REVIEW OF PAYMENT RATES FOR
BEHAVIORAL HEALTH SERVICES
COVERED BY SECTIONS 13, 17, 28, 65, AND 92

PUBLIC COMMENTS AND RESPONSES

– PREPARED FOR –

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

– PREPARED BY –

BURNS & ASSOCIATES

A DIVISION OF HEALTH MANAGEMENT ASSOCIATES

3030 NORTH THIRD STREET, SUITE 200
PHOENIX, AZ 85012
(602) 241-8520
WWW.BURNSHEALTHPOLICY.COM

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CROSS-SERVICES

1. ***Several commenters offered support for the recommended rates. One commenter expressed concerned that future policy and rule changes could impact the adequacy of the rates.***

   The support for the rate study recommendations is appreciated. The rate models reflect current service standards and planned changes when known. Any changes to service standards would go through the formal rulemaking process, which includes a public comment process during which stakeholders could offer input about changes to payment rates that they believe would be needed to implement policy changes.

2. ***Several commenters noted the need to regularly adjust payment rates to account for future cost increases.***

   P.L. 2021, Ch. 639 requires DHHS to "[e]nsure that base rate amounts developed under paragraph C are updated to keep pace with changes in the costs of delivering the service by…providing an annual cost-of-living adjustment effective on a consistent date to be established by the department for each service that has not received a rate adjustment within the 12 months prior to the effective date of the cost-of-living adjustment." In addition, for reimbursement rates determined through a rate study, the Department has committed to updating the rate study at least every five years, in alignment with P.L. 2021 Ch. 398, Part AAAA.

   As discussed in the response to comment 6, the rate models developed through this rate study are constructed to reflect providers' current costs. By outlining individual cost assumptions, the rate models are designed to allow for the regular review of the adequacy of the resulting rates. For example, as discussed in the response to comment 3, the rate models rely on data reported by the Bureau of Labor Statistics to set wage assumptions for direct care staff. The BLS publishes this data every year, allowing DHHS and stakeholders to determine how well the assumed wages reflect current market conditions. Implementation of such increases will continue to be part of the state's budget process.

3. ***Several commenters objected to setting direct care staff wage assumptions based on the 50th percentile wages reported by the Bureau of Labor Statistics, arguing that these wages are based on current, inadequate payment rates.***

   As noted by the commenters, the wage assumptions in the rate models are based on Maine-specific wage data published by the Bureau of Labor Statistics (BLS). Consistent with most other MaineCare rate studies, the rate models use the median wages (which represent the 50th percentile, the wage at which half of the staff in a given occupation earn less and half of the staff earn more) reported by the BLS (adjusted to account for wage growth as discussed in the response to comment 4). Among other reasons, the rate study relies on BLS data because it reflects wages across all industries and funding sources. That is, the wage assumptions are not based only on wage paid by public programs and, instead, are meant to reflect the broader labor market. Figure 1 compares the wage assumptions included in the rate models to those reported in the provider survey.

Figure 1: Comparison of Wages Reported by Provider and Rate Model Wage Assumptions

	Provider Survey (# of Responses)	Rate Model	% Diff.
Section 13			
Targeted Case Management	$20.99 (46)	$29.66	41%
Section 17			
Community Integration	$25.41 (25)	$26.74	5%
Community Rehabilitation Services – MHRT 1	$18.89 (2)	$20.40	8%
Community Rehabilitation Services – MHRT/C	$20.50 (1)	$26.74	30%
Skills Development – MHRT/C	$16.25 (2)	$26.74	65%
Daily Living Support Services – MHRT I	$15.89 (2)	$20.40	28%
Day Support Services – MHRT/C	No responses	$26.74	
Assertive Community Treatment-Adult – MHRT/C	$18.39 (3)	$26.74	45%
Assertive Community Treat.-Adult – LCSW/ LCPC	$23.89 (4)	$32.43	36%
Assertive Community Treatment-Adult – RN	$32.16 (4)	$40.98	27%
Assertive Comm. Treat.-Adult – Employ. Specialist	No responses	$26.59	
Assertive Comm. Treat.-Adult – Sub. Abuse Couns.	$29.88 (1)	$29.58	(1%)
Assertive Community. Treat.-Adult – CIPSS (BHP)	$19.20 (1)	$20.40	6%
Assertive Community Treat.-Adult – Psychiatrist	No responses	$177.06	
Section 28			
Children's Rehabilitation and Comm. Supp. – BHP	$17.53 (13)	$23.01	31%
Specialized Child. Rehab. & Comm. Supp. – BHP	$17.53 (13)	$24.41	39%
Children's Rehabilitation and Comm. Supp – BCBA	$42.43 (7)	$41.32	(3%)
Section 65			
Children's Behavioral Health Day – BHP	$18.58[1] (7)	$24.41	31%
Children's Behavioral Health Day – Master's	$24.35 (7)	$31.16	28%
Children's Behavioral Health Day – BCBA	$32.57 (3)	$41.32	27%
Outpatient – Psychologist	$40.79 (2)	$41.32	1%
Outpatient – LCSW/ LCPC/ LMFT/ APRN	$29.73 (34)	$32.43	9%
Outpatient – LADC	$21.89 (8)	$29.58	35%
Outpatient – CADC	$22.62 (7)	$23.57	4%
Neuropsychological/ Psych. Testing – Psychologist	No responses	$41.32	
Neuro./ Psych. Testing – Psychological Examiner	No responses	$26.74	
Adaptive Assessments	No responses	$32.43	
Specialized Group Services – various	$17.80 (4)	$20.40	15%
Children's Home/ Comm. Based Treatment – BHP	$19.89 (5)	$24.41	23%
Children's Home/ Comm. Based Treat. – Master's	$22.43 (7)	$32.43	45%
Children's Home/ Comm. Based Treat. – BCBA	$26.44 (1)	$41.32	56%

Figure 1: Comparison of Wages Reported by Provider and Rate Model Wage Assumptions

	Provider Survey (# of Responses)	Rate Model	% Diff.
Assertive Community Treatment-Child – MHRT/C	No responses	$26.74	
Assertive Community Treat.-Child – LCSW/LCPC	No responses	$32.43	
Assertive Community Treatment-Child – RN	No responses	$40.98	
Assertive Comm. Treat.-Child – Psychiatrist	No responses	$177.06	
Assertive Comm. Treat.-Child – Employ. Specialist	No responses	$27.44	
Assert. Comm. Treat.-Child – Fam./ Youth Spec.	No responses	$20.40	
Assert. Comm. Treat.-Child – Sub. Abuse Couns.	No responses	$29.58	
Clubhouse – MHRT/C	$21.61 (1)	$26.74	24%
Behavioral Therapies - Therapist	No responses	$32.43	
Behavioral Therapies – Bachelor's	No responses	$26.74	
Section 92			
Adult Behav. Health Home – Coord. (MHRT/C)	$18.95 (7)	$26.74	41%
Adult Behav. Health Home – Clinical Lead (LCSW)	$28.01 (10)	$45.48	62%
Adult Behav. Health Home – Nurse Care Mgr. (RN)	$30.31 (11)	$40.98	35%
Adult Behavioral Health Home – Psychiatrist	$150.80 (2)	$177.06	17%
Adult Behavioral Health Home – Physician	$115.38 (1)	$110.42	(4%)
Child Behavioral Health Home – Coord. (Case Mgr.)	$19.54 (9)	$26.74	37%
Child Behav. Health Home – Clinical Lead (LCSW)	$30.69 (10)	$45.48	48%
Child Behav. Health Home – Nurse Care Mgr. (RN)	$32.58 (11)	$40.98	26%
Child Behavioral Health Home – Psychiatrist	$150.78 (2)	$177.06	17%
Child Behavioral Health Home – Physician	$115.38 (1)	$110.42	(4%)

The table shows that, although the degree varies by service and position, the rate model wage assumptions generally represent a significant increase over reported wages. As discussed in the response to comment 75, the wage assumption for licensed alcohol and drug counselors was increased; otherwise, DHHS believes that the wage assumptions are reasonable.

4. ***Several commenters suggested wage inflation factor added to the BLS wage data should be increased.***

As discussed in the response to comment 3, the rate model wage assumptions are based on Maine-specific wage data published by the Bureau of Labor Statistics (BLS). The BLS publishes wage data every March for the preceding May. Thus, the BLS data used in the rate models reflects May 2021. To support the currency of the wage assumptions, an inflationary factor was applied to the BLS data to develop estimates for July 2023.

The rate study used Maine-specific estimates of growth in total net earnings from the Bureau of Economic Analysis (BEA) to develop the inflationary factor. At the time of development of the rate models, the BEA estimated that earnings in Maine increased 9.0 percent from 2020 to 2021 and an average of 3.6 percent annually between 2011 and 2021 (the current estimates are now 8.7 percent between 2020 and 2021 and 3.7 percent annually over the past ten years). Recognizing that recent

wage growth has outpaced historic trends, the rate models assumed 12 months of growth at 9.0 percent plus an annual growth rate of 3.6 percent for the remaining 14 months, producing a total inflationary factor of 13.59 percent. Commenters objected to the 3.6 percent estimate in particular, suggesting that an additional nine percent be added instead.

To evaluate these concerns, HMA-Burns considered other estimates of wage growth, finding:

- The BLS employment cost index summary reports wage and salary growth of 5.3 percent for the 12-month period ending in June 2022 (https://www.bls.gov/news.release/eci.nr0.htm)
- The Economic Policy Institute estimated year-over-year growth of 6.43 percent in May 2022 (https://www.epi.org/nominal-wage-tracker/)
- The Federal Reserve Bank of Atlanta estimated year-over-year growth of 6.1 percent in May 2022 (https://www.atlantafed.org/chcs/wage-growth-tracker)

Although reflective of national figures, there is no reason to assume that Maine-specific estimates would vary significantly (for instance, the BEA estimates for the United States overall are similar to the Maine-specific figures). These data points suggest that the nine percent growth rate assumed in the rate models for the period of May 2021 to May 2022 may be high and do not support the assumption that wages have continued to grow at that rate. Using any of these estimates for the entire period between May 2021 and July 2023 would produce an aggregate total similar to the 13.59 percent included in the rate models. Thus, DHHS continues to believe that the inflationary factor is reasonable.

5. ***Several commenters suggested that a shift differential should be added to the wage assumptions for staff who work evenings and weekends.***

   The rate model wage assumptions are intended to reflect the average hourly wage paid to staff, including any premium pay. Although the rate models do not include a specific provision for shift differentials, Figure 1 above demonstrates that the wage assumptions represent a significant increase compared to providers' reported wages, which include any shift differentials currently being paid. DHHS therefore believes the wage assumptions are reasonable.

6. ***Two commenters suggested that an inflation factor similar to the adjustment made to wage data should be added to other rate model assumptions.***

   As described in the response to comment 4, the rate study added an inflationary factor to the wage data published by the Bureau of Labor Statistics to reflect estimated growth between the May 2021 reporting period and July 2023. Although a standard inflationary factor was not added to the remainder of the rate models, the rate study did seek to reflect reasonable costs; for example:

   - Payroll tax expenses tied to wages (Social Security and Medicare taxes, unemployment insurance, and workers' compensation) were increased in concert with the wage adjustments
   - Similarly, productivity-related costs (including paid time off) also increased in concert with the wage adjustments
   - Health insurance cost data from the U.S. Department of Health and Human Services' Medical Expenditure Panel survey was increased
   - HMA-Burns researched real estate listings to validate the office space cost assumptions

   Overall, DHHS believes the proposed rates reflect providers' reasonable costs based on current conditions.

7. ***Several commenters suggested the benefit cost assumptions should be increased. In particular, commenters objected to the amounts assumed for health insurance and also stated that the amount assumed for discretionary benefits did not adequately cover costs to offer a retirement plan, dental insurance, disability insurance, and other benefits.***

   The benefit assumptions included in the rate models considered both provider survey data and independent data sources. For example, health insurance costs are based on overall employee participation rates across a mix of plan types and employer cost data derived from Maine-specific data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey.

   Overall, the benefit assumptions compare favorably to the amounts reported through the provider survey. For example, the effective per-employee cost for health insurance reported through the provider survey was $549 per month for full-time staff while the rate model includes $591. The rate models include $200 per month for other benefits whereas the average reported through the provider survey was $70. Further, the rate models assume that all staff work full-time (at least 30 hours per week) and have access to a comprehensive benefits package while the provider survey suggests that about one-third of staff providing services covered by this rate study work part-time and have limited benefits. For these part-time staff, providers reported average per-employees costs of $40 per month for health insurance (because most employees do not have health insurance) and $12 per month for other benefits. As with all other rate model assumptions, some providers will have higher benefit-related costs while others will have lower costs. Overall, DHHS continues to believe that the benefit assumptions are reasonable.

8. ***Several commenters stated that the number of days of paid time off should be increased, suggesting that the models should include between 35 and 45 days per year.***

   The rate models include 25 days of paid leave (the combination of holidays, vacation, and sick leave) for non-degreed staff and 30 days for degreed staff. These amounts are consistent with other MaineCare rate studies as well as reporting in the provider survey, which found between nine and ten holidays and about 18 days of other paid leave. In addition, these assumptions align with data for employers in the New England regions published by the Bureau of Labor Statistics, which reports an average of nine holidays as well as 16 days of other leave for employees with one year of experience, 20 days for those with two and five years of experience, and 23 days for those with five to ten years of experience. As with all other rate model assumptions, some providers will offer more generous paid leave while others will offer less. Overall, DHHS continues to believe that the paid time off assumptions are reasonable.

9. ***One commenter argued that the productivity assumptions in the rate models reflect a "perfect world".***

   In general, the rate models for services reimbursed on an hourly or 15-minute basis include productivity assumptions to account for direct care staff's non-billable responsibilities. These assumptions seek to reflect a typical workweek, acknowledging that the time spent on any given activity will vary from week-to-week. Responses to comments regarding productivity assumptions for individual services are addressed in the service-specific sections of this document.

10. ***Several commenters suggested the cost of turnover is not adequately addressed in the rate models. In particular, commenters stated that the rate models need to incorporate substantially more training (or onboarding or nonproductive) hours for new staff.***

    Providers participating in the provider survey reported turnover rates of 25 to 35 percent for direct care staff for most services. The rate models do intend to account for costs associated with this

turnover. Costs associated with human resource and training functions are part of the administrative and program support assumptions.

Additionally, the rate models include a productivity adjustment for time that direct care staff spend participating in training. Specifically, most rate models assume 50 hours of training per year for direct care staff. This total represents a weighted average of staff in their first year of employment who must receive significant training to begin delivering services and staff with more than one year of experience who require much less training. These assumptions are consistent with reporting through the provider survey. Commenters suggest that the training assumptions be dramatically increased or a new productivity factor be added to account for onboarding time for new staff. Figures reported by commenters ranged from 350 to 500 hours for nonbillable onboarding time. These figures depart significantly from the training hours reported in the provider survey, which generally found 80 to 100 hours of training in the first year of employment, so no changes have been made.

11. ***One commenter suggested mileage assumption are understated because they reflect operations during the Covid-19 pandemic.***

    As suggested by the commenter, the rate study considered provider survey results when establishing mileage assumptions for community-based services and providers' survey reporting periods generally coincide with the Covid-19 pandemic. However, when comparing reported mileage to the provider survey conducted in 2016, the figures are generally comparable for most services. Further, most rate models resulting from this rate study include an equal or greater amount of mileage than the models developed (but largely not implemented) in 2016.

12. ***Several commenters stated travel-related assumptions in the rate models are inadequate for services in rural parts of the state.***

    The rate study recommended a single statewide fee schedule rather than rates differentiated by region of the state. The rate models developed to establish the fee schedule are intended to reflect the reasonable expenses of a typical provider. For any given provider, it is expected that some costs will be greater than assumed in the rate models and other costs will be less. It is likely that rural providers will have higher travel-related costs, but they may have lower costs in other areas. Further, since most MaineCare services similarly have statewide payment rates, DHHS believes that decisions related to the development of rates that vary by region should be considered more broadly across MaineCare, and DHHS plans to review this issue with the MaineCare Technical Advisory Panel established pursuant to P.L. 2021 Ch. 639 to inform future rate determinations.

13. ***Several commenters stated that the 15 percent rates for administration and program support should be increased and that some services have higher overhead costs than others.***

    In general, the rate models assume 15 percent of the total costs relate to administrative costs and 15 percent of total costs relate to program support costs (rate models for services delivered to groups include 20 percent for program support). These assumptions are applied across all services. These amounts are in addition to other programmatic costs specifically identified in the rate models such as office space and vehicle-related expenses.

    The rate study did seek to examine difference in program support costs across services by asking providers completing the provider survey to allocate these costs to individual services. However, there were not enough responses for each individual service to draw reliable conclusions regarding cost differences. Further, the data that was reported through the survey generally found reasonably similar program support rates across services, with reported program support ranging between 10 and 20 percent for most services. As a result, the rate study included standardized administrative and

program support allowances. It is additionally noted that the 30 percent total assumed for administration and program support exceeds the amounts included in most other MaineCare rate studies.

14. Several commenters stated that the rate models do not account for various expenses, including:

- ***Office space associated with staff performing administrative and program support functions as well as common areas***
- ***Travel by direct care staff that is not related to service delivery***
- ***Office supplies and cell phones used by direct care staff***
- ***Background checks***

The expenses highlighted by commenters are incorporated in the administrative and program support assumptions included in the rate models. In total, most rate models include 30 percent for administration and program support. As noted in the response to comment 13, this total is consistent with the amounts reported in the provider survey, which covered all of the expenses noted by the commenters.

15. One commenter stated that, with the exception of Multi-Systemic Therapy, the rate models do not account for training costs.

The rate models for all services include funding for training-related costs.

For certain services with extraordinary travel-related costs such as very high registration costs and mandated out-of-state travel (such as Multi-System Therapy and Functional Family Therapy), the rate models include specific cost assumptions.

For other services billed on an hourly basis, the time that direct care staff spend in training are recognized through productivity adjustments. For services billed based on a weekly or monthly unit of service, the time that direct care staff spend in training is incorporated in the caseload assumptions (that is, the caseload assumptions intend to reflect the time that staff have to provide care after accounting for other responsibilities such as training).

Other training-related costs such as registration fees are part of the program support allowance. As discussed in the response to comment 13, the 15 percent included in most rate models for program support is consistent with the amounts reported in the provider survey.

16. Several commenters objected to payment rates that assume providers only "break even", which prevents providers from expanding their programs.

The rate models do not include any specific provision for a profit margin. Instead, the rates – which will increase rates between 6.6 to 72.3 percent depending on service – are intended to reflect the reasonable costs that providers incur to deliver services consistent with state requirements and individuals' treatment/service plans. The establishment of rates that adequately cover providers' expenses is intended to support sufficient provider capacity to meet the needs of MaineCare members. Providers able to meet service requirements and performance benchmarks at costs lower than assumed in the rate models retain the cost differential to invest as they see fit. This provides an incentive for cost efficiency.

17. ***One commenter stated support for value-based payment models, but expressed concern regarding payment withholds based on rate models intended to reflect providers' reasonable costs for service delivery. The commenter stated that the full rate should be paid regardless of performance and that supervision and education should be provided to agencies that do not achieve the performance metric. The commenter further suggested incentives above the standard rates for superior performance in order to encourage service expansion.***

    The Department will be instituting the proposed pay-for-performance provisions for adult Assertive Community Treatment, Behavioral Health Homes, and Children's Home and Community-Based Treatment through the formal rulemaking process, which includes a public comment process during which stakeholders could offer feedback regarding the proposals. The proposed provision requires that providers meet a minimum level of performance in order to receive the full rate; providers who are below that threshold would not be considered to be providing a full or acceptable level of service that equates to the full rate. Based on public comment during the rate determination process, the proposed pay-for-performance provision was amended to include the opportunity for providers with high performance to earn a one percent incentive payment in addition to the full rate.

18. ***Several commenters expressed concern about the impact of the change in MaineCare's billing policy that does not allow providers to round up to the next full unit unless they provide 80 percent of the unit of service, an increase from the current allowance of rounding-up once 50 percent of the unit of service has been provided.***

    Prior to January 1, 2023, providers were permitted to bill for a unit of service if they delivered at least 50 percent of a time-based unit. For rates billed in 15-minute increments, for example, a provider could bill for a unit of service once they provided 7.5 minutes of support.

    To better align reimbursement with services delivered, MaineCare's policy changed for services delivered on and after January 1, 2023. With that change, providers can only round up once they deliver 80 percent of a time-based unit. Thus, for a 15-minute rate, they cannot round up until they deliver 12 minutes of service. However, the new policy also allows providers to bill for partial units of service (rounded to one or two decimal places, at the provider's choosing). Thus, if a provider delivers 7.5 minutes of support, the new policy allows them to bill for one-half of a unit.

    The commenters are correct that a provider that delivers 7.5 minutes of service will see a lower payment for this particular service encounter as they would bill for one-half of a unit rather than a full unit. However, a provider that delivers 6 minutes of service will see a higher payment because, under the previous policy, they could not bill anything for this service encounter while the new policy allows for billing of 0.4 units. Thus, providers will see increased payments for any service encounter of less than half of a time-based unit, decreased payments for service encounters equal to 50 percent and less than 80 percent of a time-based unit, and no change for service encounters equal to 80 percent or more of a time-based unit. Overall, these changes should not substantially change providers' revenues.

SECTION 13 – TARGETED CASE MANAGEMENT

19. ***Two commenters requested that MaineCare establish monthly payment rates for Targeted Case Management rather than the current 15-minute rate.***

    DHHS is not currently considering the establishment of a monthly rate for Targeted Case Management, but may do so in the future. If DHHS does consider a potential change to the payment model and related service expectations, providers and other stakeholders will have an opportunity to provide input.

20. Several commenters suggested that there should be separate rates across different eligibility groups. These commenters stated different DHHS divisions have different expectations, the level of billable and non-billable support required varies across populations, and the qualifications of staff differ. Some commenters stated that rates should be higher for child populations while others suggested rates should be higher for adult populations.

The rate study did seek to evaluate differences across populations. With a 15-minute billing rate the primary difference would relate to the amount of time spent on non-billable activities. The provider survey data did not produce conclusive results about variances in this area. If in the future DHHS considers the establishment of a monthly billing unit as suggested in comment 19, at that time it will also consider whether the rates should vary by eligibility group.

For other factors, DHHS believes the rate model is sufficient for all populations. As noted in the response to comment 20, the case manager wage assumption is 41 percent higher than the average reported through the provider survey. Additionally, with a 15-minute billing unit, differences in the amount of billable supports are immaterial since providers bill based on the support they deliver.

21. One commenter stated that the wage assumption for case managers should be higher than assumed for MHRT/C's working as behavioral health home coordinators, noting that MHRT/C's are not required to have a bachelor's degree.

The wage assumption in the Targeted Case Management rate model reflects an average of the Bureau of Labor Statistics (BLS) occupational classifications for child, family, and school social workers (typically a bachelor's-level position) and healthcare social workers (typically a master's-level position). As shown in Figure 1 above, the resulting hourly wage of $29.96 is 41 percent higher than the average wage reported by respondents to the provider survey.

Although unrelated to the assumptions for TCM, most rate models for services provided by an MHRT/C, including adult Behavioral Health Homes, use a different BLS benchmark and assume a wage of $26.74 per hour.

22. One commenter questioned why the overall rate for Targeted Case Management is increasing by only 6.6 percent when wage assumptions have been increased by 13.6 percent.

As discussed in the response to comment 4, the rate study increased the published BLS wage data by 13.59 percent to develop a July 2023 estimate. As the commenter notes, the recommended Targeted Case Management rate is 6.6 percent higher than the current rate. The overall rate increase is not equal to the wage inflation factor for two primary reasons.

First and most significantly, the wage inflation factor applies to the rate models developed as part of this rate study. Most current rates reviewed as part of this project do not have detailed assumptions underlying the overall rate. In short, the wage inflation factor is being applied to the assumptions in the new rate model rather than to any portion of the current rate. Across the rate study, the rates for many services are increasing by substantially more than the wage inflation factor while other rates, including TCM, are increasing by less than the wage inflation factor.

Second, the wage assumption is only a component of the overall rate and individual components of the rate will grow by varying amounts over time. That is, wage costs may grow more quickly or more slowly than other costs.

23. One or more commenters objected to each of the productivity assumptions in the rate model, stating:

- ***The assumption of 4.5 hours per week for travel time is too low and may be impacted by reduced travel during the pandemic; one commenter suggested 11.0 hours instead.***
- ***The assumption of 1.5 hours per week for missed appointments is too low; one commenter suggested 2.0 hours instead.***
- ***The assumption of 5.0 hours per week for recordkeeping and reporting is too low due to the complexity of the Enterprise Information System (EIS) and required documentation; alternative assumptions ranged from 6.0 hours to 11.00 hours per week.***
- ***The assumption of 1.5 hours per week for employer and one-on-one supervision is too low due to complex service systems and recordkeeping; one commenter suggested 3.0 hours instead.***

Some of these commenters suggested billable hour expectations prior to paid time off and training should be closer to 25 or 26. Commenters additionally expressed concerns about the effects of turnover on productivity (which is addressed in the response to comment 10), paid time assumptions (addressed in the response to comment 8), and training (addressed in the response to comment 10). Two commenters suggested the assumed productivity levels would cause burnout and turnover.

The Targeted Case Management rate model assumes staff provide 27.50 hours of billable support during a typical week without training or paid time off and 23.67 hours per week (1,231 hours per year) overall after accounting for training and paid time off. As with all rate model assumptions, the individual productivity adjustments are meant to reflect a reasonable average and it is expected that some providers may experience more time on some activities and less on others. Overall, the assumptions are in-line with provider survey results after accounting for reported time spent on activities outside of the scope of TCM, including transporting members, providing aftercare, and performing representative payee functions and no adjustments have been made. In particular, the overall reported weighted average when adding billable activities, time transporting members, and providing after-care was 27.4 hours.

24. Two commenters stated the assumed 50 hours of training per year is insufficient. These commenters stated that case managers receive 40-50 hours of annual training after their first year of employment.

The assumed 50 hours of training per year are consistent with provider survey results, which indicated case managers receive 80 hours of training in the first year and 35 hours in subsequent years, producing a weighted average of 46 hours per year. The assumption is also consistent with MaineCare requirements and is therefore unchanged.

25. One commenter suggested that providers be permitted to bill for time spent performing representative payee activities for individuals or that a productivity assumption be added to the rate model to reflect this time. The commenter stated that the Office of Aging and Disability Services have asked case management agencies to provide this service.

Representative payee functions are not part of the scope of Targeted Case Management and are not an expectation of the service. OADS does not require case management agencies to provide representative payee services. Thus, these activities are neither billable nor incorporated in the rate model as a productivity adjustment.

26. One commenter stated their case managers travel 224 miles per week and are reimbursed at $0.44 per mile.

The Targeted Case Management rate model assumes a case manager travels 150 miles per week on average. This assumption exceeds the 90-100 miles per week reported by participants in the provider survey. As a result, this assumption is unchanged. As with all rate model assumptions, it is expected that some providers such as the commenter may have higher average mileage while others will have lower averages.

The rate model funds the cost of mileage at $0.625 per mile, the Internal Revenue Services' standard mileage rate for 2022.

27. One commenter suggested that time spent communicating with members through means other than face-to-face or telephonic contacts such as email, voicemail, and text messages be billable. Another commenter suggested that client support activities such as continued stay reviews be billable.

The Department is not considering changes to the definition of billable activities at this time. The Targeted Case Management rate model reflects current service requirements.

28. One commenter noted concerns related to the requirement that care plans must include the member's signature.

This suggestion is outside of the scope of this rate study.

29. Several commenters stated that assumed program support rate of 15 percent is inadequate. Commenters listed a number of costs incurred by providers including supervisory staff, technology-related expenses, liability insurance, and audits. Commenters suggested program rates between 20 and 25 percent.

As noted by the commenters, the Targeted Case Management rate model assumes 15 percent of the total rates for program support expenses such as those listed by the commenters. This assumption is less than reported in the provider survey (where the median reported rate was 23.8 percent of costs, and the weighted average was 25.7 percent). The provider survey results appear to be driven, in part, by the relatively small size of many programs. For example, 116 TCM providers billed for $37.5 million in services in fiscal year 2021, an average of $323,000 per provider. In comparison, 46 Behavioral Health Home providers billed for $65.4 million in services, an average of more than $1.4 million. The result is that infrastructure costs are being spread over a relatively small revenue base. When establishing the program support assumption, the rate study therefore also considered other similar services in this rate study (such as Behavioral Health Homes) as well as other MaineCare rate studies. As noted in the response to comment 13, the rate models established as part of this rate study include a total of 30 percent for administration and program support, which is greater than the overhead funding included in most previous MaineCare rate studies.

30. One commenter suggested that eligibility for Targeted Case Management be expanded to all individuals undergoing treatment within MaineCare for substance use disorders.

Service eligibility is outside of the scope of this rate study.

SECTION 17

Community Integration

31. One commenter suggested that the draft rate for Community Integration is insufficient, noting the challenges faced by individuals receiving services and a decline in the number of providers delivering services. The commenter further suggested that the rate should be $30 per 15 minutes.

DHHS recognizes the value of this service.

The commenter did not offer specific feedback on the draft rate model, but DHHS believes that the rate model assumptions, which are based on Maine-specific benchmark data and information from the provider survey, adequately reflects the cost of service delivery.

32. Two commenters suggested the MHRT/C wage be increased to match the assumed wage for case managers in the Targeted Case Management rate model. One of these commenters noted that many of MHRT/C's have a bachelor's or master's degree.

The rate models for services delivered by an MHRT/C use the Bureau of Labor Statistics occupational classification for substance abuse, behavior disorder, and mental health counselors, which is a bachelor's-level position although MHRT/C's are not required to have a degree. DHHS continues to believe this is a reasonable benchmark for MHRT/C's as well as the health home coordinator position in the adult Behavioral Health Home rate model. The Targeted Case Management rate model relies on a different BLS benchmark because of the differing qualifications for case managers.

33. Several providers state that productivity assumptions should be increased, particularly related to missed appointments, travel time (which may be reduced by the use of telehealth), and employer time. One of these commenters stated that productivity has been impacted by MaineCare's new severe mental illness discharge policy.

The Community Integration rate model assumes staff provide 27.50 hours of billable support during a typical week without training or paid time off and 23.67 hours per week (1,231 hours per year) overall after accounting for training and paid time off. As with all rate model assumptions, these assumptions are meant to reflect a reasonable average and it is expected that some providers may experience more time on some activities and less on others. Overall, the assumptions are in-line with provider survey results and no adjustments have been made.

34. One commenter suggested the assumed number of miles driven by an MHRT/C providing Community Integration be increased from 150 miles per week to 210.

The 150 miles included in the Community Integration rate model is based on the results of the provider survey as the median reported value was about 100 miles per week while the weighted average was about 200 miles. Of the 13 Community Integration providers that reported mileage, eight reported 150 miles or fewer while two of the other providers reported exceptionally high figures: 1,579 miles per week (316 miles per workday) and 870 miles per week (174 miles per workday).

As a result, this assumption is unchanged. As with all rate model assumptions, it is expected that some providers such as the commenter may have higher average mileage while others will have lower averages.

35. One commenter suggested that on-call payment should be included in the Community Integration rate model due to the need for after-hours support.

In response to this comment, on-call costs have been added to the Community Integration rate model. The rate model assumes an on-call cost of $150 per week with on-call responsibility rotated between three staff.

Community Rehabilitation Services

36. One commenter stated the rate was insufficient and that they would have to pay their staff at least $18 per hour.

The wage assumptions for both positions included in the Community Rehabilitation Services rate model exceed $18.00 per hour. The rate model assumes an average hourly wage of $20.40 for the MHRT I position and an average hourly wage of $26.74 for the MHRT/C position. The commenter did not otherwise provide feedback on specific rate model assumptions.

37. One commenter suggested the assumed wage be increased to the $29.64.

As noted in the response to comment 32, the rate models for services delivered by an MHRT/C use the Bureau of Labor Statistics occupational classification for substance abuse, behavior disorder, and mental health counselors, which is a bachelor's-level position although MHRT/C's are not required to have a degree. DHHS continues to believe this is a reasonable benchmark for MHRT/C's.

38. Two commenters suggested that travel time should be added to the rate model and that the mileage assumption should be increased to 225 miles per week.

In general, rate models for services reimbursed on a 15-minute or hourly basis include productivity assumptions to account for the cost of direct care staff's non-billable hours. For services reimbursed on a daily basis like Community Rehabilitation Services (CRS), as well as those reimbursed on a weekly or monthly basis, the rate models generally divide the full cost of direct care staff (both their direct and indirect responsibilities) over the assumed caseload. That is, the caseload assumption is intended to reflect the number of individuals that a direct care staff can serve given the totality of their responsibilities. The CRS rate model does include productivity adjustments for training and paid time as it is assumed that substitute staff will be needed during these times, but does not otherwise include productivity assumptions.

The rate model includes 175 miles per week for the team (one MHRT/C and two MHRT I's). This assumption, which is somewhat greater than the 30-50 miles per staff person reported by respondents to the provider survey, is unchanged.

Assertive Community Treatment

39. Several commenters expressed support for the proposal to establish a weekly payment rate rather than the current daily rate, but further advocated for a monthly payment rate. Commenters stated a monthly rate would reduce administrative effort and allow for contacts to be averaged over time, which would reduce instances when a provider cannot bill because service was not provided.

As noted by the commenters, the rate study recommended replacing the current daily payment rate with a weekly case rate. This recommendation is intended to recognize the requirements of the service (providing access to 24-hour supports), to align payments with service expectations (three contacts per week compared to current practices where providers may bill from one-to-seven days per week), and to reduce administrative efforts. Given the expectation for regular contact with clients, DHHS believes that a weekly payment rate is most appropriate.

40. One commenter suggested the establishment of tiered rates such as those for health home and opioid health homes.

Current Assertive Community Treatment standards do not vary based on the acuity of the individual served. The rate study therefore recommends a single rate that reflects typical staffing and caseloads needed to serve a population with a range of needs.

41. Several commenters offered suggestions relating to the requirement that individuals receive three contacts per week, including:

- ***Eliminating the requirement in lieu of allowing providers to determine the number of contacts based on a client's needs.***
- ***Counting all "touches", including unsuccessful outreach, towards meeting the requirement.***
- ***Measuring the number of contacts across a team's caseload rather than by individual client.***
- ***Allowing partial billing when a provider makes only one or two contacts during a week.***

The requirement for three face-to-face contacts per week is to ensure that the ACT service is delivered at an intensity that leads to better performance and improved outcomes. Recognizing that there will be instances when a provider may be unable to provide services despite its best efforts, the rate model has been revised to include a five percent "absence" factor.

42. Several commenters offered suggestions for performance-based outcomes that could be used in combination with or instead of the number of weekly contacts to determine payment for services expressed a need for the Department to review the quality measures and value-based payments. Suggestions included:

- ***Quality of life measures such as the Self Sufficiency Matrix or the Quality of Life Scale.***
- ***Treatment outcomes measured by the Role Functioning Scale, the Brief Psychiatric Rating Scale, and documented interventions to reduce hospitalizations.***
- ***Population health measures such as 95 percent of a program's caseload having seen a doctor.***

Additionally, one commenter expressed concern about the ability to comment on the proposed rate without knowing the details of any performance requirements.

DHHS appreciates the suggestions related to performance measures and will consider this input as value-based payment options are evaluated. Any changes to payment structures will be proposed through the formal rulemaking process, which includes an opportunity for public comment. New performance measurements and performance-based payment provisions would not be included until DHHS has formally adopted a final rule.

43. One commenter suggested that the rate model include office space for team members.

In response to this comment, specific assumptions related to office space for the LCSW/LCPC (team leader), psychiatrist, MHRT/C, registered nurse, rehabilitation counselor/ employment specialist, peer support specialist, and substance abuse counselor positions have been added to the Assertive Community Treatment rate model. Assumptions related to square footage and costs match the amounts included in other rate models.

44. Two commenters requested the timeframe for authorizations be increased from 90 days to one year.

Authorization policies are outside of the scope of this rate study.

SECTION 28 SERVICES

45. Several commenters expressed concerns regarding the potential transition to weekly payment units that are tiered based on the number of hours of service delivered. Commenters suggested that some providers would only serve those with the least support needs or deliver services at the low end of each range to maximize financial returns. Commenters also noted that this approach would require significant changes to the process for determining level of need and for plan development as well as the development of billing rules (for example, what providers would bill if a child receives fewer hours than approved). Two commenters expressed support for the draft 15-minute rates.

In response to these comments, at this time DHHS has decided to maintain 15-minute payment rates for Section 28 services.

46. One commenter expressed concern about implementing quality standards and linking payment rates to these standards. The commenter stated that subjective standards could result in disparate treatment of providers and differing payments to providers could result in the lower-paid providers permanently falling behind higher paid providers (because, for example, they would not be able to pay the same wages).

DHHS has not made any decisions related to new quality standards or how such standards would be connected to payments. Any adoption of quality measures or changes to payment structures would go through the formal rulemaking process, which includes a public comment process during which stakeholders could offer feedback regarding the proposals.

47. One commenter stated the 30 percent benefit rate is the same as the benefit assumption in the 2009 rate, which suggests benefit costs have not increased in 13 years.

It is not clear what might have been included in the 2009 benefit rate referenced by the commenter so a direct comparison cannot be made Regardless, the comparison is incomplete for several reasons:

- Rather than 30 percent, the rate models now reflect a benefit rate for BHPs of 33.5 percent for school-related services that assume a 36-hour workweek and 36.3 percent for community-based services that assume a 32-hour workweek.
- It is unknown what wage was assumed in 2009, but it was certainly less than the $23.01 per hour assumed in the current rate model. Since the benefit rate is being applied to a much higher wage base, it translates to a substantially higher dollar amount, reflecting higher costs since 2009.
- It is unknown whether the 2009 benefits rate included paid time off, but the current rate includes these hours as a productivity adjustment.

Overall, as discussed in the response to comment 7, the benefit assumptions compare favorably with information reported through the provider survey.

48. Two commenters objected to the assumption that behavioral health professionals providing school-related services work 36 hours per week on average. One of these commenters stated that the average should be more 40 hours per week because BHPs are scheduled for 40 hours and additional hours are required to cover for staff who take time off. The other commenter stated that the average should be 30 hours to reflect the number of hours that children are typically in school.

As observed by the commenters, the rate model for school-related services assumes that behavioral health professionals (BHPs) work 36 hours per week, which is based on reporting through the provider survey. This assumption is intended to reflect the total number of hours that a BHP works, not the number of billable service hours they provide. Of the 36 work hours, the rate model assumes that BHPs provide an average of about 24 hours of billable service when providing one-to-one services (productivity assumptions are lower for group services). Part of the nearly 12 hours of nonbillable time relates to paid time off. This productivity factor accounts for costs associated with paid leave.

49. Several commenters objected to the productivity assumptions in the school-related rate model. Two commenters suggested that missed appointments should be increased to two-to-three hours per week rather than the assumed 0.75 hours; one of these commenters also suggested that the time assumed for employer and one-on-one supervision should be increased from 1.5 hours per week to 2.5 hours. Commenters additionally expressed concerns about the effects of turnover on productivity, paid time assumptions, and training.

The productivity factor assumptions for missed appointments and employer time in the school-related Section 28 services are consistent with the reporting through the provider survey and DHHS believes the overall productivity assumptions are reasonable. Other comments are addressed in the cross-services section of this document (turnover is addressed in response to comment 10, paid time off is addressed in response to comment 8, and training is addressed in the response to comment 10).

50. One commenter stated the rate model for board certified behavior analysts should include additional productivity factors such as collateral contacts, recordkeeping and reporting, and missed appointments as included in the BCBA rate model for Section 65.

Board certified behavior analysts (BCBAs) are a component of Specialized Section 28 services. The rate models for Specialized services therefore include a factor for BCBA-related costs, fully funding one BCBA for every six behavioral health professionals. There is additionally a rate model to allow for billing for direct supports provided by BCBAs under Section 28. Since the full cost of the BCBA – including their nonbillable responsibilities – are already incorporated in the Specialized rate models, the Section 28 BCBA rate model does not include productivity factors related to the operation of the program to avoid duplicative payments for BCBAs' time. The rate model does include assumptions related to other nonbillable time (employer and one-on-one supervision time, training, and paid time off). Section 65 does not include a comparable Specialized service so the rate model for BCBA supports delivered through this section accounts for all nonbillable responsibilities.

51. Two commenters suggested that the rate model for board certified behavior analysts in inadequate to support contracted BCBAs that charge $100 to $150 per hour.

As with all of the rate models, the board certified behavior analyst rate model is based on an employee model. In particular, the model assumes an annual salary of almost $86,000 as well as the benefits package outlined in the response to comment 7. To validate the wage assumption, the rate study considered wage aggregators such as ZipRecruiter and Indeed.com, which reported typical wages of approximately $65,000 per year.

Although the rate model is built on an employee model, it can be applied to a contractor arrangement as well. In a contracted relationship, the wage assumption is not the appropriate comparison. In general, an agency will not separately pay for employee benefits for contractors, nonbillable time, office space, the contractor's administrative expenses, etc. Rather, all of these expenses are incorporated in the hourly rate paid to a contractor. Thus, the contractor's hourly rate should be compared to the overall rate model with the exception of overhead costs that an agency occurs regardless of whether they employ or contract with a BCBA. Considering both the BCBA costs built into the Specialized rate model and the standalone BCBA rate model to allow billing of direct supports, DHHS believes the rates are sufficient for either an employee or contractor model.

52. Several commenters stated that the 15 percent program support rate is too low, suggesting current program support costs represent 20 to 30 percent of total expenses.

As discussed in the response to comment 13, the rate models include 15 percent of the total rate for program support expenses. As additionally noted in that response, the data collected through the provider survey did not support program support rates that vary by individual services. As it relates to Section 28 services in particular, the recommended rates are between 45 and 86 percent higher than current rates. Thus, the program support funding included in the rate models translate to between 21 percent and 26 percent of the current rates, consistent with the ranges reported by most of the commenters.

53. One commenter stated that the facility, administration, and program support costs included in the rate models should be removed for special purpose private schools as these costs are paid for by the sending school district.

The school-related rate models do not include education-related expenses that should be covered by the tuition paid by the sending school district. Instead, the rates account for the costs associated with delivering the MaineCare-funded services, which includes the infrastructure costs listed by the commenter.

54. Two commenters stated that the facility cost assumption of $0.56 per billable hour is too low and instead suggested costs ranging from $1.75 to $3.24 per billable hour.

The commenters did not state which portions of the facility cost assumptions (the number of square feet per BHP, the cost per square foot, or the number of billable hours over which the annual cost is spread) they believe to be inadequate. As a result, potential changes could not be evaluated. However, it is noted that the assumption is not meant to cover all facility costs. As noted in the response to comment 53, the rate models for school-related services do not include education-related expenses, which included classroom facilities. Instead, the rate model only includes the cost of the marginal space necessary to deliver the MaineCare-funded service.

Specifically, the rate model includes the cost for 35 square feet of space to accommodate the staff providing the service. If the assumption of 35 square feet per staff is maintained, the commenter's suggested cost per billable hour presumes a cost of $50 to $93 per square foot, which is substantially higher than has been included in any previous rate studies.

55. One commenter stated that office space should be included for behavioral health professionals providing services in the community.

The rate models do not include the cost of office space unless the service is provided in a provider's facility or it is expected that a staff person will have a dedicated office. For community-based Section 28 services, it is assumed that BHPs spend nearly all of their time delivering services in the

community and do not need a dedicated office. Instead, it is assumed that, if a BHP needs to spend time in an office, it would be in shared space that would be part of the program support allowance.

SECTION 65 SERVICES

56. One commenter asked whether the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) program will be added to evidence-based services.

DHHS is not adding MATCH at this time, but may consider doing so in the future.

Children's Behavioral Health Day Treatment

57. One commenter suggested the adoption of a 15-minute billing unit for Day Treatment rather than an hourly unit to provide consistency with Section 28 services.

In response to the comment, the billing unit has been changed to 15-minutes.

58. Several commenters expressed objections to the existing limit on six hours of support per day, noting, for example, that a typical school day for children without special needs is six-and-a-half hours. One commenter stated that they deliver 32.5 hours of service per week while another reported delivering 28.0 hours.

A change to the limit on the number of Children's Behavioral Health Day Treatment service hours covered by MaineCare is outside of the scope of the rate study. The rate models developed as part of the rate study reflect current requirements.

59. Two commenters stated that the assumed workweek for behavioral health professionals should be increased from 36 to 40 hours. Another commenter stated that the assumption should be reduced to 30 hours to match the maximum amount of support that a child can receive during a week.

As noted by the commenter, the Children's Behavioral Health Day Treatment rate models assume that behavioral health professionals (BHP) work 36 hours per week. As discussed in the response to comment 60, this assumption is intended to reflect the number of hours that a BHP works rather than the amount of billable service they provide or the amount of support an individual child receives.

The 36-hour workweek assumption is equal to what is included in the rate models for school-related Section 28 services, but is somewhat greater than the 38.0 to 38.5 hours reported through the provider survey. Since increasing the work hour assumptions would reduce the rate (as it would be assumed that the additional hours would be billable, reducing the productivity factor), the 36-hour workweek assumption was retained so that the rate would not be lower than the comparable Section 28 rate.

60. One commenter stated that the Children's Behavioral Health Day Treatment rate model assumes that staff provide 36 hours of billable supports per week despite the six-hour per day (30-hour per week) cap. Another commenter stated that the rate model assumes that staff provide 27.5 billable hours per week. This commenter stated that children in their program only attend about 28 hours per week and that staff must perform additional responsibilities such as collateral contacts and supervision of behavioral health professionals.

As noted in the response to comment 59, the Children's Behavioral Health Day Treatment rate model assumes that behavioral health professionals work 36 hours per week (the master's-level rate models assume these staff work 40 hours per week). However, the models do not assume that all of these

hours are billable. Rather, the one-to-one rate model assumes that staff provide about 24 billable hours of service per week. The remaining time relates to the types of activities cited by the commenter and other nonbillable, but paid hours such as collateral contacts, recordkeeping, employer and one-on-one supervision time, training, and paid time off.

61. ***One commenter stated that the rates for master's-level staff providing Children's Behavioral Health Day Treatment services should be higher than rates for Outpatient Therapy services because school programs are only in session for about 40 weeks per year.***

    The rate model does not include a factor to account for weeks when programs are not in session as it would not be an appropriate use of Medicaid funds to pay for three months of paid leave when school-related programs are not in session (it is also not anticipated that staff receive such paid leave).

62. ***One commenter objected to the use of the same wage estimate for behavioral health professionals (BHPs) delivering Children's Behavioral Health Day Treatment services and BHPs providing Section 28 services, stating that BHPs providing Children's Behavioral Health Day Treatment services support individuals with more significant needs and must have more college or training hours compared to those providing Section 28 services. Another commenter suggested the wage assumptions should be $27 per hour in order to compete with public schools.***

    As the commenter notes, the educational and training requirements for behavioral health professionals differ between Sections 28 and 65. Over time, DHHS intends to standardize these requirements. At this time, the Department believes that the wage assumption adequately reflects the higher requirements of BHPs providing Children's Behavioral Health Day Treatment services. As shown earlier in Figure 1, the $24.41 assumption included in the rate model is 31 percent greater than the $18.58 average reported by participants in the provider survey.

63. ***Several commenters objected to the productivity assumptions in the school-related rate model. Two commenters suggested that missed appointments should be increased to two-to-three hours per week rather than the assumed 0.75 hours; one of these commenters also suggested that the time assumed for employer and one-on-one supervision should be increased from 1.5 hours per week to 2.5 hours. Commenters additionally expressed concerns about the effects of turnover on productivity and paid time off assumptions.***

    The productivity factor assumptions in the Children's Behavioral Health Day Treatment rate model were set equal to those included in the Section 28 school-related rate models as DHHS seeks to standardize rates across these programs. That said, the overall productivity assumptions are similar to reporting through the provider survey for Children's Behavioral Health Day Treatment. Discussion related to the impact of turnover on productivity are addressed in the response to comment 10 and discussion related to paid time off is addressed in the response to comment 8.

64. ***One commenter stated the training hours should be increased for master's-level staff as they have to deal with students with complex needs.***

    As observed by the commenter, the rate models generally include a standard of 50 hours of training per year across all services. The assumption is intended to reflect a weighted average, recognizing that staff typically receive more training in their first year of employment than in subsequent years.

    The assumption of 50 hours per year is consistent with provider survey results overall. There was greater variability at the service level, but there were limited responses for a number of services such that it was unclear whether the results were representative for a given service. For clinical staff providing Children's Behavioral Health Day Treatment services, eight providers reported data for one

or more staff. Their responses ranged from 40 to 350 hours of training in the first year and 24 to 134 hours in subsequent years. Although two providers reported substantially more training hours than the others, the amounts reported by the remaining providers were consistent with the rate model assumption and DHHS continues to believe the assumption is reasonable for this service.

65. One commenter stated that the facility, administration, and program support costs included in the rate models should be removed for special purpose private schools as these costs are paid for by the sending school district.

The Children's Behavioral Health Day Treatment rate models do not include education-related expenses that should be covered by the tuition paid by the sending school district. Instead, the rates account for the costs associated with delivering the MaineCare-funded services, which includes the infrastructure costs listed by the commenter.

66. One commenter questioned why the Children's Behavioral Health Day Treatment rate models for master's-level staff only include 35 square feet of service space when the rate models for Outpatient services include 200 square feet.

The square footage assumption in the Children's Behavioral Health Day Treatment rate model is only intended to cover the additional space needed to accommodate the service provider. As noted in the response to comment 65, the classroom space associated with the child should be part of the tuition paid by the sending school district. In comparison, the Outpatient Therapy rate model referenced by the commenter reflects services provided in a clinic environment and the office space assumption is intended to reflect the space in which services are provided, accommodating both the clinician and the service recipient (the rate models for community-based Outpatient Therapy do not include any square footage).

67. Several commenters stated that the 15 percent program support rate is too low, suggesting current program support costs represent 20 to 30 percent of total expenses.

As discussed in the response to comment 13, the rate models developed as part of this rate study include 15 percent of the total rate for program support expenses. As additionally noted in that response, the data collected through the provider survey did not support program support rates that vary by individual services. As it relates to Children's Behavioral Health Day Treatment services in particular, the rate for services provided by behavioral health professionals are about 10 percent higher than the current rate while the rate for master's-level staff is lower. For both services, then, the program support funding is less than suggested by the commenters, but is what can be supported by the available data.

Board Certified Behavior Analyst (BCBA) Services

68. One commenter stated that the productivity assumption is too high and that the training and missed appointments productivity factors should be increased.

The rate model for Board Certified Behavior Analyst (BCBA) services delivered under Section 65 assumes that a BCBA provides 26 billable hours of service during a typical workweek and about 22 hours per week after accounting for training and paid time off. Given that some BCBA costs are part of the program support allowance for other services they support, DHHS believes this assumption is reasonable. In regard to the specific comments, the impact of turnover on productivity is addressed in the response to comment 10 and the assumption related to missed appointments is the same as included in the rate models for other clinicians such as Outpatient Therapy services.

69. One commenter stated that the 15 percent program support rate is too low and should be increased to 20 percent.

As discussed in the response to comment 13, the rate models developed as part of this rate study include 15 percent of the total rate for program support expenses. As a newly covered service, there was no existing data to consider a different rate (although, as noted in the response to comment 13, the same rate has been applied to all services). Given the higher direct costs for this service, the rate model includes more program support funding than most services. For example, the Board Certified Behavior Analyst rate model includes $19.65 in program support per billable hour compared to $15.44 per billable hour in the one-to-one Outpatient Therapy rate for social workers.

Outpatient Therapy

70. Many commenters expressed support for recommended increases to payment rates for Outpatient Therapy services. One commenter suggested that the agency rate models are nearly 50 percent lower than their costs.

As with all rate models established as part of this rate study, the rates are intended to reflect the reasonable costs providers incur to deliver services consistent with service requirements and individuals' treatment plans. For clinic-based services provided by social workers, the rate is increasing by about 14 percent. Increases for other staff types and for services delivered in the community are larger. There was no data collected or identified as part of this rate study that suggested payment rates should be doubled as suggested by the one commenter.

71. Many commenters expressed support for standardizing Outpatient Therapy rates for independent practitioners and clinicians working for an agency. Several of these commenters stated that the increased payment rate for independent practitioners would increase the number of clinicians willing to accept MaineCare enrollees. Additionally, several of these commenters expressed dissatisfaction with current 'affiliate' relationships with agencies, citing objections related to the amounts retained by agencies and the level of paperwork required.

Conversely, several commenters objected to standardizing rates for agencies and independent practitioners, suggesting that the change will reduce MaineCare enrollees' access to services. Specific concerns include that clinicians will be less willing to work for an agency, that independent practitioners are not licensed by the Division of Licensing and Certification, that independent practitioners may not complete their continuing education requirements, and that practice violations and fraud may increase. Commenters additionally noted that agencies serve individuals with a higher acuity of need and provide additional supports such as care coordination, collateral work with guardians, and work in the community. One commenter also asked whether independent practitioners will be required to contract with crisis providers for afterhours coverage. Finally, a few of these commenters also stated several benefits of the affiliate model, including that agencies provide background checks, offer training, and ensure service authorizations.

The commenters' major areas of concern related to the additional reporting and recordkeeping agencies are required to complete and the potential disruption to the system as agencies will have difficulty recruiting and retaining staff.

Historically, MaineCare has paid lower rates for Outpatient Therapy services provided by independent practitioners compared to the rates paid for the same services provided through an agency. Since the service and individual requirements do not vary based on whether the clinician is employed by an agency, the rate study recommended that the rates be standardized. The intent is to

increase access to services by encouraging more independent practitioners to accept MaineCare reimbursement.

As noted, MaineCare already contracts directly with independent practitioners so the proposal to standardize rates does not change existing policies. Although some clinicians may choose to transition to private practices, it is likely that many practitioners prefer to be an employee rather than a business owner and will choose to remain with an agency. Additionally, there is nothing that prohibits an affiliate model; if an agency provides value equivalent to the amount of the payment they retain, independent practitioners can still choose to affiliate.

72. One commenter suggested that school-related services should be reimbursed at the community-based rate rather than the clinic-based rate. The commenter stated that school-related clinicians often provide services in the child's home.

Outpatient Therapy rates have historically been the same regardless of where the service is provided. Recognizing that delivering services in individuals' homes adds travel-related expenses, including a reduction in the clinician's productivity to allow for travel between appointments, the rate study developed separate rates for clinic-based and community-based services. Services provided in a school setting do not incur travel expenses like services provided in individuals' homes. Thus, school-related services will be reimbursed at the clinic-based rate. However, if the clinician does deliver the service in the child's home as in the example cited by the commenter, the community-based rate can be billed.

73. One commenter suggested that there should be a higher rate for assessments as they are more clinically complex in nature and require more documentation and nonbillable time.

DHHS appreciates the feedback related to the additional nonbillable time associated with assessments, but does not have the data to support different rates for assessment-related work. Instead, since it is expected that many clinicians will provide both assessments and ongoing therapy, the Outpatient Therapy rate model reflects overall productivity levels. As a result, and consistent with current practices, payment rates for assessments and ongoing therapy are the same.

74. One commenter objected to the elimination of specific rates for clinicians who communicated in American Sign Language with individuals who are deaf or hard of hearing. The commenter also noted that there are additional administrative costs associated with providing services to this population such as more effort in scheduling appointments.

The draft rate models eliminated the standalone rate model for services provided to individuals who are deaf and hard of hearing based on the presumption that services would typically include an interpreter that could be separately billed. In response to this comment, a rate model was developed for services provided by a clinician who is conversant in American Sign Language (ASL). A provider would not be able to additionally bill for interpreter services when billing the deaf and hard of hearing rate.

The rate models for services provided to individuals who are deaf and hard of hearing include a higher wage assumption for the clinician who is conversant in ASL. Additionally, since both program support and administration are calculated as a percentage of total expenses, the rate models include more funding for infrastructure to cover the types of additional costs cited by the commenter. For example, the clinic-based rate for services provided to individuals who are deaf or hard of hearing by a master's-level clinician includes 29 percent more funding for administration and program support than the standard clinic-based rate.

75. Several commenters objected to the draft rates for services provided by licensed alcohol and drug counselors and the modest difference in rates for services provided by certified alcohol and drug counselors.

In response to these comments, the wage assumption in the rate models for Outpatient Therapy services provided by licensed alcohol and drug counselors (LADCs) were revised to reflect the average of master's and bachelor'-level staff, recognizing that statute provides for both bachelor's-level and master's-level staff. With this change, the rates for Outpatient Therapy services provided by LADCs are 17 percent higher than the current rates for clinic-based services and 35 percent higher for community-based services.

76. One commenter stated that group Outpatient Therapy services require more time for preparation and documentation. The commenter also compared the total payment received when providing group services compared to one-to-one services.

The rate models for group Outpatient Therapy services attempt to address the issues cited by the commenter with larger productivity adjustments for coordination and collateral activities, participation in assessments, and recordkeeping and reporting.

The comparison of total reimbursement for group services versus individual services depends on the number of people served in the group. Since the rate model for master's-level social workers is based on a four-person group, a provider will earn substantially more when billing for four members compared to the one-to-one rate due to the higher productivity factors and absence factor in the group rate model. If they serve three individuals in a group, total payment would be roughly the same as for one-to-one services while a provider would earn less for a two-person group than for one-to-one services. DHHS considered developing separate rates for different group sizes, but decided to maintain the current approach with a single group rate to avoid adding new complication to service authorization and billing.

77. One commenter questioned the higher group rates for services provided by licensed alcohol and drug counselors (LADCs) were higher than rates for master's-level social workers.

MaineCare's payment rates for group services provided by licensed alcohol and drug counselors (LADCs) have historically been higher than the group rates for master's-level social workers and psychologists. The group rates for most social workers and psychologists have implied four members in a group while the rates for LADCs and certified alcohol and drug counselors (CADCs) have implied about two members in a group. Consistent with these historic assumptions, the rate models for LADCs and CADCs assume three members per group while the other models assume four members per group. The result is that the per-person group LADC rate is greater than the per-person group rates for other practitioners.

78. Several commenters stated that clinicians' assumed productivity was too high. Commenters suggested that the productivity adjustments should be increased for missed appointments, collateral contacts, and recordkeeping. One stated that the productivity adjustment for missed appointments should be higher for substance use Outpatient Therapy services

The rate model for clinic-based Outpatient Therapy services assumes staff provide 27.25 hours of billable support during a typical week without training or paid time off and 23.45 hours per week (1,219 hours per year) overall after accounting for training and paid time off. DHHS believes that this is a reasonable expectation. As with all rate model assumptions, the individual productivity adjustments are meant to reflect a reasonable average and it is expected that some providers may experience more time on some activities and less on others.

79. Two commenters suggested that care coordination and collateral contacts should be allowable billable activities.

The rate study does not include any recommendations related to allowable billable activities for Outpatient Therapy services. Recognizing the important role of coordination and collateral contacts, the Outpatient Therapy rate models include a productivity adjustment for these activities, which provides indirect payment for time spent on these tasks.

80. One commenter suggested that costs associated with interns and practicum students, including staff time to supervise the students and interns, be added to the rates.

Although DHHS appreciates the importance of developing the future workforce, it does not believe that these are appropriate costs to include in Medicaid-funded service rates.

Medication Management

81. Several commenters offered feedback on the draft rate models for Medication Management:

- ***Several commenters objected to the draft rates. One of these commenters suggested that current rates should be increased by more than 50 percent.***
- ***Several commenters objected to the establishment of different rates for physicians and for physician assistants and nurse practitioners. Some commenters stated that they did not disagree with separate rates, but believed that the differential was too large.***
- ***One commenter stated there should be separate rates for Medication Management services provided to adults and children. The commenter stated that services for children involve more nonbillable collateral contacts and documentation time. The commenter also cited two sources suggesting child psychiatrists earn more than adult psychiatrists, with one source reporting wages of $313,500 for child psychiatrists and $310,600 for adult psychiatrists and the other reporting $329,600 and $310,000, respectively.***
- ***One commenter suggested that payment rates should vary based on the member's acuity.***
- ***Several commenters stated that clinicians' assumed productivity was too high. Most comments related to assumptions related to missed appointments. Commenters also stated that the assumptions related to training and supervision time were too low.***
- ***One commenter stated that the amount of office space assumed in the rate model is too low, noting that it does not account for waiting areas.***
- ***Several commenters stated that the administration and program support allowances are too low, noting that these programs require a variety of support staff.***
- ***One commenter stated that administrative overhead costs could be decreased by addressing administrative issues such as overlapping oversight by different DHHS offices, multiple audits, and management of written consent for psychotropic medications.***

DHHS will not implement the rate models for Medication Management services at this time. Due to federal maintenance of effort requirements in Section 9817 of the American Rescue Plan Act (ARPA) as they apply in Maine, the rates cannot be decreased until after March 31, 2025. The Department is committed to a full public process for rate determination as required by statute, including robust stakeholder engagement, to determine what rates will be effective after the conclusion of the maintenance of effort period. If changes to current payment rates are considered at that time, the issues raised by commenters will be evaluated as part of that process.

As with all rate models, the draft rate models for Medication Management presented for public comment in September 2022 were based on Burns and Associates' analysis of provider survey data and other benchmark data. Burns recommended differentiating rates for physicians and advanced practitioners (including nurse practitioners) based on wage data from the Bureau of Labor Statistics that demonstrates that physicians earn substantially more than others. The draft rate models therefore recommended a rate for physicians that would be substantially higher than the current rates and a rate for advanced practitioners that would have been lower than the current blended rate for both physician and advanced practitioners. Due to the maintenance of effort requirements that prevent a reduction to the rate for advanced practitioners at this time, DHHS will maintain the current blended rate for both physicians and advanced practitioners.

Opioid Treatment Program (OTP) with Methadone

82. One commenter objected to benchmarking the Medication-Assisted Treatment rate to 72.4 percent of the Medicare rate rather than developing an independent rate model or using the full Medicare rate.

It is DHHS' policy to benchmark MaineCare rates to Medicare when there is an appropriate benchmark. The Department considered establishing an independent rate model for Opioid Treatment Program (OTP) with Methadone Services, but data collected through the provider survey was inconclusive with the two respondents reporting significant differences in costs. Instead, it was determined that Medicare had a comparable service that could be used as a benchmark. Consistent with the ratio employed for other services benchmarked to Medicare rates, the OTP rate was set at 72.4 percent of the Medicare rate. The resulting rate of $171.30 represents an increase of 48 percent compared to the previous rate.

Adaptive Assessments

83. One commenter suggested that the cost for assessment instruments is not accounted for in the Adaptive Assessments rate model, noting that they pay $3.80 per copy of the Vineland Adaptive Behavior Scales.

The Adaptive Assessment rate model does include a specific factor for the cost of assessment instruments. As part of the rate development process, HMA-Burns researched the cost of the assessments listed in the MaineCare Benefits Manual for Adaptive Assessments, as well as assessments used for Neuropsychological Testing, considering initial, assessment, and scoring costs. Based on this research, the rate model includes $15.00 per assessment and assumes that the assessment process takes four billable hours so that the cost of the assessment is $3.75 per billable hour.

Children's Home and Community-Based Treatment (HCT)

84. One commenter expressed support for moving to a weekly reimbursement rate. Another commenter stated that although they support a weekly rate, they would prefer a monthly payment rate. Two commenters stated their preference for maintaining a 15-minute billing rate.

DHHS intends to transition Children's Home and Community-Based Treatment (HCT) services from 15-minute billing to a weekly payment rate. This change is intended to support service providers by increasing the predictability of revenues and reducing administrative responsibilities. This change is also possible because of reasonably similar service levels across children. That is, if there was a larger

degree of variability in services, a weekly rate would be inadvisable because it would result in significant overpayment for some cases and underpayment for others.

The Department appreciates the suggestion to implement a monthly rate, but HCT is designed to be a very intensive service requiring regular engagement. That is, services missed one week cannot be 'made up' in a subsequent week. Recognizing that there will be some weeks during which a provider will be unable to deliver services due to factors outside of their control, the rate model includes a five percent absence factor.

85. Several commenters asked a number of questions related to the weekly billing rate, including:

- ***Is the rate a per-child amount?***
- ***What is the definition of a week (e.g., Sunday through Saturday)?***
- ***Will there be a minimum level of support that must be delivered in order to bill the weekly rate? And, will there be a penalty if a child does not receive all of the hours of support approved by KEPRO?***

The rate reflects a per-child, per week payment.

HCT services are designed to meet the member's individualized treatment needs delivered through a combination of medically necessary clinical interventions and may include individual therapy session(s) for the identified child, family therapy sessions, treatment team/stakeholder meetings, and/or collateral contacts. The HCT treatment team provides services that include at least one face-to-face or telehealth contact with a clinician and a monthly average of three face-to-face or telehealth contacts per week.

The claims system can accommodate overlapping weeks between months. The system does not restrict a week to be Sunday through Saturday.

The Department has suggested that providers should aim for a monthly average of three face-to-face or telehealth contacts per week, of which at least one contact per week is a clinical intervention with the clinician. Qualifying contacts are interventions provided by a treatment team member (clinician or BHP), which directly address the youth's identified treatment goals and which may include collateral contacts as defined in Section 65.05-10.

It is the Department's intention to update Section 65 this year and additional specific guidelines may take effect at that time. Until the rule is updated and in effect, providers that have delivered services consistent with Section 65 may bill the weekly rate for services even if they have not met the monthly average suggestions. Providers may not bill the weekly rate for any week in which they do not deliver HCT services.

86. Two commenters asked whether there would be quality measures tied to payment. One of these commenters asked whether payment would be reduced if the measures were not achieved and if payment would be increased if the measures were exceeded.

DHHS is in the process of evaluating potential performance measurements for Children's Home and Community-Based Treatment Services. Any resulting measurements and implications for payment amounts will be promulgated through the standard rulemaking process, including an opportunity for stakeholders to comment.

87. Several commenters stated that the assumed caseloads for behavioral health professionals and master's-level staff are too high. Some of these commenters suggested that the rate model should assume three cases per BHP.

The rate model for Children's Home and Community-Based Treatment Services assumes five cases per behavioral health professional and six cases per master's-level staff. Both figures are consistent with provider survey results.

The nine providers that submitted BHP caseload information in the provider survey reported a median value of five cases per BHP. The weighted average was four cases. However, this figure is understated because two providers that reported lower values – three cases – reported that their BHPs work fewer than 20 hours per week. For master's-level staff, both the reported weighted average and median caseloads were approximately six cases.

88. Several commenters stated that the productivity assumption for recordkeeping, missed appointments, and supervision were too low.

The draft rate models for Children's Home and Community-Based Treatment included both 15-minute and weekly billing options. The comments related to productivity apply to the draft 15-minute rate; however, as discussed in the response to comment 84, DHHS has adopted a weekly case rate. There are no productivity assumptions in a weekly rate. Instead, the full wage and benefit cost for direct service staff (accounting for both their direct and indirect responsibilities) are spread over their billable caseload.

89. One commenter expressed concern with the current policy that limits collateral contacts to five hours per year which can result in providers not being able to bill all the necessary service time.

As noted in the response to comment 84, DHHS is transitioning Children's Home and Community-Based Treatment Services (HCT) to a weekly case rate. With this change, there will no longer be billing based on hours of support and the limit on collateral contacts will not be applicable. The caseload assumptions in the HCT rate model are intended to reflect both the direct and indirect supports provided by staff.

90. Two commenters suggested that the behavioral health professional wage assumption should be increased to $29.66 per hour to match the assumption for targeted case managers.

The wage assumptions for each service seeks to reflect the requirements and responsibilities for the staff providing the service. The wage assumption for behavioral health professionals (BHPs) in the Children's Home and Community-Based Treatment Services rate model differs from the wage assumption for targeted case managers because these are different staff performing different functions; for example, case managers must have a bachelor's degree while BHPs do not. As shown in Figure 1, the HCT rate model assumes an average hourly wage of $24.41 for BHPs compared to the $19.89 average reported by participants in the provider survey.

91. Two commenters stated that the 50 miles per member per week included in the rate model is too low. One of these commenters stated that staff travel between 120 and 150 miles per week.

As indicated in the rate model, the assumption is a per member amount rather than a per staff amount. In response to these comments, however, the mileage assumption has been increased to 60 miles per member per week, translating to about 150 to 180 miles per week per staff.

92. Several commenters stated the 15 percent allocated for program support is too low. One of these commenters noted that Children's Home and Community-Based Treatment Services requires greater clinical supervision and that their program support expenses are 21 percent of total costs.

As discussed in the response to comment 13, the rate models across the targeted case management and behavioral health services covered by this rate study assume 15 percent of total expenses for

program support and another 15 percent of total expenses for administration. As additionally described in that response, there was not enough information to support administrative and program support rates that vary across services.

For Children's Home and Community-Based Treatment Services (HCT) specifically, the master's-level staff person who provides supervision to behavioral health professionals (and who provides direct services) is separately funded in the rate model. Additionally, the HCT rate model represents a 30 percent increase over current payment rates so the program support assumption translates to almost 20 percent of current rates.

Psychosocial Clubhouse

93. One commenter stated that the assumed wage should be increased from $26.74 per hour to $29.66 as staff must have both an MHRT/C and an employment specialist credential.

As noted in the response to comment 32, the rate models for services delivered by an MHRT/C use the Bureau of Labor Statistics occupational classification for substance abuse, behavior disorder, and mental health counselors, which is a bachelor's-level position although MHRT/C's are not required to have a degree. DHHS continues to believe this is a reasonable benchmark for MHRT/C's.

94. One commenter suggested that the 50 hour training assumption be increased to 100 hours to accommodate MHRT-C training, employment specialist training and other training required by Clubhouse International and the Commission on Accreditation of Rehabilitation Facilities (CARF).

The rate model includes 50 hours of annual training for staff providing Psychosocial Clubhouse services. This represents a weighted average of training that staff receive in their first year of employment and training required in subsequent years. Thus, although the total amount of training cited by the commenter may exceed 50 hours, they are not annual requirements.

95. One commenter stated that 2.25 hours per week of travel time should be added to the productivity assumption for MHRT/C's for member support and coaching.

The rate has been revised to include 2.25 hours per week of travel time prior to adjustments for annual paid time off and training, as well as 75 miles per week.

Trauma-Focused Cognitive Behavioral Therapy and Triple P

96. One commenter stated that collateral contacts are unfunded mandates should be a billable activity for evidence-based services such as Triple P and Trauma-Focused Cognitive Behavioral Therapy.

Collateral contacts are not unfunded mandates for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Triple P services.

The TF-CBT rate model includes a productivity adjustment for collateral contacts. As with all productivity adjustments, the allowance for collateral contacts provides indirect payment for these activities (that is, the nonbillable cost of collateral contacts are spread over the clinician's billable hours).

The rate models for Triple-P services are based on a per-session rate. The models generally include four hours per session, which account for both direct care and related activities such as set-up, clean-up, recordkeeping, and collateral contacts.

Multisystemic Therapy (MST)

97. Several commenters expressed concerns that grant funding from the Department of Corrections is being phased out which will result in reduced revenue used to support providers' Multisystemic Therapy programs.

The Multisystemic Therapy rate model is intended to reflect the total reasonable costs that providers incur to deliver services consistent with the treatment models. The model does not include any assumption related to supplementary funding from the Department of Corrections (DOC). That is, the rate has not included any offset related to DOC payments. Thus, there is no specific adjustment to be made related to the elimination of DOC funding.

98. One commenter stated the rate models do not account for weeks that cannot be billed because of client no shows and staff absences.

As noted by the commenter, the draft rate model did not include an allowance for weeks that the provider cannot bill because a family is unavailable to receive services. In response to this comment, an absence factor has been added to the rate model. An analysis of claims data suggested that approximately six percent of in-service weeks may not be billed, but the absence factor was set at five percent given other flexibility within the rate (for example, Multisystemic Therapy guidelines allow for up to six cases per clinician, but the rate model only assumes a five family caseload).

The rate models do not include a specific provision for paid time off as it is assumed that another team member (such as the team supervisor) will provide coverage when a clinician is on leave.

99. One commenter objected to the exclusion of certain costs when applying the administrative and program support rates.

As observed by the commenter, the Multisystemic Therapy (MST) rate model applies the administrative and program support rates to a subset of program expenses, excluding costs such as training-related travels and fees and payments to MST Services. The previous rate model applied the administrative and program support rates to all other expenses, but at a lower rate: a total of 23 percent compared to 30 percent in the current rate model. This change was made to provide for more consistency across rate models within Section 65, by applying the same overhead rates to the same categories of expenses. The result is a significant increase in overhead funding in the MST rate model. The current rate model includes a total of $181.46 per week per case for program support and administration, 38 percent more than the $131.73 included in the 2020 rate model.

Functional Family Therapy (FFT)

100. One commenter stated that supervisors should be expected to have a caseload of one family rather than the five included in the rate model.

Based on discussions with FFT LLC, the Functional Family Therapy rate model assumes that supervisors carry one-half of the caseload of a full-time clinician.

101. One commenter stated the assumed annual fees paid to FFT LLC should be based on the Phase 2 cost rather than the Phase 3 cost in order to account for turnover.

In response to this comment, the Functional Family Therapy rate model has been updated to reflect a weighted average of all three phases and the assumption that the team cycles through the three phases every four years (one year each for Phase 1 and Phase 2 and two years in Phase 3).

Substance Use Disorder Partial Hospitalization Program

102. One commenter stated that the 90 percent attendance rate assumed in the rate model and that the national average is 65 percent.

As noted by the commenter, the rate model for Substance Use Disorder Partial Hospitalization Program services includes a 90 percent attendance factor that increases the payment rate to cover providers' costs when absences prevent billing. More specifically, this factor is meant to cover the degree of absences that cannot reasonably be accounted for in the program design. That is, if a program has an attendance rate as low as 65 percent, enrollment and staffing should be designed with the expectation that there will be significant absences. However, since a program will not know with certainty when every absence will occur, the rate model includes the absence factor to ensure necessary flexibility in the program.

SECTION 92 SERVICES – BEHAVIORAL HEALTH HOMES

103. One commenter suggested the rates for adults and children be equal, stating that adult care coordinators often have more education and experience, and support individuals with complex needs.

The payment rate for children's Behavioral Health Home services exceeds the rate for adult services for two reasons. First, the rate model for children's services includes a higher wage assumption for the coordinator position because they must have a bachelor's degree whereas the requirement for coordinators for adult services is a mental health rehabilitation technician/community (MHRT/C) certification. Second, the children's model includes both a family support specialist and a youth support specialist whereas the adult model includes a single position (certified intentional peer support specialist). These differences justify the differentiated rate.

104. One commenter stated that the adult and child Behavioral Health Home rate models should include the same wage assumptions for the coordinator position.

As noted in the response to comment 103, the children's Behavioral Health Home rate model includes a higher wage assumption for the coordinator position because they must have a bachelor's degree while coordinator for adult services require only a mental health rehabilitation technician/community (MHRT/C) certification, which does not require a degree. Due to the differing requirements, the rate models continue to include different wage assumptions.

105. One commenter requested that health home coordinators for adults be permitted to have a bachelor's degree and relevant experience without meeting mental health rehabilitation technician/community (MHRT/C) requirements as is true for health home coordinators for children.

DHHS does not support a change to the requirements for health home coordinators for adults at this time.

106. Several commenters stated that they could not provide meaningful input regarding the rate model for High Fidelity Wraparound services without more information regarding service requirements.

DHHS is in the process of developing rules for the High-Fidelity Wraparound model. This rulemaking will include an opportunity for public comment, giving stakeholders an opportunity to comment on the adequacy of the rate model to comply with the proposed requirements.

107. One commenter asked why the Behavioral Health Home rate models do not account for travel time, missed appointments, recordkeeping and reporting, employer and one-on-one supervision time, and training.

The Behavioral Health Home rate models do account for the tasks listed by the commenter. However, because these services are reimbursed based on a monthly rate rather than 15-minute units, the approach differs from services billed on a fee-for-service basis.

For services reimbursed on a fee-for-service basis (such as Targeted Case Management), the rate models must account for non-billable time (through productivity adjustments) to ensure that the provider is paid enough to cover the full cost of the wages and benefits of the direct care staff. For services reimbursement on a monthly basis such as Behavioral Health Home, the rate models divide the full cost of the wages and benefits for each team member across the assumed caseload for that team member. The caseload assumptions consider all of the responsibilities of each team member, including provide direct care as well as the other responsibilities noted by the commenter. That is, the caseload assumptions are intended to reflect what is reasonable after accounting for the care needs of individuals served, the time that staff spend on travel, documentation, etc.

108. Two commenters objected to the increase in the assumed number of cases per peer support specialist and nursing care manager.

The rate study recommended several changes to the staffing assumptions based on staffing levels reported by providers:

- The number of cases per health home coordinators increased from 24 to 25 (the provider survey found 31 adults and 30 children per coordinator)
- The number of cases per nurse care managers increased from 200 to 300 (the provider survey found 425 adults and 604 children per nurse case manager)
- The number of cases per peer specialist increased from 125 to 200 (the provider survey found 263 adults per peer specialist)
- The number of cases per family support specialist and youth support specialist decreased from 125 to 100 as the previous rate model combined these positions while the updated model assumes teams include both positions (the provider survey found an overall 233 cases per family and youth support specialist)
- Psychiatric consultant support increased from 42 hours per 200 cases to 100 hours per 200 cases (the provider survey found 101 hours per 200 adults and 114 hours per 200 children)
- Medical consultant support increased from 42 hours per 200 cases to 100 hours per 200 cases (the provider survey found 248 hours per 200 adults and 119 hours per 200 children although these numbers are skewed by outlier responses)

These assumptions seek to balance the challenges providers have faced in recruitment and retention with the need to align reimbursement with the level of support actually being provided. That is, the rate study did not recommend increasing caseloads as high as was reported through the provider survey as DHHS hopes that providers will work to increase staffing.

Note that, for most positions, the figures do not represent assumed caseloads as not all individuals receive support from each team member. For example, the rate models do not assume that one peer specialist works with 200 individuals. Rather, the rate model suggests that one peer specialist is need for every 200 individuals enrolled in the program recognizing that some individuals will not receive support from this specific team member.

109. One commenter suggested that the rate models include office space for team members.

In response to this comment, specific assumptions related to office space for the health home coordinator, clinical team leader, nurse care manager, peer support specialist, family youth specialist, and youth support specialists have been added to the Behavioral Health Home rate models. Assumptions related to square footage and costs match the amounts included in other rate models.

110. One commenter suggested that the rate models include mileage for team members.

In response to this comment, specific assumptions related to mileage have been added to the Behavioral Health Home rate models. Behavioral Health Home providers participating in the provider survey reported only modest mileage. Consistent with these results, the models include ten miles per month per case.

111. Two commenters stated the assumed program support and administrative funding levels are inadequate.

As discussed in the response to comment 13, the rate models across the targeted case management and behavioral health services covered by this rate study assume 15 percent of total expenses for program support and another 15 percent of total expenses for administration. As additionally described in that response, there was not enough information to support administrative and program support rates that vary across services.

For Behavioral Health Home services specifically, per-person funding for overhead costs has been substantially increased from the original rate models – from $117 per individual per month to $167 per individual per month in the adult model – and generally exceeds other services. Additionally, the Behavioral Health Home rate models include specific funding for various clinical positions (for example, the clinical team leader, nurse care manager, and psychiatric consultant) that are incorporated in the program support allowance for other services. Finally, as discussed in the responses to comments 109 and 110, office space and mileage costs that were previously part of the program support allowance have now been separately funded in the rate models.

112. One commenter requested that adults with intellectual and developmental disabilities be eligible for Behavioral Health Home services.

DHHS is not considering this eligibility change at this time.

113. Several commenters expressed concerns that they did not have sufficient information to comment on potential changes to pay-for-performance standards and policies.

As noted in response to comment 17, any changes to payment structures would go through the formal rulemaking process, which includes a public comment process during which stakeholders could offer feedback regarding the proposals. New performance metrics and performance-based payment provisions will not begin until a final rule has been formally adopted.