reported between 150 and 200 miles per week.

This rate model assumption – like all others – is intended to be a reasonable average across all providers. For any given provider, some costs are likely to be less than assumed in the rate model and others are likely to be greater. For a provider operating in a rural area, it is almost certainly true that their staff will drive more. However, these higher costs may be offset by lower costs in other areas such as office space or wages.

- 48. Several providers objected to the amount of overhead funding incorporated in the rate model. One stated that the overhead rate, equivalent to 23 percent, is significantly less than reported in the provider survey and insufficient to comply with data collection and reporting requirements. Another commenter noted that the rate assumes an overhead cost of \$13.10 per billable hour while they calculate their cost to be \$17.80.**

With the changes to the Community Integration rate model discussed elsewhere in this document, the administrative and program support funding incorporated in the rate model is about 26 percent of the total rate – excluding the service provider tax – or \$15.73 per billable hour. As noted by the commenter, this is significantly less than reported by provider survey respondents.

Of the 16 providers reporting data for Community Integration services, seven reported an overhead rate in excess of 50 percent. Of the remaining nine providers, the average rate was 46.5 percent and the median was 43.1 percent. As discussed in the response to comment 11, it is generally true that the rate models assume less overhead funding than reported in the provider survey as the Department is concerned that generous payment rates have resulted in unnecessarily high overhead rates such as the nearly 50 percent rate reported by Community Integration providers. Rather, the overhead assumptions were derived in large measure from previous rate reviews for Section 65 crisis services and Section 92 behavioral health homes.

The Department believes that the overall rate for Community Integration is adequate to deliver the service, noting that the rate is within the range of Targeted Case Management rates elsewhere in New England.

**49. One commenter stated that the rate model does not include costs associated with information technology, supervision, administration, marketing, and financial support costs.**

This comment is not accurate; see the response to comment 10. Although the rate models do not include specific assumptions related to individual categories of overhead costs, each of the costs listed by the commenter are intended to be covered by the administration and program support components of the rate models.

**50. One commenter suggested that there should be a standalone factor in the rate model for clinical oversight. Another commenter suggested that the model should include a support position as do Section 65 services, although this service requires screening, scheduling, billing, and marketing.**

In general, the rate models do not attempt to detail specific administrative and support positions as agencies have different internal structures and these other positions often support multiple services or programs. Rather, overhead funding is comprised of a per-day amount for program support and administrative costs calculated as a percentage of the total rate. Certain services – such as Section 65 Outpatient Therapy and Medication Management – do include an additional position that is assumed to provide direct support such as scheduling and office management needed for short-duration, office-based services. For most services, however, this support is intended to be incorporated in the overall administration and program support assumptions.

**51. One commenter expressed appreciation for the inclusion of dedicated office space for MHRT/C's providing Community Integration services, but stated that the assumption does not account for common areas, which would triple the per-person allocation.**

See the response to comment 13.

**52. One commenter suggested that since the rate is being reduced, there will not be sufficient funding for the service provider tax.**

Since the service provider tax is calculated as a percentage of the payment rate, providers' tax obligation would be reduced proportional to the rate reduction. That is, if a rate is decreased by ten percent, the tax obligation is also reduced ten percent. The rate model includes funding for the service provider tax at the current six percent tax rate.

## **DAILY LIVING SUPPORT SERVICES (SECTION 17)**

### **Staff Wages, Benefits, and Productivity**

**53. One commenter stated that the rate model should include three-and-a-half hours for weekly employer and one-on-one supervision time to account for one hour of required supervision as well as staff meetings, peer audits, clinical case reviews, and crisis debriefs.**

As discussed in the response to comment 6, the productivity assumption related to employer and one-on-one supervision time has been increased to 1.5 hours per week (before adjusting for paid time off and training). Overall, the rate model assumes that staff provide 34.25 hours of billable services in a typical week. For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a staff person may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task.

Although the productivity assumption is somewhat greater than the 32.60-hour average reported by provider survey respondents, the Department believes it is a reasonable expectation.

**54. *One commenter stated that the rate model does not include time for participation in four-to-five assessments per year or time for a clinician to review assessment results.***

The Daily Living Support Services rate model does include a productivity adjustment for staff to participate in assessments and planning meetings. Specifically, the model provides about 11.5 hours per year for participating in non-billable assessments and planning meetings.

Costs associated with agency clinicians are incorporated in the administration and program support factors discussed in the response to comment 11.

**55. *One commenter stated that the rate model assumption for training is insufficient and that 50 hours per year should be included. Another commenter suggested that staff require 209 hours in the first year, which incorporates time to ‘gain knowledge’ of their caseload, including ‘spending time with the individual’.***

The Daily Living Support Services rate model includes 52 hours of training per year, which is intended to be an average across all staff, recognizing that there are more training requirements in the first year of employment and less in subsequent years. This assumption exceeds the 26-hour average reported by participants in the provider survey and the Department believes it is adequate to accommodate required training.

### **Travel, Operating, and Overhead Costs**

**56. *One commenter objected to the travel assumptions in the rate model – two hours per week per staff for travel time between members and 100 miles – are inadequate as they require staff to drive 50 miles per hour and they do not account for the fact that the service may be provided for as little as 15 minutes (meaning that there will be more unique visits).***

The mileage assumption in the rate model includes both miles driving to and from member visits and miles associated with transporting members. Time associated with the latter category of travel is billable so the associated hours would not be included in a productivity adjustment – the rate model therefore does not assume that staff must drive 50 miles per hour.

The assumption regarding the number of miles was derived from the provider survey, respondents to which reported that staff drive an average of 90 miles per week. There may be instances in which this service is provided for only 15 minutes, and in such cases staff may be driving more frequently, but this is atypical of the service (claims with a single unit of service account for one-half of one-tenth of one percent of all billed units, although there may be instances in which service units have been ‘collected’ and submitted to cover a span of a week or month such that the length of individual visits cannot be determined). Overall, the Department believes that the mileage assumption is reasonable.

**57. *One commenter stated that, while this is a community-based service and dedicated office space is not necessary, staff need access to workspaces, computers, etc.***

As discussed in the response to comment 13, the rate models resulting from this rate review generally incorporate administrative space and common areas (such as lobbies, hallways, conference rooms, and bathrooms) in the administrative and program support assumptions discussed in the response to comment 11. For services for which it is expected that staff have dedicated offices – such as clinicians delivering Outpatient Therapy – the rate models include additional funding for this

dedicated space. As the commenter notes, it is not expected that these staff have their own offices so no additional funding is included in the model.

## **SKILLS DEVELOPMENT (SECTION 17)**

### **Staff Wages, Benefits, and Productivity**

**58. *One commenter explained that, due to a shortage of MHRT/C's, provisional certifications were established. The commenter noted that these provisional staff require additional supervision, which is not incorporated in the rate model.***

The Skills Development rate model includes 1.5 hours per week for supervision and other employer time (increased from one hour in the proposed rate model as discussed in the response to comment 6), which as the commenter notes, may not be sufficient for provisional staff. However, it is likely that provisional staff earn less than the wage for 'full' MHRT/C's assumed in the rate model and that reduced costs for wages would offset the cost of additional supervision.

**59. *One commenter stated that the rate model does not include time for participation in four-to-five assessments per year or time for a clinician to review assessment results.***

The Skills Development rate model does include a productivity adjustment for staff to participate in assessments and planning meetings. Specifically, the model provides about 11.5 hours per year for participating in non-billable assessments and planning meetings for staff providing one-to-one services (the assumption increases proportionally for staff serving groups of individuals).

Costs associated with agency clinicians are incorporated in the administration and program support factors discussed in the response to comment 11.

**60. *One commenter stated that the rate model assumption for training is insufficient and that 50 hours per year should be included. Another commenter suggested that staff require 169 hours in the first year, which incorporates time to 'gain knowledge' of their caseload, including 'spending time with the individual'.***

The Skills Development rate model includes 52 hours of training per year, which is intended to be an average across all staff, recognizing that there are more training requirements in the first year of employment and less in subsequent years. This assumption exceeds the 35-hour average reported by participants in the provider survey and the Department believes it is adequate to accommodate required training.

### **Travel, Operating, and Overhead Costs**

**61. *One commenter stated that, while this is a community-based service and dedicated office space is not necessary, staff need access to workspaces, computers, etc.***

As discussed in the response to comment 13, the rate models resulting from this rate review generally incorporate administrative space and common areas (such as lobbies, hallways, conference rooms, and bathrooms) in the administrative and program support assumptions. For services for which it is expected that staff have dedicated offices – such as clinicians delivering Outpatient Therapy – the rate models include additional funding for this dedicated space. As the commenter notes, it is not expected that these staff have their own offices so no additional funding is included in the model.

## DAY SUPPORT (SECTION 17)

### Staff Wages, Benefits, and Productivity

- 62. *One commenter recommended that three different rates be established: one that assumes all support is provided by an MHRT/C, one that assumes 50 percent of the support is provided by an MHRT/C and 50 percent is provided by a clinician, and one that assumes all support is provided by a clinician.***

The Department is not establishing new service requirements for Day Support at this time. Thus, the rate model reflects existing requirements that the service is provided by an MHRT/C (noting that the service may be co-facilitated by a mental health professional).

### Travel, Operating, and Overhead Costs

- 63. *One commenter suggested that the daily per-person cost for program supplies should be increased from \$1 to \$6 in order to cover the cost of providing lunch to members.***

Providers may choose to offer a meal or snack, but are not required to do so. Food costs therefore are not incorporated in the rate model.

## ASSERTIVE COMMUNITY TREATMENT (SECTION 17)

### General

- 64. *One commenter suggested eliminating the requirement that each service recipient receive a minimum of three weekly contacts.***

The three-contact requirement will be retained as regular contacts are an important determinant of program success.

### Staff Wages, Benefits, and Productivity

- 65. *One commenter stated that the wage assumption for a psychiatrist should be increased.***

The wage assumptions in the rate models are generally tied to Bureau of Labor Statistics wage data for occupations that reflect the requirements of each service. As with the other services, the wage for psychiatrists in the draft proposed rate models was derived from the May 2014 BLS dataset. The BLS does not report wage percentiles for wages that exceed \$90 per hour so the rate models used the reported average (mean) of \$89.01 per hour (about \$185,000 per year).

In response to this comment as well as similar comments for Medication Management services covered by Section 65, the Department reevaluated the wage assumption. The May 2015 data that was released after the rate models were posted for public comment did not include estimates for psychiatrist wages. Evaluating previous datasets, the average wage from the May 2013 data was \$111.69 per hour (about \$232,000 per year) and was \$111.73 in the May 2012 data. Consequently, the final proposed rate model has been revised to reflect the average from the May 2013 data, which is the same wage assumption included in the Section 65 crisis services rate models developed in 2015.

## COMMUNITY REHABILITATION SERVICES (SECTION 17)

### General

**66. *One commenter suggested that the proposed rate increase is unnecessary.***

As with all services, the Community Rehabilitation Services rate model is intended to reflect the costs associated with providing the service consistent with MaineCare requirements. For CRS, the rate review suggested that the payment rate should be increased. The Department did further evaluate the rate model. As a result, minor changes to productivity adjustments were made as discussed in the response to comment 67 and the assumption regarding on-call payment was eliminated as three of five provider survey respondents did not report making separate on-call payments.

With these changes, the final proposed rate represents a 59 percent increase over the current rate.

### Staff Wages, Benefits, and Productivity

**67. *One commenter stated that the rate model does not include time for participation in four-to-five assessments per year or time for a clinician to review assessment results.***

Community Rehabilitation Services is reimbursed on a daily basis – accounting for the full cost of the shifts worked by MHRT I's and MHRT/C's – rather than on a billable hour basis. As such, the only productivity adjustments included in the rate model are those that prevent staff from being available to provide services and therefore require replacement staff to cover their shift. For example, if a staff person is on paid leave or attending training, a substitute would be required to fill-in. Assessments could be completed onsite so that substitute staff are not necessary. For similar reasons, the productivity adjustment for supervision and other employer time has been removed.

Costs associated with agency clinicians are incorporated in the administration and program support factors discussed in the response to comment 11.

## CHILDREN'S HABILITATIVE SERVICES (SECTION 28)

### General

**68. *One commenter asked whether the proposed rates apply to school-based services.***

School-based services will be reimbursed at the 'Center-Based' rates. To make this clearer, the label for these rates has been changed to 'Center- and School-Based'.

**69. *One commenter noted that the rate models do not account for buildings and certified teachers. One commenter stated that the rate models should account for expenses associated with the Department of Education's Child Information Network Connection (CINC) requirements.***

The rate is intended to cover the cost of treatment services only. For school-based programs, education-related costs should be covered by a school's educational funding or tuition. For instance, State regulations at 05-071 C.M.R. ch. 101, § XVIII (2015) specify that tuition for special purpose private schools should provide for the 'development and/or implementation of individualized educational programs':

### C. Tuition Computation: Special Purpose Private Schools

The daily tuition rate at a special purpose private school shall be the sum of allowable expenditures divided by the number of student days. For purposes of this computation:

- (1) Allowable expenditures, calculated for the fiscal year (July 1 to June 30) immediately before the fiscal year for which the tuition rate is computed, include only the following:
  - (a) Compensation of employees for the time spent on, and specifically identified as related to, the development and/or implementation of individualized educational programs;
  - (b) Costs of materials acquired, consumed, or expended specifically for the development and/or implementation of individualized educational programs;
  - (c) Equipment and other approved capital expenditures necessary for the development and/or implementation of individualized educational programs;
  - (d) Travel expenses incurred specifically for the development and/or implementation of individualized educational programs; and
  - (e) Indirect costs necessary for the development and/or implementation of individualized educational programs

Although capital expenditures are an educational expense, the rate model does include funding for additional space costs to accommodate treatment services. Specifically, the rate model includes 35 square feet of program space for each child<sup>4</sup> and each staff person (the rate models for group services were adjusted to provide that additional 35 square feet for each additional child).

**70. Several commenters noted differences in costs across service delivery models. One commenter stated that costs are higher for agencies that operate their own locations compared to those providing services at a facility they do not operate. Several commenters stated that center-based services should not be less than for in-home services because of higher overhead costs.**

The rate models for Section 28 services are intended to reflect the cost of delivering these services, consistent with MaineCare regulations. There are different rates for Center-Based and Home- and Community-Based services due to assumed differences in costs. While Center-Based programs have facility costs that Home- and Community-Based services do not, the latter model has travel related expenses (staff time and mileage) that increase the total cost of this service model.

For any given provider, some costs are likely to be less than assumed in the rate model and others are likely to be greater. For Center-Based services, a provider that does not need to pay for program space may well have costs that are less than assumed in the rate models. However, the models include funding for program space for those providers operating their own location.

**71. One commenter suggested that there should be a rate for two BHPs to deliver services to one child.**

The Department is not establishing a two-to-one rate for this service at this time.

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<sup>4</sup> State regulations at 05-071 C.M.R. ch. 124, § 9 requires at least 35 square feet per child in public preschool programs while the Department of Education's Space Allocation Guidelines for classroom sizes found at <https://www1.maine.gov/doe/facilities/construction/2%20%20%20Space%20Allocation%20Guidelines%20Revised%20January%202015.pdf> and maximum class sizes at 05-071 C.M.R. ch. 125, § 7 implies between 27 and 50 square feet per student in kindergarten through high school classrooms.

- 72. One commenter suggested that providers should be paid regardless of a service recipient's attendance. Another commenter stated that center-based programs have only a 45-week work year due to school vacations and holidays.**

The Department disagrees with paying for services that are not delivered.

In regards to programs' days of operation, the rate model does not include a specific assumption except for the number of service hours across which capital costs for center-based services are amortized. For this purpose, the rate model assumed that a slot is filled 1,275 hours per year. This assumption was derived from the provider survey, in which respondents reported that, on average, programs are in operation 250 days per year and children attend 25 hours per week. In response to these comments and after a review of claims data, this assumption has been reduced to 1,000 hours per year (which has the effect of increasing the rate). The adjustment only impacts the fixed capital cost (for example, the model does not assume that staff receive seven weeks of paid leave).

### **Staff Wages, Benefits, and Productivity**

- 73. Several commenters objected to the assumed wage for behavioral health professionals. One commenter stated that the assumed wage is inadequate for staff with bachelor's degrees. Another commenter stated that there should be different wage assumptions for Section 28 and Section 65 Children's Behavioral Health Day Treatment services due to different staff requirements. Other commenters suggested that BHPs providing specialized services should receive a higher wage than those providing 'regular' services, with one suggesting \$16.65 per hour.**

After updating wage assumptions using new Bureau of Labor Statistics data as discussed in the response to comment 1, the Section 28 rate models assume that BHPs earn \$15.04 per hour. This is significantly more than the \$12.07 and \$13.87 per hour averages for 'regular' and specialized services, respectively, reported by respondents to the provider survey.

Current regulations require only that staff have a high school diploma or equivalent in addition to their BHP certification. This requirement is the same for both regular and specialized services. In order to standardize requirements across Section 28 and Section 65 Children's Behavioral Health Day Treatment services, the Department intends to establish a common requirement of 60 documented college credit hours or continuing education units (with a process to grandfather existing staff). The \$15.04 per hour wage assumptions in the Section 28 and Section 65 Children's Behavioral Health Day Treatment services reflect these requirements.

In response to these comments, the Department has also established rates for BHPs that have a four-year college degree. These models assume a wage of \$22.02 per hour.

- 74. Several commenters objected to the assumption that staff provide 32.25 hours of billable service per week when members are limited to 30 hours.**

There is not a 30-hour limit for Section 28 services in MaineCare rules and a review of claims data demonstrates that, although comprising a small percentage of total program enrollment, some number of children receive more than 30 hours per week.

The assumptions related to billable hours are intended to reflect the number of billable hours that would be required to justify a 40-hour workweek. As the commenters note, the proposed Section 28 rate models for one-to-one Center- and School-Based services assumed that a 40-hour workweek would yield 32.25 billable hours. This could be achieved, for example, if a BHP works with a child receiving more than 30 hours or works with more than one child. Or, if a BHP provides fewer billable hours, it would be expected that they work fewer than 40 hours per week such that the ratio of billable hours to total hours (which is the figure that actually affects the rate) would be unchanged.

To better reflect actual practices, though, the total workweek was adjusted downwards to 36 hours per week for Center- and School-Based services and 38 hours per week for Home- and Community-Based services. This is more in-line with information from the provider survey in which most respondents reported that staff work fewer than 40 hours per week. Hours of paid time off were similarly adjusted and the assumption for employer and one-on-one supervision time was increased as discussed in the response to comment 6, but other productivity factors were unchanged so that the productivity adjustment increased overall. The rate models now assume that staff deliver 28.75 billable hours of service per week (about 25 hours after accounting for training and paid time off).

**75. Several commenters objected to specific productivity related assumptions, suggesting the model should include:**

- *Three to four hours for weekly employer and one-one supervision time to account for one hour of required supervision as well as staff meetings, peer audits, clinical case reviews, and crisis debriefs rather than the assumed one hour (one commenter stated that their staff are required to attend a three-hour group training session every week),*
- *One to four hours per week for missed appointments – a 15 percent absence rate – rather than the assumed half-hour (some commenters objected to the ‘expectation’ that staff be sent home if a member misses an appointment),*
- *45 minutes per week for classroom planning and preparation, and*
- *Five hours for travel between members rather than the assumed two hours.*

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a BHP may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. For a center-based service, the Department believes it is reasonable to expect BHPs to spend 80 percent of their time providing services before accounting for training and paid time off (the expectation for home- and community-based services is 76 percent).

**76. One commenter suggested that providers be permitted to bill for meeting with families, training new staff, observing students, creating new teaching materials, and writing plans.**

The Department is not proposing any changes to covered (billable) activities for Section 28 services. Rather, the activities cited by the commenter would be part of the productivity assumptions when performed by direct service staff and part of the program support assumption when performed by other agency staff.

**77. One commenter stated that training requirements are significant and should be specifically built into the rate model, noting that staff receive two hours of training per month. Another commenter stated that training requirements for specialized services are more significant than for ‘regular’ services, but the rate models provide the same amount.**

Training is built into the rate model as a productivity adjustment of one hour per week (52 hours per year). In response to this comment, training time for staff providing specialized services has been increased to 1.25 hours per week (65 hours per year).

### **Travel, Operating, and Overhead Costs**

**78. One commenter stated that the fixed program support cost does not adequately fund more intensive services.**

See the response to comment 11.

**79. Several commenters noted that the service provider tax should be included in the rate models.**

The commenters are correct and the rate models have been adjusted to include the six percent service provider tax.

**Board Certified Behavior Analyst (BCBA)**

**80. One commenter stated that the assumed wage for a BCBA is inadequate and should be at least \$76 per hour.**

The rate model assumes a wage of about \$36.19 per hour (\$75,300 annually) based on the median wage in Maine for a school psychologist – the category in which BCBAs are currently assigned – according to the Bureau of Labor Statistics. Few participants in the provider survey reported employing BCBAs and those that did generally reported a lower wage than assumed in the rate model (although it was not always clear whether these staff were employed on a full-time basis). At this time, the Department is not revising the wage assumption, but intends to monitor the utilization of this new service to determine whether adjustments to the rate may be necessary.

**81. Several commenters asked for what activities BCBAs will be permitted to bill. One commenter suggested that BCBAs be able to bill anything that is exclusive to a consumer, including data analysis, report writing, and parent training.**

The Department intends to work with providers and other stakeholders on defining what BCBA activities should be billable before MaineCare rules to implement the new rates are promulgated. As discussed in the response to comment 82, the cost of the BCBA is already incorporated in the rate for Specialized services, so the discussion will focus on what ‘extraordinary’ responsibilities should be billable.

**82. Several commenters asked why so many billable hours (38.75) are assumed in the rate model. One commenter stated that the BCBA rate should include travel time, recordkeeping, and supervision. Another commenter suggested a more substantial unbundling of BCBAs such that productivity is built into the BCBA rate, but the BCBA allowance in the other rates is substantially reduced.**

Costs associated with BCBAs are incorporated in the rate models for Specialized services. Specifically, these rate models include the full cost of a BCBA’s wages and benefits for every six BHPs. Since the costs of a BCBA are ‘paid for’ through the billing of the BHPs that they oversee, the rate model for direct BCBA billing includes few productivity adjustments (for employer and one-on-one supervision time, training, and paid time off).

The Department considered uncoupling BCBAs’ cost from the rate models for Specialized services so that the full cost of the BCBA is recognized in the direct billing model rather than spread across Specialized services, but was concerned it did not have enough information about the day-to-day activities of a BCBA to fully understand the implications of such a change. Rather, as noted in the response to comment 80, the Department intends to monitor the utilization of this new service to determine whether adjustments to the rate may be necessary.

**83. Several commenters asked how the ratio of one BCBA for every six BHPs was determined. One commenter noted that this assumption does not account for turnover resulting in a BCBA supervising fewer staff (such that there is not enough billing by BHPs to cover the cost of the BCBA).**

The BCBA-to-BHP staffing ratio was determined based primarily on input from the provider advisory group for Section 28 services. Most of these representatives stated that the one-to-six ratio is typical of their operations. Among the limited provider survey responses, the ratio ranged from two to 23

BHPs per BCBA. The one-to-six ratio is intended to be a reasonable average though it is possible that there may be times when the ratio is larger or smaller (due to turnover or other reasons).

**84. *One commenter noted that the rate model included an error in that the cost of office space built into the rate model was not included in the final rate calculation.***

The commenter is correct and the rate model has been revised.

## **CHILDREN’S BEHAVIORAL HEALTH DAY TREATMENT (SECTION 65)**

### **General**

**85. *One commenter asked whether the proposed rates apply to school-based services.***

The rates do apply to school-based services (by rule, Children’s Behavioral Health Day Treatment services must be delivered in conjunction with an educational program).

**86. *Several commenters disagreed with the presumption that Children’s Behavioral Health Day Treatment services are equivalent to Section 28 services.***

Although individual programs may differ, the Department believes that there is significant overlap in the factors that drive costs, including children’s eligibility, services provided, and staff qualifications. Consequently, the rate models for Children’s Behavioral Health Day Treatment and ‘regular’ Section 28 services are the same (and the BCBA component has been removed from the Day Treatment rate model since it is not a requirement of the service as it is for Specialized Section 28 services). Clinicians that provide Day Treatment services continue to bill the Master’s rate.

One existing difference between Day Treatment and Section 28 services relating to staff qualifications is being standardized. Both services require that staff be behavioral health professionals, but current regulations require 90 college hours for staff providing Children’s Behavioral Health Day Treatment compared to no college requirement to deliver Section 28 services. The Department is going to revise this standard to 60 college hours for both services. Additionally, DHHS is establishing new rates for BHPs with bachelor’s degrees.

**87. *Several commenters noted that the rate models do not account for an occupational therapy gym, playground, or kitchen, and do not account for other Department of Education requirements such as supervision by a certified teacher and a special education director. One commenter stated that the rate models should account for expenses associated with the Department of Education’s Child Information Network Connection (CINC) requirements.***

The rate is intended to cover the cost of treatment services only. Education-related costs should be covered by a school’s educational funding or tuition. For instance, State regulations at 05-071 C.M.R. ch. 101, § XVIII (2015) specify that tuition for special purpose private schools should provide for the ‘development and/or implementation of individualized educational programs’:

**C. Tuition Computation: Special Purpose Private Schools**

The daily tuition rate at a special purpose private school shall be the sum of allowable expenditures divided by the number of student days. For purposes of this computation:

- (1) Allowable expenditures, calculated for the fiscal year (July 1 to June 30) immediately before the fiscal year for which the tuition rate is computed, include only the following:
  - (a) Compensation of employees for the time spent on, and specifically identified as related to, the development and/or implementation of individualized educational programs;

- (b) Costs of materials acquired, consumed, or expended specifically for the development and/or implementation of individualized educational programs;
- (c) Equipment and other approved capital expenditures necessary for the development and/or implementation of individualized educational programs;
- (d) Travel expenses incurred specifically for the development and/or implementation of individualized educational programs; and
- (e) Indirect costs necessary for the development and/or implementation of individualized educational programs

Although capital expenditures are an educational expense, the rate model does include funding for additional space costs to accommodate treatment services. Specifically, the rate model includes 35 square feet of program space for each child<sup>5</sup> and each staff person (the rate models for group services were adjusted to provide that additional 35 square feet for each additional child).

**88. *Several commenters stated that the rate models disadvantage preschool programs that do not receive tuition.***

The Department intends to further explore the issues of preschool-related costs and funding sources with the Department of Education and service providers. Pending this conversation, the Department is withdrawing the final proposed rate models for preschool programs, though these rates continue to apply to services for school-age children.

**89. *One commenter stated that the rate models do not account for the fact that programs do not operate year-round.***

The Children's Behavioral Health Day Treatment rate models do not include a specific assumption regarding weeks or months of operation except for the number of service hours across which capital costs are amortized. For this purpose, the draft proposed rate model assumed that a slot is filled 1,275 hours per year. This assumption was derived from the provider survey. In response to these comments and after a review of claims data, this assumption has been reduced to 1,000 hours per year (which has the effect of increasing the rate). The adjustment only impacts the fixed capital cost (for example, the model does not assume that staff receive seven weeks of paid leave).

### **Staff Wages, Benefits, and Productivity**

**90. *Several commenters objected to the assumed wage for behavioral health professionals. One commenter stated that there should be different rates for BHPs that are 'support staff' (ed techs) and for BHPs that are 'supervisory staff' (teachers). One commenter stated that the assumed wage is inadequate for staff with bachelor's degrees. Another commenter noted that the average starting wage across ten select school districts is \$15.26 per hour.***

After updating wage assumptions using new Bureau of Labor Statistics data as discussed in the response to comment 1, the Children's Behavioral Health Day Treatment rate models assume that BHPs earn \$15.04 per hour. This is greater than the \$14.11 average for BHPs reported by respondents to the provider survey.

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<sup>5</sup> State regulations at 05-071 C.M.R. ch. 124, § 9 requires at least 35 square feet per child in public preschool programs while the Department of Education's Space Allocation Guidelines for classroom sizes found at <https://www1.maine.gov/doe/facilities/construction/2%20%20%20Space%20Allocation%20Guidelines%20Revised%20January%202015.pdf> and maximum class sizes at 05-071 C.M.R. ch. 125, § 7 implies between 27 and 50 square feet per student in kindergarten through high school classrooms.

Current regulations do not require that staff have a bachelor's degree. Rather, as noted in the response to comment 86, the current requirement is 90 college hours, which DHHS intends to reduce to 60 hours. However, to accommodate staff that do have bachelor's degrees, new rate models are being established with an assumed wage of \$22.02 per hour.

**91. *One commenter stated that there should be a rate for LCSWs and, if they are covered by the rate for master's-level staff, it should be the same as for Outpatient services although Day Treatment clinicians are 'more skilled'.***

The master's-level rate does apply to LCSWs. The rate model includes the same wage assumption as for Outpatient services, but the rates differ because of differences related to productivity and administrative support.

**92. *Several commenters objected to the assumption that staff provide 32.25 hours of billable service per week when members are limited to 30 hours. Commenters suggested that the expectation should be 23 to 24 hours per week.***

The assumptions related to billable hours are intended to reflect the number of billable hours that would be required to justify a 40-hour workweek. As the commenters note, the proposed Children's Behavioral Health Day Treatment rate models for one-to-one services assumed that a 40-hour workweek would yield 32.25 billable hours. This could be achieved, for example, if a BHP works with more than one child. Or, if a BHP provides fewer billable hours, it would be expected that they work fewer than 40 hours per week such that the ratio of billable hours to total hours (which is the figure that actually affects the rate) would be unchanged.

To better reflect actual practices, though, the total workweek was adjusted downwards to 36 hours per week. Hours of paid time off were similarly adjusted, but other productivity factors remained unchanged so that the productivity adjustment increased overall. The rate models now assume that BHPs deliver about 28.75 billable hours of service per week (about 25 hours after accounting for training and paid time off).

**93. *Several commenters objected to specific productivity related assumptions, suggesting the model should include:***

- *Two-and-a-half hours for weekly employer and one-one supervision time to account for one hour of required supervision as well as staff meetings, peer audits, clinical case reviews, and crisis debriefs rather than the assumed one hour (increased to 1.5 hours as discussed in the response to comment 6),*
- *Four-and-a-half hours per week for missed appointments – a 15 percent absence rate – rather than the assumed half-hour (some commenters objected to the 'expectation' that staff be sent home if a member misses an appointment),*
- *Two hours per week for program set-up, curriculum development, and treatment planning, and*
- *Time for periods during which a child is receiving services from another professional (such as a master's level staff person), which prevents the BHP's time from being billed.*

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a BHP may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. For a site-based service, the Department believes it is reasonable to expect BHPs to spend 80 percent of their time providing services before accounting for training and paid time off.

**94. One commenter stated that staff must receive training after-hours, requiring overtime pay.**

As noted in the response to the comment 92, staff are assumed to provide 28.75 hours of billable service per week. Even with other responsibilities, DHHS believes that leaves sufficient time to accommodate any training requirements without necessitating overtime.

**95. One commenter suggested that providers be permitted to bill for meeting with families, training new staff, observing students, creating new teaching materials, and writing plans.**

The Department is not proposing any changes to covered (billable) activities for Children's Behavioral Health Day Treatment services. Rather, the activities cited by the commenter would be part of the productivity assumptions when performed by direct service staff and part of the program support assumption when performed by other agency staff.

### **Operating and Overhead Costs**

**96. One commenter asked how was the cost per square foot for program space was calculated as their cost is \$71 per square foot.**

As discussed in the response to comment 13, the rate model includes \$15 per square foot as in other models based on research of the cost of advertised office space. It is unclear what the commenter included in their cost calculation, but \$71 per square foot is much greater than most advertised space.

**97. One commenter stated that the rate models do not account for child care facility requirements such as sprinkler systems.**

As noted in the response to the previous comment, the rate model includes a specific assumption related to the cost of program space based on research of advertised costs. As with all services, the cost for non-program space is incorporated in the administrative and program support components of the rate model.

### **Master's-Level Rate**

**98. Several commenters objected to the assumption that staff provide 31 hours of billable service per week when members are limited to 30 hours. Commenters suggested that the expectation should be 15.5 to 19 hours per week. In particular, commenters noted that the rate models do not account for supporting BHPs and do not include consultative time.**

The assumptions related to billable hours are intended to reflect the number of billable hours that would be required to justify a 40-hour workweek. As the commenters note, the proposed Children's Behavioral Health Day Treatment rate models for one-to-one services provided by master's-level staff assumed that a 40-hour workweek would yield 31 billable hours. This could be achieved, for example, if the clinician works with more than one child.

Additionally, the rate model does not include time associated with supporting BHPs because the cost of this support is intended to be part of the program support component of the BHP rates just as clinical support and supervision is funded in other rate models. Thus, the productivity assumptions in the master's-level rate should be considered in terms of what their workweek would look like without providing BHP support (since that portion of the clinician's time should be part of the BHP rate, including it in this rate model would effectively 'double-count' their time).

**99. Several commenters objected to specific productivity related assumptions, suggesting the model should include:**

- *Eight hours per week for Department of Education required supervision,*
- *Time for crisis interventions, which can require 10 hours for a single child, and*
- *More than the three hours assumed for recordkeeping.*

In response to these comments, the amount of time assumed for recordkeeping has been increased from three to five hours per week.

Otherwise, for any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a clinician may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. Excluding supervisory and support requirements that are incorporated in the BHP rate model as discussed in the response to comment 98, the Department believes it is reasonable to expect clinicians to spend 75 percent of their time providing services before accounting for training and paid time off.

**Board Certified Behavior Analyst (BCBA)**

**100. Several commenters made reference to the proposed BCBA rate. In particular, one commenter noted that current rules only allow BCBA's to provide supervision. Other comments related to the ratio of behavioral health professionals to BCBA's, the number of billable hours assumed in the rate model, and office space costs.**

DHHS is withdrawing its proposal to create a BCBA service within Section 65. If the Department determines that the service is warranted in Section 65, it will reevaluate the rate model assumptions at that time.

**OUTPATIENT SERVICES (SECTION 65)**

**General**

**101. Several commenters objected to any reduction in rates for Outpatient Therapy services. One commenter stated that the 'proposed 10 percent reduction' is unsustainable. Another commenter stated that proposed rates will eliminate school-based services.**

With the exception of the rates for licensed alcohol and drug counselors – which were proposed to be reduced by 17 percent, but account for less than five percent of Outpatient Therapy units – none of the rates were proposed to be reduced by ten percent. The proposed rates for agency psychologists, certified alcohol and drug counselors, and independent licensed social workers were greater than current rates, while the proposed rates for agency licensed social workers and independent psychologists were 3 percent and 4 percent lower than current rates, respectively.

Based on revisions to the rate models in response to public comments, the Outpatient Therapy rates for all practitioners other than LADCs would increase.

- 102. Several commenters stated that increased rates for independent practitioners will impair agencies' ability to hire licensed staff, hurting consumers by fragmenting care, and harming clients with the most significant needs because community practitioners refuse to treat them in private practice.**

The rate models for both agency providers and independent practitioners are intended to reflect the costs of providing services rather than encouraging one service delivery model or another. Rates for licensed social workers will still be higher for agencies than for independent practitioners, but the 'premium' for agency services will be 17 percent rather than the current 53 percent. For psychologists, the agency rate is 10 percent higher than the independent rate.

- 103. One commenter noted that the presentation document did not list psychiatric nurse practitioners as a qualified provider. The commenter suggested that these staff should be able to bill at the psychologist/psychiatrist rate.**

Advanced practice registered nurses should have been listed as a qualified provider. The rate models have been revised to list these professionals as part of the rate for LCSWs, LCPCs, and LMFTs, which the Department believes is more appropriate than the rate for psychologists and psychiatrists.

- 104. One commenter noted that the group rate for licensed alcohol and drug counselors is \$9.00 per 15 minutes, not \$7.00 as indicated in the rate model packet.**

The comparison document inadvertently listed the current certified drug and alcohol counselor group rate for LADCs. This error has been corrected in the final proposed rate model packet.

- 105. One commenter stated that the rate models do not consider efforts to implement evidence-based practices that have higher costs, such as more supervision time.**

MaineCare does not currently pay higher rates for evidence-based outpatient treatment modalities such as trauma-focused cognitive behavioral therapy. Although this rate review does not include the addition of rates for this or other evidence-based treatments, the Department is interested in further discussing the development of standards and rates for such treatments with providers and other stakeholders.

### **Staff Wages, Benefits, and Productivity**

- 106. One commenter stated that the provider survey was flawed because it requested that information be reported based on a 40-hour workweek, which may not be accurate for a salaried clinician. Another commenter stated that the provider survey results may be skewed if it incorporates data for contractors who are only paid for billable time.**

It is not true that the provider survey asked that information be reported based on a 40-hour workweek. The survey asked providers to report hours for a 'typical' workweek and respondents reported typical weeks that ranged from fewer than 20 hours to more than 46. In order to compare responses across providers, each provider's responses were scaled to a 40-hour week by adjusting the time for each activity proportionally. For example, if a provider reported a 20-hour workweek, time for each activity was doubled so that the ratios remained unchanged (that is, the percentage of time that is billable did not change).

Although providers were not asked to exclude contract staff billed on an hourly basis, a review of submitted surveys does not suggest this was an issue. Only one provider reported that staff are billable 100 percent of the time and this response was flagged as an outlier in the survey analysis.

**107. Several commenters objected to the number of billable hours assumed in the rate model, which is higher than reported by provider survey participants. Commenters suggested that staff should be expected to provide 17.5 – 26.0 billable hours per week. Related comments included:**

- **Outpatient therapists spend two hours per day on paperwork for assessments and Vinelands.**
- **Clinicians working in public schools provide considerable consultation to school staff and this time is not incorporated in the rate model.**
- **The rate models should include two hours per week for missed appointments (six hours for substance abuse services).**
- **The rate model does not include travel although clinicians sometimes do home-based work.**

After making the adjustments related to training and paid time off detailed in the response to comment 5, the rate model assumes that licensed social workers provide 26.29 hours of billable services per week, which translates to 1,358 hours per year, or a 65 percent productivity expectation.

To provide a fair comparison to provider survey results, the rate model assumptions need to be adjusted to add back paid time off and training (since the provider survey did not ask respondents to report paid time off and training as productivity adjustments). As illustrated in Appendix C of the rate model packet, the model assumes that clinicians provide 29.50 billable hours of service *before accounting for training and paid time off*, which translates to a productivity expectation of 74 percent. This assumption does exceed the amounts reported by provider survey respondents, which ranged from about 19 hours per week to 29 hours.

Given the range of responses to the provider survey, Burns & Associates researched other published productivity standards:

- A 2010 study on electronic health record benefits conducted by the nonprofit Centerstone Research Institute stated that ‘most’ clinicians have a ‘clinical percentage’ set at 62.5 percent (25 hours per week) after accounting for paid time off.<sup>6</sup>
- Various randomly selected job postings note expectations regarding billable hours, including:
  - Fireland Regional Medical Center job posting for a therapist II/ counselor in Ohio – 22 hours per week after accounting for paid time off<sup>7</sup>
  - Highland Rivers job posting for an outpatient LCSW in Georgia – 23 hours per week after accounting for paid time off<sup>8</sup>
  - Heartland Human Services job posting for an outpatient therapist in Illinois – 26.25 hours per week after accounting for paid time off<sup>9</sup>
  - River Valley Counseling Center job posting for an LICSW in Massachusetts – 28 hours per week (70 percent) presumably before accounting for time off<sup>10</sup>

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<sup>6</sup> Bennett, CC (2010). Clinical Productivity System – A Decision Support Model. *International Journal of Productivity and Performance Management*. 60(3): 311-319.

<http://www.emeraldinsight.com/journals.htm?articleid=1911824&show=abstract>

<sup>7</sup> [https://re12.ultipro.com/FIR1028/JobBoard/JobDetails.aspx?\\_\\_ID=\\*68732477A8392E46](https://re12.ultipro.com/FIR1028/JobBoard/JobDetails.aspx?__ID=*68732477A8392E46); accessed December 18, 2016.

<sup>8</sup> <http://highlandrivershealth.com/careers/>; accessed December 18, 2016.

<sup>9</sup> [http://www.heartlandhs.org/job\\_opportunities/OP%20Therapist.pdf](http://www.heartlandhs.org/job_opportunities/OP%20Therapist.pdf); accessed December 18, 2016.

<sup>10</sup> [http://rvcc-inc.org/poc/view\\_index.php?idx=22&id=8070](http://rvcc-inc.org/poc/view_index.php?idx=22&id=8070); accessed December 18, 2016.

- One Hope United job posting for an outpatient therapist in Illinois – 30 hours per week (75 percent) presumably before accounting for paid time off<sup>11</sup>
- Shorehaven Behavioral Health, Inc. job posting for an outpatient psychotherapist in Wisconsin – 30 hours per week (75 percent) before accounting for time off<sup>12</sup>
- T.W. Ponessa & Associates job posting for a licensed outpatient therapist in Pennsylvania – 30 hours per week (75 percent) presumably before accounting for time off

Although only a small sampling of job postings across the country, the comparisons demonstrate that the rate model assumptions are within industry standards, albeit towards the top of the range.

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a clinician may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. Overall, the Department believes that the assumptions are reasonable, though it is acknowledged that achieving these results may require increased efficiency.

### Operating and Overhead Costs

**108. One commenter stated that one support person for every two direct care providers does not account for human resources, billing, IT, etc.**

As noted in the response to comment 14, the Outpatient Therapy rate model includes one support position for every two service providers in order to provide direct support such as scheduling and office management. This position is *in addition* to the administrative and program support funding in all of the rate models to account for the functions cited by the commenter.

**109. Several commenters noted that the rate models do not account for total office space such as waiting rooms.**

The rate models resulting from this rate review incorporate administrative space and common areas (such as lobbies, hallways, conference rooms, and bathrooms) in the administrative and program support assumptions discussed in the response to comment 11. For services like Outpatient Therapy and others where it is presumed that staff have their own dedicated workspace, the rate models include *additional* funding for their workspace. This funding is not intended to account for the administrative and common areas that is included in the overhead funding for all services.

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<sup>11</sup> <https://recruiting.ultipro.com/ONE1005/JobBoard/f4ac3653-ed5b-cd96-4f3b-b0e52b1b3b27/OpportunityDetail?opportunityId=3cbe6d3a-ea4c-490f-99a1-aa0df5a02fea>; accessed December 18, 2016.

<sup>12</sup> <http://www.shorehavenbhi.com/pub/jobs/Job-FAQs/Outpatient-PsychoTher-FAQ.pdf>; accessed December 18, 2016.

## MEDICATION MANAGEMENT (SECTION 65)

### General

**110.** *Several commenters suggested that there should continue to be different rates for children and adults because working with children requires more collateral contacts and child psychiatrists require additional residency training. One commenter stated that there should be a higher rate for working with adults receiving Community Integration services.*

In response to these comments, the Department has established separate Medication Management rates for adults and children, consistent with current practices. In particular, the rate model for children includes an additional two hours per week for collateral contacts. The rate model does not include assumptions related to psychiatrists' residencies and given the increased wage assumption discussed in the response to comment 112, the same salary is assumed for all psychiatrists.

The Department does not believe that a separate rate for serving adults who receive Community Integration services is necessary.

**111.** *Several commenters objected to the establishment of separate, lower rates for nurse practitioners and physician assistants, although several acknowledged that these staff are paid less than psychiatrists. Some commenters noted that nurse practitioners bill physician rates under Section 90.*

The rate models resulting from this rate review include assumptions regarding costs associated with providing each service. The wage paid to the service providers is the single largest cost in the rate models. In the case of Medication Management, there are significant differences in wages to psychiatrists and those paid to physician assistants and nurse practitioners. According to data from the Bureau of Labor Statistics, the average psychiatrist salary is \$232,000 (based on May 2013 data as discussed in the response to comment 112), more than twice as much as the approximately \$96,000 earned by PAs and NPs. Providers participating in the provider survey affirmed this difference, reporting that they pay PAs and NPs approximately \$108,000 compared to about \$208,000 for psychiatrists. The Department considered building a rate model that uses an average of these various wage levels, but was concerned that the resulting rate would be insufficient to support psychiatrists' salaries. Rather, separate rates were developed that reflected the significant differences in providers' costs based on the staff providing the service.

### Psychiatrist Wages, Benefits, and Productivity

**112.** *Several commenters objected to the wage assumption for psychiatrists. Alternative suggestions included the \$203,800 average reported by provider survey respondents, \$207,500 for adults and \$229,800 for children, and \$255,500 for adult psychiatrists and \$264,800 for child psychiatrists.*

The wage assumptions in the rate models are generally tied to Bureau of Labor Statistics wage data for occupations that reflect the requirements of each service. As with the other services, the wage for psychiatrists was derived from the May 2014 BLS dataset. The BLS does not report wage percentiles for wages that exceed \$90 per hour so the rate models used the reported average (mean) of \$89.01 per hour (about \$185,000 per year).

In response to this comment, the Department reevaluated the wage assumption. The May 2015 data that was released after the rate models were posted for public comment did not include estimates for psychiatrist wages. Evaluating previous datasets, the average wage from the May 2013 data was \$111.69 per hour (about \$232,000 per year) and was \$111.73 in the May 2012 data. Consequently,

the final proposed rate model has been revised to reflect the average from the May 2013 data, which is the same wage assumption included in the Section 65 crisis services rate models developed in 2015.

**113. One commenter stated that the wage assumption should not be the same for physician assistants and nurse practitioners because the latter can practice independently.**

The rate model for physician assistants and nurse practitioners discussed in the response to comment 111 assumes a wage of \$46.92 per hour, or about \$97,600 annually. This wage is the average of the median wage in Maine for these occupations according to the May 2015 Bureau of Labor Statistics data. The occupations were combined because the median wages were so close – \$48.65 for physician assistants and \$45.19 for nurse practitioners. If the occupations were separated, the rate for nurse practitioners would be lower based on the lower median wage.

**114. One commenter stated that the rate model provides only \$4,800 per year for benefits while their costs are \$22,000.**

The commenter's figure is incorrect. The proposed rate model included \$21,300 for employee benefits, excluding paid time off. With the revised wage assumption discussed in the response to comment 112, the final proposed rate model includes \$24,400.

**115. Several commenters objected to the number of billable hours assumed in the rate model, which is higher than reported by provider survey participants. Commenters suggested that psychiatrists should be expected to provide 21.0 – 26.0 billable hours per week. Commenters made specific suggestions, stating that the rate model should include:**

- **Between 10 and 11 hours per week for collateral contacts and at least 8.9 hours for psychiatrists serving children,**
- **Between three and five hours per week for missed appointments and six hours for substance abuse services,**
- **Between 1.5 and 10 hours for weekly employer and one-one supervision time and at least two hours per week for nurse practitioners in their first two years of employment,**
- **40 hours annually for training,**
- **Additional time for APS documentation, and**
- **More time for 'other activities'.**

After making the adjustments related to training and paid time off detailed in the response to comment 5, the rate model assumes that clinicians provide 26.07 hours of billable services per week (1,356 hours per year) when serving adults and 24.29 hours per week (1,263 hours annually) when serving children.

To provide a fair comparison to provider survey results, the rate model assumptions need to be adjusted to add back paid time off and training (since the provider survey did not ask respondents to report paid time off and training as productivity adjustments). As illustrated in Appendix C of the rate model packet, the model assumes that clinicians provide 29.25 billable hours of service *before accounting for training and paid time off* when serving adults and 27.25 hours when serving children. This assumption does exceed the amounts reported by provider survey respondents, which were 24.43 hours for psychiatrists serving adults and 22.29 hours for psychiatrists serving children.

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a clinician may spend more time on a given non-billable activity than assumed in the rate model, but less time on

another task. Overall, the Department believes that the assumptions are reasonable, though it is acknowledged that achieving these results may require increased efficiency.

**116. *One commenter stated that the rate model does not account for caseload build-up or members transitioning out of service.***

As discussed in the response to comment 115, the productivity adjustments are intended to reflect a typical workweek, recognizing that a psychiatrist's actual time will vary from day-to-day and week-to-week for a variety of reasons, including those noted by the commenter. Overall, the Department believes the assumption that clinicians can provide 29.25 hours of billable service per week (or about 6 hours per weekday) when serving adults and 27.25 hours (5.5 hours per day) when serving children is reasonable.

**117. *One commenter stated that the rate model does not account for rural service delivery and the travel time between appointments, suggesting psychiatrists travel between seven and eight hours per week.***

The rate model does not include any travel-related assumption as Medication Management is assumed to be a primarily clinic-based service.

### **Operating and Overhead**

**118. *One commenter stated that the rate model does not adequately account for recruitment, training stipends, professional liability coverage, and supervision.***

The functions cited by the commenters are included in the administrative and program support factors included in the rate models. Since it is not practical to separately delineate every individual expense within a rate model, the models include two 'blanket' factors to account for these costs. In particular, the models include \$25 per day for program support and 15 percent of the total rate for administrative expenses as discussed in the response to comment 11.

**119. *One commenter stated that one support position for every two practitioners is not sufficient for billers, medical records staff, auditing/ compliance, utilization review, and supervision. One commenter suggested the rate model should assume one support position per practitioner.***

The functions cited by the commenter are not unique to Medication Management services. The costs associated with these functions are included in every rate model as part of the administrative and program support components of the models. The rate models for certain services – including Medication Management – provides funding for one support position for every two service providers in order to provide direct support such as scheduling and office management. This position is *in addition* to the administrative and program support funding in all of the rate models that is intended to accommodate the support cited by the commenter.

**120. *Several commenters stated that the office space assumptions in the rate model are inadequate. One commenter suggested that their costs are 800 percent greater than assumed in the rate model.***

As discussed in the response to comment 13, the rate models resulting from this rate review incorporate administrative space and common areas (such as lobbies, hallways, conference rooms, and bathrooms) in the administrative and program support assumptions discussed in the response to comment 11. For services like Medication Management and others where it is presumed that staff have their own dedicated workspace, the rate models include *additional* funding for their workspace. This funding is not intended to account for the administrative and common areas that is included in the overhead funding for all services.

Specifically, the rate model assumes 200 square feet of dedicated space for each clinician. The model assumes an annual cost of \$15 per square foot, based on a review of real estate listings.

## **CHILDREN’S HOME AND COMMUNITY BASED TREATMENT (SECTION 65)**

### **General**

**121. *Several commenters stated that the rate models do not account for changing standards.***

The Department believes that the new rates are sufficient to cover the cost of services consistent with MaineCare requirements.

### **Staff Wages, Benefits, and Productivity**

**122. *One commenter noted that turnover is significant because of low wages and non-traditional hours.***

The commenter’s statement is consistent with information from the provider survey in which participants reported a 44 percent turnover rate for Children’s Home and Community Based Treatment. The rate models account for turnover in two areas. First, training requirements are greater in the first year of employment than in subsequent years so the number of annual training hours included as a productivity adjustment represents a weighted average of first year and subsequent year training. Second, human resource staff and other hiring and training expenses are considered to be part of the administration and program support assumptions discussed in the response to comment 11.

More generally, the rates are intended to reflect the reasonable cost of providing services. For staff, the model includes an assumed hourly wage of \$22.02 (\$45,800 annually) for staff with bachelor’s degrees and \$27.75 per hour (\$57,700 annually) for those with master’s degree. Additionally, the model supports a comprehensive benefits package as outlined in the response to comment 2.

**123. *Several commenters objected to the number of billable hours assumed in the rate model, which is higher than reported by provider survey participants. Commenters suggested that bachelor’s-level staff should be expected to provide 25 billable hours per week and master’s-level staff should be expected to provide 17 – 19 hours. Commenters made specific suggestions, stating that the rate model should include:***

- *Between 3.0 and 3.5 hours for weekly employer and one-on-one supervision time to account for one-to-two hour of required supervision as well as staff meetings, peer audits, clinical case reviews, and crisis debriefs rather than the assumed one hour,*
- *1.6 hours for recordkeeping including the completion of reauthorizations (assuming that each reauthorization requires three hours of a clinician’s time to complete), and*
- *More time for training to cover trauma-focused cognitive behavior therapy, child parent psychotherapy, motivational interviewing, and nurturing parenting.*

The rate models have been revised for the adjustments related to training and paid time off detailed in the response to comment 5 and employer and one-on-supervision time has been increased to 1.5 hours per week in the bachelor’s rate as discussed in the response to comment 6. Additionally, although the specific trainings mentioned by the commenter are not requirements of the service, the training assumption in the rate models has been increased from 39 hours per year to 52 hours. The rate model now assumes that bachelor’s-level staff provide 27.24 hours of billable services per week (1,416 hours per year) and that master’s-level staff provide 25.92 hours per week (1,348 hours per year). As

discussed in the response to comment 124, providers will continue to be able to bill for collateral contacts so these productivity expectations include time spent on collateral contacts.

To provide a fair comparison to provider survey results, the rate model assumptions need to be adjusted to add back paid time off and training (since the provider survey did not ask respondents to report paid time off and training as productivity adjustments). As illustrated in Appendix C of the rate model packet, the model assumes that bachelor's-level staff provide 31.00 billable hours of service and master's-level staff provide 29.50 hours *before accounting for training and paid time off*. This assumption does exceed the amounts reported by provider survey respondents, which were 25.43 hours for bachelor's-level staff and 19.28 hours for master's-level staff.

For any given provider, it is likely that their actual experience will differ from various rate model assumptions related to productivity (as well as other factors). In some instances, a clinician may spend more time on a given non-billable activity than assumed in the rate model, but less time on another task. Overall, the Department believes that the assumptions are reasonable, though it is acknowledged that achieving these results may require increased efficiency.

**124. *Several commenters objected to the elimination of billing for collateral contacts.***

The proposed rate models would have eliminated the ability of providers to *directly* bill for collateral contacts, but included a productivity adjustment to effectively pay for these costs by spreading them over billable hours associated with direct services. In response to these comments, the Department has withdrawn this proposal and providers will continue to be able to bill for collateral contacts. The rate models have been revised by eliminating the productivity adjustment for collateral contacts (which has the effect of lowering the rate, but expanding the scope of services that may be billed).

**Travel, Operating, and Overhead Costs**

**125. *Several commenters stated that the rate model assumptions related to travel (six hours and 200 miles per week) are inadequate, with alternative proposals ranging from 230 to 400 miles. Specific concerns were expressed for the rural parts of the State.***

As the commenters note, the rate model assumes that staff travel 200 miles per week. This assumption was derived from the provider survey in which participants reported about 6.1 hours of travel time and 220 miles.

This rate model assumption – like all others – is intended to be a reasonable average across all providers. For any given provider, some costs are likely to be less than assumed in the rate model and others are likely to be greater. For a provider operating in a rural area, it is almost certainly true that their staff will drive more. However, these higher costs may be offset by lower costs in other areas such as office space or wages.

**126. *One commenter noted that the rate model does not account for assessment tools, listing the Adult-Adolescent Parenting Inventory, Nurturing Competency Scale, and the PTSD Reaction Index.***

The use of the cited assessments is not a requirement of the services. Thus, the cost associated with any assessments conducted as part of Children's Home and Community Based Treatment services is presumed to be part of the overhead funding included in the rate models. On a per-hour basis, the cost of assessment is small as the per-assessment cost is only a few dollars and is spread across the more than 100 hours of support that an individual receives annually (so that the assessment cost works out to less than \$0.10 per hour).

## **Multi-Systemic Therapy, Problem Sexualized Behavior, Family Functional Therapy (Section 65)**

**127.** *Commenters expressed various objections to the proposed rates for Functional Family Therapy, Multi-System Therapy, and MST-Problem Sexualized Behavior, including concerns with the total rate, wage and productivity assumptions for the staff providing services, and overhead costs.*

In the interest of continuing to support evidence-based treatments, DHHS has withdrawn the proposed reduced rates for these services. These services will continue to be reimbursed at current rates.

## **PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING (SECTION 65)**

### **General**

**128.** *Several commenters objected to the proposed rate for Psychological and Neuropsychological Testing as the service was not included in the provider survey. Commenters variously stated that the rate should be the same as Outpatient Therapy or \$90 per hour.*

The Department recognized that additional work on this rate model would be necessary when the proposed draft models were released. After the conclusion of the public comment period, DHHS and Burns & Associates met with the Maine Psychological Association to discuss the service and formulate an abbreviated survey tool to collect data regarding key rate model elements. Based on this additional work, a number of changes have been made to the rate model, including:

- A reduction in expectations regarding billable hours,
- Addition of a productivity adjustment for administrative tasks, and
- Addition of a cost factor for assessment instruments.

With these changes, the final proposed rate is \$86.99, which is less than the \$92.44 Outpatient Therapy rate for independent psychologists, but greater than the current rate of \$79.20 per hour.

**129.** *One commenter asked whether there are separate rates for independent and agency psychologists. Several commenters stated that the rate model should reflect independent psychologists rather than agency psychologists.*

As is currently true, there are not separate rates for agency and independent providers. Although the rate model will apply to both independent and agency providers, it is premised more on an independent provider model with time included for the clinician to perform administrative tasks and the program support funding eliminated.

### **Psychologist Wages, Benefits, and Productivity**

**130.** *Several commenters stated that there should be different rates for psychologists and neuropsychologists because the latter require more training and earn higher wages, and have costs that psychologists do not, including testing tables and chairs, computers, file cabinets and bookshelves, etc. One commenter stated that the rate model should assume a neuropsychologist wage of \$62.50 per hour.*

The State does not have a separate licensure category for neuropsychologists so MaineCare has not established separate rates for this profession. At this time, the Department intends to maintain this approach with the wage assumption based on a psychologist, which is the licensed classification.

**131. Several commenters objected to the number of billable hours assumed in the rate model. One commenter suggested that the rate model should assume psychologists provide 25 billable hours per week. Other comments included:**

- *The model should include productivity adjustments for documentation, collateral contacts, follow-up care, scheduling, and administrative tasks.*
- *The model includes fewer training hours than the Outpatient Therapy rate model for psychologists.*
- *There should be more supervision time as neuropsychologists participate in peer consultation.*
- *Cancellations can result in four-to-eight lost hours per week.*

Based on these comments and the additional data collection discussed in the response to comment 128, a number of changes were made to the productivity assumptions in the rate model. Adjustments were added for non-billable coordination and collateral contacts as well as administrative tasks, travel time was eliminated, and other assumptions were revised. In summary, the model now assumes that psychologists provide 28.25 billable hours per week before accounting for paid time off and training (25.18 hours after adjusting for those factors).

#### **Operating and Overhead Costs**

**132. Several commenters objected to the overhead assumptions in the rate model. One of the commenters reported a 37 percent overhead rate. Another commenter stated that the model should include one support position for every three practitioners.**

As with all of the rate models included in this rate review, the Psychological and Neuropsychological Testing includes a 15 percent administrative rate in addition to the funding for office space described in the response to comment 13. The model does not include a program support component or a support position because, as noted in the response to comment 129, the model reflects an independent practitioner. For the same reason, however, the model presumes that psychologists spend 4.5 hours per week on administrative tasks, which is equivalent to another nine percent for administration. Although less than suggested by some commenters, the Department believes the administrative funding assumptions and overall rates are sufficient.

**133. Several commenters stated that the rate model should include costs associated with testing instruments and materials.**

In response to these comments, the rate model has been revised to include the cost of testing materials. The cost of the testing materials varies significantly from instrument to instrument. The supplemental survey described in the response to comment 128 gathered information regarding the frequency with which various instruments are used. Based on this information, the rate model now includes \$15 for each completed assessment.

**134. Several commenters stated that the rate model does not account for total office space such as waiting rooms. Another commenter objected to the cost for office space, stating that office space costs \$18 per square foot, with higher costs in the Portland area.**

The rate models resulting from this rate review incorporate administrative space and common areas (such as lobbies, hallways, conference rooms, and bathrooms) in the administrative and program support assumptions. For services like Medication Management and others where it is presumed that staff have their own dedicated workspace, the rate models include *additional* funding for their workspace. This funding is not intended to account for the administrative and common areas that is included in the overhead funding for all services.

Specifically, the rate model assumes 200 square feet of dedicated space for each psychologist. The model assumes an annual cost of \$15 per square foot, based on a review of real estate listings (for example, 29 medical offices were listed at loopnet.com in March 2016, with an average cost of about \$13 per square foot).

## PROJECT ADMINISTRATION AND APPROACH

**135. *One commenter asked why Sections 13 and 17 services were included in the project when the legislation only required review of Sections 28 and 65 services.***

The fiscal year 2016-17 budget required that the Department undertake a rate study for services provided under Sections 28 and 65 of the MaineCare program (P.L. 2015, ch. 267, § AA). Given the overlaps in individuals served, providers, and services – as well as an interest in ensuring the adequacy and appropriateness of rates across MaineCare as a matter of principle – DHHS decided to expand the scope of the study to more broadly review rates for behavioral health and related supports, including those services delivered under Sections 13 and 17.

**136. *Several commenters asked how Burns & Associates, Inc. was selected to conduct this rate study and whether there was a request for proposal. These commenters stated that B&A's previous rate studies have all resulted in rate decreases.***

The legislation requiring the rate study called for DHHS to contract with a third party. The timeline in the legislation did not allow for competitive procurement. Additionally, the Department already had a contract with the national consulting firm Burns & Associates, Inc. (B&A) to assist in rate-setting; B&A had previously assisted with other rate studies, including behavioral health homes covered by Section 92 of the MaineCare program and crisis services covered by Section 65. Working with the same contractor ensured a consistent approach across these programs.

Commenters stating that all previous rate studies on which B&A has consulted have led to rate reductions are incorrect. A number of these studies have, in fact, recommended in significant proposed rate increases, including for Section 12/ 19/ 96 personal care and related services, Section 65 crisis residential services, and Section 92 behavioral health home services. Further, each of these projects have been based on similar approaches and methodologies.

**137. *Several commenters stated that providers and others have not been appropriately involved.***

The Department disagrees with these statements. Throughout the rate study, DHHS and B&A adhered to three key principles: transparency of process, granularity of analysis, and engagement of interested parties. To that end, providers and other stakeholders have had multiple opportunities to participate, including:

- Provider advisory groups for each MaineCare section were established and convened on two occasions, once to introduce the project and solicit input regarding issues impacting providers' costs and once to present the proposed rate models and receive preliminary feedback. The groups were also asked to review and comment on the provider survey before it was finalized and distributed.
- As discussed in the response to comment 140, a provider survey was developed and all providers were invited to participate.
- Burns & Associates conducted on-site visits with four providers to allow for more thorough discussions of particular services. During the public comment process, the Department and

B&A also convened meetings with a few providers to discuss Psychological and Neuropsychological Testing and Home and Community Based Treatment services.

- The proposed rate models and supporting materials were posted online and shared with providers and other stakeholders as part of an ‘informal’ public comment process preceding formal rule-making. A webinar was recorded to explain the proposals. Based on requests from several stakeholders, the timeline for submitting comments was extended from about one month to two months (and any comments received after the deadline were also accepted and considered).
- DHHS Deputy Commissioner of Finance Alec Porteous provided several hours of testimony to the Health and Human Services Committee in April 2016. The hearing was well-attended and the Department’s testimony offered broad insight into the process. Among other comments, Mr. Porteous offered that providers and stakeholders should not hesitate to contact him directly with comments or questions regarding the review.

With the finalization of the proposed rate models, the Department will move forward with rule-making, which will afford another opportunity for stakeholders to comment.

**138. *One commenter noted that the State only realizes one-third of any savings resulting from rate reductions so the decreases are ‘not worth it’.***

As the commenter states, MaineCare services receives federal matching Medicaid funds that typically provide for about 62 to 64 percent of the total cost of the program. It is true that the federal government shares in any savings proportional to its contribution to the MaineCare program (and similarly pays an equivalent percentage for any cost increases). However, it is also true that as a condition of participating in Medicaid, the State must comply with federal requirements, including the provision that payment rates are consistent with efficiency, economy, and quality of care. In accordance with these principles, the intent of the rate review was to establish rates that reflect the cost of providing services consistent with MaineCare requirements.

The Department did not establish any savings or spending targets for this project. In fact, the rates for most services including in this review are proposed to increase rather than decline.

**139. *One commenter stated that DHHS should consider rule changes to reduce requirements given rate reductions. Further, the commenter suggested there should be greater standardization across DHHS programs.***

The rates for most services included in the rate review are increasing rather than decreasing. For any service, regardless of the change to its rate, DHHS is willing to discuss and consider potential rules changes that would streamline services without undermining quality. The Department encourages stakeholders to share their specific suggestions.

**140. *Several commenters expressed concerns regarding participation in the provider survey, noting that 36 of 482 providers submitted a survey and for several categories, there were very few participants (for example, only one provider submitted information for Targeted Case Management for individuals experiencing homelessness. One commenter stated that the survey was complicated, restricting participation amongst smaller rural providers. Several commenters stated that many providers were not invited to participate in the survey. One commenter asked what is considered a ‘valid sampling’.***

A provider survey was conducted in order to collect information from providers regarding the services that they deliver and the costs associated with those services. Rather than establish a sample

based upon statistical principles, the survey was emailed to *all* providers who delivered services in fiscal year 2015, using the email addresses they had on record with DHHS. Providers were given six weeks to complete and submit the survey, but any survey submitted after the deadline was also accepted. Burns & Associates, Inc. provided technical assistance throughout the survey period including a recorded webinar that was posted online, contact information for staff to whom questions could be directed, and a page-by-page review of each survey and corresponding follow-up with participants when clarification was needed.

As commenters noted, of 482 providers who billed for one or more services included in the rate study in fiscal year 2015, 36 submitted a survey for a submission rate of 7.5 percent. Participation varied by service, with the overall figure driven down by the fact that only 22 of 338 providers of Section 65 Outpatient Therapy services participated. The majority of Outpatient providers work with MaineCare on only a part-time basis. Of the 316 Outpatient providers that did *not* submit a survey, 200 (63 percent) billed less than \$20,000 across all services included in the rate study. As a result, the 6.5 percent of Outpatient providers that did submit a survey accounted for 68 percent of Outpatient billing, indicating that the majority of services and members was represented in the survey.

The same trend is true across overall survey participation. While responding providers represented only 7.5 percent of all providers, they accounted for 48 percent of the services delivered. Higher participation in the survey is always desirable, but the response rate was in line with expectations and DHHS believes that the data offered useful points of comparison.

**141. *One commenter stated that the provider survey did not gather information related to disability and malpractice insurance or retirement accounts. Another commenter stated that the survey did not include direct care costs such as travel, utilities, and hiring expenses.***

These comments are not accurate. Disability and malpractice insurance should have been recorded on Line 10 of the ‘Operating Other’ worksheet, while retirement contributions should have been reported in Column E of the ‘Operating Staff’ worksheet (for administrative and program support staff) and Line 24 of the ‘Direct Care Benefits’ worksheet (for direct care staff). Utilities should have been reported on Line 6 of the ‘Operating Other’ worksheet while hiring expenses should have been reported on Line 9 of the same worksheet (with hiring-related staff reported on the ‘Operating Staff’ worksheet). Mileage data was collected for each (relevant) service on the applicable ‘Productivity and Other Factors’. Rather than collecting information regarding each provider’s mileage reimbursement policy, mileage in the rate models is funded at the standard IRS rate.<sup>13</sup>

**142. *One commenter stated that there were inaccuracies in the provider survey analysis packet because a different number responding providers are reported for a given service in different sections of the packet.***

The commenter noted that the number of responding providers for a single service varied in different parts of the provider survey analysis. For Community Integration for example, 17 responding providers are reported for wages, 18 for productivity and other factors, and 16 for administrative and program support costs. This difference is not the result of an error, however. Rather, some providers chose not to complete each survey form, but they were included in the analysis for those that they did complete. Looking at the Community Integration counts above, it is clear that at least two providers chose to complete the productivity and other factors worksheet but did not complete the administrative cost section.

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<sup>13</sup> Rate models with a mileage component have been updated with the calendar year 2017 rate of 53.5 cents per mile (IRS Notice 2016-79), a decrease from the 2016 rate of 54.0 cents included in the proposed rate models.

**143. Several commenters expressed concerns that provider survey data was not used to develop the rate models.**

As much as anything else, provider costs tend to reflect current rates and therefore may not reflect what costs ‘should’ be. For example, rates that are too low may result in staff wages and benefits that are not competitive while rates that are too high may result in inefficiencies. Thus, while information from the provider survey did inform the assumptions built into the rate models, data from other sources was considered as well. Examples of other information include Bureau of Labor Statistics wage data for various occupations across industries within the State; health insurance cost data from the BLS, the federal Department of Health and Human Services’ Medical Expenditure Panel Survey (MEPS), and the State’s health insurance exchange; the rates paid for comparable services in the other New England states; and providers’ published expectations regarding billable hours.

Results from the provider survey were published with the rate models so that stakeholders could easily compare the two. In brief, compared to provider survey results, the rate models generally assume higher wages than reported, equivalent benefit costs, higher productivity, and lower agency overhead.

**144. One commenter asked how ‘outliers’ in the provider survey analysis packet were defined.**

The provider survey analyses report average values with and without outliers, which are defined as responses that were more than two standard deviations from the mean.